Family Planning Medicaid Waiver Evaluators Conference Call
December 12 , 2011, 1:00-2:00 pm EST

Participants

Evaluators: Loretta Alexander, Ruth Eudy (AR): Jeff Roth (FL); Ginny Zawistowski (MN); Dave Murday (SC); Kristin Christensen (TX)

State Staff: Brenda McCormick (FL); Regina Williams (LA); Bernie Operario and Andrea Phillips (NC); Margaret Major (TN); Alex Melis and Laurie Vanhoose (TX)

Other: Adam Sonfield (Guttmacher Institute), Julie DeClerque and Ellen Shanahan (Sheps Center)

MINUTES

Approval of Minutes: Minutes of the November meeting were reviewed, and approved with clarification re: agenda to engage Feds (CDC, CMS) on their efforts to revisit FP and Title X. CMS agreed to participate on an *as needed* basis, so we should contact them and invite a CMS representative (Rebecca Burth Mack) to join us on our next call.

Announcement: Shared by Ruth regarding upcoming conference that will focus on indicators of FP effectiveness and evidence-based clinical practice: **August 5 - 7, 2012 –** *National Reproductive Health Conference 2012 – Title X, New Orleans, LA*. The Clinical Training Center for Family Planning, along with the Male Training Center for Family Planning and Reproductive Health, have announced a new collaboration to bring you the best in evidence-based clinical information! The National Reproductive Health Conference in New Orleans, LA, August 5-7, 2012.
Now two popular, national conferences wrapped up into one! Until the conference website goes live, please visit our websites for more information at www.ctcfp.org or www.fpcmtc.org.

Issues raised by Guttacher Report: Adam answered questions and clarified points. One question raised was about the statement that "*Medicaid expansions reduced expenditures on unplanned pregnancies*". It is inevitable that since States will be facing dramatically larger caseloads that overall expenditures will be higher. But a key point here is that in absence of expansions, expenditures would be even higher if there had been or were no Waivers. So, *compared to what* is the key… Comparing to past time period is not the correct comparison to gauge success, but the correct comparison, ie, using same-time cohorts, is a challenge evaluation-wise both in terms of expense and logictics. Yes, it would be the preferred methodology if trying to determine causality, etc. or answering the question, "*What would be the cost without the Waiver*?" But, it's hard! Trying to prove causality is really difficult. Rarely do we see statements of causality. Even in California's program, there is little causal language…

One of the nice things CMS did over past year is to re-examine the utility of requiring budget neutrality, and deciding that it no longer makes sense. A much easier way of keeping tabs on program costs acc to CMS thinking, is unfortunately not examining pregnancies averted, but simply *containing costs* by tracking average cost per client. In Arkansas' program, CMS has not

required budget neutrality calculations this round, rather CMS wants assurance that *costs per client* are held at no more than 4% annual increase.

Adam says there is no real documentation yet on that, officially, for States… Arkansas may the first state to address and ask for clarification. CMS is heavily preparing for health reform, not approving any waivers past December 2011, so this is not appearing to be high on their priority list.

If ACA does get implemented, will family planning, as one of the protective health services, be covered through Medicaid mechanisms? Yes. It is required to be, according to federal statutes, and has been since the 1970s… in both public and private insurance. That clarification came down over the summer and is good news.

<u>Indicator tracking and nailing down loose ends on discussion of contraceptive method indicators</u>
It isn't that states haven't been collecting data, or considering indicators and looking at access. We have flagged a number of indicators including financial measures over time, with pregnancy intendedness assumed if births are below the expected rate. Now, we need to look in more detail at contraceptive method, birth spacing, and PTB and LBW to really see effects. States haven't really reported these data in a way that allows us to link program effect to outcome and impacts. Only once in the Waiver reports to CMS (that Guttmacher reviewed) was there a direct mention of outcomes (SC), and even there it was alluded to, not conclusive. SC tried using their PRAMS unintendeness data, but it was of questionable quality and limited to women who had delivered a live birth. All others were looking at proximate measures of intendedness, not the impact of entire rates of unintended pregnancy being affected across a population of "clients-in need". So it was not easy to resolve question.

