

Texas Health and Human Services Commission

**Women's Health Program
Annual Report 2008
January 1, 2008 – December 31, 2008**

**1115(a) Research and Demonstration Waiver
Family Planning Project Number 11-W-00233/6**

Table of Contents

I.	Program Overview	1
II.	Discussion of Significant Activities for the Year	2
III.	Evaluation of Performance Measures	5
IV.	Assessment of Eligibility Determinations.....	12
V.	Conclusion	14
	Appendices	17
	Appendix A : Number of Women who Received WHP Services by Quarter	17
	Appendix B : WHP Procedures Most Used in 2008.....	17
	Appendix C : Disenrollment from WHP in 2008	18
	Appendix D : Cost Neutrality Definitions.....	18
	Appendix E : Birth Rate Calculation for DY1	20
	Appendix F : Birth Rate Calculation for Hispanic Women for DY1.....	21
	Appendix G : Cost Neutrality Calculation for DY1	22

I. Program Overview

The Texas Women's Health Program (WHP) is a Section 1115(a) demonstration waiver approved by the U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) on December 21, 2006. The demonstration started January 1, 2007, and will end December 31, 2011. The Texas Health and Human Services Commission (HHSC) Medicaid/CHIP Division is managing the demonstration.

WHP is designed to enhance women's health care services by increasing access to Medicaid family planning for women who have limited health care resources. Benefits of the program include an annual family planning exam, contraceptives, and related health screenings. The target population is uninsured women ages 18 to 44 with a net family income at or below 185 percent of the federal poverty level (FPL) who would not otherwise be eligible for Medicaid.

WHP includes three key interventions intended to increase the target population's access to Medicaid family planning services:

- extending eligibility for Medicaid family planning services to uninsured women aged 18 to 44 with a net family income at or below 185 percent FPL who would not be eligible for Medicaid without this program;
- minimizing the obstacles to enrollment for Medicaid family planning services by simplifying the provider enrollment process, implementing an adjunctive eligibility process through accessible statewide health and human services programs, and providing continuous eligibility for 12 months; and
- piloting culturally appropriate outreach efforts to Spanish-speaking/Hispanic populations.

Expansion of family planning services will reduce the number of unintended pregnancies among low-income women unable to afford counseling, contraception, and services. Currently, less than 20 percent of eligible women have access to publicly funded family planning and related preventive services through the Texas Department of State Health Services (DSHS) family planning services. The unmet need contributes to high birth rates among low-income women.

Improving access to contraception and providing counseling on the spacing of births through WHP is expected to minimize the overall number of births paid for by Medicaid. For women whose poverty limits their access to health care services, WHP could reduce the number of infant deaths and premature and low-birth-weight deliveries attributable to closely spaced pregnancies.¹ Improved access may also reduce future disability costs for children arising from premature and low-birth-weight deliveries.

¹ The Johns Hopkins Bloomberg School of Health, "Birth Spacing: Three to Five Saves Lives." Online. Available: <http://www.infoforhealth.org/pr/113/113.pdf>. Retrieved June 7, 2005.

II. Discussion of Significant Activities for the Year

The following is a summary of the significant activities undertaken from January 1, 2008, through December 31, 2008.

Milestones

- On April 7, 2008, HHSC opened a call center with newly hired WHP-dedicated staff to provide better assistance to WHP clients and providers.
- On July 7, 2008, HHSC submitted a waiver amendment to CMS requesting the addition of certain benefits to the program. The waiver amendment was approved on December 31, 2008. The waiver amendment added the following benefits to WHP:
 - An office visit
 - Radiology exams
 - An implantable contraceptive device
 - A thyroid stimulating hormone test
 - Herpes tests
 - A non-surgical sterilization method
- On October 17, 2008, HHSC re-convened the WHP outreach workgroup, which is comprised of various internal and external stakeholders, to help determine outreach strategies for the 2009 state fiscal year. After the meeting, HHSC began implementation of the 2009 outreach plan based on the input from stakeholders and the feasibility of each outreach strategy.

Program Enrollment

A total of 82,728 women were enrolled in WHP at the end of the fourth quarter of 2008, and an unduplicated total of 144,040 women were enrolled at some point during 2008.² Since implementation on January 1, 2007, an unduplicated total of 152,489 women have been enrolled in the program at some point.³

Services

A total of 58,982 women received services in the first year of the demonstration, and at least 75,809 women received services in the second year of the demonstration.^{4,5}

Appendix A presents the number of women who received WHP services each quarter in 2007 and 2008. The services most frequently used in WHP in the second year of the demonstration include family planning visits, contraceptives, and pregnancy tests. Appendix B lists the top ten services used in WHP in 2008.

Disenrollment

² The 2008 unduplicated total includes 2007 enrollees who were also enrolled in 2008.

³ Source: Texas Medicaid and Healthcare Partnership (TMHP) Ad Hoc Query Platform Client Universe, retrieved on January 22, 2009.

⁴ Source: Texas Medicaid and Healthcare Partnership (TMHP) Ad Hoc Query Platform Claims Universe retrieved on January 26, 2009.

⁵ The number of services received in the second year is approximate due to a lag in Medicaid claims data.

Texas Women's Health Program 2008 Annual Report to CMS

There were a total of 74,326 disenrollments from WHP in 2008, reflecting an unduplicated total of 73,902 women. The majority of the women were disenrolled because their 12-month enrollment certification period ended. The second most common reason for disenrollment was enrolling in another Medicaid program, Medicare, or to State Children's Health Insurance Program (CHIP). Appendix C provides the number disenrolled and the reason for disenrollment by quarter.

