Family Planning Medicaid Waiver Evaluators Conference Call
May14, 2012, 1:00-2:00 pm EDT

Participants

Evaluators: Janet Bronstein, Kari White (AL); Loretta Alexander (AR): Jeff Roth (FL); Dave Murday (SC)

State Staff: Brenda McCormick, Jocelyne Maurice and Lynn Smith (FL); Regina Williams (LA); Bernie Operario, Andrea Phillips and Marcia Swartz (NC); Margaret Major (TN)

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

MINUTES

Approval of Minutes: Minutes of the April meeting were approved, with no changes, for posting on the public side of the website.

Discussion of Compiled Wish List for Ideal Family Planning Program and Purpose of the List

Andrea was thanked for her work compiling everyone's contributions to a wish list for an "Ideal Family Planning Program". Jeff Roth remarked that it looks great, and just needs Congressional approval.

Purpose: We have been discussing together as evaluators and program managers, and listening to each other's experiences with FP Waivers for over seven years now, with input from other states, CMS staff, and also advice from Adam's (and his colleagues at Guttmacher) work and relevant articles on FP services, role of Waivers and other key programs like Title X. So, as we shift from Waivers to SPAs and prepare for changes in implementing ACA and health care reform, we want to ensure that we build on our successes, and start from point of strength and not weakness in terms of what a model FP program should look like going forward. Andrea had suggested that a useful tool going forward, as we share our findings with the various stakeholders we had identified in past calls, would be to compile a list of desired features of a model program, from a positive strength-based point of view.

Dave Murday responded making the distinction between a wish list showing our hopes and wishes for what we'd like to see in an ideal program, and an evidence-based list saying given what we have shown that works and that doesn't work, here are components and features of a family planning program that we suggest are keys for success going forward.

Question: what are our next steps turning wish list into reality…what we need to do to help make these quantitative and qualitative indicators come to life? The process is not always rational or evidence-based; the effort we put into this wish list is more a sort of inventory of everything our group would say characterizes a "strong program"— a broad description, so that

if we become involved in negotiating composition of a program, we have many features at our fingertips. This is a starting place, from which to refine, hone in, make more realistic.

Other thoughts: Loretta (AK) said Dr. Eudy took this list to the faculty on the State's committee charged with developing the insurance exchange mandated by ACA. It was extremely helpful in our request for what should be included in our Arkansas program. We included male-focused services as well, which would be an add-on to our existing "portfolio".

Andrea commented that in NC, while we are known for having "male services", we only offer vasectomy and STD checks as our service menu. It looks great on paper, but is actually very limited care. Services are offered only when males come in for an annual physical, which is less than ideal, and likely a major factor in why we do not serve many men. Others commented that although a "negative finding", it is very useful lesson learned in terms of how services would need to be expanded in terms of when they are offered, if, in fact, the objective is to reach as many men as possible.

Looking Ahead

Is there a market for an article or working paper on findings in our group, what's benefit of including men, outreach and "ancillary services" saying with some authority and supportive data… would this be welcome in the literature?

Adam asked how/if some of this state-specific experience, and more in-depth data analysis might be useful as smaller, tailored pieces with more depth on specific issue or that focus on several states? These would be pieces based on experiences from the field, for example:

- How frustrations that deal with administrative bureaucracy (for example billing and limited eligibility) take away from our ability and time to provide quality services. So many issues involve clients problems resolving bills and billing. Rather than working on x,y,z.
- States that cover men under their expansion programs: challenges, successes, and;
- Looking ahead: commonalities and unique features that have led to success.

Also, consider consulting with OPA as many of these issues are ones they have been interested in for long-time. They might also like to include suggestions.

Can the work be linked (OPA and Medicaid experiences)? This is a big wish list that we have compiled. It would be good to pare down, maybe organized according to which are standard practice, which have data to support success, which do not, but make sense to promote… some are really basic, other pie in sky, others required, some even not allowed.

There is a document published by FP OPA called "Program Guidelines for FP" (back in 2001) and are currently being updated. It delineates the rules that apply to all FP programs, with guidelines that are required for any program to be considered for funding. Prescriptive guidelines to receive funding from federal government, specific items, media review, staff, location of clinic, charting, billing, etc. So this type of document exists for all Title X providers, and may have some of these items laid out. Medicaid may have similar set across states. It is foundational, and our and wish list could be organized by: 1) here are things *not* included in the required standards, but deserve consideration: for example, outreach how to serve men;) 2) here

are other things that are "soft" ones: for example, elements that are obvious; and 3) here are others things such as: those features important to access (Note: not sure I got this important point very eloquently, but hopefully it makes sense JDeC).
Maybe if you can add these elements it will make your program even more effective and here is our experience that indicates x,y,z. Guidelines taken as bare minimum according to Fed; should do this; and then might want to think about these additional features to match your programs' needs most effectively…

Clinical protocols are reviewed according to these guidelines, that is, the bare minimum of what FP program should look like. Let's look at this list. Clarify that this is specific to Title X program where any grantee has to follow rules for all clients in their program even if Title X money not used for the other clients in their overall program. Generally, the rules for Medicaid are the rules for the State, and are the rules that the States uses throughout its FP service networks. Title X guidelines are more for providers, more on the ground level… sometime to higher-level administrative structure in terms of managing the money. Two kinds of requirements: on the ground specific services, and program level: Medicaid more about specific services and things that must be reimbursed (transportation) under SPA… some overlap between the two, in terms of Title X and OPA, but also some are very different in terms of focus and intention.

