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### Increasing Access to STI Services in the Medicaid Program

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# INCREASING ACCESS TO STI SERVICES

*In The Medicaid Program*

Milken Institute School  
of Public Health

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# EXECUTIVE SUMMARY

The United States is undergoing an epidemic of sexually transmitted infections (STIs), including chlamydia, gonorrhea, and syphilis. All three bacterial infections are detectable and treatable, yet they often go undiagnosed. Untreated chlamydia and gonorrhea can lead to serious pelvic infections and infertility; untreated syphilis can result in severe complications, including death. Congenital syphilis is increasing as well, with a concurrent rise in stillbirth and newborn deaths.

Increased resources and heightened attention are urgently needed to supplement the work of the public health infrastructure, for which STI funding has remained stagnant for two decades. Fortunately, the Medicaid program is well situated to improve STI services on a broad scale. The federal-state health insurance program covers 73 million people, and is the primary payer for family planning services for low-income women. Medicaid eligibility overlaps significantly with STI risk, and the program already covers a disproportionate share of STI-related visits.]

## *Methodology*

The goal of this project was to identify barriers and opportunities for enhancing access to STI services through the Medicaid program. In addition to analysis of peer-reviewed and grey literature, researchers focused on four states, varying by region and Medicaid expansion status, that include cities with high STI prevalence: Georgia (Atlanta), Illinois (Chicago), Maryland (Baltimore), and South Carolina (Charleston). Interviews were conducted with Medicaid officials, public health officials, providers, and a Medicaid managed care organization (MCO).

## *Findings*

The research and interviews conducted for this project identified both challenges and opportunities for leveraging the Medicaid program to improve access to STI services.

Some of the primary barriers were related to reimbursement: current models of STI service delivery, whether through public health departments or private providers, do not always optimize reimbursement from Medicaid (or, in some cases other payers). One particular concern is that some payment systems may not reimburse for the multisite, extragenital testing recommended by CDC for some populations. Interviewees also reported limitations on two approaches that are intended to improve care: there is extensive uncertainty about Medicaid enrollees' ability to self-refer for STI services and other family planning care; and reimbursement challenges hinder the effectiveness of expedited partner treatment for chlamydia and gonorrhea. Meanwhile, preventing congenital syphilis through testing in pregnancy remains a challenge in light of broader problems ensuring comprehensive prenatal care. And, adolescents and youth experience a range of privacy and confidentiality concerns in obtaining STI services.

Despite these challenges, the Medicaid program offers many opportunities for optimizing STI care. States and Medicaid MCOs have a range of levers available for incentivizing performance improvement at the plan and provider levels, and could also explore enrollee incentives. Medicaid expansions under the Affordable Care Act (ACA) have increased access to comprehensive care, including STI services for adults; more targeted Medicaid family planning expansion programs could also help reach more adults. Most states and MCOs are employing telehealth, which, in the context of STIs, could help address both transportation and stigma-based barriers to care. Medicaid claims data could serve as a rich source of information to supplement and inform public health efforts. Finally, states and MCOs have multiple conduits available for sharing general and state-specific information about STIs with patients and providers.

## Considerations

Based on these findings, the report suggests that public health officials, states Medicaid agencies, MCOs, providers and other stakeholders consider the following actions:

### Reimbursement

- Use approaches beyond traditional reimbursement to support STI service providers
- Develop ways to fund varied models of STI service delivery
- Create state-specific coding and billing resources
- Ensure reimbursement for multisite testing
- Use performance improvement programs to incentivize high-quality STI care

### Coverage and Access

- Expand Medicaid and optimize Medicaid family planning expansions
- Clarify the Medicaid family planning services self-referral policy
- Leverage increased PrEP utilization to increase access to STI services

### Specific Barriers

- Maximize privacy and confidentiality protections, especially for adolescents
- Reimburse expedited partner therapy regardless of partners' insurance status
- Extend telehealth services to innovatively cover STI care

### Technical Assistance and Outreach

- Convene a national STI affinity group
- Develop model MCO contract language
- Support and engage patients and providers

### Further Research

- Develop or expand data-sharing arrangements between Medicaid and public health agencies
- Model general and state-specific return on investment for STI services
- Monitor the impact of policy changes on STI service utilization

The emergence of the novel coronavirus (the virus that causes the disease COVID-19) has changed how people access health care in the U.S., and this phenomenon may extend into the near future. Therefore, stakeholders may wish to adapt these proposed policy and programmatic actions to suit the needs of their local communities in light of the current pandemic.

## Conclusion

The Medicaid program already serves a vital role in providing STI services to millions of Americans. Working in cooperation with the public health community and providers, state Medicaid programs and managed care plans could expand their work to improve individual and community health through a strengthened response to the STI epidemic.



## INTRODUCTION

The U.S. is currently experiencing multiple overlapping epidemics of sexually transmitted infections, or STIs, including chlamydia, gonorrhea, and syphilis.<sup>1</sup> In the face of rising STI rates, largely stagnant public health funding, and shifts in funding for reproductive health services, the Medicaid program is uniquely positioned to reduce transmission of STIs and prevent their costly sequelae.

Medicaid provides health and long-term care coverage for more than 73 million low-income Americans and is the primary sponsor of prenatal care and family planning services for low-income women.<sup>2,3</sup> States that have expanded their Medicaid programs, overall or through family planning expansions, can reach low-income adults, including childless adults, with STI services and other care.

Research has demonstrated considerable overlap between Medicaid eligibility criteria and the demographic markers of STI risk, along with a major role for Medicaid in STI care. For example, a 2013 study identified increased STI risk among young adults aged 18-26 at lower incomes.<sup>4</sup> This association persisted across racial and ethnic groups, with racial and ethnic disparities in STIs creating further gradients of risk.<sup>5</sup> According to a recent study of 25 million visits to community-based physicians between 2014 and 2015, Medicaid disproportionately covered STI-related visits compared to other payers, most likely reflecting the composition of higher-risk individuals within the Medicaid population.<sup>6</sup> And people with public insurance, including Medicaid, are more likely to receive a sexual risk assessment and recommended STI screenings than people with private insurance or without coverage.<sup>7</sup>

In partnership with public health, state Medicaid programs could play an even larger role in combating STIs by leveraging or adapting program features to expand access and improve health.

This report begins with background information on the current STI epidemic in the U.S. and on the Medicaid program, with a focus on the family planning benefit and the role of managed care organizations (MCOs). It then presents the findings of research based on peer-reviewed literature, legal analysis, and an analysis of Medicaid and STIs in four focus states, including interviews with a range of stakeholders in each state. It closes with a set of considerations for federal agencies, state Medicaid programs, Medicaid MCOs, public health officials, and other stakeholders.

## METHODOLOGY

To select focus states for this project, CDC identified the U.S. cities with the highest rates of chlamydia, gonorrhea, and syphilis. From these, CDC chose four in states representing a variety of geographic regions and Medicaid expansion status: Maryland (Baltimore), Illinois (Chicago), Georgia (Atlanta), and South Carolina (Charleston) (see Tables 1 and 2 below for detailed epidemiologic information and Medicaid program status).

A team of researchers at the George Washington University School of Public Health (GWU) conducted a review of peer-reviewed and “grey” literature regarding STIs, barriers to STI services, and STIs in Medicaid (see Appendix 1 for search terms). GWU conducted further research on the scope and policies of the Medicaid program in each of the four focus states, along with relevant state laws regarding expedited partner therapy, adolescent consent to STI services, and congenital syphilis. In addition, GWU reviewed

model Medicaid managed care contracts for the four focus states, as well as the enrollee manuals for all Medicaid MCOs operating in those states.

For each of the four states, interviews were requested with Medicaid officials, public health officials, and providers seeing a high volume of clients for STI screening and/or treatment services. GWU conducted semi-structured interviews with Medicaid agency officials in all four states, as well as officials from two state health departments (Maryland and Illinois) and two city health departments (Baltimore and Chicago). Participating providers included a federally-qualified health center (FQHC), an HIV-focused service organization, an adolescent health clinic, and an HIV/primary care clinic (see Appendix 2 for a full list of interviewees). Attempts were made to interview MCOs in each state, but only one MCO in Maryland agreed to be interviewed. All interviews were deemed exempt from review by the George Washington University Institutional Review Board.

**Table 1: STIs in the Four Focus States and High Prevalence Cities, 2018<sup>8</sup>**

State	Chlamydia			Gonorrhea			Syphilis (P&S)			Syphilis (congenital)		
	Cases	Rate (per 100,000)	Rank	Cases	Rate (per 100,000)	Rank	Cases	Rate (per 100,000)	Rank	Cases	Rate (per 100,000)	Rank
Georgia	65,936	632.2	7th	20,867	200.1	15th	1,607	15.4	4th	31	23.8	10th
Illinois	77,325	604.4	9th	25,422	198.6	16th	1,408	11.0	13th	29	18.8	16th
Maryland	35,482	586.3	12th	10,305	170.3	24th	737	12.2	12th	29	39.7	9th
South Carolina	33,910	674.9	4th	13,801	274.7	3rd	384	7.6	25th	9	15.7	18th

Cities	Cases	Rate		Cases	Rate		Cases	Rate		Cases	Rate	
Atlanta, GA <sup>1</sup>	32,883	558.8		6,658	234.0		1,094	18.6		5	38.1	
Chicago, IL <sup>2</sup>	30,292	1123.8		11,730	435.2		788	29.2		16	24.0	
Baltimore, MD	8,013	1310.1		3,596	587.9		277	45.3		8	94.1	
Charleston, SC	2,738	682.0		793	197.5		48	12.0		1	19.9	

1. For Atlanta MSA
2. 2017 data

**Table 2: Medicaid Program Characteristics<sup>9,10</sup>**

State	Enrollees	MCO Enrollment	Expansion State?	Family Planning Expansion?
Georgia	1,808,764	75%	N	Y
Illinois	3,123,580	81.4%	Y	N
Maryland	1,315,534	85%	Y	Y
South Carolina	1,037,023	75%	N	Y

## BACKGROUND

To provide context for a potentially expanded role of Medicaid in STI prevention, this section describes the current STI epidemic in the U.S. and patient and provider barriers to STI services. It then gives an overview of the Medicaid program, and discusses Medicaid's family planning benefit and the intersection of STI services with Medicaid managed care.

