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TESTIMONY
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Illinois Senate Special Committee on Medicaid Reform
November 29, 2010

Planned Parenthood of Illinois is pleased to have the opportunity to provide testimony to the Special Committee on Medicaid Reform. Our interest in Medicaid reform comes primarily from our concern about continued access to reproductive health care.

Planned Parenthood of Illinois is a non-profit health care provider that focuses on providing basic reproductive health care to low income individuals. Less than 10% of our patient population is insured. The majority of our patients are receiving some sort of government assistance for their health care, including Medicaid and Illinois Healthy Women. The implementation of Medicaid reforms carry with them important implications for our patient population.

It is imperative that, no matter what Medicaid reforms are implemented in Illinois, access to quality and comprehensive reproductive health care within the Medicaid Program is maintained. In addition, it is essential that the State of Illinois continue the Illinois Healthy Women Program which enables thousands of low income women to access family planning services while saving the State millions in taxpayer dollars. And, in these Programs, the State must continue to allow patient choice when it comes to accessing family planning services. That is, enrollees must retain the right to choose their preferred family planning provider even if that provider is not within the managed care network in which they are enrolled.

The Illinois Medicaid Program provides its enrollees with coverage for a wide range of reproductive health care services including family planning, prenatal care, and labor and delivery care. Family planning services are basic health services for women of reproductive age. Family planning includes annual physical exams, Pap tests, breast exams, testing and treatment for sexually transmitted infections including HIV, contraception, as well as education and counseling.

Contraception has been proven to have many health benefits. Various hormonal methods have been used for decades to treat a number of health conditions such as anemia, endometriosis, and dysmenorrhea. If left untreated, these conditions can be seriously debilitating to women and impair their ability to complete education or maintain employment. Certain contraceptives play an important roll in preventing the transmission of STI's and HIV. Clearly, for an individual's overall health, preventing these diseases is a far better alternative to treating them.

Another important benefit of contraception is that it enables women to plan and space their pregnancies. The typical American woman, who wants two children, spends about five years

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pregnant, postpartum or trying to become pregnant, and three decades trying to avoid pregnancy. Unfortunately, about half of all pregnancies in the United States each year are unintended (either unwanted or mistimed). In part, this is due to a lack of access to affordable birth control services. Pregnancies that are too close together can result in poor health outcomes for both the mother and infant. Closely spaced pregnancies are more likely to result in low birth weight, premature birth, and delivery complications. Ideally, pregnancies should be spaced approximately two years apart or even longer for some women. Well spaced pregnancies allow the woman to be both physically and emotionally prepared for the next pregnancy. In addition, avoiding pregnancy during times of adverse health is important for the physical well being of the woman. A woman who is ill or has a health condition when she becomes pregnant is more likely to have a poor birth outcome and the health of her child will be adversely affected.

In order to achieve the best outcomes and serve the particular needs of Medicaid clients, the Medicaid Program should cover all FDA approved methods of contraception, including emergency contraception, and both male and female condoms. Certain contraceptive methods are not appropriate for certain patients based on either medical criteria or lifestyle. Some contraceptives are contra-indicated when a woman has certain medical conditions. Some women are more likely to effectively use certain methods over other methods. Correct use of contraception is fundamental for preventing unintended pregnancy. If a patient is not going to reliably use a particular method, another should be available.

The primary goal of providing reproductive health care and access to contraception through Medicaid is to ensure the health and well being of the enrollee and their families. However, there is also a financial benefit to the State which cannot be ignored. In a time of budget crisis, the State must not be short sighted. It must look to the savings that come out of access to essential health care that includes prevention. According to the Guttmacher Institute, every $1.00 invested in helping women avoid pregnancies they did not want to have saves $3.74 in Medicaid expenditures that otherwise would have been needed. **By investing in reproductive health care that includes access to contraception, the State will enable its Medicaid enrollees to have a greater chance of improved health outcomes for both themselves and their families and thus save the State precious tax dollars.**

The Illinois Healthy Women (IHW) Program should be maintained and even expanded in order to achieve optimal savings for the State. Currently, the Program serves women whose income is at or below 200% of the federal poverty level. IHW is limited to family planning services. IHW covers physical exams, Pap tests, lab tests for family planning, testing and medicine for sexually transmitted infections found during a family planning visit, and sterilization. IHW also covers mammograms, multivitamins and folic acid if they are ordered by the doctor during the family planning visit. IHW is a voluntary program and all family planning services are confidential.

