Family Planning Medicaid Waiver Evaluators Conference Call
February 8, 2010, 1:00-2:00 pm EST

Participants

Evaluators: Janet Bronstein (AL); Ruth Eudy (AR): Jeff Roth (FL); Andrea Johnson (NC); Donna Albright, Michelle Bensenberg (TX); Dave Murday (SC); Molly Carpenter (VA)

State Staff: Lynn Smith (FL); Bernie Operario, Marcia Swartz (NC); Margaret Major (TN); Kendra Sippel-Theodore, Gerald Craver (VA)

Other: Julie DeClerque, Priscilla Guild, and Ellen Shanahan (Sheps)

Minutes

Minutes: for January were approved for posting on the public side of website with edits as discussed related to definition of "adjunctive eligibility".

Old Business: Julie is checking to see if we can set up a feature on our RNDMU/FP Waiver Evaluators website that would be interactive for both posting and editing files. *Wikki and Google Docs with Microsoft Live* were recommended.

No CMS representation on the call this month (likely due to the snowstorm in DC) so no follow up to determine whether CMS might have a chart or some summary that lists eligibility criteria for FP waiver across the states.

However, Guttmacher website has basic age, income, gender, teen enrollment and eligibility criteria listed in their document (below) that shows cross-state comparisons.
http://www.guttmacher.org/pubs/win/allstates2006.pdf)
See tables 3, 6 and 7, for breakdowns of family planning clinics and clients by type of provider. (This is for all publicly funded family planning centers, not just within Medicaid waiver programs. But it could be useful in explaining differences among states.)

Also, here is Guttmacher's latest fact sheet on state waiver programs, complete with eligibility criteria (note these are updated monthly and available on the Guttmacher website):

http://www.guttmacher.org/statecenter/spibs/spib_SMFPE.pdf

Budget Neutrality
Dave Murday asked the group to share terms and conditions (Attachment A in South Carolina's) and see across the states whether it is the actual language in the terms and conditions that is directing states differently, or whether it is different *interpretation* of the same language. Molly (VA) will be sending theirs today. TX (Michelle) will send theirs, and reports that it looks pretty much the same as SC's. Assuming that it is standard language, we can then move ahead and

focus on what we think is the best way to interpret the language and possibly come to consensus about how to do a better job of standardizing our interpretation. TX received additional guidance on their budget neutrality calculations and they will be sharing that, as well. This will be especially useful for states with newer waivers. "How do you count births to come up with the averted births calculations?" Let's figure out what the feds have written down, think it through as a group, and come back with a recommendation for CMS, much as we did for the primary care issue. FL note: They will hold off on sending the TSC until after the new guidelines for their waiver have been received.

Discussion and Other Topics:

Range of services provided through FP Waiver
Janet sent out article on care coordination. The article discusses services covered in the AL program. These do not seem to be covered in other states (for example, not in SC). The article is available on the RNDMU/FP Waiver website.
www.shepscenter.unc.edu/data/RNDMU/FPMedicaidWaiver/PublicationsandPresentations.html

Dave commented on the extended list of services during initial treatment of STDS in SC, and potential services related to follow up for complications identified in a family planning visit. For example, when the clinics follow up on abnormal PAPS, they conduct targeted outreach to women with high risk or complicated deliveries and invite them to enroll in the FP Waver. They determined that currently not all *eligible*s are *enrolled*, and that only half of those enrolled are actually using/receiving services. This means that they are only serving about 33% of those "in need" in South Carolina. What are other states covering? Follow up to complications, or other diagnosed conditions?

Funding Source and Opportunity for Service Provision to High-Risk Population
There has been a budget amendment request in Virginia to cover HPV (human papilloma virus) vaccine to prevent cervical cancer through FP Waiver, and CMS indicated they would entertain that as covered item, recently. [The proposed amendment was subsequently revised and, if included in the final budget, would direct the state Medicaid agency to report on the fiscal impact of providing cervical cancer vaccines under the waiver.] Any states doing this? VA reported that they have considered covering some follow-up diagnostic and treatment services, but it is a difficult trade-off between increasing income limit on eligibility to expand coverage for more people, or to increase services that are provided to a smaller, possibly higher-risk population. In VA, they chose to increase income level and expand number of people served at a more basic level, rather than expand the package of services provided to a select risk group.

