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Medicaid Family Planning Programs:

CASE STUDIES OF SIX STATES AFTER ACA IMPLEMENTATION

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Executive Summary

Overview

The Affordable Care Act brought sweeping changes to the Medicaid program that have had profound implications for family planning coverage, services, and providers. In particular, in the 17 states with family planning programs that have expanded Medicaid, many women have moved from limited benefit family planning programs into full-scope Medicaid or Marketplace insurance and now have comprehensive coverage, although it is less focused on family planning services. In light of the coverage trends and other ACA-related changes, this paper describes the impact on women and their partners, as well as family planning providers, of the shifting landscape for family planning. It is based largely on interviews with state officials, providers and consumer advocates in Alabama, California, Connecticut, Illinois, Missouri and Virginia – a cross-section of states in terms of geography, Medicaid expansion status, and implementation of a Medicaid family planning program. State interviews were supplemented by interviews with national experts, policymakers and family planning provider organizations. This study was conducted in Summer 2016 before the Presidential election.

Key findings

Nationwide, states that had Medicaid family planning programs prior to passage of the ACA have generally elected to maintain them, reflecting a belief that they still have an important role to play for low-income women. Maintaining a family planning program in a non-expansion state—where the program serves women who often otherwise do not qualify for Medicaid or may find Marketplace coverage unaffordable—is a relatively easy decision. In states with Medicaid expansion, however, the role of family planning programs is a more complex decision. In California, which has retained its family planning program, interviewees explained that the program serves a unique role in helping women secure high-quality, confidential family planning services. On the other hand, Illinois terminated its program one year after Medicaid expansion on the grounds that women would be able to secure family planning services through comprehensive Medicaid or a Marketplace plan. A number of interviewees supported the decision, but others expressed concern that it has resulted in diluted access to family planning services.

The ACA's reforms to eligibility and enrollment procedures have changed how many women learn about and enroll in Medicaid, creating new opportunities and challenges. For example, the requirement that Medicaid and Marketplaces use a "single, streamlined application" helps applicants avoid submitting duplicative applications with multiple entities and facilitates enrollment into comprehensive coverage. However, the "single, streamlined application" is also much longer and more complicated than many states' pre-ACA family planning applications, potentially discouraging people from applying for family planning coverage. Additionally, interviewees noted that HealthCare.gov is not yet able to assess eligibility for Medicaid family planning programs, creating a missed opportunity to connect women to family planning coverage. In particular, in non-expansion states such as Alabama that rely on HealthCare.gov to conduct final determinations of Medicaid eligibility, women who fall into the coverage gap are turned away by HealthCare.gov without any coverage even though they could be enrolled in a family planning program.

Despite strong federal protections, interviewees in some states raised concerns about affordability challenges in Marketplace plans for low income women in need of family planning services. Interviewees in several states expressed concerns about cost barriers for low-income enrollees in Marketplace plans. In particular, interviewees reported that low-income women cannot always afford

Marketplace plans even with premium tax credits and suggested that for these women in particular it is important to retain Medicaid family planning programs.

Stakeholders across the board reported that full-scope Medicaid and family planning programs generally cover the full range of family planning benefits that women are likely to require. Additionally, interviewees in all states indicated that very minor differences exist between the benefits offered in family planning programs and full-scope Medicaid, despite the fact that states have fairly wide discretion within federal guidelines to develop their family planning benefit packages. On the other hand, states vary in their coverage of "family planning-related" services, which include, for example, treatment of a sexually transmitted disease or infection identified during a family planning visit. In many respects, states have not yet fully caught up with the evolving definition of what constitutes comprehensive family planning services, which, as described in a 2014 report released by the Centers for Disease Control and Prevention and the Office of Population Affairs, increasingly includes providing preconception health services to improve infant and maternal health outcomes, offering a full range of contraceptive methods and providing sexually transmitted disease screening and treatment services to prevent infertility and improve health.

Interviewees suggested that women had access to family planning services from a range of providers that participate in family planning programs, but also raised concerns about access to services in the context of Medicaid managed care. Most interviewees reported that beneficiaries are able to obtain services due to the well-established infrastructure of states' family planning programs as well as the mission-oriented nature of many of the programs' providers. In Medicaid expansion states, enrollees have been transitioning from limited benefit programs to full-scope Medicaid and, in most instances, enrolling in Medicaid managed care organizations (MCOs). In California, where three-quarters of Medicaid enrollees are in MCOs, interviewees expressed concern that women are being assigned to primary care providers they do not know or who are difficult to get to and that MCOs are imposing step therapy and other forms of utilization review inconsistent with state and federal policy. Interviewees across states also noted that Medicaid's "freedom of choice" provision, which provides coverage for out-of-network family planning providers, is not well understood by enrollees, providers or MCOs.

There is a need for more consistent, reliable and comprehensive data on the Medicaid program's role in family planning. Limited data has made it difficult for states to draw conclusions on a range of important issues, including service utilization by type, wait times, geographic proximity of providers to enrollees, appropriateness of care, ability to see the provider of an individual's choosing, and the frequency with which people take advantage of the "freedom of choice" provision. There are notable exceptions however. California's previous evaluation efforts through the University of California at San Francisco and Alabama's annual waiver analysis reports have documented the role of the family planning programs in providing contraceptives and other services to low-income women and men. However, the lack of recent, uniform data makes it difficult to comprehensively assess how the ACA-related changes have affected access to and use of family planning services.

Family planning providers continue to face an uncertain future. Many family planning providers have long been accustomed to working in an environment dominated by fee-for-service Medicaid payments, Title X grant funding and self-pay patients, but the ACA has markedly increased the need to contract with Medicaid MCOs and Marketplace plans. Many family planning providers are seeking to re-position themselves

as providers of a broader array of services, building stronger partnership and referral relationships with other providers, and increasing their capacity to contract directly with Medicaid MCOs and Marketplace plans. Others, however, are not interested in or able to adopt these types of changes, including those who work in rural markets that do not support service expansion or in urban markets where other primary care providers already provide a full array of services. These family planning providers tend to be more focused on maintaining core family planning services and increasing reimbursement and awareness of those services. Regardless of their approach to adapting to these circumstances, family planning providers see themselves as the frontline providers of care for many low income women and are increasingly making the case to payers and policymakers who want to prevent unintended pregnancies about the value they can offer, highlighting their deep experience and training to provide family planning services, including those that pose stumbling blocks for other primary care providers (e.g., contraceptive counseling, LARC insertion), the ability to offer same-day access to family planning services, and a unique understanding of what differentiates family planning services from other medical services.

Moreover, family planning providers sit at the center of state and federal political controversies around abortion services and face significant uncertainty about funding and sustainability. While federal law guarantees that Medicaid beneficiaries can see any qualified family provider they choose, there have been efforts at the state and federal levels to eliminate some providers from the program. This will be particularly important to monitor in the months ahead, as President Trump has voiced his intention to bar federal funds to Planned Parenthood, a major provider of family planning services for Medicaid beneficiaries.

Across interviewee states, family planning issues and providers are not at the table for broad Medicaid delivery system reform efforts. Most of the states interviewed for this analysis were engaged in or exploring Medicaid delivery system reform, but none had significant initiatives that include family planning issues and providers. As with most delivery system reform efforts, they were heavily focused on the most expensive enrollees and services, not the often younger and relatively healthy Medicaid beneficiaries who use family planning services. For many interviewees, the exclusion of family planning issues from delivery system reform is a missed opportunity given that family planning can be a major gateway into the healthcare system for low income and racially and ethnically diverse women of reproductive age. Family planning providers also note that they can help Medicaid programs avoid the delivery costs associated with unintended pregnancies. Finally, interviewees highlighted that the lack of family planning specific quality measures has been a hurdle for inclusion in delivery reform efforts, as current efforts strive to provide incentives to meet target quality measures.

Long-acting reversible contraception (LARC) continues to garner significant attention from states. Many of the states in this analysis are actively reviewing their Medicaid LARC policies to reduce access barriers, recognizing LARC's high effectiveness rates and potential to reduce unintended pregnancies; however, states are also seeking to ensure women are presented with a range of contraceptive options and not unduly pressured to select a LARC. Interviewees highlighted existing barriers to accessing LARC, including: a shortage of providers trained to insert LARC methods; the high upfront cost of LARC devices for providers; and low Medicaid reimbursement rates for these procedures. A number of states are working to address these issues. For example, Illinois raised Medicaid reimbursement rates for insertions and removals of LARC devices in October 2014, and in July 2015, began allowing hospitals to receive a separate payment for LARC devices, making it more financially attractive for providers to insert LARC after delivery.

Conclusion

This study reviews the important role that Medicaid continues to play in delivery of family planning services to low-income women and how it has evolved since the passage of the ACA. Shifts in the coverage landscape, federal efforts to reduce spending on discretionary programs such as Title X, the focus on broad delivery system reform, and clinical and political trends have created an uncertain future for many family planning providers. States, enrollees, and providers have been adapting to these changes and continue to do so to ensure family planning services remain accessible to low-income women and men.

The Trump Administration has signaled its willingness to put more decisions about the program's benefits, eligibility, and distribution of funds in the hands of state policymakers. As we see in this study, several states have used the 1115 waiver process to extend Medicaid coverage for family planning services to groups that have historically been ineligible for full scope Medicaid coverage. Alternatively, state and federal policymakers could structure an 1115 waiver to scale back the range of participating providers, covered services, or eligibility criteria.

This study shows that when states have choices in crafting family planning benefits under Medicaid, the results can vary widely. Moving forward, it will be important to continue to monitor the impact of Medicaid policy changes at the state and federal levels to assess the impact of policy decisions on access to family planning services for low-income women and men.

Introduction

Overview

The passage of the Affordable Care Act (ACA) in 2010 made changes to the Medicaid program that have had considerable implications for family planning coverage and services available to low-income women. Prior to the ACA, over 3 million low income women received family planning services through stand alone, limited Medicaid benefit family planning programs.[1] The ACA enabled many low and modest-income women who were previously only eligible for family planning coverage to obtain full-scope insurance through Medicaid or the Marketplaces for the first time. These changes have altered the role of family planning programs within many states and created a more complex environment for family planning providers.

While still responding to coverage changes created by the ACA, family planning programs and providers are also facing new, emerging changes brought about by other industry trends. The ACA's delivery system reform provisions sparked changes in how care is paid for and delivered. Family planning programs traditionally operated through specialty "stand alone" providers with direct contracts with the state. These providers are now grappling with how to integrate into the broader delivery system and, in states that have expanded Medicaid, how to work with Medicaid managed care organizations (MCOs) and the transition from uninsured or limited family planning benefit packages to comprehensive Medicaid coverage. These changes are impacting how family planning providers interact and contract with Medicaid MCOs and other payers, how they are reimbursed for care, the scope of services they provide and how they form and value relationships with other providers. Besides ACA changes, Congressional and federal efforts to "defund" Planned Parenthood through limits on Medicaid and Title X funding would limit access to family planning services for women living in certain communities across the country. This study addresses the shifting landscape in which family planning services are being provided, including routes to coverage; eligibility and enrollment; benefits; access; impact on providers of changes; and delivery system reform. Based on case studies in six states and interviews with national experts, providers, advocates and government officials, it describes major trends in how women secure Medicaid family planning coverage and services and the implications of ACA-related changes for family planning providers and the role of family planning more broadly in Medicaid delivery system reform initiatives.

This study was conducted in the summer of 2016 before the November election changed the outlook for the ACA and Medicaid. The Trump Administration has signaled that they intend to give states considerably more flexibility to reshape their Medicaid programs and to block federal funding to Planned Parenthood, a leading source of family planning care for low-income women. With Medicaid reform under debate at the federal and state levels, it is important to understand the role of family planning programs and how they could be affected by Medicaid restructuring.

Background and Context

Prior to the ACA's passage, Medicaid was already the single most important payer of publicly-funded family planning services in the United States, financing more than 75% of all publicly-funded family planning services.[2] Family planning services long have had a special role within Medicaid, reflecting recognition by policymakers that there are significant social and economic consequences to unintended pregnancies, including greater poverty and reliance on public benefit programs.[3] Family planning services have been a mandatory benefit in Medicaid since 1972 and are reimbursed by the federal government at a 90% matching rate. Federal law also requires that family planning services be exempt from cost-sharing and that beneficiaries

have the right to secure the services from the providers of their choice, a provision known as the "freedom-of-choice" requirement.

Until the 1990s, however, many women simply did not qualify for Medicaid family planning services because they did not meet categorical eligibility rules that limited Medicaid eligibility to adults who were pregnant, parents/caretaker relatives, disabled or elderly. Then, with California in the lead, a number of states sought and secured Medicaid 1115 waivers to establish family planning programs that could serve low-income women, and sometimes men, beyond Medicaid categorical eligibility rules. By 2009, the year prior to passage of the ACA, at least 24 states had family planning waivers,[4] and over 3 million women had gained coverage for family planning services through these programs. California's program, FamilyPACT, was the largest, with 2.5 million enrollees, while there were approximately 942,000 enrollees in all other programs combined.[5]

Impacts of ACA Coverage Changes on Medicaid Family Planning

While family planning was not the primary focus of the Affordable Care Act (ACA), the law has had sizable implications for how many women receive family planning services and for family planning providers. The ACA extended eligibility for full-scope Medicaid to adults under 138% FPL and also created new Marketplaces that offer subsidized coverage up to 400% FPL. Although Medicaid expansion now is optional as a result of the 2012 Supreme Court decision on the ACA, the District of Columbia and 31 states have elected to expand Medicaid. In these states, many women who previously qualified only for a Medicaid family planning program have been able to secure coverage that offers a comprehensive benefit package (i.e., "full-scope" Medicaid).