CMS and OPA have been trying to work together more on these issues…Julie will look into this and find out more details. Update from Julie: CMS staff have been at the table as members of the Expert Work Groups that CDC and OPA have convened as part of the process to review and update the FP Program Requirements and Program Guidelines. These are their stated end goals:

- *To produce evidence-based or evidence-informed Title X Program Guidelines that also provide a service/contribution to the greater reproductive health community;*
- *To create a process/mechanism for keeping the Guidelines current;*
- *To use the review of evidence, and the gaps identified, to inform OPA's future research efforts.*

It is the "Program Guidance" section that discusses the issues we are raising in our Workgroup (clinical requirements, quality clinical services, and effective service delivery infrastructure).

They outline six domains:

1. *Community Outreach, Participation and Barriers to Access*
2. *Contraceptive Counseling and Education*
3. *Adolescent Services*
4. *Quality Assurance/Quality Improvement*
5. *Clinical services for female clients*
6. *Clinical services for male clients*

These are the topics and activities they have been working on that are relevant to our Waiver workgroup objectives:
<u>Topics</u>

1. *Provide feedback on those requirements /domains that are important/essential for quality family planning services (e.g., must be included in Title X Guidelines) and should be included in evidence search*

2. *Identify those requirements/domains that may be important to include in Title X Guidelines, but need evidence-based guidance or other justification that validates/supports why it should be included or how to perform effectively*

Activities

a) *OPA identified the "Must" requirements in the current Title X Guidelines that are substantiated by Statute or Regulations, as well as those that are not;*
b) *CDC drafted a possible "Organizing Framework" for portions of the Program Guidelines;*
c) *OPA and CDC mapped the Title X "Must" requirements and "Should" recommendations to the organizing framework as a usability test*

To assess evidence in the literature related to each of the six domains, the Expert group identified key questions and designed an analytic framework (see slides 29 and 30 in the attached file).

The OPA has been soliciting feedback / comments from "grantees". They have a Guidelines website for submission and comments/feedback (for Title X grantees).

If federal organizations are working together then…our work might be a friend of the court/ white paper/ to supply these workgroups with combined experience to inform the process. Have we shared anything in that process already? Yes (Julie shared info with Christina Fowler at RTI who is working with OPA and the Expert Panels. She is checking with Lorrie Gavin and Christina for update, before next call.)

Suggestion: We start with Title X guidelines as framework, and look at what might be missing or what is being covered more from payor viewpoint .

States have a lot of leeway, lots of variability.
http://www.guttmacher.org/pubs/Family-planning-SPA.pdf

One thing we may want to examine, what will Medicaid be reimbursing providers for (6-12 month supplies for pill) and are these things lining up with the guidelines in terms of what clinicians are supposed to be doing. Look at caveats in ACA re: medical homes, patient-centered outcomes provisions as these are what they are focusing on long-term.

Look at Medicaid bare bones and Title X guidelines (generally) and compare to this list. If we can find someone at CMS to help us with ACA … and put recommendations in context that related to what is Title X requirements, these are already part of OPA clinical guidelines and we see some other items that we think would benefit the programs additionally in ways that need to be included. Outreach, care coordination, male services… areas not new, but not currently considered part of routine program… Here are some data from NC, AL that show effectiveness. And here are some program costs…

First is Systemic Changes and Access to Services (summary of how people get services, who provides them and what clients must do to get them.

System issues of how services are delivered

Quality of services that are provided
What kinds of services contribute to quality of FP (EC, support)

Outcomes and evaluation (led by Jeff)
What is it we want funders to know about services and what kind of outcomes

Access, Quality, and Reaching Those Most On-Need: Andrea Phillips (NC) addressed the concept of an ideal FP program. If we were to design one how would it look? She would like to be a part of a workgroup on quality of care and how word gets out about the program, evaluating access to services, recruitment and enrollment process. Background to this activity might include the Guttmacher report and previous discussion about outreach and enrollment and 50% eligibles not enrolled or using. Marketing in NC was a strong component of outreach and recruitment, but initial work never adopted. Opposite also true, where great marketing and selling like gangbusters but clinic capacity was not ready and waiting time were very unacceptable.

Our goal is to add to the knowledge base, sooner than usual turn-around for peer-reviewed journal. Review Adam's document. Andrea knows Medicaid and can review those requirements, Bernie to review relevant program elements from Title X, under revision (are they in sharable drafts?)…to refine list so easy to see what of ours go beyond those required elements. Dave might take crack with one or two others to start to look at another list of key components building Medicaid and Title X requirements. Julie is to get an update on OPA/CDC FP Program Guidelines revision process.

Next call: June 11th at 1:00 pm EDT, noon CDT. Call in number is 919 962 2740.