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

Participants

Evaluators: Loretta Alexander and Ruth Eudy (AR): Candace King and Jeff Roth (FL); Kathleen Adams and Anne Dunlop (GA); Ginny Zawistowski (MN); Dave Murday (SC); Michelle Bensenberg and Kristin Christensen (TX)

State Staff: Brenda McCormick, Quantara Smith Williams, Dan Thompson and Regina Wiggins (FL); Bernie Operario and Andrea Phillips (NC); Margaret Major (TN); Alex Melis (TX)

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

MINUTES

Approval of Minutes: Minutes of the September meeting were discussed, with several comments and edits made before approval for posting to the public side of the web page.

This month the focus of our call was to continue discussion of our last set of indicators under review: Clinical Outcome Indicators. Representatives from Florida and Georgia offered to share measures they currently include in their Waivers related to clinical outcomes.

State level feedback on Clinical Indicators

Georgia (*FP Plus ICC Waiver*)
Ann Dunlop and Kathleen Adams from Georgia shared they have a two-tiered waiver; theirs is not the usual income- based expansion, but combination of income and risk. Their waiver has a sub-component, focusing on VLBW deliveries for eligibility. Their experience focusing on the VLBW population provided a nice lead-in to the related indicators we as a group are looking at that are birth-weight specific. Ann is a clinician, led a pilot program that culminated in design and approval of current waiver. Their waiver evaluation has been approved to analyze rates of VLBW and LBW as indicators of success especially for their IPP component. The thinking behind using these indicators showed reliability and robustness of numbers, with hopefully adequate power to draw inferences.

More background on GA waiver: general component is income-based (<200% of FPL) and then beginning Januray 1st 2011, any woman with VLBW delivery is offered thru Waiver: 24-mo PHC services up to 5 office visits, meds to control chronic condition, and case manager to assure appropriate use. We know GA VLBW babies only about 2% of births /yr but… 50% + of mortality. Number of women: 2,500 women / yr with VLBW. Vast majority of VLBW are first births, but 14% are repeat with high rate of recurrence, so we focus especially on the repeats. By focusing on delaying first pregnancies they expect to be able to impact VLBW and then focus on those who had had at least one, and trying to impact that group. Using Medicaid claims data for pre- and post-waiver to measure chronic conditions (asthma, Hypertension, diabetes) compared to a control State (pending). Looking at avoidable ER visits and hospital readmissions, so including those data for chronic conditions. They are also including general health and well-being indicators (smoking, changes in use of alcohol and drugs) through case management Resource Mother data collection. So, multiple data tracking sources: PRAMS, linked birth-death records, linked Medicaid claims. CMS was interested in inter-pregnancy interval, *repeat* VLBW group especially, as well as first time

VLBW. Limited expected numbers (including feto-infant mortality rates) with VLBW, nevertheless is included in evaluation. So, yes some power issues. We are looking at breaking out by residence in lower-income to higher income block groups. In another study, 6-state PRAMS evaluation among the Waiver states, had effect on inter-preg interval (6%) versus non-State controls.

About 1,400 women expected to be eligible in a given year. Working closely with NICU and other providers serving Medicaid to amp up efforts for recruitment and enrollment. *Right from the Start* Medicaid clients are automatically enrolled pre-delivery (200% FPL). Bigger challenge is reaching primapara and those not in public assistance program. Also the non-users or those FP users using less-effective methods.

Florida ("traditional" *FP Waiver*)
Jeff Roth shared some results from FL on their BW data. He pointed out that in Florida, PTB and LBW while indicators that are highly correlated with program success, require two-three year delay to see effect for those *participants* vs *non-participants* (as opposed to eligibles, or enrollees). Both indicators are important in that they have long-term effects (health later in life and long-term sequelae, precipitating chronic conditions in adulthood. So while 2% VLBW may appear trivial, case to be made beyond early adverse outcomes for infants and immediate high-cost hospital bills. FL evaluation included LBW to have comparable data in groups, one bumped out of SOBRA but included in FP versus others with both SOBRA and FP coverage. Women who used services had improved (8.4 versus 9.6) rates of LBW, controlling for background characteristics (age, race, educ, marital status, pre-preg BMI, plurality, smoking, and PNC). Lower odds of LBW for participants (13%) and adjusted odds 8% lower for LBW for participants. Literature in summary includes useful justification for studying relatively rare outcomes that are very serious with both immediate elevated effects but also life-long risks.