### The STI Epidemic in the U.S.

Chlamydia, gonorrhea and syphilis are generally curable with antibiotics,<sup>11</sup> yet they often remain undiagnosed. If untreated, chlamydia and gonorrhea can lead to pelvic inflammatory disease, an inflammation of the female reproductive tract that may result in chronic pelvic pain, ectopic pregnancy, or infertility.<sup>12-13</sup> Untreated syphilis can cause severe organ damage and, in severe cases, death.<sup>14</sup> Congenital syphilis can cause miscarriage, stillbirth, prematurity, low birthweight, and death.<sup>15</sup> In addition, STIs are associated with a higher risk of HIV transmission and acquisition; a recent modeling study estimated that ten percent of new HIV infections among men who have sex with men (MSM) in the U.S. are attributable to chlamydia and gonorrhea.<sup>16</sup> Analyses have identified particularly high lifetime medical costs for individuals who develop complications due to untreated STIs.<sup>17,18</sup>

CDC's 2018 STI surveillance report reflected the extent of a growing health crisis with regard to chlamydia, gonorrhea, and syphilis<sup>19</sup>:

- In 2018, there were 1,758,668 reported cases of *Chlamydia trachomatis*. From 2014 to 2018, rates of reported chlamydia cases increased among all racial and ethnic groups.<sup>20</sup>
- Since hitting a historic low in 2009, reported rates of gonorrhea increased by 82.6 percent. Drug resistance is a growing concern: more than half of all gonorrhea infections in 2018 were resistant to at least one antibiotic.<sup>21</sup>
- Rates of primary and secondary (P&S) syphilis – the most infectious stages of the disease – have risen steadily since 2001, and increased 14.9 percent from 2017–2018. Over half of cases in 2018 were among MSM, but rates among women increased by 172.7 percent from 2014–2018. In line with the increasing epidemic among heterosexuals, rates of congenital syphilis have increased each year since 2013. In 2018, there were 1,306 reported cases of congenital syphilis resulting in 78 stillbirths and 16 newborn deaths.<sup>22</sup>
- Rates of chlamydia, gonorrhea, and syphilis are all significantly higher among African Americans and Hispanic/Latinos than among whites, for both men and women.<sup>23</sup>

CDC attributes rising STI rates to a mix of factors that hinder access to health services, including poverty, substance use, and housing instability, as well as decreased condom use among groups at high risk.<sup>24</sup>

Despite these trends, federal funding for STI programming, the main source of support for state and local safety net STI clinics, remained static for two decades without adjustments for inflation, resulting in an effective cut of nearly 40 percent.<sup>25,26,27,28,29</sup> The 2020 appropriations bill does include an increase of \$3.51 million.<sup>30</sup>

Meanwhile, the federal Title X family planning program, which funds family planning and related services through safety net providers, is in the process of significant changes. Title X-funded providers, including health departments, hospitals, family planning councils, FQHCs, and private nonprofits, served approximately four million men and women in 2015, including providing almost 5 million STI tests.<sup>31</sup>

A federal regulation finalized in February 2019 prohibits providers at Title X facilities from referring pa-



tients for abortion care, and establishes stringent physical and financial separation requirements between Title X providers and facilities that use nonfederal funds to offer abortion services.<sup>32</sup> Despite opposition from the American Medical Association,<sup>33</sup> the American College of Physicians,<sup>34</sup> and the American College of Obstetricians and Gynecologists,<sup>35</sup> the rule was finalized in March 2019, with the physical separation requirement slated to come into effect in March of 2020.

As of September 2019, one large national nonprofit provider and an additional 629 clinics run by health departments, nonprofits, and FQHCs were no longer participating in Title X, either because they did not consider the new counseling restrictions compatible with the appropriate provision of patient care or because they could not meet the new separation requirements.<sup>36</sup> Other clinics and state health departments may reject the funding. The impact of these shifts in funding on STI care, and the shift of burden to other payers, including Medicaid, could be significant.

## Patient and Provider Barriers to Optimal STI Service Utilization

A large body of research illustrates some of the patient- and provider-level barriers to the optimal use, and provision, of STI services. While most studies are not specific to Medicaid, many of the findings are likely relevant to Medicaid enrollees.

For patients, evidence indicates that risk perception plays a central role in practices related to the transmission of infections. For example, individuals who underestimate their risk for STIs may be less inclined to use condoms or seek screening.<sup>37,38</sup> In one study of sexually experienced adolescents and young adults who were never tested in their lifetime, 42 percent did not seek testing because they felt they were not at risk for STIs, despite robust surveillance data demonstrating the disproportionate burden of STIs among young people.<sup>39,40</sup> Low perceived risk for syphilis was identified as a reason for not screening by 62 percent of MSM as well, despite evidence that MSM are 106 times more likely to have primary or secondary syphilis than men who primarily have sex with women.<sup>41,42</sup>

Stigma and shame associated with STIs are also significant barriers to appropriate STI diagnosis and treatment services. Qualitative research has shown an association between perceived stigma and delays in seeking STI screening and treatment for men and women.<sup>43,44</sup> Stigma may also be an important factor in adolescents' decisions to disclose sexual health behavior information to health care providers.<sup>45</sup> Similarly, internalized stigma is common after STI diagnosis and, in turn, may directly influence screening or treatment-seeking behaviors.<sup>46</sup> Other research has demonstrated that adolescents with higher levels of perceived and internalized stigma were more likely to delay seeking services.<sup>47,48</sup> For example, in one study, adolescent African American men who experienced high levels of stigma and shame were significantly less likely to get tested, self-notify partners of an STI, or deliver STI medication to their partners.<sup>49</sup>

On the provider side, adherence to recommended practices and guidelines for STI care is essential to preventing adverse outcomes associated with STIs and reducing transmission. However, evidence indicates that providers often do not fully adhere to these recommendations.<sup>50,51</sup> For example, a 2014 study in Indiana found that although most community health centers reported screening for chlamydia, gonorrhea, and syphilis, screening generally did not reflect CDC guidelines for STI testing in clinical settings, and testing was provided primarily at patient request or when symptomatic.<sup>52</sup>

Several provider characteristics are associated with more consistent delivery of STI prevention and treatment services: having received more recent professional clinical training, feeling well-trained in adolescent sexual risk assessment, and holding the belief that routine STI screening can be cost effective.<sup>53,54</sup> Additional factors associated with improved delivery of STI care include willingness to provide preventive care, acknowledging that treatment of STIs is an organizational priority, having a clear understanding of scope of guidelines, and serving a high proportion of female patients.<sup>55,56</sup>

Service providers in one study cited insufficient staffing capacity and time as infrastructural barriers to STI care, noting that staff time is needed to address STIs, to counsel patients or their partners, to keep current with managing higher-risk patients, and to monitor patient adherence to provider recommendations.<sup>57</sup> A 2003 study assessing primary care provider-perceived barriers to STI care found that lack of adequate reimbursement was the most commonly cited impediment to routine screening.<sup>58</sup> However, both of these studies predated the enhanced preventive service coverage policies of the Affordable Care Act (ACA).

## The Medicaid Program

The Medicaid program was established in 1965 as a federal-state partnership to provide medical assistance to low-income individuals.<sup>59</sup> Medicaid historically served the “categorically needy”: low-income children and their parents, pregnant women, people with disabilities, and people over 65. However, the program has grown in scope, most notably with the state option under the ACA to extend coverage to all adults living under 138 percent of the federal poverty level (FPL).

For most medical services, the percentage of costs covered by the federal government, or federal medical assistance percentage (FMAP), is between 50-77 percent, depending on a state’s average per capita income.<sup>60</sup> For enrollees who are eligible due to the ACA expansion, the FMAP is 90 percent for all services.

Today, the Medicaid program covers roughly 65.5 million people.<sup>61</sup> For adults, Medicaid provides a variety of mandatory and optional benefits, often with variation across different beneficiary populations. As a result, states have been afforded enormous flexibility on the design of their programs as long as they comply with federal requirements. For children and youth under the age of 21, one of Medicaid’s hallmark programs, Early and Periodic Screening, Diagnostic and Treatment, covers a broad array of preventive services and treatments, including prevention and screening of STIs.<sup>62</sup>

## Family Planning Services in Medicaid

All state Medicaid programs must cover family planning services and supplies as part of their standard Medicaid benefit packages and in alternative benefit plans that serve newly eligible enrollees under Medicaid expansion.<sup>63</sup> However, states have considerable discretion in identifying the specific services and supplies that are defined as family planning services in the state plans.<sup>64,65</sup>

States generally define STI testing as family planning services if provided “as part of a family planning visit”; in a 2013 Kaiser survey (the most recent available), 11 states reported defining STI and HIV tests as family planning services “all the time”; others only considered them family planning services in certain contexts.<sup>66</sup> STI treatment, in contrast, is generally defined as “family-planning-related.” For family planning services, the FMAP, which is higher than the FMAP for most other medical services for traditionally eligible enrollees.<sup>67</sup>

In some states, Medicaid also supports prevention through coverage of condoms, which are recommended by the CDC to reduce the risk of transmission of STIs.<sup>68</sup> In a 2015 survey, 27 of 41 states reported covering condoms for their traditional (non-expansion population) Medicaid enrollees, 18 states covered condoms for expansion enrollees, and 18 states covered condoms in their Medicaid family planning expansion waivers or amendments.<sup>69</sup> Most of these states require a provider prescription for the condoms.

Like most payers, Medicaid generally reimburses providers a specific amount for an evaluation and management (E/M) visit, with different rates for type and length of visit; providers have to submit diagnostic information and details about services offered. Providers may be reimbursed for additional services provided during the visit as well as for medications administered or directly dispensed during the visit.<sup>70</sup> For

example, a visit involving treatment of gonorrhea would generally be reimbursed based on an E/M visit rate plus a fee for the injection of medication. For screening and diagnosis, if lab tests are ordered, the lab, not the provider, bills for the tests.<sup>71</sup>

Medicaid reimbursement for FQHCs is somewhat different: Medicaid programs pay FQHCs through a prospective payment system (PPS), using a flat, per-visit rate typically calculated based either on past cost reporting or on local averages.<sup>72</sup> While some items may be billed “above” the encounter rate, GWU found no evidence in the literature or interviews that STI screening, counseling or treatment services have been carved out in this way.

## STI Services and Medicaid Managed Care

State Medicaid programs have increasingly turned to managed care to control program costs. Medicaid managed care can encompass a range of payment arrangements, but the dominant model is “comprehensive” managed care. In this model, state Medicaid agencies pay MCOs a fixed capitated rate per enrollee, risk-adjusted to reflect the population actually enrolled in the MCO. More than two-thirds of Medicaid beneficiaries are enrolled in comprehensive MCOs.

Under federal law, Medicaid enrollees seeking family planning services are permitted to see any Medicaid-participating provider without a referral.<sup>73</sup> This extends to MCO enrollees, who can seek family planning services from any Medicaid-participating provider whether or not the provider is in the MCO’s network. This is also termed “self-referral.”<sup>74</sup>

When family planning services are delivered through MCOs, the state can still receive a 90 percent FMAP by aggregating encounter information from the MCOs and claiming the applicable match from the federal government. The contracts that MCOs negotiate with health care purchasers can provide accountability for the delivery of specific services and fulfillment of certain performance standards.<sup>75,76</sup>

There is no published research regarding whether and how managed care influences access to STI services in the Medicaid program. Overall, some studies have found that the introduction of managed care into state Medicaid programs may cause a modest decline in racial disparities in utilization of healthcare.<sup>77,78</sup>

## FINDINGS

Review of the literature, analysis of state law in the four focus states, and interviews conducted with stakeholders identified the following challenges and opportunities for improving access to STI services in the Medicaid program.

