



Streamline Access to and Use of Family Planning Services Provided through Medicaid

In 2008, the Guttmacher Institute estimated that a “poor woman in the United States, compared to her higher-income counterpart, is nearly four times as likely to have an unintended pregnancy, five times as likely to have an unintended birth, and more than three times as likely to have an abortion.”¹ Those statistics hold despite the availability of family planning services through Medicaid, which is available to individuals who meet certain income or other eligibility criteria. Consequently, it is critical to identify systemic challenges that inhibit women who are currently on or eligible for Medicaid from maximizing the preventive family planning services that are available to them. Based on focus groups and interviews with current or recent Medicaid recipients that revealed inefficiencies in the enrollment process, limited numbers of health care providers that accept Medicaid, and lack of or incorrect information about services covered by the program, Prevention First Colorado recommends streamlining access to and use of family planning services provided through Medicaid to reduce unintended pregnancies among low-income women.

THE NEED TO STREAMLINE ACCESS TO AND USE OF FAMILY PLANNING SERVICES PROVIDED THROUGH MEDICAID

In 2006-2007, 158,719, or 10 percent, of Colorado women aged 19 to 64 were insured by Medicaid or other public programs,² with Medicaid being the largest publicly funded insurance program for that demographic. There are strict limits on who is eligible for full Medicaid benefits; typically it covers very low-income families with children, pregnant women, and people with disabilities. Between Medicaid-eligibility limits and challenges obtaining affordable health insurance that covers the full spectrum of reproductive health care needs, low-income women who do not already have children often find themselves uninsured. As a result, both unmarried and married low-income women without children lack access to affordable family planning care.

According to original research carried out by Prevention First Colorado, more than three quarters of all female Medicaid beneficiaries have had unplanned pregnancies, yet of the Medicaid population, only 19 percent of surveyed women use available family planning services.³ Women who currently were on Medicaid also were more likely to have reported having had sex without birth control when they did not want to become pregnant at some point in their lifetimes than women who currently have private insurance.⁴

The Prevention First Colorado research also revealed that women who currently are on Medicaid exhibited certain psychological barriers to the acquisition and use of contraceptives. These barriers included concerns about their partners’ perceptions of requests for contraceptive use and a perceived lack of control over pregnancy timing.⁵ In

addition, anecdotal evidence indicated that two barriers to using the Medicaid program for family planning services were challenges finding a health care provider who accepts Medicaid and perceptions that patients were unable to form long-term, trusting relationships with their providers.

Women who were Medicaid-eligible or currently or recently enrolled in Medicaid who were interviewed by Prevention First Colorado staff revealed that some of the psychological barriers they face in using available family planning services may be connected to difficulties women experience when navigating the Medicaid system. For example, some women expressed challenges finding appropriate health care providers and receiving accurate information about the extent of coverage for family planning services.⁶ To find providers who accept Medicaid coverage, patients can use an online provider-lookup tool or call Medicaid customer service. However, Prevention First Colorado interview participants reported that providers discovered through those means often had reached their quotas for patients covered by Medicaid or were not accepting any new patients, regardless of insurance type. There also were frequent reports from study participants of incorrect information in the materials they received about Medicaid providers.

Other women reported not receiving sufficient information from doctors. They also directly linked using Medicaid insurance with bad or inappropriate treatment and perceptions that health care providers negatively judged them because of their use of Medicaid. While using Medicaid may not, in fact, cause these experiences, women’s own feelings of shame at being on public health insurance may directly influence their perceptions of the providers’ attitudes and

behavior.

Anecdotal reports indicate there may be confusion among providers as to what services require a co-payment through Medicaid. Some women who participated in the Prevention First Colorado interviews reported being asked to provide a co-payment for family planning services despite federal prohibitions of such fees.⁷ Some interviewees indicated those co-payments were a financial burden to them and, in some cases, prevented them from seeking and using contraceptives and contraceptive services.

Other women interviewed by the Prevention First Colorado staff indicated that they had planned to obtain a tubal ligation, a form of permanent sterilization, following a pregnancy that was covered by Medicaid. However, those women reported being unable to do so because their reapplications for Medicaid coverage were not processed by the time the mandatory 30-day waiting period prior to the surgery had passed, making the surgery unaffordable.⁸ In other cases, women reported that doctors insisted they were too young for the procedure – despite already having multiple children. In several cases, women who had planned to have tubal ligations subsequently had at least one more child after being denied the procedure.

Data presented in Table 1 on page 25 provides information about gaps between the need for affordable family planning care, eligibility and availability of family planning services through Medicaid, and an assessment of Medicaid usage for related services – prenatal care – for select counties. Based on demonstrated gaps between populations without

health insurance and the number of Medicaid providers that provide family planning services, it can be assumed that some Medicaid-eligible users are unable to successfully navigate the Medicaid system to find a provider who is accepting Medicaid patients.

