

MEMO



TO Interested parties

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SUBJECT CMS study of Medicaid family planning waiver programs

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A total of 18 states currently have programs approved by the federal Centers for Medicare and Medicaid Services (CMS), commonly known as “waivers,” that allow the states to expand eligibility for Medicaid-covered family planning services to individuals who otherwise would not be eligible for such care—that is, to low-income individuals whose family incomes are between the state’s regular Medicaid eligibility ceiling and a somewhat higher income ceiling set by the state for the waiver program. In September 2002, CMS contracted with the CNA Corporation to conduct the first national evaluation of Medicaid family planning waiver programs. CNA partnered with the Schools of Public Health at Emory University and at the University of Alabama at Birmingham to conduct the research.

The study sought to address four major questions: whether the programs were “budget neutral,” as required by CMS; whether they increased access to and use of family planning services among the targeted group of eligible low-income women; whether they were associated with measurable reductions in unintended pregnancy in the state; and whether they resulted in an overall increase in family planning expenditures or substituted for other sources of family planning funds.

Fourteen states had waiver programs in operation at the start of the study. Of these, eight were selected to participate in the effort, with six states participating in the analysis of the first two issues and a different set of six states participating in the analysis of the last two issues.

Detailed findings of the study, which was distributed to Title X program grantees on January 16, are discussed below. In summary, however, the report makes the following conclusions:

- All six waiver programs looked at for this question not only met but exceeded the budget neutrality requirement: “Savings from averted births exceeded [the] cost of family planning coverage when the proposed model budget neutrality formula was applied.”
- Use of family planning among the target population increased in some, but not all, states included in this analysis.
- Diversity of family planning providers increased in five of the six states studied and geographic access increased in all states.

- Measurable reductions in unintended pregnancy associated with the waivers were seen in some, but not all, of the states studied.
- Total expenditures for family planning increased in all states studied, although most states used waiver funds to partially substitute for other sources of family planning funding.

Budget Neutrality

The first question addressed by the study was whether the family planning waiver programs were budget neutral, that is, whether the federal share of the cost of covering family planning services was less than or equal to the federal savings accrued by preventing unintended pregnancies in the targeted population. (CMS requires that all Medicaid waiver programs, including the family planning waivers, be budget-neutral to the federal government.) In determining whether the family planning waivers met this requirement, the researchers were specifically tasked by CMS with developing a single set of requirements for the budget-neutrality calculation that could be applied to family planning waiver programs. These requirements would replace the current patchwork, in which different states are operating under different requirements for calculating budget neutrality, depending on when their waiver applications were approved by CMS.

The researchers made several specific recommendations concerning the budget-neutrality formula, including the following:

- A three-year average should be used for baseline data, rather than one year of data, and the calculation should be made in a way that most accurately reflects the population eligible for the program;
- The formula for counting actual births should exclude births that occur within nine months of a client's enrollment date, in order to avoid counting pregnancies that began prior to enrollment but include births through nine months after the end of the program;
- Savings should be based on the average costs of maternity care and health care coverage for infant during the first year of life (rather than the first five years, as is being done in some states); and
- Averted births should be estimated using the number of women enrolled in the program, rather than the population of program participants.

With regard to the last recommendation, the report argues strongly that the calculation should be based on estimated births averted to enrollees rather to participants: "The enrollee population is more demographically similar to the general population of childbearing women eligible for Medicaid, and it includes a mix of users and non-users of family planning services, as does the general population. In addition, tracking births over the entire enrolled population strengthens

the incentives for the states to improve access to and use of family planning services for all enrolled women.”

When these guidelines were used, all six state programs resulted in savings that outstripped their costs, both overall and for the federal government. Accordingly, they not only met but also exceeded the CMS budget-neutrality requirement. Indeed, as indicated in the table below, the researchers found the number of births averted and the resulting savings to both the federal and state governments to be substantial.

Net Savings from Waiver Program					
State	Year	Births averted	Total	State Share*	Federal Share
Alabama	2000-2001	3,612	\$19,028,783	\$6,981,721	\$12,047,062
Arkansas	1997-1998	2,748	\$15,524,056	\$5,199,426	\$10,324,630
	1998-1999	4,486	\$29,748,208	\$9,411,954	\$20,336,254
California	1999-2000	21,335	\$76,182,694	\$64,314,302	\$11,868,392
New Mexico	1998-1999	507	\$1,334,435	\$652,918	\$681,517
Mexico	1999-2000	1,358	\$5,009,165	\$2,037,590	\$2,971,575
	2000-2001	1,528	\$6,510,909	\$2,650,439	\$3,860,470
Oregon	2000	5,414	\$19,756,294	\$11,077,646	\$8,678,648
South Carolina	1994-1995	2,228	\$13,634,174	\$4,135,453	\$9,498,721
	1995-1996	3,151	\$19,615,968	\$6,201,946	\$13,414,022
	1996-1997	3,769	\$23,066,926	\$7,403,462	\$15,663,464

*Calculated by The Alan Guttmacher Institute.

Access to Family Planning Services

In order to address access, the study subdivided the issue into four questions, as described below.

(1) Did the waiver programs serve a larger portion of the targeted population of low-income women than had Title X programs served previously?