### Challenges

#### Reimbursement

**STI service providers may offer care through delivery and billing models that do not fully leverage Medicaid or other third-party reimbursement.**

Interviewees described several ways that STI service providers are not able to optimize Medicaid reimbursement to support their services. Many of these challenges are not specific to the Medicaid program,

but represent challenges in the context of any third-party billing:

- **Non-billing of services:** Some STI services are simply not billed, either because of provider practice or patient preference. Staff belief that these services “should be free” is a primary barrier; some health department clinics also face legal barriers to billing.<sup>79</sup> Coding and related administrative work can be a challenge.<sup>80</sup> In addition, as one study found, a subset of patients are unwilling to use their insurance at STI clinics even when insured, though those with Medicaid were more willing to use insurance than those with private coverage.<sup>81</sup> Other research has similarly found that patients may avoid using their health insurance for the receipt of sensitive healthcare services due to confidentiality concerns.<sup>82</sup>
- **Nurse-only visits:** An FQHC provider noted that the clinic uses a nurse, rather than a physician or midwife, to offer flexible appointment spots, but that Medicaid does not reimburse FQHCs for this type of visit:

*We are not able to be reimbursed for the visit unless a [physician or midwife] actually sees the patient... It's an unfortunate holdback, and it really is a barrier to patients and a barrier to us because our nursing care is not reimbursed.*

In some states, non-FQHCs may be able to seek reimbursement for nurse-only visits, but these reimbursement rates (from Medicaid and other payers) are typically lower than for physicians or other high-level providers.

- **Support services:** Some patients receiving STI care may need support services beyond the clinical care provided in the office visit. For example, one provider explained that it would be helpful for Medicaid to provide case management support for adolescents with sexual health concerns:

*Medicaid needs to support some entities other than the ... provider. ....Medicaid MCOs have that for certain conditions. Diabetes is a great example. They have somebody who will come out and they will make sure the patient has their supplies. But we don't quite have that in sexual health, and I think young people are trying to navigate that by themselves. The data, at least around PID as an example, [shows] that they don't do it very well.... Our ability to offer some of those ancillary services or peripheral services outside the visit through Medicaid easily, I think would be critically important.*

States in fact can cover a range of types in case management services in Medicaid, but more work may be needed to identify whether and how these services could be made available to adolescents navigating STI care and other sexual health services.

- **Sustaining flexible care delivery on a reimbursement model:** More flexible STI care may be challenging to maintain based on a traditional reimbursement model, particularly in the context of declines in grant funding. For example, one provider described the value of having afternoon walk-in slots, particularly for adolescents, but noted that this model is difficult to sustain:

*I think it's harder... because all of us are riding on such thin margins that it is tenuous to have open slots.... How do you hold space open that might not be used, knowing your budget relies on seeing as many patients as reasonable or possible?*

- **Reimbursement rates for visits:** Overall, no provider interviewed for the project cited Medicaid reimbursement rates for STI services in particular as a barrier to care. However, the adequacy of reimbursement for an actual visit – typically E/M rates, adjusted for acuity and duration – may be more important than for specific tests ordered (particularly for lab tests, which are billed by the lab, not

the ordering provider). While GWU did not identify studies analyzing the impact of visit payment rates on utilization of STI screenings, a study comparing Medicaid reimbursement rates and cancer screening found that office visit rates were more consistently associated with utilization than rates for the specific screenings.<sup>83</sup> The importance of robust reimbursement for a comprehensive visit was underscored by one provider:

*It just makes the visit longer if you have to interview somebody about their risky behavior. And so one of the things Medicaid needs to pay for is that – the screening that’s done, the time it takes to talk to certain patients.*

### **Multisite/Extragenital Testing**

**State and MCO coding and payment systems, along with commercial payer systems, may not be set up to reliably reimburse for multisite STI testing as recommended by CDC.**

For some patients, appropriate screening or diagnosis of STIs requires obtaining samples from multiple sites, including extragenital sites. For example, for MSM, CDC recommends gonorrhea testing at sites of contact, including, if appropriate, urethra, rectum, and pharynx.<sup>84</sup>

However, when multiple samples are sent to a lab, some reimbursement systems, including Medicaid’s, may reject claims for any beyond the first or second sample, applying a presumption that multiple samples from the same person for the same pathogen in the same day are either fraudulent or mistakes.

It is possible to design coding and reimbursement systems that avoid this problem, as evidenced by the Centers for Medicare and Medicaid Services’ (CMS’s) National Correct Coding Initiative.<sup>85</sup> The initiative establishes “medically unnecessary edit thresholds,” or MUEs, which represent the maximum number of units of a service that can be reimbursed in a single day.<sup>86</sup> In CMS’s 2019 version for Medicare, the first three chlamydia or gonorrhea tests (CPT codes 87491 and 87591 respectively) billed in a day do not require a modifier. For four or more tests in the same day, modifier 59 can be used to indicate that the additional tests represent a “distinct procedural service” that is appropriate in the clinical circumstances.<sup>87</sup>

CMS maintains a parallel set of MUEs for Medicaid, and modifier 59 applies in the same way in that system.<sup>88</sup> However, individual state Medicaid and private coding systems are not required to use CMS’s coding, and may apply more restrictive MUEs, with or without modifiers. CMS maintains a portal through which states can download the codes, but downloads may have errors or lag behind national updates. Medicaid MCOs in a state may also choose to use different MUEs, unless other requirements apply in their contract with the state.

No national information exists regarding how state Medicaid programs cover multisite testing. In an informal survey for an earlier project on PrEP and STIs, AcademyHealth asked its network of Medicaid Medical Directors if their state FFS programs would “pose any barriers to coverage of quarterly, multi-site STD testing.”<sup>89</sup> Of the 15 medical directors who responded, seven stated that their state program did not have any barriers; one said the state program would not pay for even a second lab test on the same day, and seven were unsure.<sup>90</sup>

Medicaid programs in the four focus states for this project do not appear to have explicit policies blocking reimbursement for multisite testing, but it is unclear if their systems pose unintentional barriers. One state’s program reported generally following the CMS coding guidance. Another state noted that so little multisite testing is occurring that the system has not been tested yet. Generally, that state attempts to align its coding system with CMS, but relies on an old billing system that may not recognize all of the appropriate modifier fields.

Ultimately, if labs are not reimbursed adequately, or are reimbursed inconsistently, for multisite tests, providers may get pushback from the labs and be less likely to order them. As one provider stated:

*In other practices, I know that's true for everything... At least in my experience, if you start to realize you're not getting reimbursed for something, then you won't do it.*

### Choice of Providers

**Managed care enrollees' right to self-refer to any Medicaid provider for family planning services, including STI screening, is hindered by a lack of clarity at the enrollee, plan, and provider level.**

Many providers, including primary care physicians and pediatricians, offer STI services. Several participants felt that on paper there may appear to be sufficient providers to meet their respective states' STI care needs. However, multiple interviewees discussed variation in how well different providers or clinics provide STI care, and how comfortable patients are at different offices. As one provider noted:

*There are plenty of Medicaid participating providers. The question is how comfortable they are delivering sexual health services.*

Self-referral could increase flexibility for Medicaid enrollees to select STI service providers they are comfortable seeing. In addition, there is variation in whether public clinics participate in Medicaid MCO networks; patients who wish to get care out of network at such clinics would need to self-refer.

Interviewees described several barriers to effective implementation of self-referral. First, there is a lack of uniformity and clarity regarding when self-referral applies to patients seeking STI services. As discussed above, some states consider STI testing to be a family planning service in all cases, but others define STI testing as a family planning service only in certain contexts. Meanwhile, STI *treatment* is a family-planning *related* service. This creates a lack of clarity, for example regarding whether a patient can return to a non-network provider for an injection for gonorrhea treatment, even if self-referral clearly applied to the initial visit for STI screening.

In addition, providers and other interviewees reported that the self-referral process, and subsequent reimbursement, is not always smooth. There is variation in how providers are paid when they deliver family planning services out of network to an MCO enrollee. While some states permit providers to bill the Medicaid agency for self-referred services, Medicaid officials from two of the focus states said that their programs require MCOs to reimburse the provider, and include this cost as part of the overall capitated rate paid to MCOs. A provider described how challenging it can be to actually obtain reimbursement in these situations, to the point that it disincentivizes serving out-of-network patients:

*[Self-referral] is not something that I see applied in part because... it has been hard to get paid that way. [MCOs] fight back until you bring in the state-wide Medicaid and make them pay you. Especially an organization that has a thin budget, to have to fight that fight and not get paid for a long period of time is problematic, and once burned, it is really hard to try to convince your operations to open up and do it again.*

For some enrollees with both Medicaid and commercial insurance, a provider may be out of network for the Medicaid MCO *and* for the commercial coverage. Since commercial coverage is always primary, this could result in unexpected out-of-pocket costs for the enrollee. One provider noted that this problem was directly affecting Medicaid-enrolled patients who try to self-refer to their clinic:



*The patients are getting bills. I can't tell you the process at the insurance level, all I know is that patients come back and they say, "I thought my insurance should cover this." Or they'll get a notice saying "This is not your place, you should go here." It is also partly that we have to bill it just right, which is the other issue. I would say that some clarity around billing, particularly for these types of services.... could certainly open up patients being able to go one place for their sexual and reproductive health services...without fear or not coming in... [T]hey don't want to get a bill because these are already low-income patients.*

Beneficiaries do not appear to be receiving clear and consistent information about self-referral related to family planning services. Federal regulations require that Medicaid managed care manuals inform enrollees that they do not need a referral to see a family planning provider.<sup>91</sup> However, our analysis of the enrollee manuals for all 20 MCOs in the focus states found significant variation in how freedom of choice for family planning services is described and whether STI services are mentioned. The following examples are from a plan that is very specific about STI services and one that does not mention STIs at all:

**Example 1:**

*[Plan] has a network of providers where you can get family planning services. You may also choose to get family planning services and supplies from any out-of-network provider without a referral and it will be covered. Family planning offers counseling, supplies, and routine care to help you plan when you want to add to your family. If needed, treatment for sexually transmitted infections (STIs) is also covered. Family planning services are private. Get screened and stay healthy! Speak with your PCP if you are sexually active or have any questions or concerns. Stay safe and healthy by talking to your doctor about STI prevention.*

**Example 2:**

*Family planning services – These services are available by fee-for-service (FFS) or by your Managed Care Organization (MCO). Services must be obtained from any approved Medicaid enrolled provider:*

- Annual visit
- Contraception and supplies
- Family planning and HIV counseling
- Lab tests
- Pregnancy testing

**Expedited Partner Therapy**

**A prohibition on Medicaid reimbursement for prescriptions for non-enrolled partners limits the reach of a key STI control tool.**