It should be noted that the state Department of Health Care Policy and Financing (HCPF), the agency responsible for administering Colorado’s Medicaid program, has taken steps to simplify use of the Medicaid system for enrollees. Moreover, changes in statute either have been enacted or are being considered that could increase use of available family planning services by eligible populations. Details of specific steps being taken are discussed in greater detail in the “Currently in Colorado” section of this recommendation.

OTHER STATES AND NATIONWIDE

Preventive family planning services have long been prioritized in federally funded health care programs. In fact, Congress amended the federal Medicaid Program in 1972 to provide incentives for states to expand access to those services by, among other things, instituting a 90 percent federal-funding match.⁹ Unlike other Medicaid health services where states expend upwards of 50 cents for every dollar spent on health care, states pay only 10 cents for every dollar spent on preventive family planning services while the federal government covers the remaining 90 cents. Federal law prohibits cost-sharing or co-payments on preventive family planning services administered through Medicaid. As a result, eligible Medicaid beneficiaries can access those services without incurring out-of-pocket costs.¹⁰

Table 1: Gaps in Family Planning Care At-a-Glance: Need for Affordable Family Planning, Eligibility and Availability of Family Planning through Medicaid, and Use of Medicaid for Prenatal Care (for Select Counties)

County	Total Population without Health Insurance ¹¹	Number of Women ¹² Aged 18 to 44 Eligible for Medicaid Services [†]	Number of Medicaid Providers ¹³ who Deliver Family Planning Services [‡]	Percent of Pregnant Women who Used Medicaid to Obtain Prenatal Care ¹⁴
Adams	60,276	12,887	120	33.1%
Arapahoe	62,694	12,409	266	30.8%
Boulder	39,248	3,805	220	19.2%
Denver	101,192	17,577	483	38.3%
El Paso	71,691	14,522	219	31.7%
Jefferson	61,303	8,121	187	22.1%
Larimer	33,688	5,529	172	31.7%
Pueblo	26,093	7,419	96	57.6%
Weld	32,985	5,928	103	29.3%

† According to Medicaid-eligibility parameters at the time of this writing, this table does not reflect an expansion of eligible populations that are pending federal acceptance of Colorado’s application for a family planning waiver nor implementation of hospital provider fees authorized through the Colorado Health Care Affordability Act of 2009.

‡ Because these numbers do not reflect how many Medicaid providers are not accepting new Medicaid patients, the figures are believed to be inflated.

Federal law allows some states to offer Medicaid coverage for preventive family planning care, including contraceptive drugs, devices and related outpatient services, to individuals who would otherwise be ineligible for full Medicaid coverage by applying to the U.S. Centers for Medicare and Medicaid Services for a Medicaid waiver.¹⁵ To date, waivers have been pursued by 27 states.¹⁶ States' expansion plans vary from extending the length of time individuals are eligible for coverage to increasing income-eligibility levels to changing age-eligibility requirements. All plans attempt to demonstrate "budget neutrality" to the states based on the premise that with the 90 percent federal-funding match, states can expand preventive family planning coverage and avert more costly expenditures that would otherwise be made on prenatal, delivery, and infant care. (See Table 2 on page 26, "Impact of State Medicaid Family Planning Eligibility Expansions [Select States that Expanded Program Based on Income Eligibility].")

In addition to expanding access to family planning services covered through Medicaid, some states have taken concerted steps to streamline program enrollment processes and otherwise reduce systemic barriers to use. In California, for example, individuals previously had to apply for Medicaid coverage in person through local welfare offices. Combined with perceived social stigmas, this process and the frequent need for multiple visits to complete the application and enrollment process were identified as deterrents to use by those most in need of services. Under California's revised process, individuals can register for Medicaid at any family planning appointment, where providers can determine patient eligibility and produce a card on-site that enables the patient to access services.¹⁷

CURRENTLY IN COLORADO

Colorado's Medicaid benefits include coverage for comprehensive family planning services, including office visits and counseling, all contraceptive methods and contraceptive prescriptions at no charge, and surgical sterilization for individuals aged 21 and older.¹⁸ At the time this report was written, pregnant women and women 60 days post-partum with incomes below 133 percent of the federal poverty level

(FPL), as well as very low-income parents who earn no more than 60 percent of FPL, are eligible to apply for Medicaid in Colorado.¹⁹ (See Table 3 on page 27, "U.S. Department of Health and Human Services 2009 Poverty Guidelines and Dollar Calculations for Medicaid Eligibility in Colorado.") Pregnant women who have applied for Medicaid coverage but have not yet been accepted can receive a presumptive-eligibility card that allows them to obtain prenatal services early in their pregnancies while they wait for final Medicaid approval.