PTB is easy to measure from birth certificate data, but it isn't used by states because… assumption is that by impacting spacing we're impacting LBW and PTB. Also states are using mainly Medicaid data for reporting on Waiver numbers, and are not always linked with birth files. So, very difficult to tie effect of service use to birth outcomes, across births for the same individual.

Georgia (Emory team) showed LBW ran 7% or so, but we know if AA rate is up at 13%, and reduce it, overall majority of population not delivering LBW babies, so relatively rare event. To make case that waiver is beneficial, do we need to look at indicator that affects all women not just few? Also in Florida, where program eligibility is not just income, but risk-based, very relevant, and still tough to focus on and whether LBW should be indicator in new evaluation.

Particularly if CMS is supportive, then a number of these indicators would be the ones they would want to track to justify the new SPAs or continuing Waivers to their funders (Congress). Are programs are making a difference, which ones are they, and which ones are more beneficial to use.

<u>Remaining Indicators</u> (Dave suggested we consider dropping several)
Two issues regarding contraception: continuation rates and effectivenenss of different methods See Ruth's link to chart of effectiveness, and also Adams' recent Guttmacher report. So, what

does the group think about dropping patient care indicator and focus more on contraception: continuation, contraceptive index (% of Waiver participants using more/less effective methods)?

Continuation rates and contraceptive effectiveness are really two sides of same coin. Episodic use and continuation of method is just as important as effectiveness of method.

Data available would be *what*? How is continuity measured for Medicaid claims? Not from claims, but from patient service so get use even if no claim (IUD, condoms would not generate claims per se); or client surveys before and after visit. Some of the better measures require additional surveillance (record audit or population surveys). So, while these indicators are really important, may be limited, not feasible to collect.

What about Title X FPAR data that is provided routinely? If you focus on more effective methods (however defined), wouldn't they be in the claims data base? Issues of timing, how far back do we consider important to look, how do you know still protected by IUD if withdrawn, whether they use method, even if dispensed?

Would states want to add continuation rates to patient surveys? How many states doing surveys? Return rate only 20% in LA (Regina) so, is it still useful…4500 participants, sent out 1000 surveys, got 20% back…? Is Texas or Arkansas doing any surveys? Tx, no! Ruth from Little Rock: DOH women are surveyed routinely, not doing separate evaluation of FP women, not currently asking about continuation of contaceptive method in the survey. Types of methods (large % respond "other"). So data may not be reliable. TN does some surveys, but we don't ask about contraceptive continuation rates… So Dave asks, should we be recommending this be collected somehow by States, or not? Jeff confirms that claims and eligibility data do not provide this sort of information in FL. Costs very high and response rates make process not as efficacious. AK confirms the confirmation! YES, this is the issue. CMS has been committed enough to support admin costs for getting data on Waivers, so might be Federal support to get better information to truly assess the benefits of expanded FP services. There are some things we need to be able to track the process of continued expansions and ultimately to assess the benefits.

Discontinuing the use of budget neutrality measures basically confirms acknowledgement that FP Waiver programs are cost-effective and no longer need to conduct these calculations to make the case. Rather, indicators focused more at effectiveness of FP method and consistent use, ie, individual level assessment of program success, shifting away population level trends may be more meaningful measures. The fact is that FP does reduce unwanted pregnancies enough that the program pays for itself many times over, and we have ample evidence and literature confirming these benefits. One problem we'll need to face is that from a funder's perspective (ie, government or private payors) what are the essential indicators going forward that need to be monitored? Is the issue how well is the need being met? We need indicators that go beyond simply measuring averted births, for example to include service delivery issues; esp if climate for FP becomes weakened then we can show effectiveness of program and services with long-term ramifications (effects discussed in previous call like life-long effects of effective birth spacing).

Not just a Medicaid issue…BRFFS also dropped contraceptive method breakdown by State, so those data are limited. YRBS and NSFG limited use due to sampling and cannot get State estimates, very expensive, and unavailable for state-level program evaluative subsamples. If we can include some partners from CDC and OPA who ARE focused more on national level may be able to get their take on this and partner.