Both States show that for clinical indicators that are relatively routine, each has approached as a special study…but would they be possible to consider as routine data collection to account for comparison groups and controlling for confounding/adjust. Will / can this lead to basic reporting requirements that would be applicable more broadly (other States, larger populations, less vulnerable groups)?

Will this be new (useful) information, given past research and studies? Yes, it would be, if indeed we could show clear effect. Causality not very well established in past work, so we may have opportunity to demonstrate the associations… but we will need to assure strength of pathways and utilization of services to determine direct effects. Not to mention the changing landscape of health care. Once (if) we categorize different forms of contraception, can we show correlated effects on pregnancy intervals, and healthy outcomes? Questions may be more, not whether it worked, but *how* did it work? Increased use rate? Or moved to more effective methods? Did CMS move to SPA because of financial reasons (shown to be budget neutral)? If you offer targeted services to a specialized, high-risk population (as in Georgia program), do you get further cost-savings? Also how to quantify benefits of contraception and ICC, within States, for some of the longer-term management of chronic conditions? Remaining issues are how to keep things working? Where do we put our scarce resources? How do we move to actual birth and maternal outcomes? A shot-gun approach works, but how to refine and boost efficiency? Increase reach. What gets women into program, and helps most with least cost?

Some participants on the call mentioned studies underway or recently completed that they will reference and share with the group in the near future.
Update: thank you to Loretta Alexander (UAMS) for sharing the following:

Preemies May Be at Higher Risk of Epilepsy Later in Life. C Crump and S Gedela (Children's Hospital, Pittsburgh). Neurology Oct. 4, 2011.

Preemies at Risk for Psychiatric Disorders as Teens. (Columbia Univ Medical Center, news release, July 14, 2011)

Problems From Preterm Birth May Return in Adulthood. C Crump and K Bromberg. JAMA Sept. 21, 2011.

After a full discussion, the meeting was adjourned, due to time. We will return to the discussion in November, taking into account the data and experiences in Georgia and Florida, and consider the benefit and mechanism of how/if we might want to compile data collectively across our programs.

Other Business:

From September minutes: Adam (Sonfield) noted that almost no states are now collecting LBW or PTB data but most are collecting some sort of birth interval data. Lots of variability both in terms of time interval included and also big range of comparison groups.

We would like to review information from the Office of Population Affairs (OPA) and the Centers for Medicare and Medicaid Services (CMS).
1) Is OPA coordinating its revision of Title X Performance Measures with Medicaid Waiver staff at CMS?
2) Since CMS moved away from budget neutrality, what indicators are they using to measure progress?
3) Is OPA considering changes to the indicators we have been talking about?
4) Does CMS think that some of the clinical indicators OPA is looking at might also be useful to CMS?

Update on OPA/CMS Review of Program Indicators
We did not have time this call to get to update on OPA and indicators being tracked from Title X Family Planning Program related to service delivery, program effectiveness, and improved health outcomes. Julie is adding these to our minutes for review and discussion on our November call. (Update Nov 2nd: Julie spoke with Laurie Gavin and she is interested in our process and what indicators we are focusing on for the waivers. She will try and join our November call). Here is some background. See also Webinar slides she and Susan Muscosky presented for more details on their current work.

There are two separate but related efforts underway relevant to work we are doing on tracking indicators of public FP services and users.

1. OPA through its Office of Family Planning (led by Susan Muscosky) is partnering with CDC through its Div of Repro Health (led by Lorrie Gavin) to Revise Title X Program Guidelines. While overall effort is mostly reviewing content and infrastructure of overall program, one area includes indicators to track progress, both process and outcome/impact.
    - Process began in April 2010 with Expert Panel convening to establish and undertake the revision process, and will be completed with new guidelines being released by Fall 2012.
    - First step involved review of evidence in six domains:
        . Community Outreach and Barriers to Access;
        . Participation / Utilization;
        . Contraception Counseling and Education;
        . Adolescent Services;

    - Clinical Services for Females and Males;
    - Quality Assurance and Quality Improvement.
- The end goals:
    - Produce evidence-based / evidence-informed Title X Program Guidelines that also provide a service/contribution to the greater reproductive health community
    - Create a process/mechanism for keeping the Guidelines current
    - Use the review of evidence, and the gaps identified, to inform OPA's future research efforts

Our November call will continue discussion on final measures for clinical and fertility outcomes that we will be using and decisions about most useful activities going forward for both SPA and Waiver states.

The next call will be on Monday, November 14, 1 pm EDT (noon CDT) using the regular telephone number: (919) 962-2740.