PLANNED PARENTHOOD OF GREATER IOWA:
HEALTHY FAMILIES PROJECT

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1. EXECUTIVE SUMMARY

The federal government is an important source of funding for family planning programs. Key sources of federal funding include the Title X Family Planning Program and Medicaid family planning waivers. However, federal funding has not always been reliable or sufficient to serve all the populations who need family planning services, or to provide all the services these populations need. For example, women who are not eligible for family planning services under Medicaid waiver programs must fall back on Title-X funded services, which are not always available; and federal programs do not fund four types of long-term contraception that could play an important role in preventing pregnancies.

To fill these gaps in federal funding, 39 states currently supplement their federal family planning dollars with state-only funds. Although there is significant need for additional subsidized family planning services in Iowa -- 170,000 women in Iowa are defined as being "in need of subsidized contraceptive services" -- Iowa is one of only 11 states that does not supplement federal funding with state-only funds.

Among states that do use their own funds to supplement federal family planning dollars, two key types of programs emerge:

- **The "Minnesota" Model**: The state funds a stand-alone family planning program separate from federal funds; grantee organizations manage state money at the point of service. We call this the "Minnesota" model because no other state appears to have a stand-alone program for its state-only funds.

- **The "Merged Funding" Model**: The state adds its dollars to federal funding sources, such as Medicaid waiver funds; the state makes centralized decisions on the allocation of funds. Examples of states that use the "merged funding" model are Illinois, Wisconsin and Michigan.

Public Works has researched the structure of family planning programs nationally, in Iowa, and in other states, and makes the following key recommendations on structuring a state-funded family planning program in Iowa:

- **Create a state-funded, stand-alone family planning grants program to supplement gaps in federal funding.** In keeping with the public health mission of family planning programs, the Iowa Department of Public Health should administer the grants program. The state should develop a funding formula that ensures consistent access regardless of rural or urban status. The state should also consider a five-year project timeline for grants and ensure that the grant process is user-friendly and emphasizes provider flexibility to increase access to care for populations in need of subsidized family planning services.

- **Set aside state funds in an "Emerging Needs Fund"** to fund statewide family planning needs and fill in gaps regardless of whether an agency is a state grantee. For example, funds could be used to fill temporary gaps in access caused by problems such as the recent spike in prices for certain contraceptives. Funds could also be used for a statewide outreach program.
- **Convene a *Healthy Families Cabinet* with key government agency staff to ensure that services are coordinated and do not overlap**. Coordination in needs assessments, program development, and evaluation should be a key goal. The Healthy Families Cabinet could consider family planning within the context of other maternal and child health needs in Iowa.
- **Focus on patient access and convenience throughout program design and implementation.** For example, ensure that services are geographically accessible, minimize paperwork for patients, and ensure that family planning and related services are provided in a streamlined manner.

The remainder of this paper examines family planning funding sources nationally and in Iowa; details programs in Minnesota and other states; and makes recommendations for structuring a state family planning program in Iowa.

2. INTRODUCTION: THE BASICS ON FAMILY PLANNING FUNDING

The federal Family Planning Program

The federal government provides family planning funds through the following key programs:

- **Title X Family Planning Program**: Title X, administered by the federal Office of Family Planning, is "the only federal grant program dedicated solely to providing individuals with comprehensive family planning and related preventive health services." Title X is designed to provide access to contraceptive services, supplies, and information, particularly to persons from low- income families. Title X grantees include State and local health departments, tribal organizations, hospitals, university health centers, independent clinics, community health centers, faith-based organizations, and other public and private nonprofit agencies. Title X funds may not be used in programs where abortion is a method of family planning.[i]

- **Medicaid family planning waivers:** Medicaid family planning waivers allow states to extend coverage for family planning services to individuals who otherwise would not be eligible for Medicaid. [ii] States that have obtained approval of a family planning waiver can claim a federal reimbursement for 90% of the services and supplies provided. Iowa received approval of its Medicaid family planning waiver – the Iowa Family Planning Network - in 2006. Medicaid waivers are typically administered through state Medicaid agencies.

- **Other programs:** Other programs providing family planning funds to states include the **Title V Maternal and Child Health Block Grants** and the **Title XX** Social Services Block Grant.

Brief recap on Iowa's current Family Planning Program

Iowa's main public sources of family planning funding are from the federal government, through Title X and Medicaid Waiver funds.[1] While Iowa previously had Title XX funding for family planning services, these funds were phased out when the Medicaid waiver was put into place.

Three state-level organizations play a role in family planning funding in Iowa: the Department of Human Services (DHS), the Iowa Department of Public Health (DPH),