Repeat infections confer an elevated risk for STI sequelae, and are often due to re-exposure from untreated partners.<sup>92</sup> Expedited Partner Therapy (EPT), the provision of medication or prescriptions to a partner of an index patient without clinical assessment of the partner, was endorsed by the CDC in 2006 in its Sexually Transmitted Diseases Treatment Guidelines to promote partner treatment, particularly for selected STIs (i.e. chlamydia and gonorrhea) among women and their heterosexual partners.<sup>93</sup> The recommendations were updated regarding gonorrhea in 2012 to reflect CDC's shift to endorsing combination therapy with an injection and oral antibiotics: CDC now only recommends EPT for gonorrhea when providers are concerned that partners will not otherwise access any treatment.<sup>94</sup> Of note, EPT is

not yet recommended for the management of STIs in MSM because of the lack of data on the efficacy and the high risk of comorbidity, especially undiagnosed HIV infection, in this population.<sup>95</sup>

Currently, EPT is legally permissible in 44 states plus DC, potentially allowable in five, and prohibited in one.<sup>96</sup> States with the most permissible EPT laws may have the most success in reducing the burden of chlamydia and gonorrhea, according to prior research.<sup>97</sup> One study found that when considering intervention cost, repeat visits by index patients, and the cost of sequelae, EPT is less costly and improves partner treatment compared to other partner management techniques, such as standard partner referral.<sup>98</sup>

EPT is legally permissible in three of the four states covered in this report: Georgia, Illinois, and Maryland. Health department interviewees were enthusiastic about the promise of EPT but noted a challenge with reimbursement: if the partner is not enrolled in Medicaid – a common scenario for male partners of female patients – Medicaid will not cover the partner prescriptions. If the partner is uninsured, he has to pay out-of-pocket, creating a barrier to uptake.

An alternative approach to EPT is to directly dispense two or more courses of medication to the index patient. However, Medicaid generally would still not pay for the doses that are not intended for the index patient. Therefore, as one Medicaid medical director noted, for most providers serving high volumes of Medicaid patients, directly dispensing partner medication to the patient would be cost prohibitive. This conclusion was echoed by multiple providers, who noted that a lack of public funds and tight internal budgets make it impossible to distribute partner doses directly to patients.

### **Congenital Syphilis**

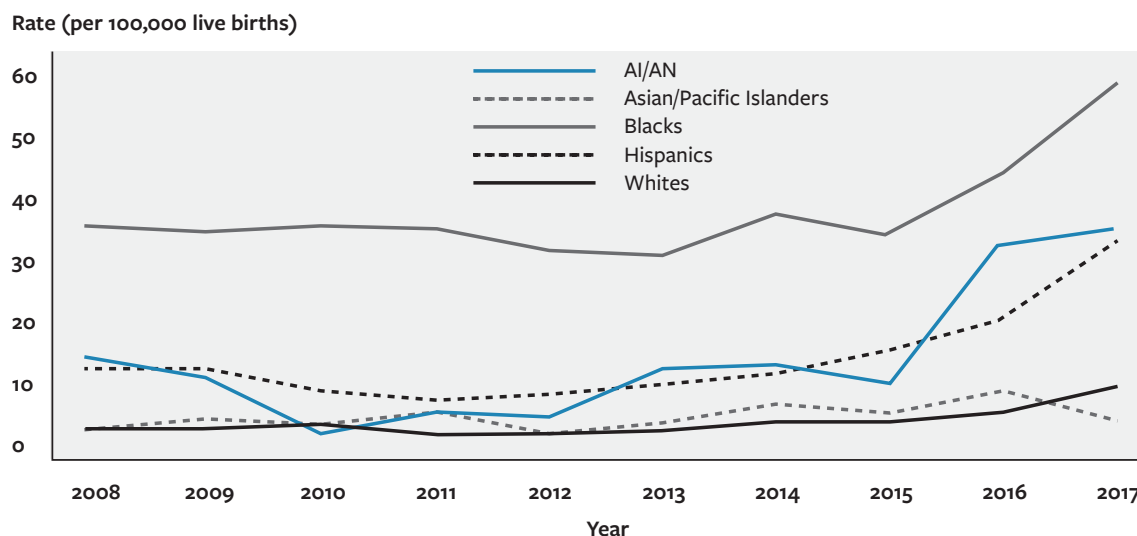
**Efforts to address congenital syphilis through the Medicaid program would depend on the state's approach to reimbursement for prenatal care.**

Untreated syphilis infection in pregnant women can be transmitted to the fetus (congenital syphilis) at any time during pregnancy or delivery if maternal genital lesions are present. Congenital syphilis is associated with stillbirth, neonatal death, and significant morbidity in infants, such as bone deformities and neurologic impairment.<sup>99</sup>

The CDC, American College of Obstetricians and Gynecologists (ACOG), and the U.S. Preventive Services Task Force (USPSTF) recommend that all pregnant women be tested for syphilis as early as possible when they first present for care, regardless of risk.<sup>100,101,102</sup> For women at high risk of syphilis exposure, including those living in communities or geographic areas with a high prevalence of syphilis, those living with HIV, and those with a history of incarceration or commercial sex work, testing is recommended twice during the third trimester: once at 28 to 32 weeks' gestation and again at delivery.<sup>103</sup> If a woman has not received prenatal care prior to delivery, she should be tested at the time she presents for delivery.

In 2018, there were a total of 1,306 cases of congenital syphilis in the U.S., including 78 stillbirths and 16 infant deaths.<sup>104</sup> The rate reflects a 39.7 percent increase compared to the year prior and a 185.3 percent increase compared to 2014.<sup>105</sup> This increase parallels the 165.4 percent increase in primary and secondary syphilis among reproductive-aged women from 2014 to 2018.<sup>106</sup> Rates of congenital syphilis have been increasing across most racial and ethnic groups, but remain highest among infants of African-American women (see Figure 1).

**Figure 1: CDC, Rates of Reported Cases by Year of Birth, Race, and Hispanic Ethnicity of Mother, United States, 2008–2017<sup>107</sup>**



Among the 50 states and DC, all but six (Iowa, Minnesota, Mississippi, New Hampshire, North Dakota, and Wisconsin) have congenital syphilis screening requirements for providers.<sup>108</sup> Forty-three states require testing at the first prenatal visit or soon after, 17 states require screening during the third trimester (with five requiring screening only if the patient is considered at high risk), and eight states require screening at delivery (with five requiring testing only if the woman is at high risk).<sup>109</sup> These are legal requirements for providers; they do not create reimbursement requirements for payers, nor is reimbursement limited to services that are legally required.

The four focus states for this project all rank among the top eighteen states for rates of congenital syphilis. In Georgia, cases have increased from a recent low of one case in 2005 to 23 cases in 2017.<sup>110</sup> Maryland saw sharp increases in congenital syphilis rates in 2017 and 2018, with the number reported in 2018 (29) the highest since 2009.<sup>111</sup> The four states reflect some of the national variation in testing requirements (Table 3):

**Table 3: Legal Requirements for Syphilis Screening among Pregnant Women by Time of Test and State, 2018**

State	First visit	Third trimester	Delivery
Georgia <sup>112</sup>	Required	Required	Required if at increased risk
Illinois <sup>113</sup>	Required	Required	
Maryland <sup>114</sup>	Required	Required	Required if at increased risk
South Carolina <sup>115</sup>	Required		

Participants in interviews for this project largely agreed that rising rates of congenital syphilis are due in part to challenges in linking women to timely and comprehensive prenatal care. Within the Medicaid program, states vary in how they reimburse prenatal care, with some offering providers a bundled payment that includes pregnancy (and sometimes delivery), others paying on an encounter basis, and others reimbursing on a line item basis for each service provided.

Because states reimburse prenatal care differently, it is difficult to make comparisons regarding how specific fee levels may influence uptake. Providers interviewed for the project did not report specific rate or reimbursement challenges for congenital syphilis testing:

*I've been practicing... for 12 years and I've never encountered a barrier in terms of testing for syphilis from Medicaid, from even private insurers.*

However, one provider did cite delays in getting women enrolled in Medicaid once eligible through pregnancy:

*Our problems largely revolve around the state-specific problems we've had with getting patients enrolled with Medicaid when they're pregnant. There's a long, sometimes months and months delay that seem inexplicable about a patient getting, applying, and being approved for Medicaid.*

It is not clear why such delays were occurring in the state, but any delay in access to prenatal care would jeopardize access to a broad range of services, particularly early in the pregnancy. Similarly, another provider noted that the main challenge is not reimbursement but ensuring that women receive prenatal care early and consistently.

FQHC's unique payment model under Medicaid extends to prenatal care, and prenatal syphilis testing is included in the encounter rate. A theoretical exception would be if a state decides to carve prenatal syphilis testing or counseling out as an add-on payment, as some states have done for long-acting reversible contraception,<sup>116</sup> but no such efforts have been identified with regard to STI services in general or prenatal syphilis screening in particular.

On the MCO side, a review of standard contracts for the four focus states reflected a lack of specificity with regard to prenatal care. All four states' contracts require coverage of laboratory services in the context of prenatal care, but only Illinois linked that coverage to ACOG and USPSTF recommendations.

## **Adolescents**

**Both inside and outside the Medicaid program, adolescent utilization of appropriate STI services is limited by concerns about privacy, as well as by a lack of foundational knowledge about sexual health.**

Over the past several decades, people younger than age 18 have increasingly gained the ability to independently consent to sensitive health services such as sexual and reproductive health care, mental health services, and alcohol and drug abuse treatment. As of October 1, 2019, 50 states and DC explicitly permitted at least some people younger than 18 to consent to STI services without parental involvement.<sup>117</sup>

However, younger patients' concerns about anonymity and confidentiality have emerged as barriers to STI services.<sup>118,119,120,121</sup> For example, in a 2014 survey by the Kaiser Family Foundation, 71 percent of women ages 18-25 agreed that it is important that information about their healthcare visits be kept confidential from a parent or spouse.<sup>122</sup> Overall, 22.6 percent of sexually experienced individuals aged 15 to 17 reported that they would not seek sexual and reproductive health care due to concerns that their parents might find out.<sup>123</sup> According to one study, if a provider did explain confidentiality standards, adolescents were more likely to participate in discussions about sexual health and to provide a urine sample for STI screening.<sup>124</sup>

A 2016 study found that while the rates of being offered STI screening did not significantly differ between adolescents with commercial plans versus Medicaid, patients with public insurance were significantly more likely to *accept* screening.<sup>125</sup> The authors hypothesized that some patients decline screening in part

due to the possibility of STI testing inadvertently being revealed to others via communications from insurance companies.<sup>126</sup> Commercial issuers are in fact often required by law to send explanation of benefits (EOB) notices and denial notices, either of which could breach confidentiality for adolescents and young adults who are still on their parents' insurance.

