Family Planning Medicaid Waiver Evaluators Conference Call
April 12, 2010, 1:00-2:00 pm EST

Participants

Evaluators: Rajeev Das, Nancy Hardt, Jeff Roth (FL); Kathy Vetter (IL); Kumarah Cosey, Andrea Johnson (NC); Donna Albright, Michelle Bensenberg, Veronica Neville (TX); Dave Murday (SC); Molly Carpenter (VA).

State Staff: Kathy Canfield, Brenda McCormick, Tamara McElroy, Catherine McGrath, Lynn Smith, Dan Thompson, Regina Wiggins (FL); Andrea Phillips, Marcia Swartz (NC); Susan Barber, Margaret Major (TN)

Other: Julie Sharp (CMS); Adam Sonfield (Guttmacher); Julie DeClerque, Priscilla Guild, Ellen Shanahan (Sheps)

Minutes

Minutes: for March were approved for posting on the public side of the website.

Old Business: Addressing Key Topics of Interest to Waiver Evaluators
Dave Murday previously outlined topics he has noted in recent years that are recurrent themes and would benefit from the groups' concentrated work. For a complete listing, see March minutes:
http://www.shepscenter.unc.edu/data/RNDMU/FPMedicaidWaiver/HistoryofTopicsDiscussed.html.

The first two topics will be covered over the next several months. We will begin discussing the third topic area (measuring averted births) on today's call.

Other topics for today's call: Accessing SS Numbers for Data Linkages, Health Care Reform and State Plan Amendments

Accessing Social Security Numbers for Linking VR with Medicaid Data: The TX evaluation team is running into roadblocks with their HHS Commission getting SS numbers. Trouble with approvals to get these to use for matched Medicaid and vital record data. They asked if any other states have had any experience with this? Yes, AK matches Medicaid claims data using SSs and also uses with PRAMS. Anyone who wants more info should email Ruth Eudy (AK) for help with strategies. FL links Medicaid claims to birth data: SSN is on the BC and Medicaid claims files only have SSN as the linking field. They submit a user agreement to their DOH and restrict use of the claims data to the conditions outlined in the MOU. AK goes though their IRB and establishes confidentiality protection via data encription and subsequent stripping of SSN after matching exercise complete. FL (Jeff Roth) and AK (Ruth Eudy) will send copies of their use agreements to Michelle in TX, and anyone else who might find it helpful. Contact Jeff or Ruth, directly. In VA, the Medicaid office sends their data to DOH and they do the matching directly. IL uses contractor who handles these matching issues.

Health Care Reform Bill: What are the future implications for FP waivers, given the passage of the HCR legislation? CMS will let everyone know once there's clarity from the budget process and they hope to be able to provide more detail soon into the future. Adam (Guttmacher) mentioned that FP related components are not part of any of the provisions that would be effective immediately (10/1/2010) or even within the first year. What does this mean? The reforms do not necessarily override activities or funding of currently approved waivers. States can choose to maintain waivers.

State Plan Amendment for Waivers: Effective date is the "date of enactment" so states can submit their plans accordingly. The plan under the new law is to allow states to do essentially what is being done under the Waiver. States can elect to continue their Waivers, if it benefits them. No evaluation required, but states can choose to continue their evaluations. Medicaid will cover everyone up to 133% poverty by 2014. Evaluating expansions separately may not make much sense. States can begin sooner than 2014 (but without the enhanced federal matching rates). Waivers may become less important in some states prior to 2014. Refer to Section XXIII.03 of the HRA for more details. Did CMS previously commission a national evaluation of the waivers? The last one was the CNA Corp, UAL, Emory report (Nov, 2003), and Julie Sharp thinks that one is the most recent. OPA has contracted with Emory for an updated cross-state evaluation. SC is trying to discern pros and cons of continuing their FP waiver… categories of FP services (initial STD treatment, colposcopy). Coverage at regular match rate… does this just apply to basic package? Is there an advantage to a state to include more than basic if they stick with Waiver? Law talks about "related services" and tries to encompass all services Waivers currently cover.