The ACA also gives states the option to establish family planning programs through a simpler mechanism than a complex and lengthy waiver application process that needed to be renewed and evaluated periodically. By enacting a state plan amendment (SPA), states could base eligibility solely on income, while waivers may limit eligibility by other criteria such as age and sex. States using the SPA option must also set the eligibility threshold for their family planning program at or below the income threshold for pregnant women in the state. Fourteen states have transitioned to or have newly established a SPA family planning program since the option became available.[6,7]

Finally, the ACA established integrated, modernized and streamlined standards for eligibility and enrollment processes that are used to evaluate eligibility for Medicaid, Marketplace coverage and related subsidies, and the Children's Health Insurance Program (CHIP). Medicaid agencies and Marketplaces are required to use a "single, streamlined application," to ensure individuals end up enrolled in whichever program for which they are eligible regardless of whether they submit their application to a Medicaid agency or a Marketplace. As a result, many more people are finding their way to coverage by applying through Marketplaces, raising the importance of understanding how Marketplace web sites and related eligibility and enrollment procedures work for women who qualify for full-scope Medicaid or family planning programs.

Other Developments

Family planning is garnering more attention than ever before at both state and national levels. In the political realm, highly controversial videos on the role of Planned Parenthood staff in disposing of fetal tissues have generated heated debate over the role of Planned Parenthood affiliates in Medicaid family planning programs. Some states have sought to ban Planned Parenthood providers from receiving any Medicaid funds while other states have ongoing inquiries into the role of clinics that offer abortion services within family planning

programs. For example, Oklahoma's Medicaid agency announced it was terminating its contracts with Planned Parenthood until, two months later, the agency reversed course and entered into "conditional one-year Provider Agreements" with the two Planned Parenthood affiliates in the State.[8] In Missouri, the Legislature passed a fiscal year 2017 budget that effectively converts the Medicaid family planning program (supported by a combination of federal and State funds) into a fully State-funded program and excludes providers who offer abortion services.

In the past few years, CMS has issued a number of regulations and informational bulletins aimed at strengthening access to family planning services. In April 2016, CMS released a final Medicaid managed care rules that includes several provisions directly relevant to family planning services.[9] As described in more detail later in the report, these include: new requirements for Medicaid MCOs to inform beneficiaries of the freedom-of-choice provision; stronger network adequacy standards for family planning providers; and, a reiteration of the importance of ensuring that beneficiaries can elect the family planning method of their choice. CMS also released three informational bulletins in 2016 on family planning: (1) reminding states that they cannot exclude family planning providers from Medicaid unless they are unfit to provide a covered service;[10] (2) encouraging best practices for promoting access to long-acting reversible contraception (LARC);[11] and (3) highlighting that states cannot employ utilization controls, such as step therapy, that would interfere with a beneficiary's right to choose her preferred method of family planning, regardless of whether a state operates a managed care or fee-for-service program.[12]

Methodology

This study is based largely on interviews with state officials, providers and consumer advocates in Alabama, California, Connecticut, Illinois, Missouri and Virginia.[13] The in-depth state case studies were supplemented by interviews with national experts, family planning provider organizations and federal policymakers with expertise on Medicaid and family planning services, quality metrics, eligibility and enrollment issues, and waivers. Using a standardized questionnaire, interviewees were asked about their perspective on a range of issues, including: the implications of the ACA for how low-income women secure family planning services; family planning benefits and access to care; the role of family planning issues in broader delivery system reform; and impacts on family planning providers. A full list of interviewees is attached as Appendix C.

These six states were selected to represent a cross-section in terms of geography, Medicaid expansion status, implementation of a Medicaid family planning program and whether that program was established via a waiver or a SPA. **Table 1** displays the characteristics of the states included in the analysis. Three of the selected states expanded Medicaid (California, Connecticut, and Illinois); two converted Medicaid family planning waivers to the state plan option (California and Virginia); one newly established a Medicaid family planning program post ACA enactment (Connecticut); two continued existing Medicaid family planning programs operated under waivers (Alabama, Missouri); and one terminated its program after expanding Medicaid (Illinois).

Table 1: Interviewees' Medicaid Family Planning Program and State Characteristics								
		Medicaid Family Planning (FP) Program				Full Scope Medicaid Expansion	% of Medicaid enrollees in Managed Care[14]	Rely on HealthCare.gov?
	Name	Waiver or SPA	Gender/Age Eligibility	Income Eligibility	FP-Related Benefits?			
Alabama	Plan First	Waiver *(Established in 2000)*	Women, 19-55 Men, 21 and older (only for vasectomies)	141% FPL	No[15]	No	0%	Yes
California	Family PACT	SPA *(Converted from waiver in 2011)*	Women, no age restrictions Men, no age restrictions	200% FPL	Yes	Yes	77%	No
Connecticut	N/A	SPA *(Established in 2012)*	Women, no age restrictions Men, no age restrictions	263% FPL	Yes	Yes	0%	No
Illinois[16]	N/A	N/A *(Waiver terminated in 2014)*	N/A	N/A	N/A	Yes	53%	Yes
Missouri	N/A	Waiver *(Established in 1998)*	Women, 18-55	201% FPL	Yes	No	51%	Yes
Virginia	Plan First	SPA *(Converted from waiver in 2011)*	Women, no age restrictions Men, no age restrictions	200% FPL	No	No	66%	Yes

Key Trends in Medicaid Family Planning

Based on the six states as case studies, a number of key trends in Medicaid's role in family planning were identified, including: the role of Medicaid family planning programs now that many people have coverage through full-scope Medicaid and Marketplace plans; eligibility and enrollment changes brought about by the ACA; growing interest in LARC; access to services, and the intersection between family planning services and broader delivery system reform. To a notable degree, interviewees based observations of their personal experiences, reflecting a dearth of state-specific data on how women access family planning services, the providers that they use, the type of family planning services that are most common, the role of managed care plans in providing family planning services, and the cost-effectiveness of family planning programs.

Role of Family Planning Programs

Nationwide, states that had Medicaid family planning programs prior to passage of the ACA have generally elected to maintain them, reflecting a belief that they still have an important role to play for low-income women. In non-expansion states, the decision to maintain a family planning program is a relatively easy one. As interviewees in Alabama, Missouri and Virginia explained, their programs provide important family planning services for women who otherwise do not qualify for Medicaid or who may find Marketplace coverage unaffordable. Alabama and Missouri simply maintained their existing waiver programs while Virginia opted to convert its waiver to a SPA, anticipating that its family planning program

would shrink after Medicaid expansion. Now, without a Medicaid expansion, many Virginians applying for health insurance at the Marketplace fall into the "coverage gap," and are instead enrolled in the state's family planning program. As a result, the state experienced a sharp increase in enrollment, although many beneficiaries are not using the coverage to secure family planning services, suggesting that they may be unsure of exactly what coverage they have (see further discussion below).

In states with Medicaid expansion, the ongoing role of family planning programs is more complex. In these states, many women who previously qualified only for a Medicaid family planning program are now able to secure full-scope Medicaid which provides them with a broad array of services that go well beyond family planning. Still, the vast majority of states expanding Medicaid that had family planning programs that predated the ACA have opted to maintain them. As California stakeholders explained, this is because family planning programs serve a unique role in helping women to secure high-quality family planning services, creating a natural focus on improving family planning services and for oversight and training. California's family planning program is particularly essential for women who remain outside of comprehensive coverage due affordability issues. Even among women who have affordable, comprehensive coverage, they sometimes elect to use California's family planning program because it is carefully designed to ensure confidentiality and privacy, even relative to a beneficiary's spouse or parents.

One Medicaid expansion state in this analysis, Illinois, opted to drop its family planning program entirely. Many Illinois interviewees viewed this decision as appropriate given that, upon expanding Medicaid and establishing a Marketplace, low-income women became eligible for full-scope Medicaid or could enroll in Marketplace plans. Some Illinois providers and advocates, however, called for a re-examination of the decision. They cited their experience that some women are having difficulty securing family planning services, particularly for women with incomes above Medicaid thresholds, because they cannot afford Marketplace premiums.

Application, Eligibility and Enrollment

The ACA's reforms to eligibility and enrollment procedures have changed how many women find out about and enroll in Medicaid (full-scope and family planning programs), creating both new opportunities and challenges. The ACA required states to adopt strategies to simplify the process of enrolling in Medicaid and Marketplace coverage including use of the "single, streamlined application." These changes have many advantages for enrollees and states alike. Most importantly, the use of a single, streamlined application allows people to be evaluated for Medicaid, Marketplace coverage, and CHIP without requiring them to fill out and submit multiple, duplicative applications. At the same time, the "single, streamlined" application is actually significantly longer and more burdensome than states' pre-ACA family planning applications, making it harder for people to apply specifically for family planning services and for family planning providers to assist with Medicaid applications. As stakeholders gain greater and greater familiarity with ACA eligibility and enrollment procedures, states, federal officials and advocates are looking for ways to have the best of both worlds – access to comprehensive coverage whenever possible but, for those who only qualify for family planning programs, a quick and efficient way to sign up.

Intersection with the Federally-facilitated Marketplace (FFM)

Nearly 70% of people in the country now live in states that rely on the Federally-facilitated Marketplace (FFM) and its eligibility and enrollment website, HealthCare.gov, as a primary vehicle for finding out about and

enrolling in coverage.[17,18] When an individual applies for coverage at HealthCare.gov and is determined ineligible for Marketplace coverage, the FFM also checks eligibility for Medicaid; however, the FFM is only able to review eligibility for major Medicaid eligibility categories – such as children, pregnant women and expansion adults. It is not yet able to determine eligibility for Medicaid family planning programs, a significant gap for women in states that have not yet expanded Medicaid.

Additionally, states that rely on the FFM have chosen whether the FFM can "assess" eligibility for Medicaid or "determine" eligibility for Medicaid. In states where the FFM "assesses" eligibility, the FFM transfers to the Medicaid agency all accounts that the FFM reviewed for Medicaid eligibility to enable the state to run its own eligibility determination processes. In doing so, the state can evaluate eligibility for all Medicaid categories, including for a family planning program. In states where the FFM "determines" eligibility, the FFM does not transfer accounts for anyone that the FFM "determined" ineligible for Medicaid.

This process creates particularly notable concern in the eight states that are "determination model" states – including Alabama.[19] Alabama residents who apply for coverage at HealthCare.gov and are found ineligible for full-scope Medicaid are told they are ineligible for Medicaid by HealthCare.gov; they are not transferred to the Alabama Medicaid agency to allow the state to determine eligibility for and enroll them in the family planning program.[20] Alabama interviewees expressed great concern about losing the opportunity to educate and enroll these individuals. In contrast, Virginia – an assessment state – receives accounts from the FFM for individuals who were found ineligible for full-scope Medicaid; the state then conducts its own processes to determine eligibility and may find the individual eligible for the family planning program.

Confusion About Coverage Status

Particularly in states that have not expanded Medicaid, interviewees highlighted that beneficiaries and providers are sometimes confused about the limited nature of the coverage available to family planning enrollees. Virginia, for example, a non-expansion state, has taken steps to ensure that low-income individuals who fall into the coverage gap are enrolled in the state's Medicaid family planning program. With significant numbers of people stepping forward and seeking coverage through HealthCare.gov, this has resulted in family planning program enrollment in Virginia increasing from 8,000 in 2011 to 110,000 in 2016. The state, however, has not experienced a corollary increase in service utilization, suggesting that new enrollees may not be fully aware of how to use their limited coverage or may not be seeking family planning services. In response, the state has undertaken an effort to educate beneficiaries and providers about how to use the family planning program. It has created a family planning member identification card that is easily distinguishable from the card used for people with full-scope coverage, developed a separate Medicaid family planning handbook and will be conducting a survey and reviewing claims data to determine if member confusion has decreased.

Even prior to ACA implementation, Alabama found significant numbers of individuals were enrolled in the Medicaid family planning program but not utilizing services. The State now requires individuals to affirmatively request an eligibility determination for the family planning program by checking a specific box on the Medicaid application.[21]

Strategies to Increase Family Planning Enrollment

To address the challenges created by new eligibility and enrollment procedures, some states are relying on proven strategies that were in use prior to the ACA, such as on-site enrollment and presumptive eligibility. In

California, for example, the state continues to allow applicants to enroll by completing a short application at their provider's office to immediately secure coverage for their visit. California interviewees routinely praised the process for its success in helping women gain prompt access to family planning services, but also noted that the State continues to work to ensure providers assist applicants with enrolling in full coverage – rather than family planning-only. Similarly, Connecticut uses presumptive eligibility for its Medicaid family planning program, allowing women to be signed up for temporary coverage at their providers' offices. In this instance, providers said that they view the presumptive eligibility policy as "crucial" to the success of the program, highlighting that people who are enrolled temporarily, begin taking advantage of their coverage, and find they are likely eligible for ongoing coverage are more motivated to complete the full application.[22]

Despite strong federal protections, interviewees in some states raised concerns about affordability challenges in Marketplace plans for low-income women in need of family planning services. Despite the availability of premium tax credits and cost-sharing subsidies for low- and moderate-income individuals in ACA Marketplaces, interviewees raised significant concerns about the affordability of Marketplace plans. In states with family planning programs, women who cannot afford Marketplace plans may still be able to directly secure family planning services through the family planning program.[23] Given these issues, advocates and providers in Illinois would like the state to re-consider its decision to eliminate the state's family planning program.