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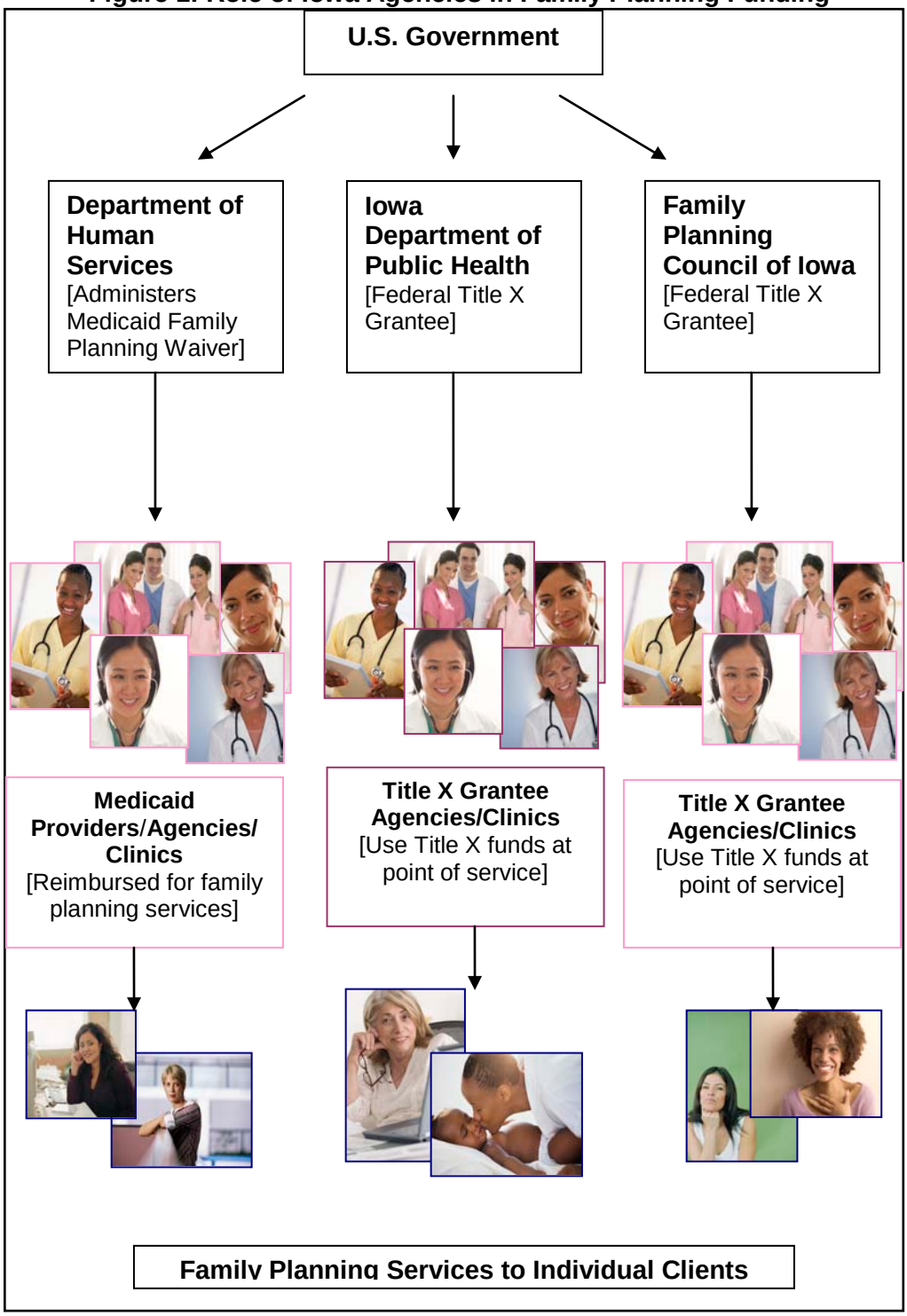
[1] Through the Medicaid family planning waiver program, the federal government provides a 90% match on many family planning services; the states then pay providers for the remainder. Some services are excluded from Medicaid family planning waivers, such as follow-up testing for cervical cancer if the original test is abnormal.

and the Family Planning Council of Iowa (FIPC). Figure 1 below shows the role of the agencies in distributing family planning funds:

Figure 1: Role of Iowa Agencies in Family Planning Funding



Title X Family Planning Program

The Iowa Department of Public Health's Family Planning Program (DPH) and the Family Planning Council of Iowa (FPCI)[iii] are the two Title X grantees in Iowa, meaning that they receive grant funds from the Federal government and distribute them to Iowa family planning agencies. Of Iowa's 99 counties:

- 48 have a full-service Title X-funded family planning clinic
- 12 have a Title X-funded family planning clinic that refers women elsewhere for physical examinations
- 39 have *no* Title X family planning services[iv]

Title X services – including contraceptive services, health education and counseling, informational materials, and community education -- are provided to patients on a sliding scale, and are free for people enrolled in Medicaid and those whose income is below the federal poverty guidelines.

Iowa Family Planning Network [IFPN] – Medicaid family planning waiver

The Department of Human Services administers Iowa's Medicaid waiver program, called the Iowa Family Planning Network. This program provides Medicaid-funded family planning services to the following individuals:

- Women whose pregnancies and deliveries were covered by Medicaid.
- Women who are legal Iowa residents ages 13-44 with income below 200% of the federal poverty guidelines.
- Women enrolled in IowaCare are also eligible for IFPN services. [However, IFPN services are not available to women already eligible for standard Medicaid.]

Although family planning clinics may provide IFPN-funded services to women immediately [known as "presumptive eligibility"], *women must apply for IFPN benefits at a family planning clinic or DHS office* in order to remain eligible for a full year. This requirement can pose a barrier to accessing follow-up family planning services after the initial family planning visit; outreach and enrollment remain a challenge for family planning agencies. In addition, this requirement may pose a barrier to women who need to receive services anonymously.

Health care facilities and providers who are enrolled as state Medicaid providers may bill the state Medicaid program for family planning services provided to women enrolled in the IFPN. They need not be Title X providers.

Gaps in Iowa Family Planning Services Remain

Iowa's publicly funded clinics currently provide contraceptive services to about 70,000 women. Yet, over 170,000 women in Iowa are defined as being "in need of

subsidized contraceptive services." That leaves *at least* 100,000 Iowa women in need of financial support to meet their contraceptive needs.

For example, the Iowa Family Planning Network covers only women with incomes up to 200% of federal poverty guidelines; however, women in need of subsidized contraceptive services are defined as women with incomes up to 250% of the federal poverty guidelines.

Despite the clear need for more publicly-funded contraceptive services in Iowa, the state ranks 48th out of fifty states and D.C. in availability of contraceptive services, and 39th out of fifty states and D.C. in terms of public funding of contraceptive services[v] And, **Iowa is one of only 11 states that do not allocate any separate state funds for family planning (other than Medicaid waiver matching funds).**[vi] A source of state funding dedicated to family planning could be used not only to fill in the current gaps in access, but also to ensure a funding stream for critical family planning services at a time when federal funding is not always reliable.

The rest of this paper will outline state-funded family planning programs in other states, and how Iowa might best implement a state-funded family planning program to ensure that all Iowa women in need of family planning services are able to receive them.

3. MODEL STATE FAMILY PLANNING PROGRAMS

According to the Guttmacher Institute, thirty-nine states use their own funding to supplement or complement federal family planning dollars. Although no national entity appears to conduct detailed tracking of the way that states spend their family planning dollars, there appear to be two principal models for how these funds are used:

- **The "Minnesota" Model**: The state funds a stand-alone family planning program separate from federal funds; grantee organizations manage state money at the point of service.

- **The "Merged Funding" Model**: The state adds its dollars to federal funding sources, such as Medicaid waiver funds; the state makes centralized decisions on the allocation of funds.