The analysis focused on clients served in “Title X programs”—that is, those women served by providers that receive some funding under the federal Title X program. Nationwide,

approximately six in 10 agencies providing family planning services receive some Title X funding, according to research conducted by The Alan Guttmacher Institute.

The study found that client counts under the waiver in four of the six states (California, Oregon, Arkansas and Alabama) exceeded the total number of clients served previously in those clinics who would have been eligible under the waiver had it been in place. (In California and Oregon, the number of waiver clients quickly surpassed previous levels of comparable low-income clients served; in Arkansas and Alabama, counts reached that level more gradually.) Waiver clients in New Mexico and South Carolina never reached prior levels. The researchers suggest, however, that this could be the result of eligible women being served with other dollars, rather than being enrolled in the waiver program. As a result, the researchers were able to conclude that overall use of family planning services among the targeted population increased in some, but not all, states.

(2) What proportion of eligible clients enrolled in waiver programs, and what proportion obtained services?

The actual penetration of the waiver program is a function of two variables: the extent to which eligible women enroll in the program *and* the extent to which program enrollees actually use services. These two variables can be combined into a single measure of the proportion of all women estimated to be eligible for the program who actually use services. This proportion varies widely across states:

	<u>In 2001, proportion of</u>		
	<u>Eligible Women Enrolled</u>	<u>Enrollees Using Services</u>	<u>Eligible Women Using Services</u>
Alabama	45%	49%	22%
California	69%	71%	48%
New Mexico	26%	31%	8%
Oregon	56%	100%*	56%
S. Carolina	46%	50%	23%

*Oregon enrolls only program users, so enrollment is 100% by definition.

The California figures are particularly interesting because they may well reflect the unique provider determined eligibility provisions in this state. Under this arrangement, providers may certify eligibility for the program at the point of service, a process that greatly streamlines the enrollment process.

With the exception of New Mexico, the waiver efforts appear to be reaching a significant proportion of those eligible. This finding is especially significant because these programs are all income-based and have as their target populations individuals who may have no previous connection to Medicaid whatsoever. Past experience with Medicaid expansions has shown that this is a particularly difficult population to reach.

(3) Did the waiver programs result in additional diversity in the provider population in a state?

California and Oregon (interestingly, the two states that showed high levels of use under the previous two questions) reported the most significant flow of clients to private-sector providers. Again, this might be a result of the design of the program. One of the specific goals of the California program was to increase utilization of private-sector providers. This was not as evident in the other four states, again, potentially because of the structure of the programs. In South Carolina and Arkansas, for example, the waiver programs were organized around the existing Title X provider network.

(4) Did family planning services become more geographically available throughout the states following implementation of a waiver program?

To determine geographic availability, the researchers divided each state's population into five segments, based on the zip code or county of residence. They then counted the number of providers in each type of these population categories. This allowed them to examine the relative availability of providers to the 20% of the population in the areas with the lowest enrollee density to the 20% of the population in the areas with the highest population density.

The report concluded that the geographic availability of physicians and non–Title X clinics increased with waiver implementation in all of the six study states. These increases were especially apparent in those geographic areas with fewer enrollees. The relative geographic availability of services, however, did not appear to be related to measurable increases in the use of family planning services under all of the waiver programs. In three states—Alabama, Arkansas and South Carolina—the improvements in geographic availability of private-sector providers was not associated with dramatic growth in clients utilizing these providers. The researchers speculate that while private practices are now more widely open to Medicaid clients, they do not serve a sufficient volume to make a major difference in use patterns. This did not appear to be the case in Oregon and California, where increases in geographic availability did co-occur with an increase in actual use of private-sector providers.

Impact on Unintended Pregnancy

Using data from a broader range of states, the researchers reported some evidence of an impact of the waiver programs on the incidence of unintended pregnancy among the larger population of low-income women in the state. Unintended pregnancy appeared to decrease in Florida and, although to a somewhat lesser extent, in South Carolina. The researchers caution that for this analysis, they were able to use data only for the entire population in the state estimated to be eligible for the waiver programs. This was an imperfect measure since, as discussed above, not all individuals who are eligible actually enroll and utilize services under the programs: “For states to see an effect on outcomes such as unwanted pregnancy in this larger population of women is commendable. If they are not seeing such effects, they could consider the eligibility structure of their demonstration and its penetration into the eligible population. Demonstrations

that cover all low-income women, for example, will likely reach more of the expansion-eligible women in a given year than those that cover only post-partum women. Given the eligibility structure of the demonstration, a higher enrollment of uninsured eligible women and a greater use of effective contraceptive services will lead to a greater likelihood that the state will see an effect on unwanted pregnancies.”

Substitution of Funding Sources

The final question addressed by the study was the extent to which funding through the waiver program supplanted funding through other federal or state funding streams. Significantly, the researchers found that all states increased the total amount of dollars spent on family planning services per woman, sometimes to a significant extent. However, the researchers also concluded that the waiver funding did in fact substitute to some extent for other state-controlled public funding (either federal or state) in five of the six states examined for this purpose. To address this issue, the researchers argue that states should be encouraged to maintain their level of contribution prior to the implementation of a waiver program. Such a maintenance-of-effort requirement could help ensure that a waiver program would be a true expansion of effort.