Medicaid FFS and MCO plans are not bound by all of the same notice requirements as commercial plans, but some do send EOBs and/or denial notices to meet certain anti-fraud or notice requirements. In addition, because Medicaid is the payer of last resort, if a patient has both Medicaid and private coverage through family, the policyholder could be notified when a provider attempts to bill private insurance first.<sup>127</sup> An exception exists for when disclosure to the policyholder could harm the minor or another person.<sup>128</sup> However, it is unclear how broadly this exception is understood or utilized. One Medicaid official stated:

*We've always generally thought that maybe the take up rate in our family planning program was lower than expected because of this.*

Beyond these privacy concerns, interviewees cited additional challenges in reaching adolescents with STI services:

- **A lack of comprehensive sex education as a barrier to adolescent utilization of STI services:** Thirty-one states mandate sex education, and the majority of states require that the programs stress abstinence.<sup>129</sup> Only sixteen states require that HIV/STI education include instruction on condoms or contraception.<sup>130</sup> In addition, seven states either require that teachers remain silent about LGBTQ issues or provide negative information.<sup>131</sup> One health department official stated that because youth “bear the burden” of STIs, it is important for public health to work within the school system, advocating for comprehensive sex education.
- **Accessibility:** Adolescents cannot always get to health clinics. Interviewees noted the importance of reaching adolescents with health services in the school setting, as well as other community-based settings and hours that are more accessible to youth than standard health clinics.
- **Insurance gaps:** One provider noted that youth have frequent gaps in coverage, even when they are Medicaid eligible.
- **Justice system involvement:** One provider cited particular challenges for youth who are involved with the criminal justice system; those challenges, and the importance of a smooth transition back to Medicaid at the particularly high-risk time of returning to the community, would be relevant for adults as well.

## Opportunities

Research and interviewees identified a number of promising ways that public health could partner with states and MCOs to promote utilization and quality of STI services delivered through the Medicaid program.

### **Performance Improvement**

**States and MCOs have numerous options for improving plan and provider performance on chlamydia testing and other STI services.**

State Medicaid agencies and MCOs can use a range of levers to incentivize improved delivery of STI services.

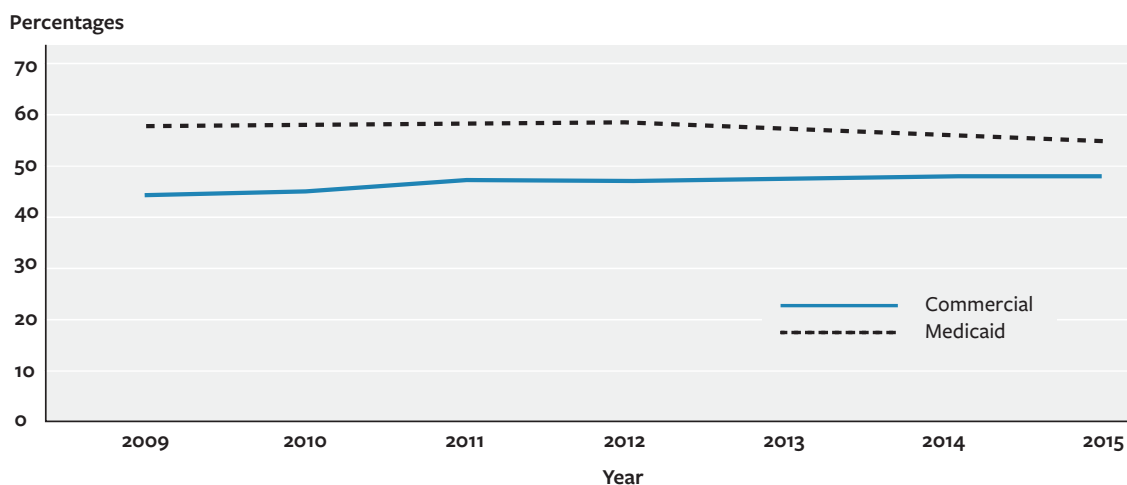
## Plan-level incentives

At the plan level, almost all states have some kind of quality improvement initiatives in place for MCOs. These can include reporting requirements and the publicizing of performance results. Many states also have “pay for performance” approaches that reward certain reporting or achievements, or “withholds” that hold back part of the capitated payments unless certain measures are met.<sup>132</sup>

States have additional levers to influence plan performance. Some states preferentially steer enrollees who have not selected plans into higher performing MCOs, a practice known as “auto-enrollment preference.”<sup>133</sup> States can mandate by contract that MCOs participate in Performance Improvement Projects, or PIPs, targeting service delivery for a specific condition or type of care. And, states can allow or require MCOs to use alternative payment models that incentivize quality care.<sup>134</sup>

Many performance improvement efforts rely on Healthcare Effectiveness Data and Information Set (HEDIS) measures developed by the National Committee for Quality Assurance. However, only one HEDIS measure addresses STIs: the proportion of sexually active women aged 16–24 who are tested for chlamydia.<sup>135</sup> This measure has allowed a comparison of screening rates across Medicaid MCOs and private plans (Figure 2, below). Overall, testing rates are suboptimal, but they are somewhat higher among Medicaid enrollees.

**Figure 2, CDC, Percentage of sexually active female enrollees aged 16–24 years who were screened for Chlamydia trachomatis infection, by health plan type and year—Healthcare Effectiveness Data and Information Set, United States, 2009–2015**



Among the four focus states, one is incentivizing MCOs based on the chlamydia HEDIS measure. South Carolina has a withhold system that rewards plans that meet certain performance measures. For 2019 and 2020, plan performance is measured based on three indices – diabetes, women’s health, and pediatric preventive care – and the chlamydia HEDIS measure constitutes 20 percent of the women’s health index.<sup>137</sup>

In Maryland, a value-based purchasing system is the primary incentive program for Medicaid MCOs. The value-based program uses nine to 12 measures per year, but chlamydia testing rates are not among them.<sup>138</sup> Similarly, in Georgia, chlamydia testing has been a reported HEDIS measure for Medicaid managed care plans, but has not been linked to any of the state’s value-based purchasing incentives for the plans.<sup>139</sup> Illinois also did not report using the chlamydia HEDIS measure for plan improvement efforts.

MCOs’ reporting requirements or performance incentives could be leveraged to identify opportunities to better support STI services and other care. For example, when an MCO’s enrollees seek STI services from providers that do not bill the plan, such as free clinics, the testing data does not count toward the



plan's HEDIS measures. It may therefore be in the interest of MCOs to identify creative ways to support services at such facilities, while developing a process for incorporating the sites' testing data into the plan's HEDIS score.

### **Provider incentives**

The Medicaid program can also use similar strategies to drive performance at the provider level. State Medicaid agencies can incentivize providers who serve FFS enrollees, and MCOs can incentivize providers within their respective networks. For example, states and MCOs can require providers to report certain measures or offer pay for performance bonuses.

Overall, there was consensus that MCOs have significant flexibility in how they incentivize provider delivery. As one Medicaid official stated,

*The MCOs can do all kinds of creative things.... They could pay individually; they could pay more or less than the fee-for-service rate... They could do quality incentives with the providers and they can frequently do all those different kinds of methodologies.*

MCO incentives for providers can be aligned with incentives in place for the plans. For example, Priority Partners in Maryland engages with providers who serve high numbers of their enrollees in order to support value-based quality measure reporting and improvement. Providers receive incentive payments based on performance regardless of whether the plan receives incentive payments from the state.

Incentives could be targeted to address specific STI-related problems such as congenital syphilis. For example, Maryland offers providers an additional \$40 for completing a prenatal risk assessment form at the first prenatal visit and developing a plan of care based on risk factors.<sup>140</sup> This type of incentive could be expanded or adapted to specifically target congenital syphilis.

### **Enrollee incentives**

In addition to encouraging plan and provider performance improvement, Medicaid MCOs can increase utilization by incentivizing enrollees. As one provider noted:

*I know a lot of Medicaid [plans] will actually provide patient incentives if they get screenings, gift cards and other kinds of gifts....It would be a nice way to outreach to these at-risk communities.*

In the context of congenital syphilis, for example, one Medicaid official cited an MCO that gave women Walmart gift cards if they completed all of their prenatal visits. Such broad prenatal incentives, or specific incentives for syphilis screening, could potentially help improve prenatal syphilis testing rates. However, if implemented, states or MCOs should consider appropriate safeguards to ensure that enrollees are not penalized for declining care.

## **Medicaid Expansions and Family Planning Expansions**

**Full Medicaid expansion decreases the number of people who are uninsured and could improve access to a full range of healthcare, including STI services. Medicaid family planning expansions expand access to family planning and family-planning-related services, including STI services.**

Full Medicaid expansion offers comprehensive coverage for all low-income adults up to 138 percent, with the federal government covering 90 percent of the costs for all medical services. Full Medicaid coverage includes coverage of STI services. As of November 2019, fourteen states had not adopted a Medicaid expansion.

A family planning expansion can also increase coverage for STI services as well as other family planning and family planning related supplies. All states have the option to expand the provision of family planning services, including STI services, to people who are not otherwise eligible for Medicaid, up to an income eligibility level no higher than that for pregnant women for Medicaid or CHIP. This expansion can be effected through a Medicaid waiver or, under the ACA, by amending the state's Medicaid plan. Because income eligibility can be higher than 138 percent, these programs can also be useful in full Medicaid expansion states for adults whose income is too high to qualify for full coverage.

As of October 2, 2019, 25 states had family planning expansions, with most setting eligibility at or near 200 percent.<sup>141</sup> Four more states offer similar state-based programs, with Iowa, Missouri and Texas excluding abortion providers. Nineteen of these states extend eligibility to men (see Appendix 3 for full list of state family planning expansion programs).