Program Staffing

Since implementation of the demonstration, HHSC has increased WHP-dedicated staff to process applications and determine eligibility in WHP. Last year, at the end of the fourth quarter of 2007, HHSC had three units dedicated to processing eligibility in WHP, and 60 full time equivalent (FTE) positions. At the end of the fourth quarter of 2008, HHSC had 92 FTEs and six units dedicated to processing eligibility in WHP, with half of the units working on initial applications and half working on renewal applications.

Applications, Renewals, and Eligibility Determinations

HHSC received 26,208 initial applications for WHP clients in the third quarter and 27,126 in the fourth quarter, bringing the total number of initial applications received in 2008 to 116,021. The total number of renewal applications received in 2008 is 22,186. HHSC processed 125,240 applications for WHP in 2008.⁶ At the end of the fourth quarter, 93 percent of eligibility determinations occurred within HHSC's 45-day processing timelines. On average, about 95 percent of the eligibility determinations occurred within the 45-day processing timelines in 2008. Hurricane Ike, which struck the Texas Gulf Coast region in September, impacted the workload and duties of eligibility staff. Because HHSC focused on hurricane response activities, WHP application processing timeliness declined in the fourth quarter and reduced the overall timeliness for the year.

From the start of the demonstration, eligibility staff has been checking the Bureau of Vital Statistics (BVS) site for birth records for in-state applicants in order to avoid pending WHP applications for missing documentation. Still, a significant percentage of applications received have been pended due to incomplete information or missing documentation. Applications are pended most frequently due to missing documentation of citizenship, particularly for those born outside of Texas whose information is not accessible through BVS. Since implementation, HHSC has taken several steps to help providers collect more of the required documentation—including encouraging the verification of citizenship at the time of the client's appointment—so that fewer applications will be pended, application processing will be faster, and fewer women will be denied.

Provider Participation and Training

All enrolled Medicaid providers that can perform family planning services within their scope of practice are eligible to provide services under WHP. HHSC does not have a separate provider enrollment process for WHP.

⁶ Health and Human Services Commission TN-01 Report, January 2009.

Texas Women's Health Program 2008 Annual Report to CMS

In January and February 2008, HHSC participated in Family Planning Community Participation Meetings hosted by the Department of State Health Services (DSHS) in San Antonio, Houston, Dallas, Lubbock, and Brownsville. In April, June, and September, HHSC and DSHS staff also participated in a series of Family Planning Provider Partnership Project meetings in Austin hosted by the Women's Health and Family Planning Association of Texas with providers participating from all over the state. These sessions and meetings gave HHSC an opportunity to hear directly from family planning providers about the ways WHP and DSHS family planning programs impact providers and clients, and to discuss how the programs could be improved.

In May, HHSC staff participated in a speaker panel in San Antonio, Texas, about women's health issues and provided an overview of WHP at the Texas Medical Association Select Committee on Medicaid, the Children's Health Insurance Program, and the Uninsured. In August, HHSC conducted a web-based interactive training for providers across the state. Topics included a program overview, provider base, eligibility criteria, application, benefits, referrals, resources, and updates. In December, HHSC participated in the 2008 Annual Project Directors' Conference for DSHS family planning contractors. The purpose of the conference was to provide national and state program updates, review federal and state requirements, provide training on program priorities and requirements, and give family planning providers the opportunity to network and share their issues and concerns.

HHSC staff continues to train providers throughout the state on location at provider conferences and through teleconference, webcast, website and e-mail updates, as well as articles in the Texas Medicaid Bulletin.

Client-Directed Outreach Activities

HHSC used several approaches to reach out to WHP clients in the second year of the demonstration. In June, HHSC modified the WHP brochure with a clearer description of the program's benefits. HHSC printed 250,000 bilingual brochures (one side in English, one side in Spanish) and made them available to community-based organizations and providers serving WHP clients. In August, HHSC printed and shipped 150,000 updated alternative client flyers for organizations that do not provide contraception (such as Catholic Charities). In addition, HHSC sent approximately 1,000,000 notices about WHP to women whose children are on Medicaid with their children's Medicaid identification card. The notices include basic program information and direct potential clients to the WHP call center for more detailed information about the program and how to apply. All client-oriented information and materials on the website are provided in English and Spanish and can be found at:

<http://www.hhsc.state.tx.us/WomensHealth/WHPForms.html>.

HHSC and DSHS regional staff, as well as the Texas Medicaid and Health Care Partnership (TMHP), promoted WHP at more than 100 community events and meetings around the state. Regional staff provided outreach and education about WHP to local governmental groups, community organizations, and providers.

Targeted Spanish-speaking /Hispanic Outreach

People who speak Spanish as a primary language comprise the state's largest hard-to-reach group for health services. Hispanic women are one of the largest growing populations in the state of Texas, have high fertility rates, and may prefer to speak in Spanish. These variables make it both essential but challenging to bring these women into the demonstration project.

HHSC made special efforts to reach the Hispanic community through transit bus advertisements for a targeted market with lower than anticipated program enrollment and a large Spanish-speaking/Hispanic population. Twenty-eight large, one-sided panels and 56 placards (in both English and Spanish) ran in buses with routes in the Northeast and South areas of Dallas beginning July 2008. Dallas was chosen as the pilot location because Dallas County had a low percentage of eligible women enrolled compared to the rest of the state and a high percentage of Spanish-speaking/Hispanic residents. The site was also chosen because the Dallas-area transit system had the required advertisement capability and local providers had sufficient capacity to serve new clients. HHSC saw an increase in call volume and applications from the Dallas area during the summer months, but it is uncertain how much of the increase was due to the transit advertisements.