Calculating Budget Neutrality / Births Averted

We have reviewed the budget neutrality language in each of our contracted terms and conditions. We are creating a general framework, using this language and how each State varies in its interpretation. We are coming up with some standard methodology to propose to CMS. Last month, Julie Sharp from CMS shared that they are in the process of clarifying the requirements and are open to States' input and feedback. It would need to be received by May 2010 or so for CMS to consider as part of their final decision-making. Kathy Vetter (IL), Dave Murday (SC) and Janet Bronstein (AL) reviewed the set of documents received, identified different definitions and summarized into four considerations for calculating "averted births" for CMS budget neutrality purposes.[1]

[1] In the recent scientific literature, calculating "averted births" is based on a methodology very different from the assumptions behind the CMS method. Most calculations of "averted births" are based on applying the effectiveness rates of different methods of contraception in different populations; no births are actually counted. If 100 women using a contraceptive method that is 80% effective change to a method that is 99% effective for one year, then 19 births are averted (20 births expected with the former method minus 1 birth expected with the latter method). This method depends heavily on data or assumptions about contraceptive use in the absence of the program and uses data from prior studies instead of current actual experience. But the only way to go when birth data are not available.

The general direction is to move to counting births nine months after the year of participation. CMS' guidance was that States have to track beyond the 9 months postpartum time period. SC was accustomed to tracking only nine months after the index project year. So, there is a move to looking more at a "cohort year" and individual level rather than the administrative project year. SC batches them, for example for CY 2008, we'd follow the year's births that occur in the last 3 months of CY 2008 and the 1st 3-mo of CY 2009. Can we come up with one (or two) more standardized ways to count actual births averted? This will help calculate cost savings in a more logical and consistent way.

What group of women should be tracked for birth rate? How and how long should they be tracked?

There are 3 basic options:

1. Individual/cohort approach. Follow all women who enroll in a given demonstration year. For each enrollee, count the number of births occurring between 9 and 20 months following date of enrollment.
    a. Strengths – Using enrollees instead of participants improves validity of baseline birth rates as benchmark; method excludes deliveries before enrollment and births to women who were pregnant upon enrollment; and follows women across demonstration years (no missed births).
    b. Weaknesses – complex, i.e., time period for tracking varies by individual; for women who enroll in the last month of a demonstration year, final data would not be available until 23 months after the end of the demonstration year (12 months enrollment, 9 months pregnancy, 3 months for reimbursement claims to be filed).

2. Batch/lag approach. Follow all women who receive a waiver service in a given demonstration year. For all participants, count the number of births occurring during the last 3 months of that demonstration year and the first 9 months of the following year. Don't include any birth occurring before first waiver service in the demonstration year.
    a. Strengths -- This excludes most births to women who were pregnant before enrollment and includes virtually all of the deliveries to women who became pregnant during the demonstration year; final data would be available 12 months after the end of the demonstration year (allowing 3 months for reimbursement claims to be filed).
    b. Weaknesses – Potentially includes some births to women who were pregnant upon enrollment and misses some births to women who got pregnant during the last month of the demonstration year; misses all births to enrollees who do not receive a waiver service during a demonstration year even though the waiver paid for contraceptives used during the demonstration year (i.e., women who received 12 months of contraceptives in one year but get pregnant before the supply runs out in the following year).

3. Offsetting errors approach. Follow all women who receive a waiver service in a given demonstration year. For all participants, count the number of births occurring during the demonstration year, regardless of whether the birth precedes enrollment or receipt of waiver service. Assumption is that births occurring before enrollment offset births occurring after the end of the demonstration year (but due to pregnancies occurring during the demonstration year).

a. Strengths – Final data are available within 3 months after the end of the demonstration year (allowing 3 months for reimbursement claims to be filed).
b. Weaknesses – There is no evidence that births to women during the demonstration year (but due to pregnancies occurring before the demonstration year) are equal to births after the demonstration year (but due to pregnancies occurring during the demonstration year); particularly bad for programs that focus on enrollment of post-partum women..

To what benchmark should their birth rate(s) be compared?
Since women cannot be randomly assigned to receive waiver services or not, two quasi-experimental methods are possible.