Even when women are able to purchase Marketplace plans, some interviewees raised concerns about ensuring access to family planning services. For example, Missouri advocates expressed concerned that Marketplace plans exclude many of the state's family planning providers while some California interviewees reported that Marketplace plans often require prior authorization for LARCs. To address these issues, advocates and other interviewees are looking for increased oversight and monitoring of Marketplace plans' compliance with family planning coverage and cost-sharing requirements. While state insurance departments may be the logical entity to provide this oversight, they have not traditionally served, or been asked to serve, this role and so may currently lack the staff and expertise to monitor how family planning benefits are provided.

Finally, there is heightened interest in dual enrollment in Marketplace plans and Medicaid family planning programs. If women can enroll in both, then the Medicaid family planning program may be able to assure continuity of care as well as offset any gaps in Marketplace plan coverage, such as narrow provider networks. While individuals are permitted to be concurrently enrolled in Medicaid family planning and Marketplace coverage in many states,[24] this is not widely understood by beneficiaries, plans, or policymakers. Alabama officials, for example, reported they are actively working with the Centers for Medicare and Medicaid Services (CMS) to ensure that the FFM's call center staff are aware that people may be enrolled in both forms of coverage and accurately inform callers of this possibility.

Benefits

Stakeholders across the board reported that full-scope Medicaid and family planning programs generally cover the full range of family planning benefits that women are likely to require. "Family planning services" are defined broadly in federal law and guidance to include the full array of contraceptive devices and procedures (e.g., IUDs, birth control pills, condoms and other forms of over-the-counter methods), exams, counseling services, laboratory tests, and other services that women and their partners might need. Within these requirements, however, states have discretion to develop their family

planning benefit packages, as well as to allow them to vary between full-scope Medicaid and a family planning program (e.g., in the selection of contraceptive options or in the number of cycles of contraception that can be dispensed at one time).[25] In practice, though, interviews revealed that very minor differences exist, if any, between the benefits offered in family planning programs and full-scope Medicaid. While there have been some differences in the past, the states in this analysis have actively worked to eliminate them. California, for example, has fully aligned benefits in recent years by adding a broader range of contraceptive methods to full-scope Medicaid (e.g., the ring and patch) and allowing women to obtain up to 13 cycles of oral contraceptives in a single dispensation. In Virginia, where modest differences in family planning benefits between the family planning program and full-scope Medicaid still exist, the Department of Medical Assistance is working to align benefits between the programs.

On the other hand, there was variation across the six states in coverage of "family planning-related" services. States that choose to operate family planning programs are not required to cover "family planning-related" services. If they do, those services are reimbursed at regular Medicaid matching rates (while family planning services are matched at the enhanced 90% Medicaid matching rate). CMS has defined family planning-related services as "medical diagnosis and treatment services that are provided pursuant to a family planning service in a family planning setting."[26] Examples of family planning-related services include the treatment of sexually transmitted disease and infections (STIs) identified as the result of a family planning visit and complications arising from use of a birth control method. Preventive services routinely provided pursuant to a family planning service are also "related" services, including vaccinations to prevent cervical cancer.

Text Box 1: Quality Family Planning Guidelines

In 2014, the Centers for Disease Control and Prevention (CDC) and the Office of Population Affairs (OPA) jointly released a set of recommendations addressing how family planning providers can deliver high-quality family planning services that help "women, men and couples achieve their desired number and spacing of children and increase the likelihood that those children are born healthy." According to the report, family planning services should include:

- Providing contraception to help plan and space births, prevent unintended pregnancies and reduce the number of abortions—emphasizing offering a full range of contraceptive methods;
- Offering pregnancy testing and counseling;
- Helping clients who want to conceive;
- Providing basic infertility services;
- Providing preconception health services to improve infant and maternal health outcomes and improve women's and men's health; and,
- Providing sexually transmitted disease screening and treatment services to prevent tubal infertility and improve health.

The definition of comprehensive family planning services has moved beyond contraceptive methods to include screening and treatment for diseases that impact women's and men's ability and likelihood to conceive and the health of babies (**see Text Box 1**). Some states, like Virginia and Alabama, do not cover family planning-related services in their programs, which some interviewees pointed out limits women's access to important

services and may contribute to confusion about the role of the family planning program.[27] States that do cover family planning-related services differ in what services they choose to cover.

For example, while all interviewee states cover the Human Papillomavirus (HPV) vaccine in full-scope Medicaid, only three states cover this service in their family planning program. Again, while all interviewee states cover colposcopies as a result of an abnormal pap smear, only three cover this service in their family planning program.[28]

Access to Family Planning Services

Interviewees suggested that women had access to services at a variety of provider sites that participate in family planning programs. Based on their experiences, most interviewees credited the well-established infrastructure of family planning programs, as well as the mission-oriented nature of many family planning providers. That said, interviewees across states varied significantly in where they believed that women usually received care. In Virginia, for example, interviewees reported that beneficiaries mostly receive services at private provider offices; in Alabama, more commonly through county-run public health agencies; and, in California, through a broad mix of public and private providers, with beneficiaries in some parts of the state relying heavily on traditional family planning clinics and federally qualified health centers (FQHCs). As discussed in more detail in the next section, however, data were notably lacking in most of the states on key access issues such as site of care, wait times, proximity of providers to beneficiaries, and use of the freedom of choice provision.

Medicaid Managed Care

In the midst of this generally positive portrait, interviewees raised a number of concerns about access, particularly in the context of Medicaid managed care. In managed care states, advocates reported that women who have switched from a family planning program into full-scope Medicaid, and therefore into a Medicaid MCO, often have more trouble securing family planning services through their MCO. In California, interviewees suggested that access issues arise because women are assigned to primary care providers they do not know or are far from their homes. More generally, they cited that MCO assignment algorithms do not take into account that the only provider many women of child-bearing age see is their OB/GYN, not a primary care provider. Interviewees were also concerned that MCOs sometimes impose step-therapy or other forms of utilization review inconsistent with state policy and federal regulations. Notably, Connecticut interviewees explained that the state discontinued its Medicaid managed care delivery system and moved back to direct state oversight in part because it was difficult to ensure that MCOs implemented the state's policies as intended. Now, the Connecticut Medicaid agency can directly address any concerns providers or beneficiaries identify regarding barriers to accessing family planning services. Advocates and providers agreed it has become increasingly important to monitor how MCOs approach coverage of family planning services. Most of the states interviewed for this project had not yet reviewed their MCO contracts through a family planning specific lens (see **Text Box 2** for an exception in Illinois). Those that have often do not yet have a plan for monitoring and enforcing unique provisions of importance to women and family planning providers (e.g., freedom of choice). Across different states, advocate and provider interviewees alike raised concerns about MCOs treating family planning services like other services – rather than as a preventive service -- and imposing excess utilization review for LARC in particular. While state interviewees pointed to their authority for broad MCO oversight, as

a practical matter, it was difficult to identify mechanisms, processes, or data that demonstrated how states could ensure on-the-ground compliance with protections like freedom of choice.

Text Box 2: Illinois's Approach to Oversight of Family Planning Services in a Managed Care Setting

Prior to terminating its family planning program in December 2014 and transitioning from fee-for-service to a managed care delivery system, Illinois implemented the "Family Planning Action Plan" (FPAP) as a means of ensuring that MCO contracts offer continuous access to high quality comprehensive family planning services. Through the FPAP, Illinois increased reimbursement rates and modified payment policies to encourage use of the most effective forms of contraception. The FPAP also requires that all Medicaid clients receive evidence-based counseling and have easy access to all methods of family planning without cost-sharing (co-pays/deductibles/co-insurance), step therapy failure requirements, or prior authorization.

Freedom of Choice of Provider

Interviewees reported that the "freedom of choice" provision is not well understood by beneficiaries, family planning providers, and MCOs. This rule enables women to go to any Medicaid provider of their choice to secure family planning services (see **Text Box 3**). Beneficiaries often are not aware of the option and, in many instances, Medicaid MCOs have not yet established an appropriate infrastructure to implement it. As a result, interviewees reported instances when some beneficiaries who seek services from an out-of-network family planning provider were erroneously told they cannot see such providers. Providers also reported that when they do see patients who have gone out of network, they face major hurdles securing reimbursement from Medicaid. In some states interviewed for the analysis, providers could not even identify, despite trying, whether they should seek reimbursement from a beneficiary's MCO or from the state. The new Medicaid managed care rule published in May 2016 seeks to address some of these issues, both by requiring appropriate access to family planning providers in-network (i.e., reducing the need for beneficiaries to use the freedom of choice provision) and by requiring plans to educate consumers about the provision.

Fee-for-Service Challenges

Finally, fee-for-service states also raised some access issues. In Alabama, where most women in the family planning program are served through the state's Department of Public Health Title X clinics, interviewees flagged that women may face long waits for appointments and may have to access some LARC-related services elsewhere because of state scope of practice laws.[29,30] Alabama is not alone in having challenges in making the full range of contraceptive methods readily available to women. As noted in a later section on LARC, many providers struggle to have a stock of devices and trained staff who can conduct LARC procedures. Because of access challenges, a number of providers and advocates argued that maintaining specialized family planning clinics and providers is important because they allow for more focused, time-intensive counseling sessions, better provider training on family-planning specific issues like LARC insertion, and "all-in-one visit" provision of contraceptive services (lab work, stock of LARCs and other forms of contraceptives).

Data

There is a need for more consistent, up-to-date, reliable and comprehensive data on Medicaid and family planning. While the states in this analysis could provide basic data on enrollment and expenditures in their family planning programs, they usually lacked a set of comprehensive data on Medicaid family planning, making it difficult to definitively draw conclusions on a range of questions, including service utilization by type, wait times, geographic proximity of providers to enrollees, appropriateness of care, ability

to see the provider of an individual's choosing, and the frequency with which people take advantage of the "freedom of choice" provision to see out-of-network providers.

While research has found that family planning waiver programs have resulted in increases in the share of women using contraception and declines in unintended pregnancy, there has been a dearth of data in recent years.[31] One notable exception is California, which, until recently, has contracted with the University of California at San Francisco (UCSF) to conduct an ongoing evaluation of its Medicaid family planning program. Over the years, UCSF produced a series of evaluation materials, including an annual report on provider and client populations, services utilized, fiscal issues, and county-level characteristics, as well as analyses on whether women in need of family planning services are receiving them. These rigorous evaluations have documented the impact and reach of Medicaid funding for family planning in the state. For example, the most recent evaluation shows that the state's Medi-Cal and Family PACT programs provided family planning services to nearly two-thirds (65%) of California's low-women in need of publicly-funded contraceptives.[32] In the spring of 2016, however, the state discontinued its contract with UCSF. The state now plans to conduct its evaluation activities in house. It is too early to assess the implications for the state's ability to maintain its high standards for evaluation and monitoring, but several interviewees raised concerns, noting that major questions are arising about the implications of women transitioning from the family planning program to full-scope Medicaid (e.g., what is the effect on access and utilization? Use of LARC?).

An additional exception is the evaluation of Alabama's family planning program, conducted by the University of Alabama at Birmingham. The evaluation, required because the family planning program is operated through a Medicaid 1115 waiver, addresses metrics associated with all of the State's demonstration objectives (for example, "increase the portion of women eligible for [the family planning program] who actually enroll, and reduce race/ethnicity and geographic disparities in enrollment") as well as other measures that allow ongoing monitoring of the program. As part of ongoing monitoring, the evaluation plan uses claims data and participant surveys to review issues such as reasons for not using family planning services, choice of birth control, services accessed during family planning visits and use of care coordination services.

Text Box 3: Key Provisions of the Medicaid Managed Care Final Rule Related to Family Planning

On May 6, 2016, the Centers for Medicare and Medicaid Services (CMS) published a final rule seeking to modernize Medicaid managed regulations and align them with evolving Medicare and Marketplace requirements. The final rule includes a number of provisions related to family planning services and providers, including:

- **"Freedom of Choice:"** Managed care entities must inform patients of their ability to obtain family planning services and supplies, without prior referral, from out of network providers.
- **Network Adequacy**: States must specify time and distance standards for different provider types, including OB/GYNs, and provide female enrollees access to a women's health specialist for routine and preventive services. Additionally, contracts must require demonstration of sufficient in-network family planning to ensure timely access to services.
- **Utilization Management Controls**: Contracts may only impose utilization controls for family planning services if they protect the enrollee's freedom to choose their method of family planning.
- **Provider Non-Discrimination Protections**: Plans may not discriminate against qualified family planning providers (or other types of providers) "solely for providing services within their scope of practice."