HHSC regional staff also provided information about the program to groups such as the Office of Border Affairs, the Texas Migrant Council, and the HHSC Colonias Initiative group. All materials intended for client use are in both English and Spanish.

Next Demonstration Year

- HHSC will continue to implement the state fiscal year 2009 outreach plan.
- HHSC will seek technical assistance from CMS on the evaluation of primary care referrals.
- Legislation passed during the 81st Texas Legislative Session may have an impact on WHP services, outreach activities and enrollment, and may require federal approval to implement.

III. Evaluation of Performance Measures

Design

Management and Coordination

The Evaluation Department of the HHSC Center for Strategic Decision Support (SDS) evaluates the WHP demonstration. The Evaluation Department includes professional evaluators with expert knowledge of the HHSC data systems and unlimited access to the data. In addition to the Evaluation Department, SDS includes the demographers who provided population data for the evaluation.

Texas Women's Health Program 2008 Annual Report to CMS

Performance Goals

As specified in the demonstration waiver requirements, HHSC has identified ten specific performance goals intended to positively impact the target population.

Goal 1: Increase access to Medicaid family planning services.

Goal 2: Increase Hispanic women's access to Medicaid family planning services.

Goal 3: Increase the use of Medicaid family planning services.

Goal 4: Provide WHP participants diagnosed with a medical condition not covered by the family planning benefit package with referrals to appropriate health providers.

Goal 5: Reduce the number of births.

Goal 6: Reduce growth rate of Medicaid-covered Hispanic births.

Goal 7: Increase the spacing between pregnancies to an interval of 24–59 months among WHP participants with a prior birth.

Goal 8: Reduce the number of low-birth-weight deliveries.

Goal 9: Reduce the number of premature deliveries.

Goal 10: Reduce Medicaid costs expended for pregnancy, prenatal care, delivery, and infant care.

Hypotheses

HHSC has four hypotheses about the outcomes of the WHP demonstration.

Hypothesis 1: WHP participants will have a lower birth rate than would have been expected without WHP.

Hypothesis 2: Hispanic WHP participants will have a lower birth rate than would have been expected without WHP.

Hypothesis 3: WHP participants will be more likely than similar women who did not participate in WHP to increase the spacing between pregnancies to an interval of 24–59 months.

Hypothesis 4: A lower birth rate among WHP participants will reduce Medicaid expenditures for pregnancy, prenatal care, delivery, and infant care.

Texas Women's Health Program 2008 Annual Report to CMS

Timeline for Report Data

Data collection for the WHP evaluation began on the first day of the WHP demonstration and will be collected throughout the demonstration. This annual report includes Medicaid eligibility and claims data from January 1, 2008, through December 31, 2008. It also updates the report with 2007 data that, due to data lags, were finalized after the 2007 annual report was submitted to CMS.

Analysis

The evaluation of WHP is guided by the performance measures submitted to CMS in the Evaluation Plan. The performance measures include descriptive measures that provide information about WHP implementation. They also include outcome measures for WHP participants and women in appropriate comparison groups. The evaluation tests HHSC's hypotheses about WHP outcomes by comparing outcomes for WHP participants to those for the comparison group using appropriate analysis techniques.

The performance measures and the hypothesis tests will be used to identify demonstration successes and opportunities for improvement, to revise the WHP strategy or goals if necessary, and to develop recommendations for improving WHP and similar programs in other states.

Two data sources critical to the evaluation are subject to lags in data availability:

- **Monthly Medicaid claims files.** Although the monthly Medicaid claims files include all claims paid during the month, they do not include claims for all services provided during the month. There is a lag between the time the service is provided and when the claim is submitted and paid. Most claims are submitted and paid within three months of the service date, but some claims are submitted and paid much later.
- **Bureau of Vital Statistics (BVS) birth records.** BVS birth records will be used in this evaluation to determine which deliveries were low birth weight and which were premature. There is a lag of approximately five months between the date of birth and the date the preliminary birth record is available through BVS.

The annual performance measures are based on the data available at the end of the demonstration year. This report on the second year of the demonstration addresses all of the performance goals except for Goal 8, reducing the number of low-birth-weight deliveries and Goal 9, reducing the number of premature deliveries. These goals require the use of BVS birth records data that are not yet available due to the five-month lag. Goals 5, 6, 7, and 10, based on Medicaid claims for births, are addressed for the first year of the demonstration. These goals cannot be addressed for the current year of the demonstration due to the nine-month lag between pregnancy and birth and the three-month lag in Medicaid claims data and will be updated in the next annual report.

Texas Women's Health Program 2008 Annual Report to CMS

Goal 1: Increase access to Medicaid family planning services.

At the end of 2008, 82,728 women were enrolled in WHP. WHP enrollees were not eligible for Medicaid family planning services prior to WHP, so all enrollments in WHP represent an increase in access to the services. The enrollment in WHP from January 2007 to December 2008 is shown in Table 1. The monthly numbers represent the total enrollment during that month, taking into consideration new enrollments and disenrollments. The number of clients enrolled in WHP in recent months is incomplete due to the lag in the Medicaid eligibility data and is anticipated to increase.

Table 1: Women's Health Program Enrollment

Month	2007	2008
January	9,424	89,107
February	18,850	81,633
March	28,532	80,178
April	37,150	80,481
May	45,636	80,436
June	52,750	80,536
July	58,803	80,973
August	65,155	81,799
September	70,585	82,713
October	76,590	83,620
November	81,037	84,368
December	84,899	82,728

Source: Texas Medicaid and Healthcare Partnership (TMHP) Ad Hoc Query Platform Client Universe, retrieved on January 22, 2009.