Family planning expansion enrollees are eligible for family planning services as already defined in law (see Background), as well as “medical diagnosis and treatment services that are provided pursuant to a family planning service in a family planning setting.”<sup>142</sup> CMS has clarified that these “family planning related” services can include STI treatment, regardless of the initial purpose of the visit:

Sound clinical practice and the provision of high-quality, comprehensive care dictates that specific family planning services are provided along with certain family planning-related services. The United States Preventive Services Task Force recommends “high-intensity behavioral counseling to prevent sexually transmitted infections (STI) for all sexually active adolescents and for adults at increased risk for STIs” (where increased risk includes patients with an active STI). **In addressing the needs of a patient with an active STI, providers will, as a matter of course, provide behavioral counseling on contraceptives. Contraceptive counseling is a family planning service. Therefore, CMS has determined that services such as the diagnosis and treatment of an STI are always provided “pursuant to” a family planning service.** These services will be eligible for Medicaid coverage as family planning related services, regardless of the initial purpose of the visit.<sup>143</sup> (emphasis added)

Three of the four states covered in this report have Medicaid family planning expansions, and interviews with providers and state officials from these states reflected both the importance and further potential of family planning expansion programs in providing access to STI services:

- South Carolina has a family planning expansion with coverage for men and women up to 194 percent of the FPL. The program covers family planning and related services, as well as preventive services recommended by USPSTF and a physical exam visit every two years.<sup>144</sup> Testing and treatment for STIs (syphilis, chlamydia, gonorrhea, herpes, candidiasis and trichomoniasis) are included, but only during the enrollee's initial or annual family planning exams or physical exam visit.<sup>145</sup> Because South Carolina has not expanded Medicaid overall, this program extends access for STI and other related services to a large number of adults who would otherwise be entirely uninsured.
- Georgia's family planning expansion waiver covers women aged 18 to 44 who are able to become pregnant and who have incomes up to 200 percent of the FPL. The state also has more intensive family planning expansion programs serving women who have had a low birthweight baby or a very low birthweight baby. For all categories of enrollees, services include lab tests and antibiotic treatments for STIs identified during a routine or periodic family planning visit.<sup>146</sup> Enrollees are also entitled to up to 12 one-way trips to and from appointments (nonemergency medical transportation).<sup>147</sup>
- Until recently, Maryland's family planning expansion, which includes STI screening and treatment with zero cost sharing, covered women of reproductive age up to 200 percent of the FPL.<sup>148</sup> Because

Maryland is a Medicaid expansion state, in recent years the program largely served women between 138 and 200 percent of the FPL. In 2019, the state switched its family planning expansion from a waiver to a state plan amendment, shifting to cover services for both men and women with incomes under 259 percent of the FPL.<sup>149</sup> State Medicaid officials believe the expansion will allow them to increase the reach of STI and other screenings for the eligible population.

## Telehealth

### States' Medicaid telehealth policies could support STI counseling to address stigma and transportation concerns.

Telehealth is generally used to describe services offered when the provider and patient are physically located in different settings and communicating in real time through telecommunications; the term can also encompass synchronous “store and forward” of information as well as remote patient monitoring.

Currently, all 50 states plus DC offer Medicaid reimbursement for live video services in some setting or for some services, but requirements vary significantly with regard to the types of services eligible for telehealth reimbursement, the type of provider who can be reimbursed, and eligible originating sites (where the patient can be located).<sup>150</sup> Meanwhile, Medicaid MCOs may offer telehealth services that differ from the state's FFS program as long as they are consistent with state law.<sup>151</sup>

The majority of interviewees agreed that telehealth has the potential to improve access to STI services. A patient could receive care via telehealth while visiting an office that is conveniently located but may not have providers with the confidence, knowledge, or cultural competency to counsel on sexual health. Remote access to counseling around STIs could help address multiple barriers to care, including transportation and stigma.

Certain implementation policies could help optimize the use of telehealth for STI services. Since most states require the patient to be at a provider's office, one way to address stigma or confidentiality concerns could be to allow the patient to request privacy in the “exam room” during the consultation, as permitted under DC law.<sup>152</sup> States could also consider an expansion of coverage to include visits when the patient is at home, particularly for “sensitive services.” In addition, existing national telehealth services such as Teladoc, Nurx or Plush (see Figures 3-5, below) do permit the patient to be at home. Some Medicaid MCOs already provide access to this type of national telehealth service for their members.<sup>153,154</sup>

Figure 3: Teladoc STDCheck page (www.teladoc.com/sexual-health/)

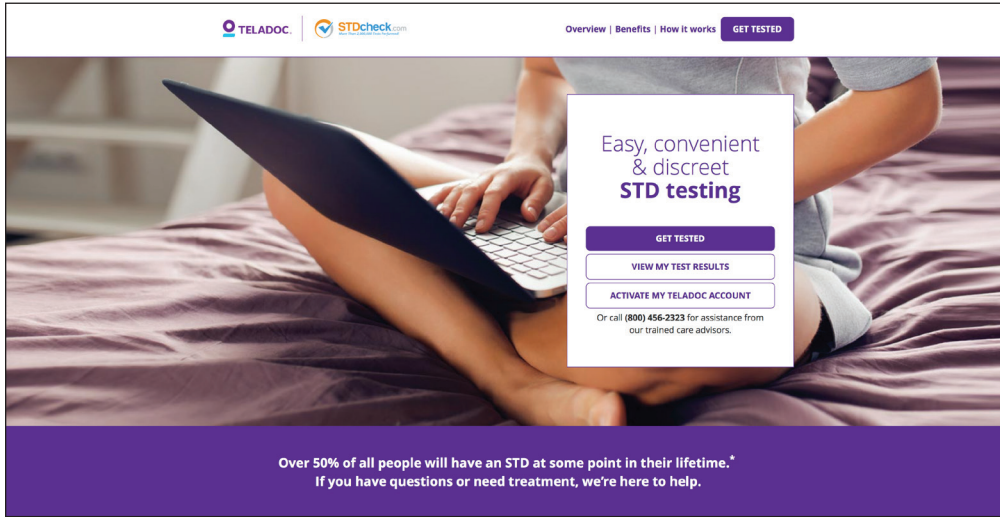


Figure 4: Nurx STI Testing Page (www.nurx.com/sti-testing/)

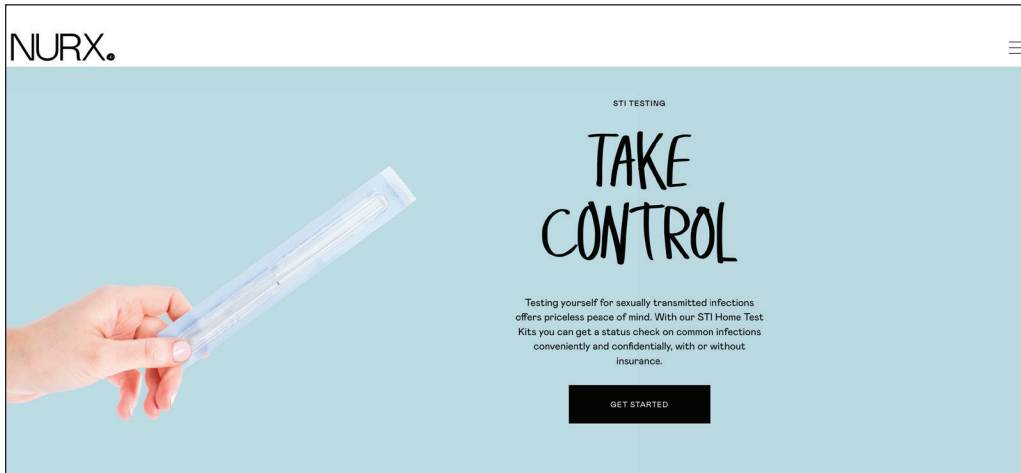
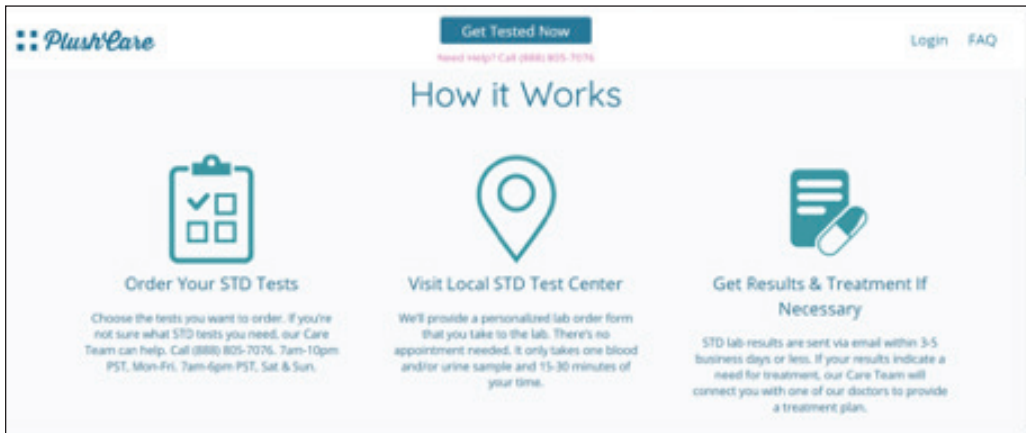


Figure 5: PlushCare STD Test Page (www.plushcare.com/testing/index/)



## Medicaid Data Analysis

### Public health officials are eager to explore the use of Medicaid claims data related to STIs.

An analysis of Medicaid claims data can provide information about enrollees' utilization of services. State programs have data for all claims that they directly reimburse. States also receive encounter data from MCOs, which retain their own, sometimes more detailed, data on all claims. Claims can typically be stratified by age, sex, and other demographics (though race and ethnicity data are often missing from claims forms, and claims do not record identity or sexual orientation). Medicaid claims often lag behind delivery of services by as much as several months, so analyses generally cannot present a “real time” picture of services. However, claims analysis can provide a useful snapshot from a given recent time period, and allow identification of trends over time.

State Medicaid agencies and individual Medicaid MCOs could conduct in-house analyses of their STI-related claims to identify trends in diagnoses, treatment uptake, or service utilization. In many cases, however, public health departments may have more STI-specific interest and the bandwidth to conduct such analyses. Data-sharing agreements between Medicaid and public health agencies can allow more robust analyses of health issues across the Medicaid population while providing for the security and confidentiality of individual information. For example, a public health surveillance unit only receives reports of positive test results. Allowing public health agencies to access Medicaid claims analysis would reflect all laboratory tests performed, including those that were negative, enabling analysis of overall trends and disparities.<sup>155</sup>

Public health departments interviewed for the project stated that access to STI-related claims data or analyses from their respective Medicaid agencies would be helpful. One public health official noted that in their state, an MCO had expressed particular interest in a formal collaboration around STI data.

One state Medicaid official said that STI claims analysis is “certainly something we could do.” They stated that participation in the federal HIV affinity group had supported claims analysis around HIV in collaboration with the state’s department of health. Another official stated that conducting claims analysis would “absolutely” help in identifying current screening and treatment rates, and in setting a baseline for improvement efforts. A third was more skeptical:

*You'll have to show me the advantages or benefits of doing that, because you can mine the data, but then the data has to lead you someplace... I have serious doubts if collecting, analyzing and studying that data would really be, time-wise and effort-wise, so valuable.*

This comment underscores the importance of clearly defining the public health relevance and usefulness of proposed analyses.

