Family Planning Medicaid Waiver Evaluators Conference Call
March 12, 2012, 1:00-2:00 pm EDT

Participants

Evaluators: Janet Bronstein, Kari White (AL); Candace King (FL); Dave Murday (SC); Kristin Christensen (TX)

State Staff: Lyndolyn Campbell (GA): Regina Williams (LA); Bernie Operario, Andrea Phillips and Marcia Swartz (NC); Margaret Major (TN)

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

MINUTES

Approval of Minutes: Minutes of the February meeting were approved, without changes, for posting on the public side of the website.

Important Questions to Pursue Summarizing Waiver Successes:
We reviewed the chart that Janet initiated framing questions of interest according to four different audiences: state program managers, clinical providers, payors/insurers, and Federal government (CMS/administrators) and what we anticipate that they will be interested in. The question is, "*What have we learned from demo programs that we would want to see continued in the SPAs going forward?"* For example, taking extra effort to inform people of their coverage eligibility that made a difference in terms of utilization. It is a continuous new cohort and so, the issue of underutilization/access has been effectively addressed in some of our programs through outreach, communication, targeted marketing, and one-on-one contact. *Is this going to be continued under the SPAs?* We used to do presumptive eligibility and then went to annual eligibility. *Do we know what the impact of what that was?* In SC, we were doing 2-year eligibility at one point and Feds said to move back to one year… and we never assessed how "dialing back to one year made any difference. *Are there other states that want to investigate these issues further?* If so, we'd have a good set of conclusions and could make suggestions about stronger program components going forward.

Issue of Program Costs and Monitoring Factors Influencing Efficiencies:
Another central set of questions that have been tracked over time through the Waivers relate to cost and cost-effectiveness. *What are the costs of providing FP services, what drives those costs, and have we seen results in terms of desired outcomes (averted births, birth spacing, healthier birth outcomes for pregnancies? Do we serve the same people every year or are we always getting new people?* NC has seen that continuation rates (old data through HDs, HSIS, defined as 18 months) measures as patient rates for women over 20 and above had relatively high rates (>60%) Onslow and Wayne (military) were of state average. New system not reliable yet, but Title X and HD Medicaid clients had fairly high rates. Teen continuation rates fall in lower 40% range. In SC, we looked at using annual visits within 9-15 months subsequent… prior to waiver, rates were averaging 20%, and went up to 50-56%, and then started falling back so that in later years (by 2008) they were dropping to about 45% continuation. *Do we know why we saw*

these declines? Might be outreach was falling off? Program managers are not necessarily attuned to this, focused on following procedures and keeping in line with regulations and budget neutral. Thus the role of tracking services over time and evaluating program features.

Do We Have a Critical Mass of Data to Analyze?
Which states would we have? AL, SC, and maybe NC. FL may have data. FL program starts *post-partum* and then tracks forward for multiple years…it was one of our evaluation questions in FL, so yes, it would be of interest. AK may also have data. *Is there a cohort of women who are continuous? Is there a cohort who are intermittent?* Then, we would also want to look at where there are interruptions due to births. *Also, how was continued use and birth spacing related over time.* FL looked at birth spacing and outcomes in terms of cost savings.

Other Issues to Consider: Care Processes and Quality Indicators
Are there reductions in births due to effective contraception or is continued use effective? What is the most practical/acceptable definition for effective contra? We have been working on that, using Guttmacher's categories.

SC is looking at RWJ funding to evaluate the effect of contraction of FP (reduced funding for providing services) on use of effective methods; closing of Title X clinics and use of effective contraception.

Other Issues to Consider: Supplemental Counseling and Case Management
Only two states, AL and GA, would have data to evaluate on this. So we would be limited in terms of cross-state comparisons. But, it still might be interesting to compare between the two states, the use of supplemental counseling and case management and see if there is any effect on likelihood of contraceptive use. Most of the effective methods require a medical prescription so the process of using could be tracked through the clinic data files and bill that would be generated after such a visit. In other words, it's an 'askable' question.

Other Issues to Consider: Known Impact of FP on Subsequent Maternity Costs
Enrollees in program versus actual service users is often very low. Are they getting their SOBRA 60 days PP FP under that? In early days of SC we had close to 90% of eligibles enrolling, and now the proportion is way down, to 45%, less than half. *Was there an increase in births to eligibiles as decline in enrollment over time? Was it due to cutting back on outreach in SC, or what are the other changes over time that occurred? Were the "automatic" conversations from SOBRA not happening as well over time?* If women moved through reproductive years, with high rates of sterilization in South, or increase in use of IUDs and so not at-risk? Try and track by survey, but hard. Ask Food stamp population as proxy for enrollees about program awareness and have low rates… (JDeC, sorry, my notes are scanty on this and going forward)

Pricing of FP services: Insurers would want to know something about this. Hard to pool data due to wide range of methods of bundling services and costs. But is there anything we can say like formulary type approaches? Cost per user has roughly doubled over time, due to the costs side. The HD changed the way they billed.

Are any unnecessary services provided or is there overuse of services? Are there limits on care that can be received: Example in NC limit set at one annual exam and six FP visits per year. In LA, only 4 visits per year including Pap test are allowed. Some providers may give shots every 11 weeks, and may do a Pap when a shot isn't due, resulting in recipient running out of visits. We are evaluating internally to address the issue. GA also has a four-visit limit excluding annual exam. It would be useful to examine the number of visits when there is no cap, and what is the distribution of visits. Over use? Unintended pregnancies?

Users vs. non-users and are we reaching those most in-need? What should we be sure to retain in design of our SPAs going forward? SC had participation by CHCs and non-HD providers originally, but they declined dramatically over time (but may have just been our numbers down).

Will we see increase in provider types in ACA and what difference will it make? Will it expand access or substitute? We can look retrospectively to see how many have been FQHCs. In SC for example, very low numbers. Might be served at FQHC and not billing Medicaid.

Looking Forward: Boil list down to priority questions and then circulate for feedback both among the states to make sure feasible to do analyses and also to CMS, CDC to ensure questions are in line with each of their interests looking ahead.

The next call will be on Monday, April 9, 1 pm EDT (noon CDT) using the regular telephone number: (919) 962-2740.