In addition, the state Legislature passed a law in 2008 that removed the previous statutorily defined income-eligibility limit for expanded access to preventive family planning services through Medicaid and vested HCPF with the authority to tie income-eligibility limits to federal poverty levels by using calculations that demonstrate budget neutrality.²⁰ To take advantage of this change in statute, HCPF has submitted a waiver application to the U.S. Centers for Medicare and Medicaid Services that, if approved, would extend eligibility for family planning services through Medicaid to women with incomes of up to 200 percent of FPL, including women without children.²¹ This program expansion is contingent upon both federal approval and the availability of state and federal funds that can be allocated to preventive family planning services. As a result, a wider pool of Coloradans, including childless adults, is expected to be eligible to receive preventive family planning services through Medicaid.

Coloradans seeking preventive family planning services also may benefit from the Colorado Health Care Affordability Act of 2009, which authorizes HCPF to assess a hospital provider fee. The revenue generated by this fee will be used in part to expand Medicaid coverage to childless adults up to 100 percent of the federal poverty level.²²

Currently, pregnant women and children can apply for Medicaid at any of the county departments of human or social services located in Colorado's 64 counties or at any of 111 application assistance/presumptive eligibility sites. Other eligible individuals, including men or non-pregnant women, must apply for Medicaid at their county department of

Table 2: Impact of State Medicaid Family Planning Eligibility Expansions (Select States that Expanded Program Based on Income Eligibility)²³

Net Savings from Expansion of Medicaid-Administered Family Planning Programs					
State	Year	Births Averted	Total (Estimated)	State Share	Federal Share
Alabama	2000-2001	3,612	\$19 million	\$7 million	\$12 million
Arkansas	1998-1999	4,486	\$30 million	\$9.4 million	\$20.3 million
California	1999-2000	21,335	\$76 million	\$64 million	\$12 million
New Mexico	2000-2001	1,528	\$6.5 million	\$2.7 million	\$3.9 million
Oregon	2000	5,414	\$20 million	\$11 million	\$8.7 million
South Carolina	1996-1997	3,769	\$23 million	\$7 million	\$15.7 million

Table 3: U.S. Department of Health and Human Services 2009 Poverty Guidelines and Dollar Calculations for Medicaid Eligibility in Colorado²⁴

Family Size	2009 Federal Poverty Level (100 percent)	Amount for Eligibility (133 percent)
1- Person Household	\$10,830.00	\$14,403.90
2- Person Household	\$14,570.00	\$19,378.10
3- Person Household	\$18,310.00	\$24,352.30
4- Person Household	\$22,050.00	\$29,326.50

human or social services. Although applications also can be downloaded from the HCPF Web site or are available upon request by phone, those applications currently cannot be completed in real-time either online or over the phone. Applications must be taken or sent to the correct office of the county department of human or social services.²⁵

A bill introduced during the 2009 legislative session would authorize HCPF to use online- and phone-based technologies to streamline re-enrollments for Medicaid. This streamlined process could minimize occurrences of post-partum women losing Medicaid coverage while completing the mandatory 30-day waiting period prior to a tubal ligation or foregoing other contraceptive care. The bill was still pending as of this writing.²⁶

From the date that the county department of human or social services receives a complete application, the county has 45 days to process the application. Once an application is approved, Medicaid coverage is effective as of the date the application was signed by the applicant.²⁷ There are, however, several pieces of information that must be provided with an application before eligibility can be determined, such as pay stubs and citizenship/identification verification documents.²⁸ For some clients, collecting and providing this information imposes a significant delay in enrollment and therefore increases the likelihood that an eligible individual will forego birth control counseling and use of contraceptives while waiting for acceptance into the program.

In January 2009, HCPF launched the Benefits Collaborative Initiative to provide a “process for ensuring that benefit coverage decisions are based on the best available clinical evidence and that all benefit coverage policies promote the improved health and functioning of Medicaid clients.”²⁹ The initiative aims to increase awareness among both Medicaid patients and health care professionals who provide services to beneficiaries. The process brings together clients and advocates, Medicaid providers and contractors, the Medicaid Medical Advisory Committee, policymakers, and other state agencies and partners to establish parameters for services eligible for coverage under Medicaid. Reproductive health care services, including preventive family planning services,

are included in the areas of coverage being addressed during this process. One recommendation specific to the Prevention First Colorado research findings is that pregnant women covered by Medicaid should receive contraceptive counseling, especially about tubal ligations, in the early stages of their prenatal care. This could reduce the number of Medicaid-eligible women who lose coverage while completing the mandatory 30-day waiting period prior to the procedure and subsequently experience unintended pregnancies.