Goal 2: Increase Hispanic women's access to Medicaid family planning services.

At the end of 2008, 42,101 Hispanic women were enrolled in WHP. The enrollment of Hispanic women in WHP also indicates an increase in their access to Medicaid family planning since they were not eligible for these services prior to implementation of WHP. The enrollment of Hispanic women in WHP from January 2007 to December 2008 is shown in Table 2. The number of clients enrolled in WHP in recent months is incomplete due to the lag in the Medicaid eligibility data and is anticipated to increase.

Table 2: Hispanic Women's Health Program Enrollment

Month	2007	2008
January	5,013	45,328
February	10,099	41,198
March	15,200	40,419
April	19,707	40,579
May	24,057	40,558
June	27,548	40,655
July	30,381	40,901

Texas Women's Health Program 2008 Annual Report to CMS

August	33,478	41,434
September	36,216	41,981
October	39,228	42,486
November	41,400	42,923
December	43,241	42,101

Source: Texas Medicaid and Healthcare Partnership (TMHP) Ad Hoc Query Platform Client Universe, retrieved on January 22, 2009.

Goal 3: Increase the use of Medicaid family planning services.

An unduplicated total of 75,809 women had a paid Medicaid claim for WHP services received in 2008. Therefore, 52.6 percent of the unduplicated total of 144,040 women enrolled in WHP in 2008 received WHP services in the second year of the demonstration.^{7,8} The monthly number of WHP clients with a paid claim is shown in Table 3. The numbers for recent months are incomplete due to the lag in the Medicaid claims data and will increase substantially.

Table 3: Number of Women's Health Program Clients with a Paid Claim

Month	2007	2008
January	5,867	13,101
February	6,932	11,400
March	8,259	11,980
April	9,198	13,058
May	10,200	11,896
June	9,668	12,365
July	9,851	13,001
August	10,901	12,089
September	9,672	13,124
October	11,846	13,737
November	10,384	10,268
December	10,326	8,996

Source: Texas Medicaid and Healthcare Partnership (TMHP) Ad Hoc Query Platform Client Universe, retrieved on January 26, 2009.

Goal 4: Provide WHP clients diagnosed with a medical condition not covered by the family planning benefit package with referrals to appropriate health providers.

HHSC requires providers to refer WHP clients diagnosed with a medical condition that is not covered by the waiver to the appropriate health care providers. Table 4 shows the number of WHP clients that received services through Title V (The Maternal and Child Health Services Title of the Social Security Act), Title X (Family Planning Services and

⁷ Medicaid claims data for 2008 are incomplete.

⁸ Enrollment periods overlap demonstration years. Therefore, some of the 2008 WHP enrollees were also enrolled in 2007 and received WHP services in 2007, and some of the 2008 WHP enrollees were also enrolled in 2009 and received WHP services in 2009.

Texas Women's Health Program 2008 Annual Report to CMS

Population Research Act), and Title XX (Social Services Block Grant). Services provided through these other titles represent referrals to other funding sources for services not available through the waiver, including treatment of sexually transmitted infections.

Table 4: Women's Health Program Clients who Received Additional Family Planning Services in 2008

Type of Service	Family Planning Services Fund Type			
	Title V	Title X	Title XX	Total ^a
Drugs and Supplies	469	786	10,586	11,841
Medical Counseling and Education	515	1,517	42,722	44,754
Exams and Office Visits	427	568	7,765	8,760
Contraceptive Devices and Related Procedures	15	7	969	991
Non-Reimbursable Procedure Codes	98	1	0	99
Laboratory Procedures	408	1,777	23,361	25,546

Source: TMHP Business Objects Query. Prepared by Department of State Health Services, Family and Community Health Services - Health Data Assessment & Reporting and submitted on Friday, 13, 2009.

^a If a client received more than one service or was funded by more than one funding source, she was counted in each Type of Service and in each Fund Type.

Goal 5: Reduce the number of births.

To determine whether the increased access to family planning services among WHP participants was associated with a measurable reduction in births, the methodology prescribed by CMS was used to compare the birth rate of Demonstration Year 1 (DY1) WHP participants to the adjusted base year birth rate. The base year birth rate is the 2003 birth rate for women likely to be eligible for WHP (i.e., family income at or below 185 percent of the Federal Poverty Level and ineligible for Medicaid except for pregnancy).⁹ The base year birth rate was adjusted to reflect the age and ethnicity distribution of DY1 participants. The adjusted base year birth rate was 11.6 percent. The DY1 participant birth rate was 4.1 percent. These birth rates demonstrate a reduction in births to DY1 participants.

Thus Hypothesis 1, that WHP participants will have a lower birth rate than would have been expected without WHP, is correct. The details of these calculations are presented in Appendix E.

Goal 6: Reduce growth rate of Medicaid-covered Hispanic births.

To determine whether the increased access to family planning services among Hispanic WHP participants was associated with a measurable reduction in births, the methodology prescribed by CMS was used to compare the birth rate of DY1 Hispanic WHP participants to the adjusted base year birth rate for Hispanic women. For this comparison, the base year birth rate is the 2003 birth rate for Hispanic women likely to be

⁹ Appendix D provides definitions of the variables used in these calculations.

eligible for WHP (i.e., family income at or below 185 percent of the Federal Poverty Level and ineligible for Medicaid except for pregnancy). The base year birth rate was adjusted to reflect the age distribution of Hispanic DY1 participants. The adjusted base year birth rate for Hispanic women was 10.1 percent. The DY1 birth rate for Hispanic participants was 4.9 percent. These birth rates demonstrate a reduction in births to Hispanic DY1 participants.