Discussion about other related work revising FP/Medicaid FP Waiver evaluation indicators
We reviewed the summary from last month's minutes, covering OPA and CDC-P work on revising FP program guidelines including evaluation indicators that would be tracked over time. (As a housekeeping item, we clarified that the summary in last month's minutes should be listed as an addendum as they were not formally discussed during previous calls).

There are two separate but related efforts underway relevant to work we are doing on tracking indicators of public FP services and users. We clarified that the two efforts are:

1. OPA through its Office of Family Planning (led by Susan Muscosky) to revise Title X standards of care including FPAR data and performance indicators; and
2. CDC through its Division of Reproductive Health (led by Lorrie Gavin) to revise (national) FP Program Guidelines.

While overall effort is mostly reviewing content and infrastructure of clinical programs, one area includes indicators to track progress, both process and outcome/impact. This is the topic of one of their six workgroups, and is called *Quality Assurance and Quality Improvement*. We will try and get more details about their work and the indicators they are considering for reporting.

Several questions arose relating to extent of coordination between CMS and these OPA/CDC-P efforts: Since CMS has moved away from requiring calculation and evidence of budget neutrality, then going forward, what indicators are they going to be using to measure progress? Does CMS think that some of the clinical indicators OPA is looking at might also be useful to CMS?

The group discussed reactions to efforts: one big question being, what about outcomes? Could we recruit anyone from OPA or RTI re: sharing some of their details on indicators. Maybe on upcoming calls?

Questions that have been raised on Final measures for our Clinical Indicators:
What is the best/most reasonable/ feasible number of months to "bracket" for individual year-to-year participation rates?

- SC started using 9 -15 months, after which they searched for another annual visit. Do others have good measures they like for continuation rates and "clinical care"?

- Ruth mentioned they are linking women longitudinally to do survival analysis. They also had the same question, wondering whether there is a standard definition or expected periodicity (i.e., 9-15 months).

- Adam: better to get at more consistent contraceptive use, and gaps coverage, rather than simply periodicity of visits (months of continuous coverage).

- CA looked at a12-month supply "frame" and a 3-month supply frame, and if the difference in time frame had any effect on resultant visits. Is it a useful measure?

Is it better to refine, or better to drop this indicator? If a key component of a FP program is that where women are eligible for two years (as in FL) to have improved birth spacing…we don't really strongly incentivize women to participate for a full two-year period. What is the best measure to capture effective service? Measure of program success?

- Guttmacher has suggested using "% women using effective contraception".

Is there any way to define effective contraception?

- Dave found one measure with long list and wide range of methods…
- Is it simply LARCs?
- PA divides use into 4 categories: abstinence, non-use, more effective (hormonal, IUDs and sterilization), and less effective (everything else).
- CA has 4 tiers (I: implants and sterilization; II: hormonal; III: condoms; IV: Other).
- Case to be made between LARCs and patch and rings in everyday effectiveness, and then between hormonals and condom group… another big gap. If one focuses only on top tiers, the numbers are small and do not necessarily focus on most often provided program services.

- Manufacturers have to get FDA approval and establish level of effectiveness in population, with product packaging that was produced "scientifically" to bring it to market. Typical and perfect use rates terminology gets around those method claims.

How to frame this? Instead of solving the effective vs. not-effective issue… for program evaluation we'd want more users to move generally toward Tier I and II groups… another way to look at it is to collapse into an effectiveness index using *typical use* failure rates, and weight according to how many users there are in the program, and use these results.

We will continue this important topic next call, and will include discussion of fertility outcomes. Which ones will we be using taking into account many states' pending decisions about most useful activities going forward for both SPA- and Waiver-delineated programs. For example with selected clinical outcomes like PTB: which is best to use, <37 weeks or <32 weeks? Or is it (even) appropriate to expect impact on VLBW and PTB given other risk factors at play? Isn't a key factor of family planning the healthy spacing and intentionality of the pregnancy that subsequently increases odds of having term delivery at normal weight?

The next call will be on Monday, January 9th, 1 pm EST (noon CST) using the regular telephone number: (919) 962-2740.