The "Minnesota" Model

To supplement federal Medicaid Waiver and Title X funds[2], Minnesota operates a unique state-funded family planning grants program called the **Family Planning Special Projects (FPSP) program**. Unlike most states that use their own funds for family planning, Minnesota's program is ***stand-alone***, meaning that funds are distributed

[2] Minnesota does not have as much of a Title X infrastructure as Iowa. Minnesota's Title X grantees are Planned Parenthood of Minnesota and one city/county health department.

separately from other family planning funds.

Key elements of FPSP are as follows:

- **Administering agency:** FPSP is administered by Minnesota's Department of Health, Maternal and Child Health Section. DOH issues an RFP for grant funding, conducts grant reviews, allocates funding to agencies in eight regions based on a regional funding formula, and analyzes reports from grantees. DOH also participates in a statewide Maternal and Child Health Task Force to discuss family planning and related issues. DOH employs one to two full-time staff members to oversee and administer the FPSP program.

- **Distribution of grant funds:** Under the FPSP program, established by the Minnesota Legislature in 1978 [Minnesota Statute, Section 145.925],[vii] family planning organizations such as local health departments, tribal organizations, and non-profit organizations may apply for FPSP grant funding on a bi-annual basis. Minnesota allocates its FPSP grants according to a regional statewide funding formula, through which family planning providers within each region compete for grant funding.[viii] The regional approach to funding – as opposed to a statewide competition -- helps the state maintain a better balance of services between urban and rural areas. In addition, the state recently allocated extra funding for clinics in rural areas of the state.

- **Services provided**: Similar to most states that allocate their own funds to family planning programs, Minnesota's state-only family planning funds are used to fill in gaps in federal funding. In particular, state funds are used to:

    1. Expand the population served beyond what is allowed in Federal funding or waiver programs, or
    2. Expand the number of services provided.In general, FPSP funds may be used for family planning method services including medical and non-medical methods of family planning, counseling and referral; public information; and outreach.[ix]

    However, FPSP dollars may not be used to *replace* federal funds already used by an agency for family planning information or services.[x]

    In CY2006, FPSP funds were used to provide **family planning methods** to 26,855 clients, including 1,639 men.[xi] FPSP also provided funding for the **counseling** of 30,791 clients, including 2,650 men. Over 34 percent of those counseled were between the ages of 20-24; another 33 percent were 25 and older.[xii] Two agencies received funding for **outreach activities only** (no family planning services).

    In Minnesota, state funds are *not* used to build new family planning clinics or other infrastructure. However, Minnesota grantee agencies reach some underserved or rural populations through a *"Clinic Without*

Walls" program, in which the main FPSP grantee contracts with regional locations, such as social services offices, to serve as a place for exams. Even if there is no place to conduct a physical exam, family planning providers can use the regional location as a base for providing services that do not require a physical exam, such as contraception counseling, refills, or certain STI tests. This service operates much like a Red Cross blood drive, in that providers go into a location, conduct the clinic, and then leave the location as it was originally.[xiii]

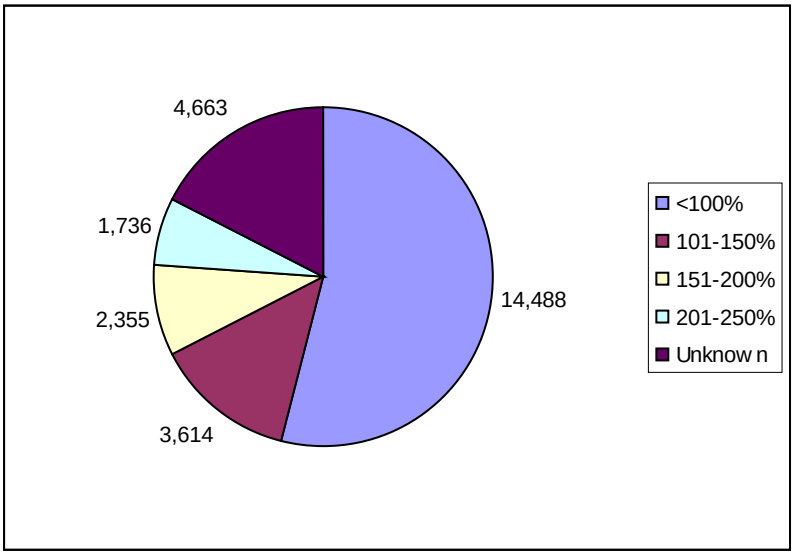
Finally, FPSP provides funding for a family planning hotline, which is run by one family planning agency in Minnesota that received the funding on a competitive grant basis. In CY2006, the hotline received over 4700 calls.[xiv] Iowa already has a Healthy Families Line, administered by the Department of Public Health Family Planning Program.[xv]

- **Eligible individuals**: The FPSP grant funds are intended for both "women and men who have difficulty accessing family planning services because of various barriers including poverty, lack of insurance, race, ethnicity, age or culture."[xvi] In Minnesota, the Medicaid waiver program provides services for women with incomes up to 200% of the federal poverty guidelines. However, women are still considered at risk of unintended pregnancy and "in need of publicly funded contraceptive services and supplies" if their incomes are below 250% of federal poverty.[xvii] In addition, Title X Guidelines require agencies to provide discounts to clients with incomes up to 250% of federal poverty.[xviii] State-funded programs like the FPSP make it possible to provide free services to these individuals, thereby increasing the affordability of contraceptive services.

  In CY2006, FPSP funds were used to provide services to 26,856 clients, over half of whom lived below the poverty level, as shown in Figure 2 below.

- **Grantee Responsibilities**: Agencies must submit a grant application on a biennial basis in order to qualify for funds. Grantee agencies must also submit reports to the Department of Health, including measures such as the age of clients served, services provided, demographics, and a narrative report.

Figure 2: Number of FPSP Clients Served, by Income Level CY2006



- **Program successes:** Minnesota estimates that it saves $4 in costs associated with unintended pregnancy for every dollar spent on family planning. Minnesota's rates of abortion, teen pregnancy and unintended pregnancy have steadily declined since the inception of this grant program. Between 1978 and 2003, the program succeeded in expanded services from 29 counties to 62 counties, and doubling the number of agencies funded, from 20 to 41. [xix]

Implementation example: Agency 1

The following is an example of how one large agency in Minnesota has implemented the FPSP grant program in its facilities.