Provider and Delivery System Reform Implications

Implications for Providers

Family planning providers continue to face an uncertain future. Women's shift to greater use of Medicaid MCOs and Marketplace plans has created administrative and cultural changes for family planning providers, who were accustomed to fee-for-service Medicaid, Title X and self-pay patients. This availability of managed care coverage combined with Medicaid expansion is shaping the systems where women receive family planning services—particularly by increasing access to private providers—putting downward pressure on patient volume for some family planning providers. This change is occurring at the same time as use of LARC and revisions to pap smear recommendations are also reducing the number of visits that women need to get their contraceptive care. Furthermore, in many states, these challenges are combined with calls to lower Medicaid spending growth and political pressures that some family planning providers, like Planned Parenthood face as a result of the larger abortion debate (see **Text Box 4**).

Text Box 4: Missouri's Transition to State-Funded Family Planning Program

In April 2016, the Missouri Legislature passed a fiscal year 2017 budget requiring that Medicaid funding for family planning services not be "expended to directly or indirectly subsidize abortion services or procedures or administrative functions and none of the funds…may be paid or granted to an organization that provides abortion services."[33] As a result, Missouri is required to transition its federally- and state-funded family planning demonstration to a program funded with State-only dollars because, to receive federal funding, the State would have to include all qualified providers in the program. Missouri's Medicaid agency released a demonstration phase out plan for public comment that indicates the State-funded program, titled "Missouri Woman's State-Funded Health Services Program," effective as of March 30, 2017.[34]

These significant changes to the family planning program bring uncertainty to enrollees trying to access family planning services and to family planning providers. From 2011 to 2012, Texas took several actions to reduce funding to and then exclude Planned Parenthood affiliates from its family planning program, eventually replacing its Medicaid family planning demonstration with a state-only funded program. Analysis of these changes were associated with reductions in provision of LARC and increases the rate of childbirth covered by Medicaid.[35] Other studies have found that maternal mortality is on the rise in Texas but have not conclusively identified the cause of their increase.[36]

As a result of these changes and challenges, many family planning providers interviewed for this report indicated that they are facing significant pressure to adjust their approach to providing care. Some are re-positioning themselves as providers of a broader array of services, including primary care and behavioral healthcare services. For example, family planning providers in California, Connecticut, and Virginia mentioned expansion into additional primary care services as a strategy to attract new patients, address unmet needs and better position themselves for longer-term sustainability.

Family planning providers are also starting to build stronger partnerships and referral relationships with other providers for needed services. For example, a Planned Parenthood affiliate in Virginia that expanded into primary care joined a safety net collaborative with FQHCs and free clinics, allowing it to tightly manage care while also referring out to specialists for needed services. In Connecticut, a Planned Parenthood affiliate hired staff to help women whose breast health issues were identified during a family planning visit connect with other providers who offer additional, specialized services (e.g., mammograms) and find insurance coverage if necessary.

Interviewees, however, also noted that not all family planning providers are interested in or able to adopt such changes. Many family planning providers either operate in rural markets that do not support service expansion or in urban markets with too many competing primary care providers, including FQHCs that long have been partners in meeting other primary care needs of the underserved population. Other providers would rather stick closer to core family planning services, and focus on increasing reimbursement and awareness of those services.

Many family planning providers reported putting new effort into contracting with Medicaid managed care and Marketplace plans. They said they found this work to be particularly challenging because they must develop contractual arrangements with each plan, rather than simply contracting with a single entity (the state agency). In Missouri, interviewees noted that only about 50% of family planning sites that receive Title X funds have experience with and are comfortable with contracting and negotiating with MCOs. Despite administrative challenges, many providers have sought this pathway in the hopes that successful contracting would raise reimbursement rates and offset declines in volume and stagnation of Title X funding. Additionally, contracting with Medicaid managed care entities is one way to "solve" the challenge of obtaining reimbursement for providing out-of-network services, as allowed under the freedom of choice requirement.

Providers continue to press Medicaid MCOs for higher reimbursement for family planning services. In California, providers report that reimbursement arrangements are lower in Medicaid managed care than they receive under fee for services through FamilyPACT, in the state's family planning program. With significant numbers of women moving from the family planning program to full-scope Medicaid, they report that this has posed fiscal challenges for family planning providers. In other states, providers report that many Medicaid MCOs have a "take it or leave it" approach when they offer rates to family planning providers, attributing this to MCOs not accruing the benefits of preventing unintended pregnancies because of high churn in and out of MCOs.

Some public health family planning providers, such as county departments of public health, reported that they largely continue to operate "as usual," experiencing little direct impact from the ACA. These providers are sustaining their family planning work with a combination of government grants, self-pay, foundation funding, and some Medicaid dollars. Although they have experimented with helping their clients find coverage, some interviewees reported that they had eased up on these efforts in recent years.

Role of Family Planning in Delivery System Reform

Many states are engaging in efforts to improve health outcomes and lower costs, spurred by State Innovation Model (SIM) grants, new opportunities for Medicaid waivers that can finance some of the cost of delivery system reform, and a steady drumbeat from the Center for Medicare and Medicaid Innovation on the imperative to reform the health care delivery system. These efforts will continue in light of final MCO regulations, which encourage states to implement alternative payment structures and provide states with enforcement mechanisms to ensure value-based MCO payment structures are enacted.

Interviewees, however, consistently report that family planning issues are not being addressed in discussions of Medicaid and delivery system reform. Among the six states reviewed for this paper, none had included family planning services in their reform efforts except in the context of maternity care (e.g., LARC insertion post-delivery). The exclusion of family planning providers from the larger debates over delivery system reform

reflects the heavy focus on the most expensive enrollees and services, not the often younger and relatively healthy Medicaid beneficiaries who use family planning services. Many interviewees expressed concern that the exclusion of family planning services by MCOs and state agencies is a major missed opportunity, reflecting a lack of understanding that many women consider their family planning provider to be their primary source of care and feel more comfortable sharing information with them.

In making the case for their role in delivery system reform, provider interviewees explained that they are often the gateway into the healthcare system for low income and racially and ethnically diverse women of reproductive age. Their populations are generally healthy, but due to their socioeconomic status, are at greater risk of developing chronic illnesses and experiencing behavioral health and substance abuse issues, making it important that reform efforts include them. Additionally, they noted that research indicates that the government saves $7 for every $1 spent on family planning programs[37] and that family planning providers can help Medicaid programs avoid the delivery costs associated with unintended pregnancies, as well as poorer maternal and infant outcomes associated with unplanned pregnancies or inadequate spacing between pregnancies.

As family planning providers begin to advocate more aggressively for inclusion in delivery system reform efforts, they are starting to produce some changes. For example, Connecticut has received a $45 million SIM grant from the federal government to transform how healthcare services are delivered in the State. Connecticut family planning providers have been tracking this initiative and actively participating in it by serving on governance committees that oversee the effort. One of Planned Parenthood's affiliates in Connecticut has been invited to participate in the "Advanced Medical Home Vanguard Program" within the State's SIM structure, allowing it to receive technical support to transform the practice, more effectively work with other members of the local health care community and, ultimately, potentially improve care and lower costs.

Other interviewees mentioned that the lack of family planning specific quality measures has also been a hurdle for inclusion of family planning services in delivery reform efforts, as current efforts strive to provide incentives to meet target quality measures as well as manage high-cost populations. Some quality metrics address reproductive health issues, such as chlamydia screening, STI/STD screening, and cervical cancer screening, but they fall short of measuring whether family planning services are being provided effectively. Recognizing the critical role that quality measures play, the federal government and states are pursuing the development of usable family planning metrics. The 2014 CDC/OPA guidelines on provision of high-quality family planning services includes a recommendation to measure the proportion of women using contraception, highly-effective methods of contraception, or LARC methods.[38] In collaboration with the CDC and OPA, CMS's Maternal and Infant Health Initiative[39] aims to collect and report data on new developmental quality measures to increase the use of effective contraception in Medicaid and CHIP. In September 2015, CMS granted 13 states and one U.S. Territory $400,000 total over four years to support their efforts to collect this information, though states may also report voluntarily. The measures[40,41] are presented in **Text Box 5**:

Text Box 5: Quality Measures for Family Planning—2014 CDC and OPA Guidelines

The percentage of women ages 15–44 at risk of unintended pregnancy that:

- Adopted or continued use of the most effective or moderately effective FDA-approved methods of contraception
- Adopted or continued use of LARC

Among women ages 15 through 44 who had a live birth, the percentage that:

- Adopted or continued use of the most effective or moderately effective FDA-approved methods of contraception within 3 and 60 days of delivery
- Adopted or continued use of LARC within 3 and 60 days of delivery.

These measures were reviewed and adopted by the National Quality Forum in Fall 2016. Approval and validation of the measures are important steps for family planning services and providers to be recognized in measurement programs and broader delivery reform efforts. For now, though, the nascent stage of quality measures for family planning services has exacerbated the challenge of integrating family planning services into larger delivery system reform efforts.

Long-Acting Reversible Contraception (LARC)

Long-acting reversible contraception (LARC) continues to garner significant attention from states. While condoms and oral contraceptives are the most common forms of birth control that women use, about one-third of women who have been sexually active in the past year and who use a contraceptive reported using a LARC.[42] Recognizing their high effectiveness rates and potential to reduce unintended pregnancies (see **Text Box 6**), many of the states in this analysis are actively reviewing their Medicaid LARC policies to reduce access barriers, while also seeking to ensure women are presented with a range of options and not unduly pressured to select a LARC.

Interviewees noted that a significant barrier to accessing LARC is the shortage of providers trained to insert LARC methods, which has been documented by other studies. Family planning-specific providers (e.g., Title X grantees) typically have received specialized training and have experience with the range of LARC options, but of primary care practitioners nationwide, only 42% are comfortable inserting IUDs, and only 11% for implants.[43] As interviewees in Illinois pointed out, some providers can be reluctant to complete training even when it is available and sometimes hold onto misconceptions about LARCs (e.g., the erroneous belief that women should use IUDs only after giving birth at least once). In response to these challenges, states such as California and Virginia have organized provider training and educational opportunities aimed at dispelling myths about LARC and increasing the number of providers trained to offer these methods.

A second major barrier to LARCs has been cost and some states in this analysis are seeking to address is the high upfront cost of LARC devices for providers. One aspect of high-quality family planning is the same day provision of contraceptive methods once they are selected by a woman, but the high costs of LARCs makes stocking these devices financially challenging for family planning providers. States typically reimburse providers upon LARC insertion, not when the device is purchased; therefore, providers must take on financial risk and cover the upfront cost of LARC devices in order to maintain an adequate supply. If a woman requests a LARC method but fails to return for insertion at a follow-up appointment, the provider must absorb the cost of

the device unless it is used by another patient. Moreover, LARC devices are usually expensive— they can run up to $900[44] per device–and so keeping them in stock is prohibitively expensive for many providers. To address the situation, Illinois, as CMS highlighted in an April 2016 Informational Bulletin, is piloting a new program with Bayer HealthCare and Teva Pharmaceuticals (both LARC manufacturers) to make selected LARCs available in physician offices without upfront physician costs.[45]

An additional barrier to accessing LARC is the low Medicaid reimbursement rates for procedures. In most of the six states in this analysis, provider and advocate interviewees maintained that reimbursement rates for LARC insertion is generally low. In Missouri, in particular, interviewees noted that some family planning providers have stopped offering LARC in recent years due to the reimbursement rates. Some states, including California and Illinois, are responding by increasing Medicaid reimbursement rates for LARC dispensing and insertion. Illinois, for example, implemented the "Family Planning Action Plan" in October 2014, which raised Medicaid reimbursement rates for LARC devices and insertion/removal.[46]

States are also working to address LARC within the scope of Medicaid maternity payments. States historically reimburse hospitals for a woman's labor and delivery within a single prospective maternity payment. State interviewees were concerned that in an effort to lower costs, providers may be dis-incentivized from offering LARC to post-partum women if the cost is included within that bundled payment. To address this concern, some states have opted to reimburse for LARC outside of the maternity bundle. In July 2015, Illinois started allowing hospitals to receive a separate payment for LARC devices, and for non-employed hospital providers to bill separately for the insertion, making it more financially attractive for providers to insert LARC after delivery.[47]

Interviewees also raised concerns about insufficient patient education and counseling on LARC methods. With little or no reimbursement for contraceptive counseling, providers have no financial incentive to counsel individuals on their contraceptive options, including LARC. Advocates and provider interviewees, in particular, noted that increasing and optimizing reimbursement for contraceptive counseling should be a priority in light of the emerging range of contraceptive choices. In particular, interviewees noted that reimbursement for non-licensed, non-clinical counselors, such as certified contraceptive counselors, could be beneficial and is similar to what is currently in place in many states for other programs (e.g., tobacco cessation counseling).

Text Box 6: Washington University School of Medicine's Contraceptive CHOICE Center

The Contraceptive CHOICE Center at the Washington University School of Medicine received a Center for Medicare and Medicaid Innovation grant to develop and test a contraceptive provision model that targets women at the highest risk for unintended pregnancy. The Center used this grant to design a standardized approach to contraceptive choice counseling that removes inherent provider and patient bias regarding different contraceptive methods, and demonstrated that it ultimately reduced unintended pregnancies. When using the Center's comprehensive counseling approach, counselors or staff members walk patients through all the different tiers of contraceptive options, starting with the most effective options (e.g., LARC). Researchers at the Center found that the use of contraceptive choice counseling increased patients' satisfaction with their contraceptive method, increased the use of LARCs and reduced the rate of unintended pregnancies among their sample population.