## Patient and Provider Engagement

### State Medicaid agencies and MCOs have a range of options for reaching out to enrollees and providers about STIs.

For enrollees, states and MCOs can work with public health to develop clear information emphasizing screening recommendations as well as how and where to receive services. As one public health official noted:

*I think more clients should know that those services are available not just when they're pregnant or they're having an issue, but for those patients under the age of 26, that it's encouraged for them to get yearly testing. The MCOs could certainly have some ownership in terms of reaching out to their clients.*

Some of this information could be conveyed through enrollee manuals and ongoing letters and mailings. In addition, MCOs can sponsor education and outreach events in the community. For example, Priority Partners, a Medicaid MCO in Maryland, has a team of Community Health Advocates (CHAs) who engage as liaisons to providers of both health and social services and identify community needs. When asked how this approach could theoretically be applied to address barriers to STI services, the plan officer responded,

*First and foremost, probably with the local health department, organizations that work with our pregnant population, our school-based health centers and schools, I would use methods that would inform populations with STDs, (teenagers, adults, substance users etc.), hoping to ensure that they get the information. Then, we would make them aware of where they can go to get treatment.*

*I believe some of the barriers for these populations are social determinants of health: housing, transportation, food insecurity, and childcare, to name a few. We offer transportation for our members. We cover pregnancy tests, STD testing and contraceptives. We are willing to work with community partners to address and educate on these issues, especially if it is highly prevalent in their area. We would ask, "How can we help?"*

In addition, multiple interviewees noted that MCOs could play a role in engaging providers by sharing STI screening recommendations, instructions on billing specific to that state/MCO, and continuing medical education (CME) opportunities. Outreach can also occur at the state level; for example, one Medicaid official said that if a health issue becomes a priority, the state program can conduct education and outreach through provider letters, direct meetings, and other channels to improve knowledge and highlight the importance of the issue. In contrast, another state Medicaid program said that most provider education in the state is conducted by provider specialty groups, without the agency's involvement.

## CONSIDERATIONS

Based on challenges and opportunities identified through this project, GWU offers the following considerations for policy and programmatic actions at the federal, state, and plan level. These recommendations should be considered in the context of changes in the way that people access care due to the COVID-19 pandemic.

### Reimbursement

Reimbursement challenges are rarely unique to Medicaid, so ideally, states could work to identify multipayer solutions to create uniformity and predictability for providers. States and MCOs can work with public health and providers to:

**Use approaches beyond traditional reimbursement to support STI service providers:** State Medicaid programs and MCOs could support STI services through a number of approaches in addition to traditional reimbursement for clinical services. For example:

- If STI clinics in a state or community are serving high numbers of Medicaid enrollees at low or no cost (e.g. due to legal or logistical barriers to billing), they can work with state Medicaid agencies and MCOs to develop memoranda of understanding (MOUs) or other arrangements to support the services. In addition to supporting their members' health, this would allow the MCOs to include those providers' screening rates in their HEDIS measures.
- State Medicaid programs and MCOs can also consider ways to support public health departments'



Disease Intervention Specialists (DIS), who provide crucial STI notification and navigation services but are not typically reimbursed by insurance.<sup>156</sup>

- Medicaid programs and MCOs can work with clinics that already receive Medicaid reimbursement to identify barriers to care that could be addressed in a targeted fashion. For example, if a clinic serves a large number of an MCO's clients, that MCO can help support navigation or transportation services in addition to reimbursing for care.

**Develop ways to fund varied models of STI service delivery:** STI care is not always optimally delivered through scheduled appointments with high-level providers. Public health and providers could work with Medicaid to find ways to support alternative models of care that meet the sexual health needs of enrollees, particularly for communities and populations disproportionately affected by STIs, including youth, MSM, and communities of color. For example:

- Medicaid agencies or MCOs can provide operating support for clinics that offer unscheduled drop-in hours, an approach that increases access but can be difficult to sustain at close budget margins.
- States and MCOs can also identify ways to reimburse for nurse-only visits when they are clinically appropriate for STIs but may not otherwise be reimbursable in every setting.

States and MCOs could also consider novel reimbursement mechanisms for STI services, such as bundled payments for an episode of care or for providing STI-related services over a period of time. However, because most STI diagnosis and treatment is fairly straightforward and inexpensive, STIs may not rise to a level of warranting development of a bundled payment, (though a broader sexual/reproductive health bundle could be considered for some providers or groups). Broader bundled payment mechanisms that are not specific to STIs could include reporting measures related to STIs to ensure that appropriate services are delivered within the primary care bundle.

**Create state-specific coding and billing resources:** Public health agencies and providers can work with Medicaid to develop state-specific billing and coding resources for public health departments or other entities that are less experienced with third-party billing.<sup>157+158</sup>

**Ensure reimbursement for multisite testing:** States can ensure that their FFS programs are appropriately reimbursing for multisite, extragenital testing for chlamydia and gonorrhea. For example, when public health officials in Louisiana became aware that FFS Medicaid was rejecting multisite lab claims for STIs, they were able to work with the state Medicaid program to implement reimbursement for multiple samples.<sup>159</sup> States can encourage or require MCOs across the state to apply the same reimbursement policies, and MCOs can also proactively check and adjust their payment systems to reimburse multisite testing when appropriate.

Providers in the state should receive clear instruction from the Medicaid program and MCOs regarding coding and modifiers for multisite testing. States can also consider working with other payers to align payment policies to support more consistent provider reimbursement and practice.

**Use performance improvement programs to incentivize high-quality care:** States with high rates of chlamydia can consider including the chlamydia HEDIS measure in MCO performance incentive programs. States can also require MCOs to engage in Performance Improvement Projects focused on STIs, extending beyond the HEDIS chlamydia measure to include gonorrhea and syphilis efforts. Similarly, MCOs can include chlamydia in provider incentive programs, particularly if the plans serve regions of the state with particularly high chlamydia rates. MCOs can also consider giving enrollees incentives for STI testing. In developing performance incentives related to STI services, states and MCOs should incorporate safeguards against coercion and cherry-picking.

Many state Medicaid programs and MCOs have initiatives to improve the quality of prenatal care, including value-based payments, bundled payment models, or enrollee incentives. State public health agencies can work with their respective Medicaid agencies and with MCOs to understand how prenatal services are reimbursed in their state and to identify opportunities for promoting timely prenatal syphilis testing for Medicaid enrollees, including through provider and enrollee incentives.

## Coverage and Access

**Optimize Medicaid coverage for family planning services.** Full Medicaid expansion provides coverage of comprehensive services, including STI services, for all low-income adults. Medicaid family planning expansions provide coverage for STI screening and treatment as well as other sexual health services. States, particularly those without full Medicaid expansions, can maximize the reach of family planning expansions by covering men as well as women including STI treatment within the scope of covered services, and offering expansive income eligibility levels.

**Clarify self-referral policy:** Medicaid MCO enrollees are legally entitled to seek family planning services, often including STI services, from any Medicaid provider. However, this policy is not being clearly executed at the state, MCO, or provider level. States can provide clear instructions to MCOs regarding reimbursement procedures when enrollees obtain care out of network. In addition, states and MCOs can provide standardized, clear language to enrollees regarding their right to self-refer for family planning services and to providers explaining how reimbursement under the policy is implemented in that state.

**Prioritize STI Screening and Treatment through PrEP Activities:** Pre-Exposure Prophylaxis (PrEP) to prevent acquisition of HIV is a key component of efforts to end the HIV epidemic. CDC recommends multisite testing for bacterial STIs every 3-6 months for PrEP users.<sup>160</sup> Some data suggest that PrEP use is associated with higher rates of STIs, possibly because of declines in use of barrier methods such as condoms. However, a modelling study found that the regular STI screening and treatment recommended with PrEP use could result in a net *decrease* in STIs among men who have sex with men.<sup>161</sup> Initiatives to expand access to and utilization of PrEP should include rigorous efforts to ensure that multisite bacterial STI testing is provided at the recommended intervals to maximize STI control.

## Addressing Specific Barriers

**Maximize privacy and confidentiality protections, especially for adolescents:** Confidentiality of STI services remains a paramount concern, particularly for adolescents and young adults. States can determine if they are maximizing Medicaid privacy rights and ensure that MCOs are following the same protective practices. Medicaid FFS and MCO plans can inform providers and patients about privacy protections, as well as opportunities to suppress notices and/or third-party billing for sensitive services.

States can also assess their laws related to HMOs and/or Medicaid to identify opportunities to strengthen default privacy protections for sensitive services, including STI services. For example, some states have undertaken a number of policies to protect confidentiality for privately insured patients; in some states, those privacy protections also apply to Medicaid MCOs.<sup>162</sup> In addition, states can enact specific policies to prevent privacy violations in Medicaid. For example, Illinois passed a law in 2015 requiring Medicaid MCOs to suppress all notices related to “sensitive services,” defined as mental health, substance use, reproductive health, family planning, STI, sexual assault, and domestic abuse services; the policy applies to enrollees of all ages.<sup>163</sup> New York issued a policy memorandum in 2017 detailing notice suppression requirements for MCOs. The policy specifically applies to services received by minors, and is applicable to a similar set of sensitive services, along with other care to which a minor legally consents.<sup>164</sup>

**Reimburse expedited partner therapy regardless of partners' insurance status:** Because EPT is specifically intended to prevent re-infection of the index patient, CMS could consider developing a policy that defines the partner dose in EPT as for the benefit of the patient and therefore eligible for Medicaid reimbursement, regardless of partners' insurance status or provision of partners' names. There is precedent for such policies: CMS allows maternal depression screening to be billed under a child's EPSDT benefit even if the mother is not a Medicaid enrollee, "since the maternal depression screening is for the direct benefit of the child."<sup>165</sup> In addition, CMS applied this principle to services for neonatal abstinence syndrome that include counseling for the mother: when the mother is not Medicaid-eligible, services may be claimed as a direct service to the infant.<sup>166</sup>

In the absence of national policy change, states could decide to cover EPT fully with state dollars, tailoring the policy to match the state's EPT laws and maximize access.

**Extend telehealth services:** At the state level, Medicaid agencies and MCOs can consider whether and how their existing telehealth policies could support STI services. States can consider whether extending telehealth coverage to encounters when the patient is at home would help enhance access to services that are affected by stigma in addition to any geographic or transportation barriers. State public health agencies can help providers identify opportunities for home or lab testing in conjunction with telehealth STI services.

## Technical Assistance and Outreach

**Convene a national STI affinity group:** In conjunction with the forthcoming National STI Strategy, CDC and CMS could consider developing an STI Affinity Group. Like earlier affinity groups on HIV and Hepatitis, state public health offices focused on STIs could be required to apply in collaboration with their respective Medicaid agencies. An STI affinity group could guide states in developing a range of collaborations related to STI services in Medicaid, while identifying best practices to highlight for other states and ensuring dissemination of those resources. The group could serve as a core locus for implementing the forthcoming National STI Strategy in the context of the Medicaid program.

In addition to an affinity group, CDC can provide targeted support for STI grantees to engage with their respective Medicaid agencies.

**Develop model MCO contract language:** CMS could consider working with CDC and other stakeholders to develop model contract language related to STIs for Medicaid MCOs. Recommended language could address a variety of topics covered in this report, including self-referral for STI services, with notification for enrollees and clear reimbursement pathways for non-network providers; reimbursement for multisite testing; and reporting/ quality improvement standards.