- ***From the provider perspective:*** This agency receives funds from Title X, the Medicaid Family Planning Program (Medicaid waiver), and the FPSP. It operates a marketing and enrollment program to inform women of the availability of free family planning services and help them enroll in the Medicaid Family Planning Program, if eligible.[xx] The agency has modeled its FPSP services largely on the services provided through the Medicaid waiver. [xxi] Therefore, *FPSP funds are used by this agency mostly to serve additional populations rather than provide new types of services.* However, it is important to note that under the FPSP program, grantees have flexibility in how their funds are used and administered.

  The agency uses a "tiered" system to determine how to cover services, as noted below.

- **Tier 1**: The first priority of this grantee is to enroll as many women as possible in the Medicaid waiver program (Minnesota Family Planning Program).[3]

- **Tier 2**: This agency uses FPSP funds to extend family planning services to populations not covered under the Medicaid waiver. For example, the agency uses FPSP funds to cover women who are out of the age or income ranges for the Medicaid waiver or who need anonymous services. Examples of individuals who would not be covered under **Iowa's** current Medicaid waiver, but who could be covered through a state-funded program, include those who are:

  - Slightly out of the age range for Medicaid services (13 to 44); for example, they have just turned 45, but could still become pregnant and cannot afford contraceptive services;
  - Above the income limits (200% Federal Poverty Level), but still cannot afford contraceptive services;
  - Residents of other states (e.g. college students) who do not have the necessary paperwork to apply for Iowa's Medicaid program under current Federal guidelines;
  - Men who could benefit from free family planning counseling and supplies;
  - Women who are abused or homeless and risk losing their Medicaid coverage due to frequent changes in location.

- **Tier 3**: This agency uses Title X funds to cover any remaining *service needs* not covered by the Medicaid waiver or the FPSP funds. For example, both the Medicaid waiver and the FPSP grant specify that STI screening and treatment may only be conducted in the context of a family planning visit. Therefore, if a woman comes in outside needing STI services outside of a family planning visit, PPMNS uses Title X funds to cover the services.

- ***From the patient perspective***: The services provided by this grantee are ***seamless*** from a patient perspective. Women who might be eligible for free family planning services through the Medicaid waiver are able to apply on-site at a clinic. However, if they do not fit the eligibility criteria (for example, they are one year too old for the waiver), they can still receive services at the clinic, and the clinic can decide "behind the scenes" to use FPSP or Title X funds to cover their care.

Implementation example: Agency 2

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[3] Because Minnesota allows for two months of "presumptive eligibility", women may receive Medicaid family planning services immediately and are eligible for two months of services; in order to receive a one-year enrollment, they must apply to the State and successfully enroll in the program.

This agency does not receive Title X funds, but is a Medicaid provider. It runs several separate programs with its FPSP dollars, including 1) Provision of family planning services; 2) A statewide family planning and STI hotline; 3) General community education and outreach and 4) An education and outreach program for the deaf, hard of hearing, and blind.

- ***From the provider perspective:*** This agency includes its FPSP grant funds in its budget along with funds from private sources. Like Agency 1, this agency attempts to sign up as many women as possible for the Medicaid waiver. If a woman is not eligible, or needs services not covered by the waiver, the agency uses FPSP and other funding to cover these services or populations.

General feedback about the program from this provider included:

- FPSP funds provide an important source of flexibility in providing additional services to patients that are not possible with Federal dollars. *A stand-alone program is important,* because agencies need flexibility in deciding the best ways to use the funds, whether to provide wraparound services or outreach to key populations.
- FPSP has not been adequately funded through the years; although current funding is $10 million over 2 years, it only brings funding back to 2004 levels and is "not coming anywhere close to the need" in Minnesota.
- The Medicaid family planning waiver has brought an important source of funding, but also new administrative challenges in enrolling women in the program. The agency conducts a 20-minute screening over the phone with new patients to help them determine their eligibility for the Medicaid waiver, encourage them to fill out the forms, and explain the various proofs of income they must bring with them to the appointment. Follow-up is also a concern, since many women who sign up for the waiver fail to send in the necessary proofs of income to complete the application process. While the agency continues to work on Medicaid waiver outreach, *this makes the existence of FPSP funds especially important as a fall-back mechanism to ensure the agency can continue providing services to clients.*
- The grant process itself presents challenges in that it is cumbersome and extremely competitive. This creates particular challenges for small agencies without a sophisticated grant-writing infrastructure. While additional funding would help reduce the level of competitiveness, other suggestions included providing the funding to counties to distribute to agencies based on need. While the state provides training for grantees,

additional training on grant-writing would be useful, as well as a "buddy system" that pairs new grantees with experienced agencies.[4]

- One of the big challenges to effective outreach is that the FPSP rules prevent agencies from conducting outreach in schools. [Other key informants in Minnesota independently mentioned this was a problem as well].

- ***From the patient perspective***: As with Agency 1, the services provided by this agency are ***seamless*** from a patient perspective. Agency 2 also maintains a strong focus on outreach into the community.

The "Merged Funding" model

In general, there are no set rules for how states use their own funds for family planning programs. However, most states have a far less defined structure for their state family planning dollars than Minnesota. In some states, family planning dollars do not even appear as a line item in the budget, making it difficult to track state spending in detail.[5]

***The common thread in the merged funding model is that the state adds its own dollars to other funding sources, such as Title X or Medicaid waiver funds, and makes centralized decisions on the allocation of funds*.** By contrast, in Minnesota, decisions on the use of state funds are more decentralized, with individual grantees (though of course within guidelines set by the state). The regional funding mechanism ensures that rural organizations have a greater chance of successfully obtaining funding, since they are not placed at a competitive disadvantage with their urban counterparts. In addition, this decentralized approach means that organizations can better tailor their approaches to the populations in their areas.

A key difference between the "Minnesota model" and the "Merged Funding model" is that in Minnesota, the FPSP grantees have more flexibility in determining how to use state funds to fill in gaps in federal funding, whereas in other states, these decisions are made more centrally. This allows agencies to provide more seamless access to services for their patients and tailor needs to their particular geographic areas.