At the same time, a significant number of provider, state and advocacy interviewees highlighted the importance of adopting a nuanced, balanced approach when promoting LARC. They cited the long history of forced

sterilization of low-income women, particularly women of color, and the controversy that erupted over coercive practices used in the 1990s to promote Norplant as reasons to act with sensitivity. While strongly supportive of LARC, they advocated for a balanced approach that provides women with the information and counseling that they need to make an informed decision and, if they freely opt for a LARC method, the opportunity to readily access it. One state explained that it has steered clear of actively promoting LARC insertion at delivery unless women have agreed to the procedure well in advance because of concerns that doing so would be reminiscent of earlier coercive practices.[48]

Conclusion

In the six years since passage of the ACA, Medicaid and its role in family planning has evolved significantly. The change of federal administration, however, may result in many changes to the ACA, to Medicaid, and to family planning services. We have seen in Medicaid expansion states many low-income women have moved from family planning programs to full-scope Medicaid. Although this brings enormous benefits to women who can now receive comprehensive care, it has increased the importance of ensuring that Medicaid managed care organizations are well equipped to address the family planning needs of low-income women. In recognition of this, CMS issued a series of guidance aimed at ensuring that states and Medicaid MCOs deliver family planning benefits in accordance with federal standards and newly strengthened requirements that plans inform beneficiaries of their freedom to choose their family planning provider. This federal guidance could be adapted by the future federal administration through regulatory actions.

In non-expansion states, Medicaid family planning programs are perhaps more important than ever, offering key benefits to many low-income women who remain uninsured because they fall into the coverage gap. Efforts to cap Medicaid through block grants or entitlement caps could result in more limited federal requirements and incentives to support these programs, especially if the 90% federal Medicaid match requirement is lifted. States would likely still have the option to operate the limited scope family planning programs, but with limited funding and without the enhanced match, they may choose to direct funds to other services.

Despite the strong consensus in the United States that it is cost-effective and important to reduce the rate of unintended pregnancies, family planning remains on the margins of delivery system reform conversations. With the exception of Connecticut, none of the states in this analysis had actively incorporated family planning services into their state-driven delivery system reform efforts. One promising development in this regard is the expanding body of work aimed at developing performance metrics to evaluate whether women are receiving high quality family planning services.

Perhaps the aspect of family planning that is garnering the most attention from federal and state officials is the issue of how best to promote access to LARC. A number of the states in this analysis had actively reviewed their policies to ensure that there were not inappropriate medical utilization requirements on use of LARCS and/or had launched initiatives to train more providers on LARC insertion. However, there still is a marked discrepancy between the policies that states have “on the books” and the reality of access to LARC, as reported by a number of advocates and family planning providers. Moreover, although the issue of how best to support providers in having LARCs in stock is well recognized, most states had not yet devised approaches to tackling it.

As the frontline providers of care for many low income women of all racial and ethnic backgrounds, many family planning providers are frustrated to find themselves excluded from delivery system reform conversations or struggling to contract with multiple MCOs to provide care to women who long have been their patients. Many are increasingly making the case to payers and policymakers who want to prevent unintended pregnancies about the value that they can offer, highlighting their deep experience and training to provide family planning services, including those that pose stumbling blocks for other primary care providers (e.g., contraceptive counseling, LARC insertion), the ability to offer same-day access to family planning services, and a unique understanding of what differentiates family planning services from other medical services.

This analysis highlighted the lack of data available to systematically assess the implications of the ACA for Medicaid and its role in providing family planning services. With so much at stake for low-income women, family planning providers and policymakers are eager to continue to reduce unintended pregnancy rates, it will be important to find ways to gather data in the future on what is working and where more needs to be done to ensure that women in Medicaid continue to have access to high-quality family planning services.

Finally, this study was conducted in the summer of 2016 before the election changed the outlook for the ACA and Medicaid. The Trump Administration has signaled its willingness to put more decisions about the program's benefits, eligibility, and distribution of funds in the hands of state policymakers. As we see in this study, several states have used the 1115 waiver process to extend Medicaid coverage for family planning services to groups that have historically been ineligible for full scope Medicaid coverage. However, state and federal policymakers could potentially also apply the 1115 waiver to restrict the range of participating providers, covered services, and eligibility criteria.

This study shows that when states have choices in crafting family planning benefits under Medicaid, the results can vary widely. Moving forward, it will be important to continue to monitor the impact of Medicaid policy changes at the federal and state levels to assess the impact on access to family planning services for low-income women and men.

Appendix A: State Comparison Chart

	Alabama	California	Connecticut	Illinois[49]	Missouri	Virginia
Medicaid Family Planning Program						
Name	Plan First	Family PACT	N/A	N/A	N/A	Plan First
Waiver or SPA	Waiver *(Established in 2000)*	SPA *(Converted from waiver in 2011)*	SPA *(Established in 2012)*	N/A *(Waiver terminated in 2014)*	Waiver *(Established in 1998)*	SPA *(Converted from waiver in 2011)*
Gender/Age Eligibility	Women, 19-55 Men, 21 and older (only for vasectomies)	Women, no age restrictions Men, no age restrictions	Women, no age restrictions Men, no age restrictions	N/A	Women, 18-55	Women, no age restrictions Men, no age restrictions
Income Eligibility	141% FPL	200% FPL	263% FPL	N/A	201% FPL	200% FPL
FP-Related Benefits?	No[50]	Yes	Yes	N/A	Yes	No
Family Planning Program Enrollment (Source: state interviews)	103,288 (as of 12/31/15)	1,000,000 (2016 estimate)	274 (2016 estimate)	N/A	71,000 (2016 estimate)	110,000 (2016 estimate)
Coverage Landscape						
Expanded Medicaid?	No	Yes	Yes	Yes	No	No
% of Medicaid Enrollees in Managed Care[51]	0%	77%	0%	53%	51%	66%
Rely on Healthcare.gov?	Yes	No	No	Yes	Yes	Yes
Demographics						
Distribution of adults ages 19-64 enrolled in Medicaid, by sex, 2014 (Source: U.S. Census Bureau)	Female: 60% Male: 40%	Female: 55% Male: 45%	Female: 58% Male: 42%	Female: 53% Male: 47%	Female: 56% Male: 44%	Female: 59% Male: 41%
Distribution of women ages 19-64, by FPL, 2014 (Source: U.S. Census Bureau)	Below 100% FPL: 18% Below 400% FPL: 67%	Below 100% FPL: 16% Below 400% FPL: 62%	Below 100% FPL: 9% Below 400% FPL: 46%	Below 100% FPL: 14% Below 400% FPL: 58%	Below 100% FPL: 11% Below 400% FPL: 59%	Below 100% FPL: 12% Below 400% FPL: 52%
Health insurance coverage of women ages 19-64, 2014 (Source: KFF Women's Health Insurance Coverage)	ESI: 57% Direct purchase: 8% Medicaid: 13% Other: 9% Uninsured: 14%	ESI: 53% Direct purchase: 9% Medicaid: 22% Other: 4% Uninsured: 13%	ESI: 67% Direct purchase: 8% Medicaid: 14% Other: 3% Uninsured: 8%	ESI: 63% Direct purchase: 7% Medicaid: 16% Other: 3% Uninsured: 11%	ESI: 64% Direct purchase: 7% Medicaid: 11% Other: 5% Uninsured: 13%	ESI: 63% Direct purchase: 9% Medicaid: 7% Other: 9% Uninsured: 13%

Appendix B: State Profiles

Alabama State Profile

Family Planning Overview: Alabama operates Plan First, a waiver program that covers family planning services for women ages 19-55 with incomes up to 141% FPL. The program also covers vasectomies for men age 21 and older with incomes up to 141% FPL. Alabama's Plan First program does not cover other medical services. The Alabama Medicaid Agency manages eligibility and enrollment for the program. The Alabama Medicaid Agency collaborates with the Department of Public Health (DPH) to administer a unique case management program for Plan First enrollees. The DPH operates 84 health centers where many enrollees seek care.

Alabama Medicaid/CHIP Eligibility Levels as % of FPL[52]

Eligibility levels do not include 5% income disregard

Children by Age (Medicaid)			Separate CHIP	Pregnant Women (Medicaid)	Parents	Childless Adults
0-1	1-5	6-18				
141%	141%	141%	312%	141%	13%	N/A

Share of Medicaid Population Covered by Different Delivery Systems[53]

	% of Medicaid Population Covered
Fee-for-Service (FFS)	36%
Primary Care Case Management (PCCM)	64%

Brief Program History: Alabama established Plan First in October 2000 through an 1115 waiver. At that time, the program provided family planning services for women ages 19-44 with incomes up to 133% FPL not otherwise eligible for Medicaid or Medicare or for those who were losing Medicaid pregnancy coverage after 60 days postpartum. Plan First was expanded in 2008 to include women ages 19-55. In the most recent waiver amendment, the eligibility level was adjusted to 141% FPL[54] due to ACA rules for basing eligibility on the Modified Adjusted Gross Income (MAGI) formula and men were added as eligible individuals for vasectomies only. The State elected not to pursue a state plan amendment (SPA) due to the administrative burden of converting from a waiver to a SPA. As of December 2015, 103,288 individuals were enrolled in Plan First.

Program Enrollment & Access to Care: Individuals who apply for Medicaid with the State Medicaid agency must affirmatively opt-in to have their eligibility determined for the Plan First program. An applicant would check a box on the Medicaid application to indicate interest in Plan First in order to have his/her eligibility determined for the program. Alabama developed this approach in 2010 after finding that enrollees who had been auto-enrolled were not utilizing or interested in family planning services. Individuals who apply at HealthCare.gov do not have their eligibility determined for Plan First.

Plan First enrollees have access to a network of nearly 1,7000 providers, including public health clinics, FQHCs, and private providers.[55] Notably, there is at least one public health site that offers family planning services in all but one county. These sites serve as key access points since much of Alabama is designated as a medical shortage area for primary care by the federal Health Resources and Services Administration.[56]

Intersection with Full-Scope Medicaid: Alabama enrolls "full-scope" beneficiaries into either fee-for-service or primary care case management plans. Full-scope enrollees have access to family planning and family planning-related services, whereas Plan First enrollees are covered only for family planning services.

LARC: Alabama promotes LARC utilization through provider education using the program's website, ALERTS, care coordination in the Maternity Care program, in public health clinics and through the use of ADPH case management system. Notably, information about different types of contraceptive coverage and educational materials for both Plan First recipients and providers are available on the website and through outreach education provided through a partnership agreement with DPH. DPH provides family planning outreach services to Medicaid eligibles and potential Medicaid eligibles to include orientation pamphlets, posters, and flyers, designed to increase awareness of the availability of benefits of family planning methods.

Nurse practitioners providing services in a public health clinic use a tiered contraceptive chart to counsel patients on the effectiveness of different contraceptives, including LARCs. State law bars a nurse practitioner from inserting an IUD without a physician on staff, so women electing IUDs at a public health clinic are referred out to a physician. Nurse practitioners are permitted to remove IUDs without physician oversight.

In April 2014, Alabama started reimbursing hospitals for LARCs inserted immediately post-delivery. Specifically, the State covers the hospitals' cost of the LARC device or implant and insertion is billable to Medicaid when the insertion occurs either immediately after delivery and before discharge from an inpatient setting, or in an outpatient setting after delivery and immediately after discharge from an inpatient setting.[57]

According to Alabama's most recent waiver evaluation, LARC utilization among Plan First enrollees increased slightly from 2009 to 2014, from 29% to 32%.[58]

Other Initiatives: Alabama provides case management for individuals at high risk for unintended pregnancy and has made a concerted effort to ease Plan First enrollment and renewal processes.

- Case management has been a key component of the waiver since its inception in 2000. DPH employs social workers who cover all of Alabama's 67 counties to conduct risk assessments to determine if Medicaid recipients enrolling for family planning services are at high risk for unintended pregnancies. When an individual is identified as high risk, social workers complete a psychosocial assessment and follow-up with individuals regarding family planning appointments and birth control.
- Case managers play an important role in linking women that seek care under the Plan First program and elect an IUD insertion with a provider that can insert an IUD.
- In 2012, Alabama started offering express lane eligibility and utilizing data from the Department of Human Services to process automatic renewals for the Plan First program.

Delivery System Reform: Alabama plans to transition its Medicaid program to managed care delivered through hospital and provider led entities called Regional Care Organizations (RCOs), an initiative that received CMS approval in 2016. RCOs will offer the same services currently provided to FFS and PCCM beneficiaries. The State plans to evaluate family planning outcome measures including utilization of LARC and other forms of birth control. Plan First enrollees will continue to enroll in Medicaid FFS, not through RCOs.

California State Profile

Family Planning Overview: California administers its "Family PACT" program though a State Plan Amendment (SPA) for women and men "of childbearing age" (there are no official age limitations) with incomes up to 200% of the FPL who have no other source of family planning coverage. Enrollees in Family PACT are covered for family planning services and limited family planning-related services. The Department of Health Care Services (DHCS) manages Family PACT as well as California's Medicaid program, Medi-Cal while the Office of Family Planning (OFP), which sits within DHCS, provides administrative oversight for the Family PACT program and family planning policies for the DHCS at large.

