Family Planning Medicaid Waiver Evaluators Conference Call
April 9, 2007, 1.00-2.00 pm EDT

Participants

Evaluators: Janet Bronstein (AL), Molly Carpenter (VA), Andrea Johnson (NC), Kathy Langlois (MS), Debeshi Maitra (SC), Bo Martin, (NC), Dave Murday (SC), and Jeff Roth (FL)
State Staff: Danni Atkins (FL), Marie Melton (FL), Bernie Operario (NC), Traci Perry (LA), Tahirah Rashadeen (LA), Marcia Swartz (NC), Tri Tran (LA), and Lorie Williams (NC)
Sheps Center Staff: Priscilla Guild and Ellen Shanahan
Others: Melissa Romaire (CMSO) and Adam Sonfield (Guttmacher)

Not on the Call

Evaluators: Mario Ariet (FL), Paul Buescher (NC), Kim Dauner (SC), Holly Felix (AR), Mike Resnick (FL), Ila Sarkar (MS), and Catherine Sreckovich (NC),
State Staff: Emily Anderson (KY), Sydney Atkinson (NC), Sondra Burns (LA), Bonnie Cox (GA), Joe Holliday (NC), Karen Jackson (FL), Catherine McGrath (FL), Helen Sancho (FL), Bill Sappenfield (FL), Janet Sheridan (SC), Robyn Slate (NC), Cindy Thames (MS), Betsy Wood (FL), and Angie Yow (NC)
Sheps Center Staff: No one
Others: Nancy Dieter (CMSO), Kathleen Farrell (CMSO), Meredith Robertson (CMSO), and Paul Youket (CMSO)

Lorrie Williams introduced the new evaluators for North Carolina, Bo Martin and Andrea Johnson. They work in the Chicago office of Navigant Consulting, Inc. Navigant has offices in 20 states as well as in the United Kingdom, Canada, Hong Kong, and the People's Republic of China. Bo reported that they have quite a lot of experience working on evaluations with state government and departments of health around the US. We are pleased to have these new members to our group. Priscilla will send them copies of past minutes and other summary documents.

The topic for today's call was, "Investigating the Possibility of Getting Consistent Population-in-Need Estimates for Each State with a Waiver." Janet Bronstein, Dave Murday, Adam Sonfield, and Bernie Operario took the lead on this call. On Friday material from Janet Bronstein on three ways to measure the denominator for family planning waiver enrollment and usage was sent to each participant. She used the 2000 Census, CPS Microdata (2002), and AGI estimates for sexually active women (2001-02). Her notes on using these three datasets are as follows:

- ***2000 Census data:*** Data can be obtained on women in the population by age, income, and race, but do not show Medicaid coverage. Data can be obtained by county but are not updated each year.
- ***CPS Microdata:*** Data can be obtained on women in the population by age, income and race. The number of women covered by Medicaid can be adjusted for. Data available for 2002-2005, but not by county.
- ***AGI Data on the Female Population In-Need of Contraceptive Services (2001-02):*** This data source adjusts population numbers to show sexually active women. Data are available by county, age group, poverty status and race, but cross tabs of these categories are not published so age by poverty status denominators cannot be generated and women in the lowest income groups already eligible for Medicaid cannot be broken out. Numbers are available by county but are not available for more recent years.

Janet found the CPS data to be the most flexible. In using these three datasets to estimate the "potentially" eligible population for Alabama, the following three figures were obtained:

- ***2000 Census data:*** 205,060;
- ***CPS Microdata (2002):*** 188,523; and
- ***AGI Data on the Female Population In-Need of Contraceptive Services (2001-02):*** 99,140.

The following summarizes using these three numbers as the denominator to estimate the percent of the "potentially" eligible population enrolled and the percent of the "potentially" eligible population served in Alabama.

Data Source	% "Potentially" Eligible Population Enrolled	% "Potentially" Eligible Population Served
2000 Census data	55.69%	28.32%
CPS Microdata (2002)	60.58%	30.81%
AGI Data (2001-02)	115.19%	58.58%

Dave reported that SC also ran these figures using the AGI data after the last conference call and got similar data to AL (110% "potentially" eligible population enrolled and 45% served). Having comparable data for states is useful in identifying states whose outreach efforts look more successful and finding out what these states are doing.

CMS was asked if they had any recommendation about which numbers to use. Melissa Romaire said that CMS did not want to be prescriptive to states about how to do their evaluations and states should do what makes the most sense to them. She did caution states that if they reported a number that looks like they are enrolling more then 100% of the eligible population, they would need to footnote and describe why this is happening or they could expect a call from CMS asking them to do this. She said she did not see a problem using different denominators for the percent enrolled and the percent served.

Dave asked if Janet had ever used the intermediate Census data from the American Community Survey to get population estimates. She has used it in her work with Arkansas but did not use it in the estimates she prepared for this call. Dave was concerned about using the CPS since it does not go back before 2002 and would not be comparable to the data used in the baseline estimates. Janet did not feel that the baseline estimates needed to be revised and prefers the CPS data even though it does not go back prior to 2002.

The participants on the call agreed that the CPS data were best used to estimate the percent of the "potentially" eligible population enrolled and the AGI data were best used to estimate the percent of the "potentially" eligible population served. Adam reported that the AGI has the data to produce more estimates than are reported and with the increased frequency of the National Survey of Family Growth, which is used to get estimates of the percent of women who are sexually active, able to have children, and not pregnant or desiring to get pregnant, more timely data will be available to use in making the estimates. The biggest problem will be staffing-up at AGI to do this more frequently. Using AGI data as the denominator to look at the percent of the target population served makes sense since the Medicaid Family Planning Waiver is to be used primarily for the provision of contraceptive services and the AGI estimates are of "poor" women in need of these services. It would make sense to enroll women who would be eligible for the waiver but not in need of contraceptive services so when they did need them they would already have a payment source.

The issue of removing people with private insurance came up. These people were not removed from the Alabama estimates since Alabama only goes to 133% of poverty and very few would have private insurance. For a state that goes to 200% of poverty, this would be an issue to consider.

Bernie reminded the group that these measures are intermediate measure of success and should be used to manage and plan better programs. The ultimate outcomes are the unwanted births averted and budget neutrality measures.

Picking up on the discussion from last month, if a state is interested in evaluating their outreach efforts they need more than the statistics on the population enrolled and/or served. They need survey data from consumers or potential consumers on their experiences with the waiver. Alabama, South Carolina and Florida are all doing consumer surveys. Both AL and SC are doing phone surveys of users, enrollees, and the eligible population with very good response rates. NC is also planning to do phone surveys.

The topic of the next call, “Revisiting Birth Spacing as an Outcome Measure for Medicaid Family Planning Waivers.” Kim Dauner has agreed to lead this call and since she was not on this call, Pris will e-mail Kim to make sure she can still do it.

Next Call: May 14th from 1 until 2 PM EDT. The call-in number for all the calls will be (919) 962-2740.