**Support and engage patients and providers:** State Medicaid programs and MCOs can provide clear, state-specific messaging to enrollees regarding STIs, screening recommendations, where and how to access services, and the availability of services without cost sharing. This information can be included in enrollee manuals, online, in regular mailings, or in targeted mailings to high-prevalence communities.

Meanwhile, public health officials can work with state professional societies to identify ways to increase understanding of, and comfort with, sexual health and STIs for Medicaid-participating providers. In addition, programs and plans can give providers state-specific information about STI rates, benefits, and billing procedures. Communication can be targeted to portions of the state with high rates of STIs.

## Further Research

### **Develop or expand data-sharing arrangements between Medicaid and public health agencies:**

Public health agencies can develop clear proposals for how Medicaid claims analysis could help supplement surveillance data to support STI control efforts. They can work with Medicaid agencies and MCOs to expand existing data-sharing agreements (e.g. those focused on HIV) to include STI data as appropriate. Even without a data-sharing agreement, state Medicaid agencies and MCOs can conduct their own analyses of STI claims data and work with public health agencies to develop responses to address identified problems and gaps.

**Model general and state-specific return on investment for STI services:** State Medicaid programs and MCOs might be more motivated to focus on STIs if presented with relevant evidence on the financial return on investment (ROI) for STI services. This case may be particularly strong in the context of HIV, given recent evidence that as many as ten percent of HIV transmissions may be attributable to chlamydia and gonorrhea.<sup>167</sup> State-specific data or models – like a 2009 analysis of the economic burden of STIs in Illinois<sup>168</sup> – would be particularly useful in developing a case for promoting STI services, and would help inform conversations with private payers and other healthcare decision-makers in the state.

**Monitor impact of federal policy changes on STI service utilization:** Interviewees expressed concern that recent policy changes in the Title X program will have a significant negative impact on access to reproductive health services. Researchers can ensure that any analyses of the impact include specific attention to STI services and both the health care and health outcome effects. In addition, analysis of the health impact of other federal policies, such as the public charge rule's impact on utilization of health services, can include assessment of any declines in utilization of STI services. For such analyses, CDC can identify other sources, including the National Survey of Family Growth,<sup>169</sup> that may offer useful utilization and risk data.

## CONCLUSION

Rates of chlamydia, gonorrhea, and syphilis continue to rise in the U.S., yet all three are detectable and treatable. The Medicaid program offers key opportunities to reach patients and providers with education and services to address STIs and improve individual and community health. Medicaid agencies, MCOs, public health departments, and other stakeholders can work together to develop targeted plans to fully leverage those opportunities.

## APPENDIX 1: Methodology and Search Terms for Literature Review

GWU conducted a literature review of peer-reviewed articles to ascertain barriers to access to sexually transmitted infection (STI) services, focusing on chlamydia, gonorrhea, and syphilis. CDC approved an initial list of search terms, which was expanded upon in order to find relevant articles.

### *Methodology*

GWU searched PubMed, Scopus, and Google Scholar databases. All searches were limited to articles published in English, on U.S. human population, and full-text available. Articles related to HIV/AIDS diagnosis and treatment were excluded.

Following abstract and secondary full-text reviews for relevancy, 146 articles were identified. Citations and abstracts for all articles are included for your reference, sorted by publication date. The articles have been saved and can be sent to CDC staff.

### *Search Terms*

The following search terms were used in combination to find relevant articles on barriers to access to STI services. Some searches utilized Medical Subject Headings (MeSH Terms) and included:

1. Sexually Transmitted Diseases [MeSH Terms]  
*MeSH terms automatically search all articles including the following sub-categories:*  
Chlamydia; Gonorrhea; Syphilis
2. Medicaid [MeSH Terms]
3. Insurance, Health, Reimbursement [MeSH Terms]  
*Sub-category:* Reimbursement Mechanisms (including Fee-for-Service Plans +, Physician Payment Review Commission, Prospective Payment System +, Reimbursement Disproportionate Share, Reimbursement Incentive, Relative Value Scales)
4. Referral and Consultation [MeSH Terms]  
*Sub-category:* Remote Consultation (including Distance Counseling, Secondary Care, Tertiary Healthcare)
5. Health Services Accessibility [MeSH Terms]  
*Sub-category:* Health Equity
6. Managed Care Programs [MeSH Terms]  
*Sub-categories:* Competitive Medical Plans; Health Maintenance Organizations; Independent Practice Associations; Patient Freedom of Choice Laws; Preferred Provider Organizations; Provider-Sponsored Organizations
7. Barriers

## Appendix 2: Project Interviewees

### Medicaid Agencies and Managed Care (5 interviews)

**Brian Dowd**

Deputy Executive Director  
Policy, Compliance and Operations  
Office  
Medical Assistance Plans  
Georgia Dept. of Community Health

**James Bradford, MD**

Director, Clinical and Medical Affairs  
South Carolina Dept. of Health and  
Human Services

**Alyssa L. Brown, JD**

Deputy Director  
Innovation, Research, and Development  
Office of Health Care Financing  
Maryland Dept. of Health

**Nancy Brown**

Health Policy Analyst, Advanced  
Office of Innovation, Research, and  
Development  
Maryland Dept. of Health

**Arvind K. Goyal, MD, MPH, MBA**

Medical Director,  
Illinois Dept. of Healthcare & Family  
Services, Medical Programs

**Sierra Butler MHA, CRCA**

Senior Consultant - Coverage and  
Benefit Design  
South Carolina Dept. of Health and  
Human Services

**Kathy Pettway**

Senior Director, Priority Partners  
Johns Hopkins HealthCare LLC

**Tricia Roddy**

Director, Planning Administration  
Office of Health Care Financing  
Maryland Dept. of Health

### Public Health Agencies (3 interviews)

**Linda Alexander, MD, MPP**

Medical Director for the Maryland Title  
X Family Planning Program and the Title  
V Maternal and Child Health Block Grant  
Maryland Dept. of Health and Mental  
Hygiene

**Danny Brikshavana, MPH**

Chief  
Illinois Dept. of Public Health STD Section

**Diane Hanlon**

Family Planning Nurse Consultant  
Office of Family Planning and  
Reproductive Health  
Maryland Dept. of Health and Mental  
Hygiene

**Valina Hartman**

Office of Family Planning and  
Reproductive Health  
Maryland Dept. of Health and Mental  
Hygiene

**Elisabeth Liebow, MPH**

Policy and Program Associate  
Center for STI Prevention  
Maryland Dept. of Health and Mental  
Hygiene

**Marcia Pearlowitz**

Deputy Chief  
Center for STI Prevention  
Maryland Dept. of Health and Mental  
Hygiene

**Kenneth Ruby, III, LCSW-C, MBA**

Chief  
Center for STI Prevention  
Maryland Dept. of Health and Mental  
Hygiene

**Tammy Rutledge, MHA, CQA**

Director, STI Surveillance  
Chicago Dept. of Public Health

**Victoria Stinson**

Special Programs Coordinator  
Office of Family Planning and  
Reproductive Health  
Maryland Dept. of Health and Mental  
Hygiene

**Irina Tabidze, MD, MPH**

Senior STI Epidemiologist  
Division of HIV/STI  
Chicago Dept. of Public Health

### Providers (4 interviews)

**DeWayne Ford, MA**

Director of Prevention Services  
AID Atlanta

**Jami Dybik**

Practice Manager  
Truesdale Medical Center, Palmetto  
Community Care

**Caroline M. Hoke, MD**

Chief Clinical Officer  
Erie Family Health Centers

**Heather A. Parkhill, CRNP**

Family Nurse Practitioner  
Truesdale Medical Center, Palmetto  
Community Care

**Maria Eva Trent, MD, MPH**

Director of Adolescent Medicine  
Fellowship Program  
Johns Hopkins  
Professor of Pediatrics



## Appendix 3: Medicaid Family Planning Eligibility Expansions

(Adapted from Guttmacher Institute, 2019)<sup>170</sup>

State	Overall Medicaid expansion state?	BASIS FOR ELIGIBILITY		ELIGIBLE POPULATION INCLUDES		ORGANIZED AS A:		WAIVER EXPIRES
		Based Solely on Income	Losing Full-Benefit Coverage	Men	Individuals <19	State Plan Amendment	Waiver	
Alabama		146% <sup>†*</sup>		X			X	9/30/22
California	Yes	200%		X	X	X		N/A
Connecticut	Yes	263% <sup>†</sup>		X	X	X		N/A
Florida			For any reason		X		X	Ω
Georgia		200%*			‡		X	Ω
Indiana	Yes	146% <sup>†</sup>		X	X	X		N/A
Iowa <sup>ψ</sup>	Yes							
Louisiana	Yes	138% <sup>†</sup>		X	X	X		N/A
Maine	Yes	214% <sup>†</sup>		X	X	X		N/A
Maryland <i>*updated from Guttmacher source to reflect recent change to SPA</i>	Yes	259%*		X	X	X		N/A
Minnesota	Yes	200%		X	X	X		
Mississippi		199% <sup>†*</sup>		X	X		X	12/31/27
Missouri <sup>ψ</sup>	Yes							
Montana	Yes	216% <sup>†*</sup>					X	Ω
New Hampshire	Yes	201% <sup>†</sup>		X	X	X		N/A
New Mexico	Yes	255% <sup>†</sup>		X	X	X		N/A
New York	Yes	223% <sup>†*</sup>		X	X	X		N/A
North Carolina		200% <sup>†</sup>		X	X	X		N/A
Oklahoma		138% <sup>†*</sup>		X	X	X		N/A
Oregon	Yes	250%		X	X		X	12/31/2021
Pennsylvania	Yes	220% <sup>†</sup>		X	X	X		N/A
Rhode Island	Yes		Postpartum		X		X	12/31/18
South Carolina		199% <sup>†</sup>		X	X	X		N/A
Texas <sup>ψ</sup>								
Vermont <sup>ψ</sup>	Yes							
Virginia	Yes	205% <sup>†*</sup>		X	X	X		N/A
Washington	Yes	260%*		X	X		X	12/31/2023
Wisconsin	Yes	306% <sup>†</sup>		X	X	X		N/A
Wyoming			Postpartum				X	Ω
<b>TOTAL</b>		<b>22</b>	<b>3</b>	<b>19</b>	<b>21</b>	<b>15</b>	<b>10</b>	

\* State also extends Medicaid eligibility for family planning services to people losing full-benefit coverage after the end of the postpartum period.

† This eligibility ceiling includes a standard “disregard” to an applicant’s income equal to five percentage points of the federal poverty level.

‡ Includes 18 year olds but not younger individuals.

Ω This state is currently seeking an extension for this waiver.

ψ The state operates an entirely state-funded program to provide family planning services. In Iowa, individuals with incomes up to 300% of the federal poverty line (FPL) are eligible. In Missouri and Texas, women at least 18 years of age with incomes up to 185% of the FPL are eligible. In Missouri, women losing Medicaid postpartum are also eligible. In Vermont, anyone with an income up to 200% of the FPL is eligible.

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