California Medicaid/CHIP Eligibility Levels as % of FPL[59]

Eligibility levels do not include 5% income disregard

Children by Age (Medicaid)			Separate CHIP	Pregnant Women (Medicaid)	Parents	Childless Adults
0–1	1–5	6–18				
261%	261%	261%	317%	208%	109%	133%

Share of Medicaid Population Covered by Different Delivery Systems[60]

	% of Medicaid Population Covered
Fee-for-Service	23%
Managed Care Organizations	77%

Brief Program History: Family PACT was established by the legislature in 1997 as a state-funded program. In 1999, California received approval through a waiver for the program and began receiving matching federal funds. California converted the waiver to a SPA in 2011, retroactive to July 2010, eliminating the need to negotiate and renew the waiver at regular intervals. The state uses an option included in the ACA to extend eligibility under the SPA to individuals who, had they applied on or before January 1, 2007, would have been eligible under the standards and processes in place at that time. One exception is that because California now determines eligibility using the Modified Adjusted Gross Income (MAGI) methodology, applicants (with the exception of those aged 17 or younger) must report household income rather than individual income. Family PACT enrollment has been declining in recent years, with 1.3 million enrolled in June 2015, down from to 1.7 million in June 2013.[61] Enrollment is expected to continue to decline as more individuals gain comprehensive coverage through Medi-Cal or Marketplace plans.

Program Enrollment & Access to Care: Individuals apply for and enroll in Family PACT directly through their providers by filling out a two-page application in which they attest to residency, household income and lack of other health insurance. Providers assess eligibility based on attested information. They can issue eligible individuals a Family PACT enrollment card on-site at the time of application, allowing them to provide needed services on the same day the individual applies for coverage. During the Family PACT enrollment process, providers are also encouraged to assist individuals who may be eligible for full Medi-Cal coverage in completing their application or advise them on where they can obtain further application assistance.

Family PACT enrollees can access family planning services through 2,200 providers, including a range of both public and private providers.[62]

Intersection with Medicaid Managed Care: Since California expanded Medicaid under the ACA, some Family PACT enrollees with incomes less than 138% FPL have become eligible for full-scope Medi-Cal. While the State has not tracked the number of individuals that have transitioned from Family PACT to full-scope Medi-Cal, the vast majority of enrollees have likely moved into Medi-Cal managed care plans (approximately three-quarters of all full-scope enrollees are enrolled in managed care plans). At the time of Medicaid expansion, there were some minor differences between the benefit packages for full-scope Medi-Cal versus Family PACT. Since then, however, the State has made a concerted effort to align the benefit package for the two programs, primarily by adding some new services to full-scope Medi-Cal.

LARC: While the proportion of Family PACT clients utilizing LARC methods has increased over the past ten years, California continues to work to further educate and train providers on LARC methods. For example, the State has conducted webinars for Family PACT and Medi-Cal providers to dispel common myths about LARC placement and to encourage providers to offer women the option of same-day LARC insertion. The State also continues to examine challenges that providers may face related to obtaining LARC devices and reimbursement for LARC procedures.

Other Initiatives: California has undertaken efforts to develop family planning quality measures and transition eligible individuals into comprehensive coverage, including:

- DHCS will continue to implement quality improvement and utilization management improvements within Family PACT, which would further enable the State to evaluate the quality and cost-effectiveness of services provided through the program. These evaluation efforts will replace a long-standing contract the state previously held with UCSF to evaluate Family PACT.
- California was a recipient of $400,000 from CMS's Contraceptive Use Measure Grant,[63] which it is using to develop LARC quality measures aimed at improving access to LARC.
- Medi-Cal distributed grants to providers, including Family PACT providers, to conduct enrollment outreach to their patients who may be eligible for comprehensive coverage through Medi-Cal.

Delivery System Reform: California's first "Bridge to Reform" 1115 waiver, which included a Delivery System Reform Incentive Payment (DSRIP) program, expired after five years on October 31, 2015. After months of negotiations to renew the waiver, CMS agreed to extend "Bridge to Reform" until the end of 2015 and then granted approval for the renewal waiver, Medi-Cal 2020, which took effect on January 1, 2016 and operates through December 31, 2020. Medi-Cal 2020 includes a number of different initiatives aimed at broader delivery system reform and preparing public hospitals for alternative payment methodologies, but family planning is not a focus of any of them.

CONNECTICUT STATE PROFILE

Family Planning Overview: Connecticut administers its family planning program through a SPA for men and women of child-bearing age (including minors) who are not otherwise eligible for full-scope Medicaid, with incomes up to 263% FPL. Enrollees in the program are covered for both family planning and family planning-related services. The program is administered by the Department of Social Services (DSS).

Connecticut Medicaid/CHIP Eligibility Levels as % of FPL[64]

Eligibility levels do not include 5% income disregard

Children by Age (Medicaid)			Separate CHIP	Pregnant Women (Medicaid)	Parents	Childless Adults
0–1	1–5	6–18				
196%	196%	196%	318%	258%	150%	133%

Share of Medicaid Population Covered by Different Delivery Systems[65]

	% of Medicaid Population Covered
Fee-for-Service	100%
Managed Care Organizations	0%

Brief Program History: Connecticut's family planning SPA went into effect on March 1, 2012. While there was interest in establishing a family planning waiver prior to the implementation of the SPA, a program was never established. When the ACA made the SPA option available, the State leveraged the simpler implementation process.

Program Enrollment: Using presumptive eligibility, providers trained by DSS deemed as qualified entities submit a condensed online application via the DSS "ConneCT" system for those who appear eligible for the family planning program. To obtain coverage beyond the presumptive eligibility period—which lasts through the conclusion of the month following the month of application--individuals must apply through Access Health CT (the State-based Marketplace) either online or by phone and can be determined eligible for full-scope Medicaid, the Marketplace or the family planning program. The vast majority (>90%) of family planning program enrollees originally entered the program by applying for presumptive eligibility at the Planned Parenthood of Southern New England affiliate.

Enrollment in the family planning program beyond the presumptive eligibility period has fallen from 361 individuals in July 2015 to 274 individuals in June 2016. This decline is primarily the result of individuals obtaining full coverage through the Marketplace or in full-scope Medicaid.

Intersection with Medicaid Managed Care: Connecticut no longer operates a Medicaid managed care program. In 2012, Connecticut's Medicaid program transitioned from contracting with managed care organizations (MCOs) for the delivery of care to fee-for-service, leveraging several Administrative Service Organizations (ASOs) to help with program administration.

LARC: LARC methods are included in the family planning program benefit package. The State also promotes LARC insertions for post-partum women immediately following delivery by allowing hospitals to bill for immediate post-partum LARC outside of inpatient delivery codes.

Other Initiatives: *None identified*

Delivery System Reform: In December 2014, CMS' Center for Medicare & Medicaid Innovation awarded Connecticut up to $45 million through a State Innovation Model grant to implement the Connecticut Healthcare Innovation Plan. While the Innovation Plan does not include any family planning-specific components, family planning providers have been invited to participate in some programs.

ILLINOIS STATE PROFILE

Family Planning Overview: Illinois does not have a separate Family Planning waiver or State Plan Amendment for the provision of family planning services. Instead, Illinois embeds family planning and family-planning related services within Medicaid's comprehensive benefit package. The Illinois Department of Healthcare and Family Services (HFS) administers the full Medicaid program, with the Bureau of Quality Management overseeing family planning services, among other initiatives, within the broader Medicaid Program.

Illinois Medicaid/CHIP Eligibility Levels as % of FPL[66]

Eligibility levels do not include 5% income disregard

Children by Age (Medicaid)			Separate CHIP	Pregnant Women (Medicaid)	Parents	Childless Adults
0-1	1-5	6-18				
142%	142%	142%	313%	208%	133%	133%

Share of Medicaid Population Covered by Different Delivery Systems[67]

	% of Medicaid Population Covered
Fee-for-Service	21%
Primary Care Case Management	27%
Managed Care Organizations	53%

Brief Program History: Between 2004 and 2014, the State operated the "Illinois Healthy Women" family planning waiver for women ages 19-44 with incomes up to 200% of the federal poverty level (FPL). The program was administered through the Bureau of Maternal and Child Health Promotion (BMCHP) within HFS. Illinois ended its family planning waiver program on December 31, 2014 with the understanding that women enrolled in the waiver would have the opportunity to enroll in comprehensive coverage -- either in Medicaid expansion (for those with incomes at or below 138% of the FPL) or in a qualified health plan with financial assistance on the Marketplace (for those with incomes between 138% FPL and 200% FPL). BMCHP was recently merged into the Bureau of Quality Management.

After Illinois decided to end the waiver program, the State was granted a "transition year" across 2014 to conduct outreach to enrollees, educating them about the closing of the program and opportunities to enroll in either full coverage Medicaid or a Marketplace Qualified Health Plan (QHP) with premium tax credits. While waiver enrollees could not be automatically enrolled into the Medicaid expansion program because the State's system did not capture enrollees' income as a percentage of FPL, State data indicate that 45% of waiver enrollees had transitioned to full coverage Medicaid as of February 2016. A portion of waiver enrollees most likely gained coverage in the Marketplace QHPs, although information on the number of enrollees is not available.

Medicaid Enrollee Access to Family Planning Benefits: Medicaid enrollees have access to family planning services as a part of their comprehensive Medicaid benefit package. The majority of enrollees likely to seek family planning services are enrolled in Medicaid managed care.

In June 2014, Illinois Medicaid released a new policy providing guidance to all Medicaid-enrolled providers regarding comprehensive quality family planning and reproductive health services. In October 2014, Illinois took a step to increase access to family planning services, and most notably LARC methods, by increasing Medicaid reimbursement rates for the following procedures:[68]

CPT Code	Description	Previous Rate	New Rate
11981	Insertion of implant	$72.30	$88.00
11982	Removal of implant	$87.00	$99.00
11983	Removal and reinsertion of implant	$108.00	$143.00
58300	Insertion of IUD	$44.00	$88.00
58301	Removal of IUD	$37.40	$37.40
58300 + 58301	Removal and reinsertion of IUD	$44.00	$106.70

Intersection with Managed Care: In 2015, Illinois' Medicaid program transitioned from predominantly fee-for-service to over 50% managed care. Knowing that the family planning enrollees transitioning to full coverage Medicaid would be enrolled in Medicaid MCOs, the State rolled out the "Family Planning Action Plan"[69] (FPAP) to help smooth the transition and ensure that enrollees continued to receive access to comprehensive family planning services. The FPAP articulates for providers and MCOs that:

- All Medicaid providers must offer the full spectrum of family planning contraceptives with no cost sharing, step therapy or prior authorization;
- The Free Choice of Provider statute allows enrollees to see any Medicaid provider regardless of managed care network status; and
- Enrollees should receive education and counseling on all FDA-approved contraceptives, from most to least effective, with most effective including long acting reversible contraceptives (LARC)—intrauterine devices (IUD) and the contraceptive implant.
- The Medicaid agency oversees MCOs and their provision of family planning services. In addition to contracting requirements, the Medicaid agency:
- Requires MCO attendance at periodic in-person meetings, during which the Medicaid agency communicates updates, critical program information, and provides trainings, including on family planning services and how to improve birth outcomes;
- Requires MCOs to provide intensive care management to enrollees under the prenatal care plan which includes family planning education and counseling; and
- Is in the process of updating its methodology for withholding a portion of MCOs' capitation rates contingent on their meeting certain performance measures. Consideration will be given to family planning metrics when the updated developmental contraceptive performance measures are finalized.

LARC: Illinois has implemented several policy and payment changes to increase access to LARC. In addition to the coverage and counseling requirements outlined in the FPAP, Illinois has: (1) increased reimbursement for insertion, removal and reinsertion of LARCs in outpatient settings; (2) increased the dispensing fee for LARC purchased through the 340B program; (3) allowed separate reimbursements for an Evaluation & Management visit in which the provider and patient discuss contraceptive options and a same-day LARC procedure; (4) allowed hospitals to separately bill for a LARC device that is provided immediately postpartum in the inpatient hospital setting;[70](5) ensured that federally-qualified health centers and rural health centers receive reimbursement for actual acquisition costs for LARC devices under the 340B program separate from the encounter rate; and (6) implemented a pilot program to ensure outpatient providers maintain sufficient supplies of LARC methods.[71]

Other Initiatives: Illinois has deployed other payment and billing changes across fee-for-service and managed care to ensure access to a range of contraceptive methods, including:

- Increasing the reimbursement rate for vasectomies;
- Permitting FQHCs and RHCs to bill fee-for-service for transcervical sterilization devices, which the State describes as alternatives to hospital-based surgical sterilization that do not require incisions or general anesthesia;
- Establishing a contraceptive education/counseling enhanced rate for eligible providers;
- Increasing medical dispensing fee add-ons for certain 340B birth control methods beyond LARC; and,
- Requiring providers to dispense three month supplies of certain contraceptives whenever possible and medically appropriate.

Additionally, on July 29, 2016, Governor Bruce Rauner signed into law House Bill 5677,[72] which ensures that all FDA-approved contraceptive drugs, devices and supplies are covered without cost-sharing by individual and group plans regulated by the state or that cover state employees, retirees and their dependents. While plans are not required to include all FDA-approved, therapeutic equivalents of a drug, device or product on formulary, plans must make available without cost-sharing any off-formulary methods recommended by a patient's provider based on medical necessity. The bill also ensures that 12 months' worth of contraception may be dispensed at one time and requires coverage for patient education, counseling on contraception, contraceptive follow-up services and voluntary sterilization procedures. The law is scheduled to take effect January 1, 2017.