1. Pre / post comparisons. This is currently used; pre-waiver birth rate(s) for a baseline year is calculated and post-waiver birth rate(s) for waiver participants is compared to the baseline birth rate(s).
    a. Strengths – Easily understood and applied; no complex adjustments for population differences needed.
    b. Weaknesses – Pre-waiver birth rate(s) includes all women in the target population (family planning users and family planning non-users) while the post-waiver birth rate(s) only includes family planning users; approach assumes that, but for the waiver, the baseline birth rate would continue without change – while this may be a reasonable assumption for a few years post-intervention, it is unreasonable to assume that, but for the waiver, the baseline birth rate would stay the same for more than 5 years. In addition to national trends that change over time, contraceptive methods and use are constantly changing.
2. Comparison group. A contemporary group with characteristics similar to the waiver participants (or that can be statistically adjusted to account for measured differences) is identified and birth rate data is collected for comparison to waiver participants.
    a. Strengths – Use of a contemporary comparison group adjusts for changes over time.
    b. Weaknesses – Significant differences between the comparison group and waiver participants may not be measurable; factors influencing birth rate may not affect both groups in the same way (especially true if another state is used for comparison).
3. When using quasi-experimental methods, often it is recommended to use more than one method. Using a three-year baseline trended by national birth rates to account for secular and population (age/ethnicity) trends would be better, but no "best" benchmark is obvious. Each state has its own issues, so not a one-size-fits-all solution.

How should women for whom the waiver covered a permanent method (sterilization) be counted?
While the expense of a permanent method might be offset by credit for an averted birth during that demonstration year, the benefit to Medicaid from future averted births is not counted (by definition, women with permanent methods are excluded from the waiver in future years). To include the benefits from averted births in future years, these women should be included in the denominator of birth rates for future demonstration years.

State Excerpts:

Alabama Family Planning Demonstration

- The demonstration aims to increase the number of women receiving comprehensive reproductive health services while reducing unintended pregnancy for Medicaid-participating, childbearing women with income at or below 133 percent of the Federal poverty level (FPL).
- BA = (base year fertility rate - fertility rate of demonstration participants during DY) x (number of demonstration participants during DY), where fertility rates will be measured per thousand. The base year fertility rate will be adjusted for age groupings, using the age distribution of the actual demonstration participants and predetermined age-specific fertility rates. Participants are all women who obtain one or more covered medical family planning service(s) through the demonstration. At its option, the State may also adjust the fertility rates for ethnicity.
- The base-year fertility rates must reflect fertility rates during 1999 for individuals in families with income up to 133 percent of the FPL. The fertility rates will include births paid by Medicaid.

Arkansas Family Planning Demonstration

- The demonstration will provide family planning services to uninsured women of child bearing age who have a net family income at or below 200 percent of the FPL who are not otherwise eligible for Medicaid, CHIP, the State's (HIFA) demonstration or any other creditable coverage for family planning services.
- BA = (base year fertility rate - fertility rate of demonstration participants during DY) x (number of female demonstration participants during DY). The base year fertility rate will be adjusted for age groupings, using the age distribution of the actual demonstration participants and predetermined age specific fertility rates. Participants are all women who obtain one or more covered medical family planning service(s) through the demonstration. At its option, the State may also adjust the fertility rates for ethnicity.
- The base-year fertility rate must reflect fertility rates during 1997 for individuals in families with income at or below 130 percent of the FPL and ineligible for Medicaid except for pregnancy. The fertility rates will include but are not limited to births paid for by Medicaid.

Illinois Family Planning Demonstration

- The demonstration will provide family planning services to uninsured women of child bearing age who have a gross family income at or below 200 percent of the FPL, who are not otherwise eligible for Medicaid, CHIP.
- BA = (base year fertility rate - fertility rate of demonstration participants during DY) x (number of female demonstration participants during DY). The base year fertility rate will be adjusted for age groupings, using the age distribution of the actual demonstration participants and predetermined age-specific fertility rates. Participants are all women who obtain one or more covered medical family planning service(s) through the demonstration. At its option, the State may also adjust the fertility rates for ethnicity.
- The base-year fertility rate must reflect fertility rates during 2001 for individuals in families with income at or below 200 percent of the FPL and ineligible for Medicaid except for pregnancy. The fertility rates *are* limited to births paid for by Medicaid.

Louisiana Family Planning Demonstration

- The demonstration aims to increase the number of women receiving comprehensive reproductive health services while reducing unintended pregnancy for Medicaid participating, childbearing women with income at or below 200 percent of the Federal poverty level (FPL).
- BA = (base year fertility rate - fertility rate of demonstration participants during DY) x (number of demonstration participants during DY), where fertility rates will be measured per thousand. The base year fertility rate will be adjusted for age groupings, using the age distribution of the actual demonstration participants and predetermined age-specific fertility rates. Participants are all women who obtain one or more covered medical family planning service(s) through the demonstration. At its option, the State may also adjust the fertility rates for ethnicity.
- The base-year fertility rate must reflect fertility rates during 2003 for women in families with income up to 200 percent of the FPL and ineligible for Medicaid except for pregnancy. The fertility rates will include births paid by Medicaid.

