Family Planning Medicaid Waiver Evaluators Conference Call
January 10, 2011, 1:00-2:00 pm EST

Participants

Evaluators: Jeff Roth (FL); Kumarah Cosey and Andrea Johnson (NC); Dave Murday (SC); Molly Carpenter (VA)

State Staff: Kathy Canfield, Mary Canova, Brenda McCormick, Ghasi Phillips and Lynn Smith (FL); Tara Sangster-Clark for Linda Wheal (IL); Bernie Operario, Andrea Phillips and Marcia Swartz (NC); Susan Barber and Margaret Major (TN): Gerald Craver (VA)

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

Minutes

Approval of December Minutes: Minutes approved as amended for publication on public side of web page. There was a request to spell out LARC in December minutes to read "long-acting reversible contraceptive methods."

Update from CMS on State FP Waivers
Busy time of the year, so no CMS representatives on the call today.

Update from Guttmacher (National Perspective)
Although Adam sent an email saying he could attend meeting, after the initial technical difficulties with conference call line, he did not join so no update from Guttmacher.

Update on State Decisions (SPA vs Waivers):
FL: We are definitely going with the waiver until December 31, 2013 (Kathy Canfield).

IL: Email note from Linda Wheal: Illinois is preparing our SPA to start moving through the bureaucratic approval process, however, we are still trying to come up with the estimated numbers to be served and the extra cost outlay of converting to a SPA.

SC: SC received 30-day notice of evaluation cancellation. As of January 1, SPA is effective. There is a large Medicaid deficit to take care of.

NC: Waiver extended to 3/31/11 but we are going with SPA after that (Andrea Phillips).

List of Indicators to Illustrate Waiver Success:

What are the important indicators for FP Waiver programs? Some are quality of care. Others relate to access and utilization. Some try and show outcomes. List (see below) has 40 + so we need to be narrowing performance measures down…which ones strike the group as most important?

The Workgroup picked up the discussion from last month, reviewing the next groups of indicators to see if there may be good candidates that would be useful as comparative benchmarks to assess historical benefits of the FP Waiver. We think that if we can focus on a limited number of indicators across our states, and collect those data, we might be able to produce something very worthwhile and informative. Reference document distributed and posted on the web: State Family Planning Waiver Evaluation Indicators (By Topic/Focus)

The goal is to come up with indicators for cross state comparison. Today's conference call went through clinical and fertility outcomes.

Everyone has budget neutrality calculation– topic for February's call.

Outcomes – Clinical: are these worth pursuing?
Should we include LBW and preterm delivery? Is one more a measure of mother's health and pregnancy experience and the other (LBW) more a measure of the infant's health? No, not really. (Bernie: can have LBW without being premature, for example).
Both **12 and 13** are valuable? Information in general is good, states that are able to provide linked birth certificate-FPW participant data would provide better information but numbers may be too small.
Decision: Leave these two on the list for at least one round of data collection? YES

Outcomes – Fertility:
#14, 15, 16: Is age at first birth a good indicator? Or would be percentage of births to women less than age 19 be better? Or other age brackets 15-17 and 18-19? Among women using the waiver, how many are giving birth at specific ages? What age is considered acceptable or desirable? At what age do we want teens to delay first birth to show success of waiver? What are the optimal years?

Rather than absolute maternal age, maternal education may be a better measure of preferred age at first birth. Maternal education is available on birth certificates – both the old (1989) and new (2003) versions, although using somewhat different categories.

However, the age band 15-19 years is a national standard for assessing teen births. On the other hand, Guttmacher Institute separates data on younger and older teens.

What is the purpose of a benchmark for maternal age at first birth? Does it measure success of the FP Waiver if age at first birth increases among waiver participants? Bernie pointed out that Title X Family Planning programs have historically been non-prescriptive, that is, supporting the individual's reproductive choices regarding both contraceptive method and fertility.

Dave mentioned that many state waivers do not cover teens because they are eligible for Medicaid.

#17: Improvements in rates of subsequent births within a suboptimal interval among specific populations of interest, e.g., waiver enrollees and participants; users of public and private services; women receiving and not receiving care coordination.