Thus Hypothesis 2, Hispanic WHP participants will have a lower birth rate than would have been expected without WHP, is correct. The details of this comparison are presented in Appendix F.

Goal 7: Increase the spacing between pregnancies to an interval of 24–59 months among WHP participants with a prior birth.

The spacing between pregnancies for DY1 participants was determined by examining Medicaid data for DY1 participants with a Medicaid birth where the pregnancy occurred in DY1 and the birth occurred at least nine months after the participant's first paid WHP claim.¹⁰ If those participants were on a Medicaid case for another child or children, the participant was considered to have a prior birth and the birth date of the youngest of those other children was used for the birth spacing analysis. Approximately 48 percent of births to DY1 participants with prior births were 24 to 59 months after the prior birth. For comparison, Medicaid records were examined for women who did not enroll in WHP and who had a Medicaid-paid birth during the same calendar months. If a comparison group woman was on a Medicaid case for another child or children, she was considered to have a prior birth and the birth date of the youngest of those other children was used for the birth spacing analysis. Of those in the comparison group with a prior birth, approximately 39 percent of the births were 24 to 59 months after the prior birth. Thus Hypothesis 3—that WHP participants will be more likely than similar for women who did not participate in WHP to increase the spacing between pregnancies to an interval of 24–59 months—is correct. Table 5 presents the results of this analysis.

Table 5: Birth Spacing for Women with a Prior Birth

	Less than 24 Months	24 through 59 Months	More than 59 Months	Total
WHP DY1 Participants	18.4%	48.2%	33.3%	100.0%
Comparison Group	29.3%	38.7%	32.0%	100.0%

Source: HHSC Eligibility Systems, retrieved on February 13, 2009.

Goal 8: Reduce the number of low-birth-weight deliveries.

This goal will be addressed in the 2009 Annual Report, when BVS data are available.

Goal 9: Reduce the number of premature deliveries.

This goal will be addressed in the 2009 Annual Report, when BVS data are available.

¹⁰ These criteria were also used for goals 5 and 6.

Goal 10: Reduce Medicaid costs expended for pregnancy, prenatal care, delivery, and infant care.

To estimate the reduction of Medicaid costs due to the use of family planning services by DY1 WHP participants, the adjusted base year birth rate was used to project the number of births DY1 participants would have been expected to have if there were no WHP demonstration. According to the methodology prescribed by CMS, the difference between the expected number of births for WHP participants had there been no WHP demonstration and the actual number of WHP births is considered to be the number of births "averted" by the WHP demonstration. The estimated Medicaid cost of these births (including pregnancy, prenatal care, delivery, postpartum care, and the first year of infant care) is considered to be Medicaid savings due to births averted.

DY1 results indicate that approximately 4,390 births were averted and that the reduction of Medicaid costs was estimated to be about \$45 million. After paying the costs associated with the program, WHP services provided in DY1 saved about \$32 million. The cost neutrality analysis presented in Appendix G provides the details of this analysis.

The cost neutrality analysis shows that the WHP program was cost neutral in DY1. Based on the methodology prescribed by CMS, DY1 WHP expenditures were approximately 28 percent of the estimated savings due to births averted.

IV. Assessment of Eligibility Determinations

Design

Management and Coordination

WHP initial applications and renewal applications are processed by a WHP-dedicated unit of eligibility advisors within HHSC Office of Eligibility Services. To evaluate the integrity of WHP eligibility determinations, HHSC Office of Family Services Quality Assurance (QA) audits a sample of determinations monthly. Auditors evaluate whether the determination to grant, sustain, or deny benefits was correct, and if incorrect, the root cause of the error.

Assessment Plan

Each month, a total of 80 WHP case actions are audited. Case actions include initial applications, renewal applications, and reported changes that result in WHP eligibility being granted, sustained, or denied. To generate the sample of WHP case actions that will be audited, HHSC QA pulls a random sample of 40 positive case actions and 40 negative case actions from a database of all WHP case actions that occurred in the month.

Positive case actions are determinations to grant or sustain WHP benefits. They include applications and renewals that are certified and reported changes that result in the continuation of benefits. Auditors review positive case actions to determine if WHP benefits were granted or sustained appropriately. Negative case actions are

Texas Women's Health Program 2008 Annual Report to CMS

determinations to deny or terminate WHP benefits. They include applications and renewals that are denied and reported changes that result in the termination of benefits. Auditors review these negative case actions to determine if WHP benefits were denied or terminated appropriately.

The error rate is determined by dividing the number of cases in error by the number of cases sampled. Ten percent is considered an acceptable error rate. If the error rate for either positive or negative cases is more than ten percent in any three consecutive months, corrective action is required. The corrective action plan includes a description and timeline of the actions planned or taken.

Timeline for Implementation and Reporting Deliverables

Data collection for WHP eligibility determinations began on the first day of the WHP demonstration and will be collected throughout the demonstration. Results of audits from January 2007 through November 2008 for both the positive and negative samples are included below.

Analysis

WHP Benefits Granted or Sustained (Positives)

WHP met its goal ten out of the 12 months that eligibility determinations for positives were assessed. The errors that occurred did not require corrective action, and the leading causal factor was an incorrect eligibility begin date that did not coincide with the first day of the application month.