Finally, the Illinois Medicaid agency contributed to the national effort among the federal Department of Health and Human Services Office of Population Affairs, Centers for Medicare and Medicaid Services, and Centers for Disease Control and Prevention to develop contraceptive use performance measures.

Delivery System Reform: There are no new statewide delivery system reform efforts underway.

Missouri State Profile

Family Planning Overview: Missouri administers its family planning program through an 1115 waiver for uninsured women ages 18-55 with incomes at or below 201% FPL. Enrollees in the program are covered for both family planning and family planning-related services. The program is co-managed by two divisions within the Department of Social Services: MO HealthNet (Missouri's Medicaid agency) and the Family Support Division (FSD). FSD manages program eligibility and MO HealthNet handles policy and claims administration.

Missouri Medicaid/CHIP Eligibility Levels as % of FPL[73]

Eligibility levels do not include 5% income disregard

Children by Age (Medicaid)			Separate CHIP	Pregnant Women (Medicaid)	Parents	Childless Adults
0–1	1–5	6–18				
196%	148%	148%	300%	196%	18%	N/A

Share of Medicaid Population Covered by Different Delivery Systems[74]

	% of Medicaid Population Covered
Fee-for-Service	50%
Managed Care Organizations	51%[75]

Brief Program History: Missouri's initial family planning program was approved as part of an 1115 Medicaid managed care demonstration project, which ran from May 1, 1998 through March 1, 2004, before being extended through September 30, 2007. On October 1, 2007 Missouri implemented the current family planning program entitled "Women's Health Services Program." At the request of the State, CMS subsequently renewed and extended this program through December 31, 2014, then again through December 31, 2017. Missouri did not see a need to transition the waiver program to a State Plan Amendment. Program enrollment has grown from an average monthly enrollment of approximately 60,000 in 2013 to approximately 71,000 in 2016.

Missouri recently suspended the family planning waiver and replaced it with a state-funded program titled "Missouri Women's State-Funded Health Service Program." All existing waiver program enrollees will be automatically transitioned into the state-funded program. Program eligibility and benefits are expected to remain the same. This change is being made because language authorizing funding for the program no longer complies with all terms and conditions of the waiver. As passed by the legislature[76] and described in the State's Public Notice,[77] Medicaid funds in Missouri will no longer be "expended to directly or indirectly subsidize abortion services or procedures or administrative functions and none of the funds…may be paid or granted to an organization that provides abortion services."

Program Enrollment: Missouri employs the same application, verification, and renewal processes for full-scope Medicaid and the family planning program. Pregnant women enrolled in Medicaid are automatically enrolled into the family planning program 60 days postpartum.

Intersection with Medicaid Managed Care: Half of Missouri's full-scope Medicaid enrollees are enrolled through a Medicaid managed care plan. Family planning benefits are aligned across the family planning waiver

program, Medicaid fee-for-service (FFS) and Medicaid managed care plans. Medicaid managed care plans in Missouri are required to offer care management for individuals receiving family planning services and to contract with Title X and other family planning providers. Additionally, plans must have internal quality improvement procedures for a variety of clinical areas, including family planning, well-woman care, and maternity.

LARC: LARC methods are included in the family planning program benefit package. Missouri recently expanded access to LARC for both Medicaid and family planning program enrollees by separately reimbursing hospitals for LARC insertions for post-partum women immediately following delivery.[78]

Other Initiatives: *None identified*

Delivery System Reform: Missouri is not currently pursuing delivery system reform efforts; however, Missouri will be expanding Medicaid managed care eligibility criteria by May 2017, with the primary goal of transitioning more children into managed care plans. The family planning program will remain FFS.

VIRGINIA STATE PROFILE

Family Planning Overview: Virginia administers its "Plan First" program though a State Plan Amendment (SPA) for women and men of any age with incomes up to 200% FPL. Enrollees in Plan First have coverage of family planning services, but not family planning related services. The Department of Medical Assistance Services (DMAS) administers the Plan First program and contracts with the local Department of Social Services to perform eligibility determinations and enrollment of members in Plan First. The Department of Health (VDH) is the largest provider of safety-net family planning services through its Title X clinics.

Virginia Medicaid/CHIP Eligibility Levels as % of FPL[79]

Eligibility levels do not include 5% income disregard

Children by Age (Medicaid)			Separate CHIP	Pregnant Women* (Medicaid)	Parents	Childless Adults
0-1	1-5	6-18				
143%	143%	143%	200%	143%	49%	0%

*Virginia also has a Health Insurance Flexibility and Accountability CHIP waiver that covers pregnant women over the Medicaid income limits up to 200% of FPL.

Share of Medicaid Population Covered by Different Delivery Systems[80]

	% of Medicaid Population Covered
Fee-for-Service	34%
Managed Care Organizations	66%

Brief Program History: Virginia first established a family planning program through a waiver in 2002. This Medicaid waiver extended family planning services for two years to Medicaid pregnant women enrollees after delivery, if they continued to meet eligibility requirements. In 2007, coverage was expanded to all women and men with incomes less than 133% FPL and the lower age requirement of 19 was removed. The income limit was then raised to 200% FPL in 2008. In 2011, Virginia transitioned the family planning program from a waiver to a State Plan, eliminating the need for demonstration renewals every three years as well as waiver evaluations and reports. Since Virginia converted to a State Plan, the requirement for individuals to complete a separate application for family planning upon losing full-scope Medicaid coverage was removed, thus enrollment increased substantially from 8,000 in 2011 to approximately 110,000 in 2016. Notably, the State has not seen a corollary increase in utilization of services in Plan First, reflecting that many of the enrollees are not using services.

Program Enrollment & Access to Care: As part of the Affordable Care Act, Virginia uses a single, streamlined application for most Medicaid eligibility categories, including Plan First. Prior to implementation of the single, streamlined application, Virginia used a shorter, family planning-only form. Individuals between the ages of 19 and 64 who apply for Medicaid using the streamlined application who are not found eligible for full-scope Medicaid but are determined eligible for Plan First are automatically enrolled, unless they opt out for Plan First determination. Individuals under age 19 and over 64 must opt in to be evaluated for the Plan First program if they are not determined eligible for a full Medicaid covered group.

Plan First enrollees may obtain family planning services from any Department of Medical Assistance Services (DMAS) enrolled fee-for-service provider.

Intersection with Medicaid Managed Care: Two-thirds of Virginia's Medicaid enrollees with comprehensive coverage are enrolled in a Medicaid managed care plan. Family planning services are included in the comprehensive benefit package and are very similar to those offered to family planning SPA enrollees. DMAS is evaluating programmatic differences and working to align the programs.

LARC: Virginia is working on reforms to eliminate payment barriers and increase access to and utilization of LARC in a variety of settings, including physician offices and hospital-based immediate postpartum LARC insertion. The Virginia DMAS is working with the Virginia Department of Health (VDH), Physician and Nurse Practitioner Provider Associations, and the Medicaid and CHIP managed care health plans to increase provider and member education as well as outreach efforts on the benefits of LARC and processes needed to streamline reimbursement for the LARC devices.

Other Initiatives: Virginia has taken steps to address Plan First enrollment issues and increase access to contraception, including through the following activities:

- DMAS and VDH jointly conducted targeted outreach to encourage enrollment into the Plan First program for several years. Each agency received funding to devote staff to these efforts, including outreach to patients and providers, and met regularly to discuss the outcomes of these efforts.
- DMAS modified the Plan First ID card and member handbook to differentiate the program more clearly from Medicaid, resolving confusion among providers and consumers about whether women had family planning only or full-scope Medicaid.
- While all categories of contraceptives are covered, in 2016 Virginia increased access to oral contraceptive methods by eliminating it from the "preferred drug list" (PDL). Removing contraceptives from the PDL removes all prior authorization requirements from oral contraceptives since the Commonwealth does not have "non-preferred" agents. Currently, physician-administered contraceptive methods are not on the PDL and must be purchased by the practitioner and billed upon administration.
- In 2015, VDH dedicated funding to increase accessibility of LARCs as part of an initiative to reduce unintended pregnancy. VDH continues to support availability of LARCs for VDH clients as long as funding allows. The intent is to compare statewide unintended pregnancy rates before 2015 and after this 2015 LARC initiative to measure efficacy and LARC selection by clients.

Delivery System Reform: In February 2016, Virginia submitted an 1115 Medicaid waiver application to CMS requesting authority to implement a $1 billion Delivery System Reform Incentive Payment (DSRIP) initiative. The initiative would establish networks of high performing providers that would partner with managed care organizations to improve and coordinate care and ultimately transition to new payment models for high-cost Medicaid enrollees. Family planning providers and metrics were not incorporated into the proposed demonstration.

Appendix C: List of Interviewees

ALABAMA

Medicaid Agency:

Gretel Felton, Deputy Commissioner for Beneficiary Services
Jerri Jackson, Director of the Managed Care Division
Sylisa Lee-Jackson, Associate Director of Maternity, Plan First/Family Planning, and Nurse Midwife Programs

Department of Public Health, Bureau of Family Health Services:

Meredith Adams, Director of Social Work
Diane Beeson, Director of Women's and Children's Health Division
Leigh Ann Hixon, Plan First Manager

CALIFORNIA

Department of Health Care Services (DHCS):

Nicole Griffith, Assistant Division Chief of the Office of Family Planning (OFP)
René Mollow, Deputy Director of Healthcare Benefits and Eligibility
Christina Moreno, Division Chief, OFP
Laurie Weaver, Assistant Deputy Director of Healthcare Benefits and Eligibility

University of California at San Francisco (UCSF)

Claire Brindis, Professor of Pediatrics and Health Policy and Director of the Institute for Health Policy Studies. Previously, lead of UCSF Family PACT Evaluation, OFP, DHCS
Heike Thiel de Bocanegra, Associate Professor, Department of Obstetrics, Gynecology & Reproductive Services. Previously, director of UCSF Family PACT Evaluation, OFP, DHCS
Dr. Christine Dehlendorf, Associate Professor, School of Medicine

University of California, Davis

Eleanor Schwarz, Professor of Medicine. Previously, medical director of UCSF Family PACT Evaluation, OFP, DHCS

Planned Parenthood Affiliates of California:

Kathy Kneer, President and CEO

California Family Health Council:

Amy Moy, Vice President of Public Affairs
Julie Rabinowitz, President and CEO

CONNECTICUT

Department of Social Services:

Nina Holmes, Health Program Supervisor, Division of Health Services
Daniel Patterson, Public Assistance Consultant, Eligibility Policy and Program Support
Mark Shock, Director of Eligibility Policy, Division of Health Services
Robert Zavoski, Medical Director, Division of Health Services

Planned Parenthood of Southern New England:

Susan Lane, Director of Planning and Grants
Judy Tabar, President and CEO

ILLINOIS

Department of Healthcare and Family Services

Mary Doran, Bureau Chief, Bureau of Program and Policy Coordination
Teresa Hursey, Acting Administrator, Division of Medical Programs
Linda Wheal, Maternal Health Program Manager, Bureau of Quality Management

Chicago Department of Public Health:

Kai Tao, Deputy Commissioner, Chief Program Officer

Planned Parenthood of Illinois:

Brigid Leahy, Director of Public Policy

EverThrive:

Kathy Waligora, Director Health Reform Initiative

University of Chicago, Center for Interdisciplinary Inquiry and Innovation in Sexual and Reproductive Health:

Lee Hasselbacher, Policy Coordinator, Family Planning and Contraceptive Research

MISSOURI

MO HealthNet:

Glenda Kremer, Assistant Deputy Director of the Program Operational Unit
Nancy Nikodym, Social Services Unit Manager
Jayne Zemmer, Assistant Deputy Director of Clinical Services Policy & Operations

Department of Social Services (DSS):

Jennifer Tidball, Deputy Director
Kim Evans, Deputy Director for Income Maintenance, Family Support Division

St. Louis Planned Parenthood:

Mary Kogut, Chief Executive Officer
Angie Postal, Director of Public Policy

Missouri Family Health Council:

Michelle Trupiano, Executive Director

Missouri Foundation for Health:

Thomas McAuliffe, Director of Health Policy

Contraceptive Choice Center at the Washington University in St. Louis:

Dr. Tessa Madden, OB-GYN and Assistant Professor at the School of Medicine
Dr. Timothy McBride, Professor at the George Warren Brown School of Social Work

VIRGINIA

Department of Medical Assistance Services

Ashley Harrell, Policy & Services Manager, Maternal & Child Health Division
William Lessard, Director of Provider Reimbursement
Linda Nablo, Chief Deputy Director
Daniel Plain, Senior Health Care Services Manager
Cheryl Roberts, Deputy Director for Programs

Department of Health:

Sulola Adekoya, Medical Director for Regional Health Services

Janelle Anthony, Family Planning Quality Assurance Nurse
Cornelia Deagle, Director of the Division of Children and Family Health

Richmond City Health District:

Danny Avula, Deputy Director
Laurinda Davis, Public Health Nurse Supervisor

Planned Parenthood Advocates of Virginia:

Cianti Stewart-Reid, Executive Director

The Virginia League for Planned Parenthood:

Paulette McElwain, President and CEO

Virginia Poverty Law Center:

Jill Hanken, Health Attorney

FEDERAL & NATIONAL EXPERTS

Centers for Medicare and Medicaid Services (CMS): Center for Medicaid and CHIP Services (CMCS), State Demonstrations Group:

Andrea Casart, Director, Division of Medicaid Expansion Demonstrations
Julie Sharp, Technical Director, Division of State Demonstrations and Waivers

CMS: CMCS, Children and Adults Health Programs Group:

Stephanie Bell, Deputy Director, Division of Eligibility & Enrollment
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Endnotes

[1] Ranji U & Salganicoff A. State Medicaid Coverage of Family Planning Services: Summary of State Survey Findings. Kaiser Family Foundation. November 2009.