HIV Testing: Are other States targeting high-risk women through their waiver? No response. Waiver covers HIV testing and this is a possible missed opportunity to test for HIV under waiver. It is an mechanism to make it a priority for MDs to include in their clinic screenings — among physicians as well as other FP providers. ACOG guidelines stipulate the importance of knowing client's HIV status (CDC revised the recommendation in 2006). States might consider this (to do HIV testing more) and use the Waiver as a mechanism for recouping costs. Evaluators could track this and monitor how well it is being used.

Other Mechanisms for Tracking High-Risk Indicators
States used to collect "high risk indicators" (previously LBND, parity/gravidity/age, # abortions, fetal loss) were all MCH hi-risk indicators but no longer monitoring on a regular basis. Is there a current list of hi-risk indicators or a way of using Medicaid claims linked to prior births to do this? …or is there any mechanism though evaluation indicators to devise a more meaningful measure of "in-need, at-risk" and who are enrolled and not using, ie — "Unmet Need"?

In Florida, they have had success in linking up Children's Program data and Medicaid high-risk ob program. They have studied the # women who delivered (Yr 2004) and who were enrolled in the high-risk program (n=9500) and who subsequently enrolled in the FP waiver… Problem was that we could only find 2% of those women. Some may have been uninterested in contraception, but many were unfound. Postpartum women who were surveyed, reported that 60% had actually received the waiver services). But this was only 60% of the 2%, so only 103 women!

Angels program: easy to find out whether high-risk deliveries are subsequently enrolled in waiver, or not, and follow them afterwards. It is possible to track the # of eligibles and then the # of participants, looking in Medicaid claims to see if services were provided. (Question: Is this part of the Florida program above, or was it a separate comment from another State /Program?)

We might need to supplement our list of of potential indicators and add to our set of measures a set of indicators that ID high-risk women. Our goal would be to include a measure showing the % of high-risk women served. There may be some guidelines related to what should occur in FP visit (like HIV testing) and the % women receiving services are getting the recommended tests, services. Are there other services we could track to determine if rendering is happening? Janet (AL) has developed a set of content measures: she flags a test by service: for example, depo injection, or IUD, or pill refill, HIV test, or care coordination, "active contraception" (NSFG definition). Janet is showing HIV testing is happening more in HD (public) than private offices (60% about). Are other states doing this? Andrea in NC is looking at effectiveness of BC methods through claims data, and type of contra being used, "Pocket Guide" from Bridging the Gap Foundation and using their weighting factors for prescription methods to determine "effectiveness".

This might open up a whole area of other indicators that can show the need for change, and how and if we are reaching those most in need in terms of testing as effectively or reaching high risk populations or using the most effective contraceptive methods. Also, for targeted education, this may provide data to help programs move in the right direction.

Do you look at the entire Title X population and see if there's cross-over, or how do you disentangle the two populations (Ie, Medicaid and Waiver)? Janet (AL) does only by clinic of service (private or HD), so the count is not unduplicated. Across Title X what proportion of them who are seen has declined and % who are seen are not on Medicaid so that number has also shrunk so loosing total numbers of women receiving publicly funded FP services.

FL: You want to postpone childbirth among women who are id'ed as high-risk so want to increase "efficiency" of targeting services. But from a FP waiver point of view, cost saving as well as high morbidity and mortality justify more targeted services. Waivers provide some

funding for examining and tracking the trends and showing effectiveness. We can use waiver evaluation and key findings to inform the general State FP program. Waiver issues are all applicable to general program and it's an advantage that we are not fully exploiting. In spite of what Title X has done, the reporting requirements have never been adequately detailed to answer some of these key issues. So, as long as waivers are around, how can we measure effectiveness beyond cost-effectiveness and budget neutrality?

Other Business

Call for Papers: The American Evaluation Association has their call for papers, due in March. Meeting is in San Antonio, TX in early November. This Evaluator's effort would be something worth sharing more broadly. Anyone interested would be welcome to join in doing a paper. These calls and the history of our group might be an interesting panel for state/gov TIG, indicators and examples of how useful they can be. The meeting is in San Antonio. Michelle will spearhead the effort with help from Julie and folks at Sheps.

Any agenda items for future calls, please send forward to Dave Murday, Julie DeClerque, or Ellen Shanahan.

Next Call: Monday, March 8th from 1 until 2 PM EST. The call-in number is (919) 962-2740.