Month	2007	2008
January	15.0%	15.0%
February	2.5%	5.0%
March	12.2%	2.5%
April	1.0%	12.5%
May	2.5%	5%
June	0.0%	10%
July	17.5%	2.5%
August	25.0%	5%
September	5.0%	0%
October	15.0%	0%
November	7.5%	2.5%
December	5.0%	-

WHP Benefits Denied or Terminated (Negatives)

WHP did not meet its goal for the sample. Many new eligibility staff have been hired for the WHP call center in the past year, and management of staff has also been transferred. These changes, in addition to the redistribution of staff resources due to Hurricane Ike, have contributed to an increase in errors. The leading causal factors for errors were:

Texas Women's Health Program 2008 Annual Report to CMS

incorrect denial for failure to allow a full ten days for the applicant to provide requested verification; incorrect denial for failure to provide information that is not required to determine eligibility; and the applicant's household income was not correctly accounted for. March 2008 was the third consecutive month in which the error rate exceeded ten percent, requiring corrective action. Corrective action continued through the remaining nine months.

Month	2007	2008
January	4.7%	45.0%
February	2.5%	27.5%
March	5.0%	30.0%
April	5.0%	22.5%
May	5.0%	45.0%
June	2.5%	55.0%
July	5.0%	40.0%
August	15.0%	25.5%
September	25.0%	40.0%
October	17.5%	22.5%
November	10.0%	35.0%
December	47.5%	-

Summary of Corrective Action Plan

The corrective action plan was implemented on January 1, 2008, and is ongoing. HHSC management staff will continue to reinforce and review policy on reporting changes and determining eligibility with all WHP eligibility advisors and conduct random case reading samples to ensure staff is following policy correctly and granting and sustaining benefits accurately. HHSC management will thoroughly train new WHP staff on how to mitigate the top eligibility processing errors. It is possible that a defect in the eligibility determination system may be contributing to the errors, particularly, not allowing the full ten days for the applicant to provide verification before denying the case. HHSC has filed a system defect with the contractor that manages the eligibility determination system in order to ensure that the system is denying cases appropriately as indicated in policy.

V. Conclusion

Successes

In its second year, the Women's Health Program (WHP) has proven to be a success at expanding access to Medicaid family planning services to uninsured women in Texas. Since implementation, on January 1, 2007, an unduplicated total of 152,489 women have been enrolled in WHP at some point. WHP has also been successful at expanding access

Texas Women's Health Program 2008 Annual Report to CMS

to Medicaid family planning services to Hispanic women. By the end of 2008, more than half of all women enrolled in WHP were Hispanic. WHP has provided family planning services to at least 75,809 clients from January 2008 through December 2008.

Due to gestation and the lag in Medicaid claims data, this report includes the first examination of WHP birth data and the cost neutrality of the program. These analyses are for the first year of the demonstration (DY1). Analyses indicate that all four HHSC hypotheses about WHP outcomes were correct for the data included in this report:

- WHP participants had a lower birth rate than would have been expected without WHP,
- Hispanic WHP participants had a lower birth rate than would have been expected without WHP,
- WHP participants were more likely than similar women who did not participate in WHP to increase the spacing between pregnancies to an interval of 24–59 months, and
- the lower birth rate among WHP participants reduced Medicaid expenditures for pregnancy, prenatal care, postpartum care, delivery, and the first year of infant care.

WHP was estimated to have averted approximately 4,390 births in DY1, and the reduction of Medicaid costs was estimated to be about \$45 million. After paying the costs associated with the program, WHP services provided in DY1 saved about \$32 million. The WHP program was cost neutral in DY1: WHP expenditures were approximately 28 percent of the estimated savings due to births averted.

HHSC identified several opportunities for improvement of ongoing operations in the second demonstration year, including improving the integration of WHP with other publicly funded family planning programs, seeking input from stakeholders, and developing innovative outreach strategies.

While any Medicaid provider can participate in WHP, most WHP clients are seen at more than 300 publicly funded clinic sites that receive family planning funding through DSHS. HHSC and DSHS have collaborated closely to ensure that WHP policies and procedures integrate well with DSHS's established programs. Benefits policy is one area HHSC identified in which improvements could be made with respect to integration. WHP and DSHS's family planning programs generally cover the same services, but each covers a few benefits the other does not. In 2008, HHSC and DSHS evaluated the benefits of both programs to identify appropriate modifications to coverages that could more closely align the two programs. In order to help accomplish this, HHSC submitted a waiver amendment to CMS to cover additional benefits. Such changes will benefit providers by enabling them to focus more on serving clients and less on tracking the different benefits of each program, thereby helping to streamline reimbursements.

Texas Women's Health Program 2008 Annual Report to CMS

In 2008, through Family Planning Community Participation meetings hosted by DSHS and the Family Planning Partnership Project meetings hosted by the Women's Health and Family Planning Association of Texas, HHSC gathered input from stakeholders on ways WHP could be improved. HHSC will continue to work with providers and other stakeholders through public forums, workgroups, and conferences.

Finally, HHSC has identified opportunities to improve WHP outreach by piloting and evaluating a new outreach strategy. In 2008, HHSC investigated opportunities to market WHP through public advertisements. HHSC piloted WHP transit advertisements in a specific region of the state with low program enrollment and a high Spanish-speaking/Hispanic population. In 2009, HHSC will continue to implement broad-based outreach strategies to raise awareness about the program and improve program enrollment.

Next Steps

HHSC continues to seek new opportunities to improve WHP outreach and program enrollment. Throughout 2009, HHSC will meet with internal and external stakeholders to help determine the most effective outreach opportunities to pursue within the limitations of the WHP outreach budget. As new benefits are added to traditional Medicaid family planning, reimbursement rates change, and DSHS family planning programs evolve, HHSC WHP staff will continue to work with Medicaid family planning and DSHS staff to improve program coordination.