Implementation example: Michigan[xxii]

[4] While the "Buddy System" concept was thought to be difficult in a competitive environment, Iowa could consider a system in which "buddy" agencies are in different regions and therefore not competing with one another.
[5] Key Informant Interview, Elizabeth Nash, Guttmacher Institute

In Michigan, almost all family planning dollars from federal and state sources are merged into one funding stream. Michigan's sources of family planning dollars are federal Title X family planning funds, Title V Maternal and Child Health block grant funds, Medicaid Waiver funds, state general revenue funds, and state "Healthy Michigan" tobacco revenue funds. Michigan's Department of Community Health (comparable to the Department of Public Health) is the Title X grantee and administers the state's family planning funds. While Michigan's Medicaid agency (Medical Services Administration) handles eligibility for the Medicaid waiver, the Department of Community Health oversees services provided through the waiver.

In addition to the merged funding that is the main source of family planning funding in Michigan, the state maintains a separate "special projects" fund for non-pregnancy prevention projects such as cervical cancer diagnosis and treatment as well as STI testing.

Family planning providers in Michigan receive their family planning funds in a lump sum from the state. Federal and state funding is not differentiated; however, because Title X funding is included, all providers receiving this funding must follow federal Title X regulations.

Implementation example: Illinois Healthy Women Program

Illinois uses state funds to supplement its Illinois Healthy Women program – a Medicaid waiver program -- which provides family planning services to women based on a sliding income scale. Decisions about which services to supplement are made centrally. For example, whereas Federal funding restrictions may not allow reimbursement for folic acid supplements during a family planning visit, Illinois chose to allow use of state funds for this purpose.[6]

- ***From the Provider Perspective***: Providers must be official state Medicaid providers in order to bill for Illinois Healthy Women services. If a patient needs services that are not covered by the Medicaid waiver, but the state has determined that it will use state-only funds to cover these services, then the provider may bill the state Medicaid program for those services. However, if a patient is not eligible for the Illinois Healthy Women program, needs anonymous services, etc., that provider does not have state funding to "fall back on."

- ***From the Patient Perspective***: Patients must be enrolled in the Illinois Healthy Women Medicaid Waiver program to obtain state-funded services (except during an initial 2-month presumptive eligibility period). Therefore, if the 2-month presumptive eligibility period is up, and the woman does not become enrolled in Illinois Healthy Women, she will not be able to obtain state-funded services outside of a Medicaid provider. Without other coverage,

[6] Key Informant Interview, Illinois Department of Health

she will have to obtain family planning services elsewhere (such as a Title X clinic) in order to obtain low or no-cost family planning services. However, these services may not be supplemented by state funds, so she will be restricted to services allowed under federal rules.

Implementation example: Wisconsin

Wisconsin's main sources of family planning funding are Title X funds (administered by Planned Parenthood of Wisconsin), Title V Maternal and Child Health Block Grants, and state general revenue funds. The Division of Public Health within the Department of Health and Family Services (DHFS) administers Title V and state family planning funds.

Wisconsin's DHFS maintains a focus on creating a statewide "system of care" for family planning, based on a legislative mandate to "allocate state and federal family planning funds under its control in a manner which will promote the development and maintenance of an integrated system of community health services."[xxiii] To fulfill this mandate, DHFS merges its Title V and state general revenue funds into one funding stream. Based on the results of a statewide needs assessment conducted every 5 years, these funds are then distributed to agencies in areas that *are not already being served by Title X funds*, via an RFP process.

According to one grantee, approximately 1/3 of clinics in Wisconsin are funded by the mix of Title V/State funds; another 1/3 are Title X-funded; and the final 1/3 are self-sustaining. Approximately 32,000 women in Wisconsin obtain family planning services through the Title V/State funded clinics.[xxiv]

4. OPTIONS AND CONSIDERATIONS FOR IOWA

The table below shows a preliminary glance at the differences between the two models under consideration, and how Iowa might structure its program.

Table 1: Minnesota Model and Merged Funding Model Side-by-Side

	Minnesota Model	Merged Funding Model	Considerations for Iowa
Key administrative agency	Dept of Health, Maternal and Child Health Section	Varies; typically Department of Health	Department of Public Health, Division of Family Planning
Services	Key grantee in MN models its services after Medicaid waiver services.	Vary; states "fill in gaps" in federal funding. For example, additional state-covered services may include folic acid supplements, STI	Could provide flexibility in use of state funds to complement federal funds

		testing, outreach-only programs, or contraceptive services not funded by the federal goverment.	
Target population	Men and women up to 250% FPL; women otherwise not eligible for Medicaid waiver.	Varies; populations may include individuals not eligible for Medicaid waivers due to income, age, or sex.	Allow services for women up to 250% FPL or otherwise ineligible for Medicaid waiver, who need anonymity, or for other reasons.
Benefits	• Visibility and transparency strengthen program. • Grant funding on a bi-annual basis. • Regional funding formula; helps support rural areas. • May not replace federal dollars. • More provider flexibility at point-of-service on who to serve and what to cover. • Tailored to suit specific state, regional, and local needs. • More accessible services for clients. • Used to provide direct services, not infrastructure. • More than doubled number of counties with	• Does not require separate grants administration infrastructure. • Central decision-making may standardize services and quality across the state (but may not be adequately tailored to each region).	Consider a "hybrid" model that uses some state funds for a grants program, and others to centrally "fill in gaps" in federal programs. For example, create a statewide "Emerging Needs Fund" for emerging access problems that affect the entire state.

	services (from 29 to 62) and number of agencies funded (from 20 to 41), from 1978-2003.		
Disadvantages	• Women who are not eligible for the Medicaid waiver must go to an FPSP grantee site to obtain state-funded services. • Grantees may have increased reporting and evaluation requirements. • Application process may be more cumbersome than for a less formal state funding process.	• Funding decisions (e.g. cuts) are less visible to the public. • Less provider flexibility on services and populations covered. • Federal enrollment rules and guidelines will still restrict populations served. • State-funded services may only be available through official Medicaid providers.	

