Family Planning Medicaid Waiver Evaluators Conference Call
July 11, 2011, 1:00-2:00 pm EST
Participants

Evaluators: Loretta Alexander (AR); Jeff Roth (FL); Dave Murday (SC); Kristin Christensen (TX)

State Staff: Bernie Operario and Andrea Phillips (NC); Margaret Major (TN); Stacey Johnston (TX)

Other: Adam Sonfield (Guttmacher Institute); Ellen Shanahan (Sheps)

Minutes

June minutes were approved for public posting by call participants. Since attendance at this summer call was low, other members of the group are invited to review the minutes and suggest additions or corrections.

In June, the group began discussing clinical indicators. Since SC was the only state to look at age at first birth, no cross-state comparisons are possible. Therefore the group proceeded to discussion interpregnancy or inter-birth intervals.

Last month Jeff agreed to talk about PTB or LBW at a future date. He indicated his readiness to do so when the group completes its discussion of pregnancy or birth intervals. Jeff then noted that the RNDMU data tables on high risk and optimal intervals illustrate some of the issues that arise in using such an indicator. First, there is the need to clarify what is being measured: interpregnancy or inter-birth interval; and second, the cut points to be used to describe a high-risk interval (less than six months? less than 12 months?) or optimal pregnancy or birth interval.

Jeff also cites a new study by researchers at Emory University on interpregnancy interval and its relationship to preterm birth among African American and White women. (Hogue CJ, Menon R, Dunlop AL, Kramer M. Racial disparities in preterm birth rates and short interpregnancy interval. An overview. *Acta Obstet Gynecol Scandinavica*, 2011.)

Adam noted that the available data sources determine whether an interpregnancy interval can be determined, or only an inter-birth interval. In addition, for any population, inter-birth rates will be based on a smaller number of events than interpregnancy rates but if the data are consistent, the difference is likely to be consistent over time. On the other hand, it is not possible to measure the upper limit of intervals in a Waiver population.

Adam then raised the issue of comparison groups. He noted that Rhode Island had compared all Medicaid users to all private insurance users. Other states had compared Waiver participants to other Medicaid recipients.

Jeff noted that for Florida, the comparison groups were participants (who received services) and enrollees (who did not receive services. Short interpregnancy rates among those who did not receive services was 32% and among those who received services, 20%. Since the Florida report has not been finalized, these are preliminary rates.

Dave noted that if states are limited to Medicaid data, then all states in the group can calculate inter-birth intervals, which would serve as the basis for state-to-state comparison. Without linked birth-Medicaid data we lose some research capability, the ability to calculate interpregnancy interval. While states in the group may report to their own state and to CMS using indicators that differ state to state, they may still be willing do a supplementary run to calculate rates for the indicator selected by this group. Adam summarized the discussion

by noting that the literature focuses on the better measure (IPI), but if the available data are birth data, then use don't overcomplicate the issue but use what you can.

Representatives of various states commented on their state's capacity: Bernie noted that NC has linked birth certificate-Medicaid files and so could produce interpregnancy intervals. Loretta said that Arkansas has separate data systems that are not linked. Texas said that it would take a special request and IRB approval for any data request to produce interpregnancy interval data.

Dave notes that some measure of birth spacing is an important marker for a family planning program, but if some states cannot link, then the group should use the lowest common denominator. He asked if this group had a recommendation to the larger group (for the September meeting when more people should be available) concerning a birth interval measure?

Adam asked whether the comparison among states would be sufficient or do we need to establish an objective goal? For example, Healthy People 2020: current rate 35%, IPI, 18 months; target 10% improvement (to 31.7%)

Which groups should be compared: waiver participants; waiver enrollees or women with Medicaid births? Data for all Medicaid deliveries are available even if linked birth certificate-Medicaid files are not available.

Jeff asked if the purpose of Medicaid family planning programs is to close gap between birth outcomes of low-income women and higher-income women.

Dave proposed using the RNDMU state-level data as 'background", then plotting each state's data (IPI or IBI) to see whether waiver data converges over time toward rates for the total population. He volunteered to plot SC IBI and IPI against RNDMU; anyone who has data is invited to do the same.

Dave confirmed with Jeff that he would lead a discussion of the low birth weight and preterm birth indicators during the September call.

It was noted that in Region IV and nationally about half of all deliveries are paid for by Medicaid. Loretta noted that in Arkansas the 2009 rate was 65.5% . Adam volunteered to send a link to the Guttmacher Institute data on the cost of births from unintended pregnancy to the group.

Group members are invited to keep the group apprised of emerging issues related to the Waiver. Since South Carolina no long has a Waiver Dave is not able to be as up-to-date on these as in the past and welcomes input to the group.

The August 8 call will continue discussion of birth and pregnancy interval indicators. Again, group members are invited to compare their available data to the RNDMU data at
<http://www.shepscenter.unc.edu/data/RNDMU/LongitudinalExcelTables/DataTablesExcel.html>
Go to Domain IV: Pregnancy and select Spacing (Risk, Optimal) for the two Excel files.