North Carolina Family Planning Waiver Program

- The demonstration aims to increase the number of women and men receiving comprehensive reproductive health services while reducing unintended pregnancy for non-Medicaid-participating, childbearing women with income at or below 185 percent of the Federal poverty level (FPL).
- BA = (base year fertility rate - fertility rate of demonstration participants during DY) x (number of demonstration participants during DY), where fertility rates will be measured per thousand. The base year fertility rate will be adjusted for age groupings, using the age distribution of the actual demonstration participants and predetermined age-specific fertility rates. Participants are all women who obtain one or more covered medical family planning service(s) through the demonstration. At its option, the state may also adjust the fertility rates for ethnicity.
- The base-year fertility rates must reflect fertility rates during Base Year 2003, for women in families with income at or below 185 percent of the FPL. They must be adjusted for the age for all potential demonstration participants. The fertility rates will include births paid by Medicaid.

South Carolina Family Planning Demonstration

- The demonstration aims to increase the number of women receiving comprehensive reproductive health services while reducing unintended pregnancy for Medicaid-participating, childbearing women with income at or below 185 percent of the Federal poverty level (FPL).
- BA = (base year fertility rate - fertility rate of demonstration participants during DY) x (number of demonstration participants during DY), where fertility rates will be measured per thousand. The base year fertility rate will be adjusted for age groupings, using the age distribution of the actual demonstration participants and predetermined age-specific fertility rates. Participants are all women who obtain one or more covered medical family planning service(s) through the demonstration. At its option, the State may also adjust the fertility rates for ethnicity.

- The base-year fertility rate must reflect fertility rates during 1993 for individuals in families with income up to 185 percent of the FPL. The fertility rates will include births paid by Medicaid.

Texas Women's Health Waiver

- The demonstration will provide family planning services to uninsured women from the ages of 18-44 with a net family income up to 185 percent of the FPL who are not otherwise eligible for Medicaid, the State Children's Health Insurance Program, Medicare, or have creditable health insurance coverage.
- BA = (base year fertility rate - fertility rate of demonstration participants during DY) x (number of female demonstration participants during DY), where fertility rates will be measured per thousand. The base year fertility rate will be adjusted for age groupings, using the age distribution of the actual demonstration participants and predetermined age-specific fertility rates. Participants are all women who obtain one or more covered medical family planning service(s) through the demonstration. At its option, the State may also adjust the fertility rates for ethnicity.
- The base-year fertility rate must reflect fertility rates during 2003 for individuals in families with income up to 185 percent of the FPL and ineligible for Medicaid except for pregnancy. The fertility rates will include births paid for by Medicaid.

Virginia Family Planning Demonstration

- The demonstration aims to provide family planning services to uninsured women losing their Medicaid eligibility 60 days after the birth of their child. These women are automatically eligible for women's health services for a maximum of 1 year after their Medicaid eligibility. The demonstration also aims to provide family planning services to men and women of childbearing age who are U.S. citizens with a net family income at or below 133 percent of the Federal poverty level (FPL).
- BA = (base year fertility rate - fertility rate of demonstration participants during DY) x (number of demonstration participants during DY), where fertility rates will be measured per thousand. The base year fertility rate will be adjusted for age groupings, using the age distribution of the actual demonstration participants and predetermined age-specific fertility rates. Participants are all women and men who obtain one or more covered medical family planning service(s) through the demonstration. At its option, the State may also adjust the fertility rates for ethnicity.

- The base-year fertility rate must reflect fertility rates during 2001 for individuals in families with income up to 133 percent of the FPL and eligible for Medicaid only because of pregnancy. The fertility rates will include births paid by Medicaid.

Dave Murday will be sending an email asking each state to review the three basic ways of doing the calculations and determining which way makes the most sense for their population and program conditions. We will compile these and finalize recommendations on our May call.

Next Call: Monday, May 10th from 1 until 2 PM EST. The call-in number is (919) 962-2740.