Basic Principles of a Recommended Model

A state-funded family planning program offers Iowa the opportunity to improve access to family planning services, contraception, and education for the more than 100,000 Iowa women in need of subsidized contraceptive services. While the exact model can vary, and a state-funded family planning program also offers the state, its regions, and its family planning agencies far greater flexibility in providing family planning services than they currently have. Regardless of the program model chosen, however, **Public Works** recommends that the state decide on a set of core principles for its program. In particular, the program should:

From the State Perspective:

- Design and offer services from a public health philosophy and perspective;
- Utilize existing infrastructure to facilitate immediate implementation;

- Coordinate efforts among related agencies;
- Use state funds to complement, not substitute for, existing federal funds;
- Chart progress on a regular basis, including a planned evaluation integrated with the kick-off of the program.

From the Provider Perspective:

- Minimize bureaucracy and administrative requirements for providers, including as streamlined an application and reporting process as possible;
- Allow for flexibility in services provided and populations served at the point of service (within state guidelines), to allow for a comprehensive, streamlined patient visit;
- Provide a streamlined application process for the client.

From the Patient Perspective:

- Be available in previously underserved (or un-served) areas of the state;
- Be seamless to the patient.

As the program is developed in further detail, stakeholder agencies and individuals should be brought together to determine the core principles that they feel best meet the needs of the state moving forward.

Iowa Healthy Families: State Infrastructure

In developing an Iowa Healthy Families program, the state will have a number of strategic decisions to make in determining the state infrastructure for the program. Again, **Public Works** recommends that at a minimum, the following principles be established in determining the state infrastructure:

- Design and offer services from a public health philosophy and perspective;
- Utilize existing infrastructure to facilitate immediate implementation;
- Coordinate efforts among related agencies;
- Use state funds to complement, not substitute for, existing federal funds;
- Chart progress on a regular basis, including a planned evaluation integrated with the kick-off of the program.

A state infrastructure design that might meet these criteria is shown in the table below:

Principle	**Recommended action**
Design and offer services from a public health philosophy and perspective.	Place program within Department of Public Health's Family Planning Program.[xxv] *At least* one full-time position will likely be required to

	manage the state-funded program.[xxvi]
Utilize existing infrastructure to facilitate immediate implementation.	Department of Human Services continues to administer Medicaid family planning waiver; DPH and Family Planning Council of Iowa continue to administer Title X funds.
Coordinate efforts among related agencies.	Convene a ***Healthy Families Cabinet*** with key government agency staff to ensure that services are coordinated and do not overlap.
Use state funds to complement, not substitute for, existing federal funds	Create a separate "***Emerging Needs Fund***" to address statewide problems that restrict access to services, such as the recent spike in prices for certain birth control pills, the prohibition on low-cost contraception for college health centers,[7] or new reproductive health services not covered under federal programs (e.g. Gardasil vaccine). Emerging needs could be assessed on a collaborative basis among all relevant government and family planning agencies. Prior to program kick-off, conduct detailed analysis through ***Healthy Families Cabinet*** of gaps in services; emphasize these services in RFP to potential grantees and/or "fill in gaps" in Medicaid Waiver/Title X services. For example, ensure that state funds cover long-term contraception not covered by federal family planning programs. Provide technical assistance to agencies to help with determining gaps in access to family planning services.
Chart progress on a regular basis, including a planned evaluation integrated with the kick-off of the program.	Set aside evaluation funding for the design of a program evaluation that includes specific program goals/objectives, outcome measures, and data collection methods. Since evaluations are stronger when developed alongside a program, this step is important to take at the program's inception. Evaluation measures, reporting requirements, and structure should be aligned with other family planning programs (Medicaid, Title X) to the extent possible to minimize reporting requirements.

[7] By federal rules, college health centers were recently prohibited from negotiating for low-cost contraception. A state "Emerging Needs Fund" could help cover the cost of contraception for college health centers, thereby ensuring more affordable access to contraception for the state's college students.

Iowa Healthy Families: From the Provider Perspective

Principle	Recommended action
Minimize bureaucracy and administrative requirements for providers, including as streamlined an application and reporting process as possible.	Consider modeling grant applications on existing programs in Iowa, such as Title X. Consider a 5-year project period rather than Minnesota's biennial project period, to minimize the need for grant applications. Through ***Healthy Families Cabinet***, review existing administrative requirements for family planning agencies and tailor state requirements accordingly.[8] Consider convening family planning agencies on an annual basis to share best practices and obtain input on ways to improve the program.
Allow for flexibility in services provided and populations served at the point of service (within state guidelines), to allow for a comprehensive, streamlined patient visit;	This principle would be best realized through the creation of a competitive state family planning grants program like Minnesota's FPSP. As noted above, a more centralized decision making process would not allow for this flexibility.
Provide a streamlined application process for the client.	As part of their application for state funds, family planning agencies should be required to show the process they would use for determining eligibility for services. The state could also consider creating a standardized "checklist" and/or other guidance to help agencies determine eligibility for services. For example, agencies could be required to use the Medicaid waiver application form to determine eligibility first for Medicaid, then for state family planning funding.

Iowa Healthy Families: From the Patient Perspective

Principle	Recommended action

[8] For example, Minnesota's FPSP program issued an 84-page RFP for its family planning services; Iowa should determine if similar detail should be required for agencies that may apply for state funds.

Services should be available in previously underserved (or un-served) areas of the state.	The state should increase access to family planning services for women and men in previously underserved or un-served areas of the state through: • A regional funding formula that allows for appropriate levels of funding in rural areas; • Innovative programs like "Clinics Without Walls" that allow services to be delivered to rural areas; • Mail-in prescription services; • Targeted outreach and counseling services.
Services should be seamless to the patient.	As noted above, the state and family planning agencies should make special efforts to ensure that any application, enrollment, or other processes are the least burdensome possible for patients, and services should be designed so that once a patient arrives at a facility, their family planning needs can be met in one visit. Patient convenience and satisfaction should also be included as outcome measures in evaluations.

5. CONCLUSION

Family planning services are necessary for women's health, yet too many Iowa women experience barriers to obtaining these services. Moreover, pregnancy prevention has important fiscal consequences for the state. Federal funding is often inadequate to meeting the needs of the 170,000 Iowa women in need of subsidized contraceptive services.