One of the goals of IHW is to help low income women plan and space their pregnancies. The women eligible for IHW would become eligible for full Medicaid coverage should they become pregnant. Studies have shown that a large proportion of babies born to Medicaid eligible women are the result of unintended pregnancies. In addition, individuals who are eligible for Medicaid tend to have poorer health status than the general population, in part because of factors related to

poverty and lack of access to care. The combination of a lack of planning and likelihood of poor health status leads to greater risk of complications and poor outcomes for Medicaid births. If women have access to regular medical care and the ability to plan pregnancies BEFORE they become pregnant, they are more likely to have intended pregnancies with better outcomes. Therefore, IHW provides women with basic reproductive health care services that empower them to improve their health and plan their families. This in turn results in better health outcomes for women and their children and vast savings to the State's Medicaid Program overall.

If the goal is to make sure women are empowered to take care of their reproductive health, we must give the option of choosing where they go and ensuring that barriers to access are eliminated. As I stated above, one of the most important factors in whether or not a woman will be successful in her efforts to plan her family is the effective use of contraception. Provider access and choice has a large influence on this. If a woman faces barriers accessing care and receiving contraceptive services, she may forgo using contraception, use it improperly, or use a less effective method, all of which put her at risk of unintended pregnancy. Therefore, she must have family planning providers available to her.

In addition, because of the personal and intimate nature of family planning care, the patient must feel comfortable with the provider she sees. If a woman is uncomfortable with a provider or does not feel she can openly discuss sexual health issues with her provider, she is more likely to misuse or forgo use of contraception. Again, this puts her at risk of unintended pregnancy. **Therefore, the State must continue to allow Medicaid enrollees to choose their family planning provider even if it means going outside of a preferred provider network or managed care plan.**

The State must also address the problems that result in a limited number of Medicaid providers. A Medicaid card does not guarantee access. Currently, there is a shortage of Medicaid providers in the State of Illinois. For many of our Medicaid patients, Planned Parenthood is their only medical provider because they cannot find other providers in their community who will see them. If they can find another family planning or primary care provider, there is often a long waiting list. A delay in access to care puts patients at risk of unintended pregnancy.

Planned Parenthood routinely has Medicaid patients for whom it is determined that they need additional or specialized care that we cannot provide. However, finding providers who can meet their needs and are willing to take Medicaid is a challenge. This is particularly so in the area of obstetric and gynecological care. Some providers are willing to take Medicaid patients, but limit the number they allow in their practice. Some providers will see privately insured patients quickly, while there is a long wait for Medicaid patients.

There are multiple reasons why Illinois medical providers shy away from taking Medicaid patients. First, Medicaid rates tend to not only be below the reimbursement rates of insurance and other government programs like Medicare, but also, the Medicaid reimbursement often does not cover the actual cost of providing certain medical services. Therefore, providers lose money when they see Medicaid patients. Non-profit providers like Planned Parenthood, have in their

mission to serve patients at all income levels. But, this commitment puts a strain on non-profit budgets. Private, for-profit providers do not have a similar commitment to serving a diverse population, leaving the low-income patient load to a limited number of non-profit providers. The **State should reassess Medicaid rates with a focus on covering the actual cost of care in order to encourage providers to participate in the Program.**