[2] Sonfield A & Gold RB. Public Funding for Family Planning, Sterilization and Abortion Services, FY 1980–2010. Guttmacher Institute. March 2012.

[3] Gold RB, Richards CL, Ranji U, & Salganicoff A. Medicaid's Role in Family Planning. Kaiser Family Foundation and Guttmacher Institute. October 2007.

[4] Ranji U & Salganicoff A. State Medicaid Coverage of Family Planning Services: Summary of State Survey Findings. Kaiser Family Foundation. November 2009.

[5] Ranji U & Salganicoff A. State Medicaid Coverage of Family Planning Services: Summary of State Survey Findings. Kaiser Family Foundation. November 2009.

[6] Gold RB. Back to Center Stage: ACA Decision Gives New Significance to Medicaid Family Planning Expansions. Guttmacher Institute. October 2012.

[7] Guttmacher Institute. State Policies in Brief: Medicaid Family Planning Eligibility Expansions. As of March 2016.

[8] Murphy S. Planned Parenthood to continue contracts with Oklahoma. *Associated Press, Chicago Tribune*. June 30, 2016.

[9] Centers for Medicare and Medicaid Services (CMS), Department of Health and Human Services (HHS). Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability. Published in the Federal Register on May 6, 2016.

[10] CMS, HHS. Clarifying 'Free Choice of Provider' Requirement in Conjunction with State Authority to Take Actions against Medicaid Providers." SMD #16-005. April 19, 2016.

[11] CMS, HHS. State Medicaid Payment Approaches to Improve Access to Long-Acting Reversible Contraception. CMCS Informational Bulletin. April 8, 2016.

[12] CMS, HHS. Medicaid Family Planning Services and Supplies. SHO #16-008. June 14, 2016.

[13] Consumer advocates were available in a limited number of case study states.

[14] State Health Facts. Share of Medicaid Population Covered under Different Delivery Systems. Kaiser Family Foundation. As of July 1, 2015. Accessed May 24, 2016.

[15] Alabama's waiver provides the authority to offer family planning related services; however, state interviewees reported that family planning related services are not covered.

[16] Prior to termination, Illinois operated the "Illinois Healthy Women" family planning waiver for women ages 19-44 with incomes up to 200% FPL.

[17] State Health Facts. Total Number of Residents. Kaiser Family Foundation. 2014.

[18] State Health Facts. State Health Insurance Marketplace Types, 2016. Kaiser Family Foundation.

[19] States that utilize the Federally-facilitated Marketplace (or "HealthCare.gov") must elect whether to have the FFM make assessments of Medicaid/CHIP eligibility and transfer the account to the Medicaid/CHIP agency for a final determination ("assessment model") or whether to delegate the authority to make Medicaid/CHIP eligibility determinations to the FFM ("determination model"). The eight determination states are Alabama, Alaska, Arkansas, Montana, New Jersey, Tennessee, West Virginia, and Wyoming. Marketplace model selections can be found: https://www.medicaid.gov/medicaid-chip-program-information/program-information/medicaid-and-chip-and-the-marketplace/medicaid-chip-marketplace-interactions.html

[20] In contrast, 29 states are "assessment model" states that allow the FFM to assess Medicaid eligibility for them, but, that then take the information that people provided to the FFM and use it to conduct the final Medicaid determination themselves. This allows them to apply state-specific eligibility rules and procedures, and, in the process, to evaluate people for eligibility for family planning programs.

[21] Alabama's Application for Health Coverage & Help Paying Costs. Question 7 on Page 2 of 11.

[22] When California converted its family planning program from a waiver to a SPA, it leveraged the ACA's state option to use eligibility standards and processes that were applied on or before January 1, 2007, thereby permitting the State to continue its use of enrollment into the family planning program on-site at providers' offices based on attested information.

[23] Depending on state-specific rules, applicants in waiver states may be deemed ineligible for a Medicaid family planning program if they have access to alternative coverage that includes family planning services.

[24] People can still enroll in a Marketplace plan and receive a premium tax credit even if they also are enrolled in a Medicaid family planning program. This is because Medicaid family planning programs do not constitute minimum essential coverage, and so do not preclude someone from premium tax credit eligibility. However, in some states, including California, Medicaid family planning rules adopted under waivers limit the coverage to people who otherwise lack family planning benefits.

[25] Ranji U, Bair Y, & Salganicoff A. Medicaid and Family Planning: Background and Implications of the ACA. Kaiser Family Foundation. February 2016.

[26] CMS, HHS. Family Planning Services Option and New Benefit Rules for Benchmark Plans. SMDL #10-013. July 2, 2010.

[27] Family planning-related services are those services administered along with a family planning service (e.g., contraceptive counseling). Some examples of family planning-related services include the treatment of STIs, physical exams conducted as part of an annual family planning visit, and preventive services (e.g., HPV vaccine).

[28] Walls J, Gifford K, Ranji U, Salganicoff A, & Gomez I. Medicaid Coverage of Family Planning Services: Results from a State Survey. Health Management Associates and Kaiser Family Foundation. September 2016.

[29] Alabama's Department of Public Health Title X clinics are staffed primarily by nurse practitioners who, under state law, cannot insert or remove IUDs or implantable devices unless there is a physician on staff. For example, if a woman selects an IUD as her form of birth control, the clinic must refer her to an off-site provider for insertion.

[30] Alabama Administrative Code, Chapter 560-X-14-.03(2).

[31] Kearney M & Levine P. Reducing Unplanned Pregnancies through Medicaid Family Planning Services. Brookings Institute. July 2008.

[32] Cross Reidel J & Thiel de Bocanegra H. Access to Publicly-Funded Family Planning Services by Women in Need, Fiscal Year 2009-10 to Fiscal Year 2012-13. Bixby Center for Global Reproductive Health, University of California. November 2015.

[33] Missouri House Bill 2011, 98th General Assembly, 2016.

[34] Missouri Department of Social Services. Public Notice of Suspension of Federal Expenditure Authority for Section 1115 Family Planning Demonstration. Accessed August 4, 2016.

[35] Stevenson AJ, Flores-Vasquez IM, Allgeyer RL, Schenkkan P, & Potter JE. (2016). Effect of Removal of Planned Parenthood from the Texas Women's Health Program. *The New England Journal of Medicine*. Vol. 374:853-860.

[36] MacDorman M, Declerq E, Cabral H, & Morton C. (2016). Recent Increases in the U.S. Maternal Mortality Rate: Disentangling Trends From Measurement Issues. *Obstetrics and Gynecology*. Vol. 128, No. 3, (447-455).

[37] Frost J, Sonfield A, Zolna M & Finer L. (2014). Return on Investment: A Fuller Assessment of the Benefits and Cost Savings of the US Publicly Funded Family Planning Program. *The Milbank Quarterly*. Vol. 92, No. 4, (667-720).

[38] Gavin L, Moskosky S, Carter M, et al. (2014). Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs. *MMWR*; 63.

[39] Center for Medicaid and CHIP Services. CMCS Maternal and Infant Health Initiative: Improving Maternal and Infant Health Outcomes in Medicaid and CHIP. Accessed August 4, 2016.

[40] Office of Population Affairs and Centers for Disease Control. Measure PCU: Use of Contraceptive Methods by Women Ages 15-44 (Developmental Measure). Accessed August 3, 2016.

[41] Ibid.

[42] Salganicoff A, Ranji U, Beamesderfer A & Kurani N. Women and Health Care in the Early Years of the ACA: Key Findings from the 2013 Kaiser Women's Health Survey. Kaiser Family Foundation. May 2014.

[43] Pace LE, Dolan BM, Tishler LW, Gooding HC, & Bartz D. (2015). Incorporating Long-acting Reversible Contraception Into Primary Care: A Training and Practice Innovation. *Women's Health Issues;* Vol. 26(2), pp.131-134.

[44] Yoost J. (2014). Understanding Benefits and Addressing Misperceptions and Barriers to Intrauterine Device Access among Populations in the United States. *Patient Preference and Adherence*; 8, pp.947–957.

[45] CMS, HHS. State Medicaid Payment Approaches to Improve Access to Long-Acting Reversible Contraception. CMCS Informational Bulletin. April 8, 2016.

[46] Illinois Department of Healthcare and Family Services. Illinois Family Planning Action Plan. October 2014.

[47] CMS, HHS. State Medicaid Payment Approaches to Improve Access to Long-Acting Reversible Contraception. CMCS Informational Bulletin. April 2016.

[48] While the immediate post-partum period is a particularly favorable time to provide LARC methods due to the softened state of the cervix, there are ethical concerns about attempting to advise or counsel women on contraceptive methods during the time of delivery.

[49] Prior to termination, Illinois operated the "Illinois Healthy Women" family planning waiver for women ages 19-44 with incomes up to 200% FPL.

[50] Alabama's waiver provides the authority to offer family planning related services; however, state interviewees reported that family planning related services are not covered.

[51] State Health Facts. Share of Medicaid Population Covered under Different Delivery Systems. As of July 1, 2015. Kaiser Family Foundation. Accessed May 24, 2016.

[52] Medicaid.gov. Medicaid & CHIP In Alabama. State Profiles, Eligibility.

[53] State Health Facts. Share of Medicaid Population Covered under Different Delivery Systems. As of July 1, 2015. Kaiser Family Foundation. Accessed May 24, 2016.

[54] Eligibility levels for both men and women go up to 146% when the income disregard in the ACA is considered.

[55] Alabama Medicaid. Provider List. Family Planning/ Plan First. As of May 13, 2016.

[56] Health Resources and Services Administration. Data Warehouse. Map Tool. Accessed August 25, 2016.

[57] CMS, HHS. State Medicaid Payment Approaches to Improve Access to Long-Acting Reversible Contraception. CMCS Informational Bulletin. April 8, 2016.

[58] Bronstein J. Evaluation of Plan First. Demonstration Year 14. UAB School of Public Health. March 2016.

[59] Medicaid.gov. Medicaid & CHIP in California. State Profiles, Eligibility.

[60] State Health Facts. Share of Medicaid Population Covered under Different Delivery Systems. As of July 1, 2015. Kaiser Family Foundation. Accessed May 24, 2016.

[61] California Department of Health Care Services - Office of Family Planning. Family PACT Client Data, 2013-2015. August 2015. Accessed August 2, 2016.

[62] Family PACT Homepage. California Department of HealthCare Services.

[63] CMS, HHS. Maternal and Infant Health Initiative Grant Award Announcement. September 10, 2015.

[64] Medicaid.gov. Medicaid & CHIP in Connecticut. State Profiles, Eligibility.

[65] State Health Facts. Share of Medicaid Population Covered under Different Delivery Systems. As of July 1, 2015. Kaiser Family Foundation. Accessed May 24, 2016.

[66] Medicaid.gov. Medicaid and CHIP in Illinois. State Profiles, Eligibility.

[67] State Health Facts. Share of Medicaid Population Covered under Different Delivery Systems. As of July 1, 2015. Kaiser Family Foundation. Accessed May 24, 2016.

[68] Illinois Department of Healthcare and Family Services. Provider Notice regarding Important Family Planning Policy Change and Payment Increases. October 10, 2014.

[69] Illinois Department of Healthcare and Family Services. Our Medicaid Commitment to Family Planning. August 20, 2014.

[70] Illinois Department of Healthcare and Family Services. Hospital Billing and Reimbursement for Immediate Postpartum Long Acting Reversible Contraceptives. June 30,2015.

[71] CMS, HHS. State Medicaid Payment Approaches to Improve Access to Long-Acting Reversible Contraception. CMCS Informational Bulletin. April 8, 2016.

[72] Illinois House Bill 5576. 99th General Assembly.

[73] Medicaid.gov. Medicaid & CHIP in Missouri. State Profiles, Eligibility.

[74] State Health Facts. Share of Medicaid Population Covered under Different Delivery Systems. As of July 1, 2015. Kaiser Family Foundation. Accessed May 24, 2016.

[75] Data may not sum to 100% due to rounding.

[76] Missouri House Bill 2011, 98th General Assembly, 2016.

[77] Missouri Department of Social Services. Public Notice of Suspension of Federal Expenditure Authority for Section 1115 Family Planning Demonstration. Accessed August 4, 2016.

[78] Missouri Department of Social Services. LARC Devices Inserted Post-Partum During an Inpatient Hospital Stay. Provider Bulletin. Accessed August 16, 2016.

[79] Medicaid.gov. Medicaid & CHIP in Virginia. State Profiles, Eligibility.

[80] State Health Facts. Share of Medicaid Population Covered under Different Delivery Systems. As of July 1, 2015. Kaiser Family Foundation. Accessed May 24, 2016.

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