Therefore, **Public Works** recommends that Iowa:

- **Create a state-funded, stand-alone family planning grants program to supplement gaps in federal funding.** In keeping with the public health mission of family planning programs, the Iowa Department of Public Health should administer the grants program. The state should develop a funding formula that ensures consistent access regardless of rural or urban status. The state should also consider a five-year project timeline for grants and ensure that the grant process is user-friendly and emphasizes provider flexibility to increase access to care for populations in need of subsidized family planning services.
- **Set aside state funds in an "Emerging Needs Fund"** to fund statewide family planning needs and fill in gaps regardless of whether an agency is a state grantee. For example, funds could be used to fill temporary gaps in

access caused by problems such as the recent spike in prices for certain contraceptives. Funds could also be used for a statewide outreach program.

- **Convene a *Healthy Families Cabinet* with key government agency staff to ensure that services are coordinated and do not overlap**. Coordination in needs assessments, program development, and evaluation should be a key goal. The Healthy Families Cabinet could consider family planning within the context of other maternal and child health needs in Iowa.
- **Focus on patient access and convenience throughout program design and implementation.** For example, ensure that services are geographically accessible, minimize paperwork for patients, and ensure that family planning and related services are provided in a streamlined manner.

6. APPENDIX A

Appendix A: Family Planning Model States At-a-Glance

State	Source of funding	Program name, department/agency
Minnesota	State-funded Family Planning Special Projects grants (breakdown of state grant awards can be found at http://www.health.state.mn.us/divs/fh/mch/familyplanning/grantees2007-2009.html) Medicaid 1115 Family Planning Waiver program[9]	Family Planning, Maternal and Child Health Section, Minnesota Department of Health
Michigan	State funds[10] Title X[11]	Michigan Family Planning Program, Department of Community Health
Wisconsin	State funds[12]	Wisconsin Family Planning Reproductive Health Program, Department of Health and Family Services
Illinois	State general revenue funds[13] Title X Title XX Title V	Family Planning Program, Department of Human Services Office of Family Health
Maryland	State funds Title X Private and non-profit agencies[14]	Maryland Family Planning and Reproductive Health Program, Center for Maternal and Child Health, Family Health

9 http://www.health.state.mn.us/divs/fh/mch/familyplanning/grantees2007-2009.html
10 http://www.sfpainfo.org/atf/cf/%7bB088B03E-D7FD-40B0-81B7-AF82FCBA7C57%7d/SFPAMedicaidReport.pdf
11 http://www.michigan.gov/mdch/0,1607,7-132-2942_4911_4912_6216-12562--,00.html
12 http://www.sfpainfo.org/site/c.hhKOIZPFIoE/b.1407851/k.CA66/Region_5.htm
13 http://www.dhs.state.il.us/chp/ofh/MIH/FamPlan.asp
14 http://www.fha.state.md.us/mch/familyhome/

		Administration
Connecticut	State funds[15]	Family Planning Program, Connecticut Department of Public Health
New Jersey	State funds[16]	Family Planning Services, Family Health Services, Department of Health and Senior Services

7. APPENDIX B

Appendix B: FPSP Statute
[145.925, Minnesota Statutes 2006][17]

145.925, Minnesota Statutes 2006

145.925 FAMILY PLANNING GRANTS.

Subdivision 1. Eligible organizations; purpose. The commissioner of health may make special grants to cities, counties, groups of cities or counties, or nonprofit corporations to provide prepregnancy family planning services.

Subd. 1a. Family planning services; defined. "Family planning services" means counseling by trained personnel regarding family planning; distribution of information relating to family planning, referral to licensed physicians or local health agencies for consultation, examination, medical treatment, genetic counseling, and prescriptions for the purpose of family planning; and the distribution of family planning products, such as charts, thermometers, drugs, medical preparations, and contraceptive devices. For purposes of sections 145A.01 to 145A.14, family planning shall mean voluntary action by individuals to prevent or aid conception but does not include the performance, or make referrals for encouragement of voluntary termination of pregnancy.

Subd. 2. Prohibition. The commissioner shall not make special grants pursuant to this

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15 http://www.dph.state.ct.us/BCH/Family%20Health/Womens_Health/family_planning_services.htm

16 http://www.state.nj.us/health/fhs/children/familyplan.shtml

17 Available from: http://www.revisor.leg.state.mn.us/bin/getpub.php?pubtype=STAT_CHAP_SEC&year=current&section=145.925&image.x=26&image.y=1

section to any nonprofit corporation which performs abortions. No state funds shall be used under contract from a grantee to any nonprofit corporation which performs abortions. This provision shall not apply to hospitals licensed pursuant to sections 144.50 to 144.56, or health maintenance organizations certified pursuant to chapter 62D.

Subd. 3. Minors. No funds provided by grants made pursuant to this section shall be used to support any family planning services for any unemancipated minor in any elementary or secondary school building.

Subd. 4. Parental notification. Except as provided in sections 144.341 and 144.342, any person employed to provide family planning services who is paid in whole or in part from funds provided under this section who advises an abortion or sterilization to any unemancipated minor shall, following such a recommendation, so notify the parent or guardian of the reasons for such an action.

Subd. 5. Rules. The commissioner of health shall promulgate rules for approval of plans and budgets of prospective grant recipients, for the submission of annual financial and statistical reports, and the maintenance of statements of source and application of funds by grant recipients. The commissioner of health may not require that any home rule charter or statutory city or county apply for or receive grants under this subdivision as a condition for the receipt of any state or federal funds unrelated to family planning services.

Subd. 6. Public services; individual and employee rights. The request of any person for family planning services or the refusal to accept any service shall in no way affect the right of the person to receive public assistance, public health services, or any other public service. Nothing in this section shall abridge the right of the individual to make decisions concerning family planning, nor shall any individual be required to state a reason for refusing any offer of family planning services. Any employee of the agencies engaged in the administration of the provisions of this section may refuse to accept the duty of offering family planning services to the extent that the duty is contrary to personal beliefs. A refusal shall not be grounds for dismissal, suspension, demotion, or any other discrimination in employment. The directors or supervisors of the agencies shall reassign the duties of employees in order to carry out the provisions of this section. All information gathered by any agency, entity, or individual conducting programs in family planning is private data on individuals within the meaning of section 13.02, subdivision 12.