Finally, HHSC will continue to offer in-person and web-based trainings to educate providers about WHP eligibility and benefits. HHSC will work with provider associations, such as the Texas Medical Association, to identify ways to improve provider participation, especially among providers who do not contract with DSHS for Title V, Title X, and Title XX. Such efforts will allow more women in Texas access to family planning services.

Appendices

Appendix A: Number of Women that Received Women's Health Program Services by Quarter*

Quarter	2007	2008
1 st	17,115	31,158
2 nd	24,140	31,810
3 rd	25,989	32,115
4 th	27,979	28,196

* Unduplicated within each quarter but not across quarters.

Source: TMHP Ad Hoc Query Platform Claims Universe, retrieved on January 26, 2009.

Appendix B: Women's Health Program Services Used Most Frequently in 2008

Rank	Procedure Code	Service
1	99213	Follow-up Family Planning Visit
2	S4993	Oral Contraception
3	81025	Pregnancy Test
4	99214	Annual Family Planning Exam
5	J1055	Depo-Provera
6	A4267	Condom
7	88142	Pap Test
8	81002	Urine Screening Test
9	87591	Gonorrhea Screening
10	87491	Chlamydia Screening

Source: TMHP Ad Hoc Query Platform Client Universe retrieved on January 26, 2009.

Appendix C: Disenrollment from the Women's Health Program in 2008

Reason for Disenrollment	First Quarter (%)	Second Quarter (%)	Third Quarter (%)	Fourth Quarter (%)	Total (%)
Certification period ended	17,713 (79.6)	15,240 (73.9)	12,668 (70.5)	9,800 (72.7)	55,421 (74.6)
Certified for Medicare, Medicaid, or State Children's Health Insurance Program	3,126 (14.1)	1,438 (7.0)	1,097 (6.1)	866 (6.4)	6,527 (8.8)
Individual ineligible, is pregnant	0 (0)	1,490 (7.2)	1,713 (9.5)	1,440 (10.7)	4,643 (6.2)
Individual not certified, does not meet program requirement	271 (1.2)	1,421 (6.9)	1,490 (8.3)	533 (4.0)	3,715 (5.0)
Voluntary withdrawal	896 (4.0)	492 (2.4)	473 (2.6)	344 (2.6)	2,205 (3.0)
Other	234 (1.1)	538 (2.6)	539 (3.0)	504 (3.7)	1,815 (2.4)
Total	22,240	20,619	17,980	1,3487	74,326

Source: Disenrollment Interface from HHSC Eligibility Systems.

Appendix D: Cost Neutrality Definitions

Demonstration Year 1 (DY1) is calendar year 2007.

WHP Participants in DY1 are WHP enrollees with at least one paid WHP claim for a service delivered in Demonstration Year 1.

WHP Participants with Medicaid Births for DY1 are DY1 WHP participants with a Medicaid-paid birth in which the pregnancy occurred in DY1 and the birth occurred at least nine months after the participant's first paid WHP claim and no more than nine months after the participant's last day of enrollment in DY1. Some of these births occurred in DY2, but births after September 2008 were excluded because the pregnancy probably occurred in DY2.

WHP Birth Rate for DY1 = DY1 WHP Participants with Medicaid Births / DY1 WHP Participants

WHP Participant Proportions by Ethnicity and Age for DY1 = Number in Ethnicity and Age Group in DY1 / Total Number of DY1 WHP Participants

Texas Women's Health Program 2008 Annual Report to CMS

Base Year Population is the estimated number of low-income (family income at or below 185 percent of the Federal Poverty Level) Texas women in 2003 ineligible for Medicaid except for pregnancy. Base Year Population excludes non-citizens and low-income women who would be eligible for TANF. Data are from the 2003 American Community Survey.

Base Year Women with Medicaid Births is the number of women with a Medicaid-paid birth in 2003. Base Year Women with Medicaid Births excludes Medicaid births to non-citizens and to women on TANF.

Base Year Birth Rates = Base Year Women with Medicaid Births / Base Year Population

Base Year Birth Rates Adjusted for DY1 Participant Proportions = Base Year Birth Rate * DY1 WHP Participant Proportion. This adjustment weights the base year birth rate for each ethnicity and age group by the prevalence of that group among DY1 WHP participants so the total across all ethnicity and age groups equals a base year birth rate that reflects the ethnicity and age of DY1 WHP participants.

Projected Births to DY1 WHP Participants If No WHP = Number of DY1 WHP Participants * Base Year Birth Rate Adjusted for DY1 Participant Proportions

Births Averted = Projected Births to DY1 WHP Participants - Actual Births to DY1 WHP Participants

Average Cost of Medicaid Birth in DY1 includes prenatal care, delivery, postpartum care, and first year of life costs for infant.