Another opportunity to increase use of available family planning services is through Medicaid’s reimbursement process. Currently, Medicaid eligibility can be backdated 90 days from the date of signature on the application. If a patient paid her own medical bills during those 90 days, she can return to the health care provider who provided medical services, tell the provider that she was covered by Medicaid at the time services were provided, and receive reimbursement for expenses from the provider. The health care provider then bills Medicaid for the services.³⁰ However, research carried out through Prevention First Colorado found that women did not consider family planning an important enough medical issue to incur out-of-pocket expenses when they were uncertain of reimbursement. As a result, they tended to forego such services.

In addition to the measures already being taken to maximize patients’ use of the Medicaid system discussed above, HCPF has taken specific steps to decrease barriers to use of the entire program. These measures include:

- redesigning the agency’s Web site to be more client- and provider-friendly;
- developing and publishing one-page fact sheets describing covered benefits;
- partnering with community organizations to raise awareness about covered services; and
- participating in an advisory capacity in the development of a privately funded, community-based social marketing and educational campaign aimed at increasing use of contraceptives by low-income women who are eligible for Medicaid and Title X family planning services.³¹

BARRIERS TO IMPLEMENTATION

Statewide analyses of Colorado’s health care challenges reveal a systemic shortage in the number of Medicaid providers necessary to meet the health needs of low-income Coloradans. In fact, some counties in Colorado have no Medicaid providers.³² This raises questions as to whether the current system could support expansions of Medicaid-eligible populations in general and for provision of preventive family planning services.

Research shows that complex billing rules and regulations, as well as low and/or inconsistent reimbursement to providers, contribute to health care providers’ unwillingness to accept Medicaid. While the need to increase the number

of providers who accept Medicaid is not unique to family planning services, Prevention First Colorado research shows this challenge contributes to the lack of contraceptive use among Medicaid-eligible women. Medicaid reimbursement rates to providers were scheduled to increase under the fiscal year 2008-2009 budget approved by Colorado's General Assembly; however, the current economic downturn has left questions as to whether those increases will be sustained during fiscal year 2009-2010.

Funding for Colorado's public health insurance programs comes from several sources, including state General Fund money and federal funds from the U.S. Department of Health and Human Services. Because Colorado faces a deficit of almost \$1 billion in General Fund revenues for fiscal year 2009-2010 compared to fiscal year 2007-2008 levels, it is unclear the extent to which HCPF will be able to expand access to preventive family planning services and expend resources to clarify and publicize Medicaid coverage benefits and expedite Medicaid enrollment processes. It is also unclear how funds allocated to Colorado for health care in the \$787 billion American Recovery and Reinvestment Act, enacted in February 2009, will impact the provision of preventive family planning services through Medicaid.

FIRST STEPS

Based on barriers to use of family planning services by Medicaid-eligible women, multiple steps are recommended to achieve streamlined access to and use of family planning services provided through this public benefits program. Specifically, the following steps are recommended:

1. Audit Medicaid providers who provide family planning services to determine where and when co-payments are being charged. Based on these findings, evaluate whether provider education is necessary to ensure that all health care providers who accept Medicaid deliver consistent, accurate information about expected out-of-pocket costs for Medicaid beneficiaries.
2. Require that all Medicaid benefit packages include all contraceptive drugs, devices and medical services approved by the U.S. Food and Drug Administration and related outpatient treatments as core benefits.
3. Based on the gap between the estimated number of Medicaid-eligible women aged 18 to 44 and those actually enrolled in the program, develop strategies to identify and enroll additional women of child-bearing age that include county-level outreach and education efforts, changes in the Medicaid-enrollment processes, and increases in points-of-enrollment, whether on-site, online, or over the phone.
4. Standardize Medicaid practices to ensure uninterrupted access to all contraceptive drugs, devices and outpatient services for post-partum women, including: pre-birth counseling on the procedures available, processes for

consenting to and obtaining a tubal ligation; and providing alternatives for women who give birth in hospitals that will not allow tubal ligations to be performed.

5. Revise the reimbursement process to better educate Medicaid-eligible individuals about the process, which health care expenditures are eligible for reimbursement if expenses occurred in the 90-day backdating window, and how to recover money paid out-of-pocket for health care services during that backdating window. As part of efforts to revise the reimbursement process, expedite reimbursements for preventive family planning services to increase use of contraceptives by Medicaid-eligible women who are particularly at-risk for unintended pregnancy.

Because Medicaid is contingent upon public funds, shortfalls in state and federal revenue could delay implementation of the above recommendations. However, results of research carried out by Prevention First Colorado indicate that taking these specific steps could significantly reduce systemic barriers to preventing unintended pregnancy among two of the demographic groups most at-risk for unintended pregnancy – Medicaid-eligible women and women without insurance.

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