Subd. 7. Family planning services; information required. A grant recipient shall inform any person requesting counseling on family planning methods or procedures of:

(1) Any methods or procedures which may be followed, including identification of any which are experimental or any which may pose a health hazard to the person;

(2) A description of any attendant discomforts or risks which might reasonably be expected;

(3) A fair explanation of the likely results, should a method fail;

(4) A description of any benefits which might reasonably be expected of any method;

(5) A disclosure of appropriate alternative methods or procedures;

(6) An offer to answer any inquiries concerning methods of procedures; and

(7) An instruction that the person is free either to decline commencement of any method or procedure or to withdraw consent to a method or procedure at any reasonable time.

Subd. 8. Coercion; penalty. Any person who receives compensation for services under any program receiving financial assistance under this section, who coerces or endeavors to coerce any person to undergo an abortion or sterilization procedure by

threatening the person with the loss of or disqualification for the receipt of any benefit or service under a program receiving state or federal financial assistance shall be guilty of a misdemeanor.

Subd. 9. Amount of grant; rules. Notwithstanding any rules to the contrary, including rules proposed in the State Register on April 1, 1991, the commissioner, in allocating grant funds for family planning special projects, shall not limit the total amount of funds that can be allocated to an organization. The commissioner shall allocate to an organization receiving grant funds on July 1, 1997, at least the same amount of grant funds for the 1998 to 1999 grant cycle as the organization received for the 1996 to 1997 grant cycle, provided the organization submits an application that meets grant funding criteria. This subdivision does not affect any procedure established in rule for allocating special project money to the different regions. The commissioner shall revise the rules for family planning special project grants so that they conform to the requirements of this subdivision. In adopting these revisions, the commissioner is not subject to the rulemaking provisions of chapter 14, but is bound by section 14.386, paragraph (a), clauses (1) and (3). Section 14.386, paragraph (b), does not apply to these rules.
History: 1976 c 9 s 2; 1977 c 305 s 45; 1978 c 775 s 1; 1981 c 311 s 39; 1981 c 356 s 176; 1982 c 545 s 24; 1983 c 289 s 115 subd 1; 1Sp1985 c 9 art 2 s 16; 1986 c 444; 1987 c 309 s 25; 1991 c 199 art 2 s 1; 1991 c 292 art 2 s 32; 1997 c 187 art 5 s 19; 1997 c 203 art 2 s 15

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[i] U.S. Department of Health and Human Services, http://opa.osophs.dhhs.gov/titlex/ofp.html
[ii] Kaiser Family Foundation. Medicaid: A Critical Source of Support for Family Planning in the United States. April 2005. http://www.kff.org/womenshealth/upload/Medicaid-A-Critical-Source-of-Support-for-Family-Planning-in-the-United-States-Issue-Brief-UPDATE.pdf
[iii] U.S. Department of Health and Human Services, Title X Family Planning Grantees, Delegates, and Clinics. http://opa.osophs.dhhs.gov/titlex/servicesdirectory/titlexgdcs_regVII.pdf
[iv] Iowa Department of Public Health, http://www.idph.state.ia.us/hpcdp/common/pdf/fp_map.pdf
[v] Guttmacher Institute, "Contraception Counts, Iowa" http://www.guttmacher.org/pubs/state_data/states/iowa.html

Guttmacher Institute, "Public Funding for Contraceptive, Sterilization and Abortion Services, FY 1980-2001" http://www.guttmacher.org/pubs/fpfunding/tables.pdf

[vi] Guttmacher Institute, "Public Funding for Contraceptive, Sterilization and Abortion Services, FY 1980-2001" http://www.guttmacher.org/pubs/fpfunding/tables.pdf. The other states not providing state funds for family planning are Arizona, Idaho, Iowa, Nebraska, Nevada, New Mexico, North Dakota, Oregon, Texas, Utah and Washington DC.
[vii] History of Minnesota's Family Planning Special Grants Program, http://www.health.state.mn.us/divs/fh/mch/familyplanning/history.html
[viii] Minnesota Department of Health, http://www.health.state.mn.us/divs/fh/mch/familyplanning/spec-proj/extramoney.pdf
[ix] Minnesota Department of Health, http://www.health.state.mn.us/divs/fh/mch/familyplanning/spec-projects.html
[x] Minnesota Rule 4700.2500 Use of State Funds Available for Family Planning Special Project Grants. http://www.revisor.leg.state.mn.us/arule/4700/2500.html

[xi] Family Planning Special Projects, Statistical Report for CY2006, http://www.health.state.mn.us/divs/fh/mch/familyplanning/spec-proj/cy06statreport.html
[xii] Family Planning Special Projects, Statistical Report for CY2006, http://www.health.state.mn.us/divs/fh/mch/familyplanning/spec-proj/cy06statreport.html
[xiii] Key Informant Interview, Minnesota family planning agency
[xiv] Family Planning Special Projects, Statistical Report for CY2006, http://www.health.state.mn.us/divs/fh/mch/familyplanning/spec-proj/cy06statreport.html
[xv] Iowa Department of Public Health, http://www.idph.state.ia.us/hpcdp/family_planning.asp
[xvi] Minnesota Department of Health, http://www.health.state.mn.us/divs/fh/mch/familyplanning/spec-projects.html
[xvii] Guttmacher Institute, Women in Need of Contraceptive Services and Supplies, 2004. (2006), http://www.guttmacher.org/pubs/win/win2004.pdf
[xviii] U.S. Department of Health and Human Services, Program Guidelines for Project Grants for Family Planning Services. (2001) http://opa.osophs.dhhs.gov/titlex/2001guidelines/2001_ofp_guidelines_complete.pdf
[xix] History of Minnesota's Family Planning Special Grants Program, http://www.health.state.mn.us/divs/fh/mch/familyplanning/history.html
[xx] Planned Parenthood of Minnesota, 4Now, http://www.plannedparenthood.org/mn-nd-sd/free-birth-control-4now.htm
[xxi] Key Informant Interview, Planned Parenthood of Minnesota
[xxii] Key Informant Interview, Michigan Department of Community Health
[xxiii] Wis. Stat. 253.07 Family planning.
[xxiv] Key Informant Interview, Planned Parenthood of Wisconsin
[xxv] See Appendix A for examples of other states that place programs within state Departments of Health.
[xxvi] One full-time coordinator oversees Minnesota's Family Planning Special Grants program; the program also previously had a dedicated Reproductive Health Coordinator on staff. Other Department of Health staff provide "in-kind" supervision, financial, and contracts analysis.