Target Expenditure = Savings Due to Births Averted = Births Averted * Average Cost of Medicaid Birth in DY1 (*Target expenditure is the "break-even" point for cost neutrality*)

Waiver Expenditures = DY1 WHP Medicaid claims

Administrative Expenditures = DY1 Evaluation Expenditures + DY1 Outreach Expenditures

Total WHP Expenditures = Waiver Expenditures + Administrative Expenditures

Total WHP Expenditures as a Percent of Target Expenditure = Total Expenditures / Target Expenditure

**Appendix E: Calculation of Women's Health Program Demonstration Birth Rates
for Demonstration Year 1**

Ethnicity and Age Groups	WHP Partici- pants - DY1	WHP Partici- pants with Medicaid Births - DY1	WHP Birth Rate - DY1	WHP Partici- pant Propor- tions by Ethnicity and Age - DY1	Base Year** Population	Base Year Women with Medicaid Births	Base Year Birth Rates by Ethnicity and Age	Base Year Birth Rates Adjusted for DY1 Partici- pant Propor- tions
White								
18-19	3,220	131		5.50%	31,165	6,032	0.19	0.01065
20-24	7,119	279		12.16%	120,274	17,224	0.14	0.01742
25-29	3,696	104		6.31%	67,341	7,971	0.12	0.00747
30-34	1,571	28		2.68%	58,889	3,572	0.06	0.00163
35-39	1,025	12		1.75%	44,380	1,429	0.03	0.00056
40-44	587	1		1.00%	59,147	349	0.01	0.00006
Black								
18-19	1,606	78		2.74%	13,182	2,904	0.22	0.00604
20-24	3,754	153		6.41%	40,008	7,962	0.20	0.01276
25-29	2,280	71		3.90%	34,474	3,878	0.11	0.00438
30-34	1,131	14		1.93%	25,514	1,677	0.07	0.00127
35-39	664	11		1.13%	23,712	714	0.03	0.00034
40-44	370	2		0.63%	36,081	180	0.00	0.00003
Hispanic								
18-19	4,276	259		7.31%	52,555	9,977	0.19	0.01387
20-24	11,068	631		18.91%	176,147	23,955	0.14	0.02571
25-29	6,890	356		11.77%	173,234	12,864	0.07	0.00874
30-34	3,880	163		6.63%	165,526	6,880	0.04	0.00276
35-39	2,570	59		4.39%	140,456	3,004	0.02	0.00094
40-44	1,525	7		2.61%	113,724	722	0.01	0.00017
Other								
18-19	252	4		0.43%	3,786	193	0.05	0.00022
20-24	529	15		0.90%	14,402	650	0.05	0.00041
25-29	260	6		0.44%	11,627	538	0.05	0.00021
30-34	124	3		0.21%	10,066	496	0.05	0.00010
35-39	81	0		0.14%	10,162	217	0.02	0.00003
40-44	56	0		0.10%	10,038	57	0.01	0.00001
Totals	58,534	2,387	0.04078	100.00%	1,435,890	113,445	-	0.11578

Source: Texas Medicaid and Healthcare Partnership (TMHP) Ad Hoc Query Platform Client and Claims Universes (Base Year Women with Medicaid Births retrieved on September 9, 2010; all other data retrieved on December 1, 2008).

* Demonstration Year 1 (DY1) is calendar year 2007.

** Base Year is 2003.

**Appendix F: Calculation of Women's Health Program Demonstration Birth Rates
for Hispanic Women in Demonstration Year 1**

Ethnicity and Age Groups	WHP Partici- pants - DY1	WHP Partici- pants with Medicaid Births - DY1	WHP Birth Rate - DY1	WHP Partici- pant Propor- tions by Ethnicity and Age - DY1	Base Year** Population	Base Year Women with Medicaid Births	Base Year Birth Rates by Ethnicity and Age	Base Year Birth Rates Adjusted for DY1 Partici- pant Propor- tions
Hispanic								
18–19	4,276	259		14.15%	52,555	9,977	0.19	0.02687
20–24	11,068	631		36.64%	176,147	23,955	0.14	0.04983
25–29	6,890	356		22.81%	173,234	12,864	0.07	0.01694
30–34	3,880	163		12.84%	165,526	6,880	0.04	0.00534
35–39	2,570	59		8.51%	140,456	3,004	0.02	0.00182
40–44	1,525	7		5.05%	113,724	722	0.01	0.00032
Totals	30,209	1,475	0.04883	100.00%	821,642	57,402	-	0.10111

Source: Texas Medicaid and Healthcare Partnership (TMHP) Ad Hoc Query Platform Client and Claims Universes (Base Year Women with Medicaid Births retrieved on September 9, 2010; all other data retrieved on December 1, 2008).

* Demonstration Year 1 (DY1) is calendar year 2007.

** Base Year is 2003.

**Appendix G: Calculation of Women's Health Program Cost Neutrality for
Demonstration Year 1***

	Total	Federal Share of Costs**
WHP Savings Due to Births Averted		
Projected Births to DY1 WHP Participants If No WHP	6,777	
Actual births to DY1 WHP Participants	2,387	
Births Averted	4,390	
Average Cost of Medicaid Birth in DY1	\$10,159	\$6,169
Target Expenditure = Savings Due to Births Averted	\$44,595,601	\$27,080,679
WHP Expenditures (defined by CMS)		
Waiver Expenditures	\$12,382,209	\$11,143,895
Administrative Expenditures	\$75,000	\$37,500
Total WHP Expenditures	\$12,457,209	\$11,181,395
Cost Neutrality		
Total WHP Expenditures as a Percent of Target Expenditure	27.93%	41.29%
<i>The program is considered cost neutral because Total WHP Expenditures are less than the Target Expenditure (i.e., the Savings due to Births Averted).</i>		

* Terms are defined in Appendix D. All data in the table include error due to rounding.

** For DY1, Medicaid birth expenditures had approximately a 60.725 percent Federal Medical Assistance Percentage (FMAP). This FMAP was derived by prorating the Texas FMAP for federal fiscal years 2007 and 2008. WHP Waiver Expenditures had approximately a 90 percent federal participation rate. WHP administrative expenses had a 50 percent federal participation rate.