Jeff commented that it would be easier to measure the birth-to-birth interval. While this is true, it discounts the burden of pregnancy on a woman's body if the pregnancy does not result in a live birth. Premature births also skew the numbers if using birth-to-birth data. Both birth interval and inter-pregnancy intervals will underestimate the actual rates because they may not capture all pregnancies such as those ending in a spontaneous or non-reported abortion. Dave noted that a recent article summarizing indicators supports birth to conception as the better measure. The group agreed that this is a valuable indicator.

#18: Birth rates among waiver enrollees and participants comparing users of private and public providers with and without care coordination is not good for cross-state comparison because AL is the only state that uses care coordination in Waiver so no data are available for other states. Drop this indicator? YES

#19: Comparative fertility rates among participants at or below the federal poverty level and between pre-waiver and post-implementation (including by ethnicity) in budget neutrality calculations are already being included in budget neutrality calculations. Since states use different poverty levels for waiver eligibility, cross-state information would likely not be comparable. Drop this indicator? YES

#20: Pregnancy intendedness among specific groups. On the individual level, intendedness is difficult to measure for many reasons including its "volatility" over the perinatal period. Dave commented that South Carolina reported intendedness among participants for a while but stopped when it became clear that it did not change much over time, and more intended pregnancies were not necessarily associated with choice of contraceptive method.

However, as a population indicator, a measure of intendedness has merit even though it may have limited validity and reliability as currently measured in PRAMS, for example.

Maybe we should just observe changes in fertility rates over time and if they are lower or higher consider that as an indicator of waiver effectiveness rather than individual intendedness. Dave asked whether one could infer greater intendedness if the fertility rate among participants is lower than would be expected for that population (for example SOBRA?), since the waiver, presumably, does not prevent intended pregnancies.
Drop this indicator? YES

#21: GIS mapping of major waiver outcomes including enrollment and participation by county. Only South Carolina and North Carolina employ mapping. Since it is not really used in driving policy is it a useful indicator? Drop this indicator? YES.

Looking back at previously discussed measures:
Question about #8: How do we measure continuity over time? Two measures need to be distinguished: continuity of enrollment and participation in Waiver services over time (may or may not include contraception), and continuous use of a contraceptive method.

In regard to continuity of utilization Jeff asked whether there was a way to measure whether women are enrolled for a short or long time, whether someone drops out and returns so that program is credited for offering services but not penalized for women who leave for reasons not

associated with barriers or lack of satisfaction? A degree of tracking is possible using charges for annual visits, but reasons behind a break in continuous service utilization is sometimes hard to determine when participants move in and out of eligibility or move from place to place. A basic tracking method might be to count the number of visits, using a basic identifier for each participant.

In regard to continuity of method, Bernie noted that there used to be a way to monitor continuity by the number of return visits for pills or injections by individual women. Results show that rates for teens are always lower than for adult women, for example. But for women using long-acting reversible methods (or sterilization) whose claims records have fewer method entries, this becomes more difficult. He suggested that the claims database should have a method-specific code, in order to facilitate tracking method continuity.

Question about #10: What is an accepted definition of highly effective methods? "Highly effective" is a term used by the Texas group in their report and since no one from Texas was on the call due to the technical difficulties, we should ask them to describe the rationale for inclusion as "highly effective." Whether the term "highly effective" or "long-acting" is better for cross-state comparison indicators will require further work by the group. The usefulness of various schemas such as the Federal Drug Administration's and the Guttmacher Institute's categorizations should be studied and reported back to the group and a decision made on a common indicator.

Jeff raised a question regarding the audience for these data: who will have access to our report and for what exactly will the cross-state comparison be used?

Dave replied that they are intended to be an internal tool providing benchmarks by which evaluators and data analysts can gauge program success relative to that of other states. It is not meant to be a comprehensive summary since the waivers differ in duration of the waiver and eligible populations (by sex, income level, and age).

Next Steps:
Dave will ask each state for budget neutrality data since all states collect these data. He will send out an email asking for data to populate a table.

Next call: February 14th at 1:00 pm. The call-in number is (919) 962-2740.