Still, there are some for-profit providers who have Medicaid patient populations. However, both the non-profit and for-profit providers must not only struggle with low reimbursement rates, but they also must have the capacity to carry a large proportion of their billings for six months or more before they are paid. This can lead to serious cash flow problems and the need to borrow without being repaid for the interest on the unpaid Medicaid bills. Many agencies, both non-profit and for-profit, have had to rethink their participation in numerous State programs because of the budget crisis. The State's reputation for long delays in payments is not encouraging to a medical provider who is considering becoming a Medicaid provider. Seeing how reimbursements by the State have been conducted in the past several years may deter providers who do not want to take on additional financial risk. **Therefore, the State must address the backlog of unpaid bills and ensure that medical providers receive priority and are paid in a timely manner.**

Another deterrent from becoming a Medicaid provider is the fear of added bureaucracy. Medicaid billing can have a reputation of being slow to process and the computer system can be cumbersome and inefficient. Also, by becoming a Medicaid provider, the provider opens himself up to all of the regulations and rules of the program. This may be unappealing when the provider hears reports of what it's like to go through a Medicaid audit or to challenge audit findings. **The Department of Healthcare and Family Services must make sure that it has clear, easily understandable, and detailed rules for working within the Medicaid Program. Burdensome audits must be limited so that the time taken away from providing direct care to patients does not become a hindrance to the financial well being of the organization.**

One item which may help in relieving some of the challenges of participation in the Medicaid Program is the Department's commitment to the conversion to electronic medical records (EMR's). Hopefully, this will create a standardization of medical record keeping that will eliminate some of the confusion when it comes to billing and chart keeping. But, the conversion to EMR's carries with it other challenges. The most difficult one for non-profits like Planned Parenthood is the expense of purchasing and implementing a new EMR system. We estimate the cost of software and equipment to be at least $500,000 for our agency which has 17 clinic sites. This is an enormous expense for a non-profit agency that has a large proportion of patients on Medicaid or other low income support programs. We are aware that starting in 2011 federal incentive payments will become available for the meaningful use of EMR's and health information technology. **We encourage the State and the Department to enact a system that ensures that providers can be approved for EMR incentive payments as well as be paid in a timely manner.**

In 2014, under health care reform the State will face the challenge of enrolling and serving a new population of Medicaid eligible individuals. Because of this, Planned Parenthood would like to take this opportunity to point out some issues related to Medicaid under health care reform.

The Department of Healthcare and Family Services estimates that the 2014 eligibility standards could add 700,000 – 800,000 individuals to the Medicaid rolls. By continuing and improving the IHW Program, the State will already have a number of these individuals in its database and will have a head start in enrolling converting the newly eligible into full Medicaid. Despite this, the enrollment of individuals whose income is up to 133% of FPL will be a monumental task. Many Illinoisans will become eligible for Medicaid for the first time in their lives. They may have had no prior experience with any kind of health care coverage, including Medicaid. **A targeted outreach program must be implemented to inform these people of their new Medicaid eligible status and to educate them about the health care system as a whole. Enrollment and using the system must be made as simple and accessible as possible.**

In addition, there will be a population of individuals and families who may be eligible for multiple programs during a given year. For example, an adult, single man may have insurance from his employer which is a small business participating in the Exchange. But, when he loses his job, he becomes eligible for Medicaid coverage. If the process for transferring his coverage is difficult or delayed, he may fall through the cracks and end up outside of the system with no access to care. Likewise, coverage for a family whose members are covered by multiple programs and eligibility changes during the year for some members and not for others can be very confusing. If families become frustrated, they too may not access health care. **Therefore, moving between Medicaid and other insurance programs such as Child Health Insurance or coverage in the Exchange must be as easy and seamless as possible.**

In addition to addressing the bureaucracy of enrollment and transfer between private insurance and State programs, the State must deal with the current issues of patient access, provider shortages, and burdens on providers, so that State will be prepared to handle the influx of the newly eligible in 2014. Therefore, the State and the Department of Human Services must begin it work now to address these changes and improve the Program for future Medicaid recipients. The establishment of this Special Committee on Medicaid Reform is an important first step. Planned Parenthood looks forward to working with the members of this committee, the General Assembly, the Governor, and the Department of Healthcare and Family Services to improve the Medicaid Program for all of the people of Illinois.

Thank you again for this opportunity to provide the Committee with our comments today.