

**Texas Health and Human Services Commission**

**Women's Health Program  
Annual Report 2009  
January 1, 2009 – December 31, 2009**

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

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## I. Program Overview

The Texas Women's Health Program (WHP) is a Section 1115(a) demonstration waiver that the United States Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) approved 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 reduce expenditures related to Medicaid-paid births by providing free family planning services to low-income women. Program benefits include an annual family planning exam, contraceptives, related health screenings, and follow-up contraceptive management visits. The target population is uninsured women ages 18 to 44 whose net family income is at or below 185 percent of the federal poverty level (FPL) and who are not otherwise 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 otherwise be eligible for those types of services;
- 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
- increasing the number of minority women who participate by piloting culturally appropriate outreach efforts to Spanish-speaking/Hispanic populations.

Expanding family planning services will reduce the number of unintended pregnancies among low-income women who are unable to afford contraception and other family planning services. Currently, fewer 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 Medicaid-paid births. In addition, for women whose poverty limits their access to health care services, WHP may reduce the number of infant deaths and premature and low-birth-weight deliveries attributable to closely spaced pregnancies.<sup>1</sup> Improved access also may reduce future disability costs for children arising from premature and low-birth-weight deliveries.

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<sup>1</sup> The Johns Hopkins Bloomberg School of Health, "Birth Spacing: Three to Five Saves Lives." Online. Available: <http://www.inforhealth.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, 2009, through December 31, 2009.

### *Milestones*

- On April 1, 2009, HHSC made available 16 new benefits through WHP. CMS approved these new benefits through a waiver amendment on December 31, 2008. The new WHP benefits include:
  - A low complexity new client office visit
  - Radiology exams
  - An implantable contraceptive device
  - A thyroid stimulating hormone test
  - Herpes tests
  - A nonsurgical sterilization method.
- On June 19, 2009, HHSC implemented activities to enforce section 32.0248(h) of the Texas Human Resources Code, the state statute governing WHP. Section 32.0248(h), enacted in 2005, stipulates that HHSC must ensure that, in administering WHP, it does not contract with an entity that performs elective abortions. In order to enforce this section of the code, HHSC requires all providers who have been reimbursed for WHP services in 2008 and 2009 to submit a form certifying that they have not and do not perform elective abortions. (The WHP certification form is included as Attachment A.)<sup>2</sup>
- On August 1, 2009, HHSC implemented a change to the automated eligibility system for WHP. The change grants WHP coverage to women who submit a WHP application during their last month of Medicaid for pregnant women coverage, beginning on the first day of the month they are eligible for WHP following their application date. This change helps eliminate a gap in coverage for women transitioning from Medicaid for pregnant women to WHP.

### *Program Enrollment*

97,468 women were enrolled in WHP at the end of the fourth quarter of 2009, and an unduplicated total of 151,989 women were enrolled at some point during 2009.<sup>3</sup> Since WHP was implemented on January 1, 2007, an unduplicated total of 217,377 women have been enrolled in the program at some point.<sup>4</sup>

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<sup>2</sup> In June 2009, HHSC sent the WHP certification form to providers who had billed for WHP services and included the form as an attachment to the 2009 second quarter report. The attached certification form is a revised version that was sent to providers in September 2009.

<sup>3</sup> The 2009 unduplicated total includes 2007 and 2008 enrollees who were also enrolled in 2009.

<sup>4</sup> Source: Texas Medicaid and Healthcare Partnership (TMHP) Ad Hoc Query Platform Client Universe, retrieved on January 18, 2010.

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### *Services*

58,982 women received services in the first year of the demonstration, and 79,373 women received services in the second year of the demonstration. At least 88,491 women received services in the third year of the demonstration.<sup>5,6</sup> Appendix A presents the number of women who received WHP services each quarter in 2007, 2008, and 2009.

The services most frequently used in WHP in the third year of the demonstration include family planning visits, contraceptives, and pregnancy tests. Appendix B lists the top ten services used in WHP in 2009.

### *Disenrollment*

There were a total of 74,188 disenrollments from WHP in 2009, reflecting an unduplicated total of 73,327 women. The majority of the women were disenrolled because their 12-month enrollment certification period ended. The second most common reason for disenrollment was being pregnant. Appendix C provides the number disenrolled and the reason for disenrollment by quarter.

### *Program Staffing*

Since implementing the demonstration, HHSC has increased WHP-dedicated staff to process applications and determine eligibility for WHP. At the end of the fourth quarter of 2009, HHSC had 93 full time equivalent positions and six units dedicated to processing eligibility in WHP, with half of the units working on initial applications and half working on both initial and renewal applications.

### *Applications, Renewals, and Eligibility Determinations*

HHSC processed 47,736 applications in the fourth quarter of 2009 (40,944 initial applications and 6,792 renewal applications). In 2009, HHSC processed a total of 164,275 WHP applications (137,579 initial applications and 26,696 renewal applications).<sup>7</sup>

At the end of the fourth quarter, 93 percent of eligibility determinations occurred within HHSC's 45-day processing timelines. On average, about 96 percent of the eligibility determinations occurred within the 45-day processing timelines in 2009, representing a 1 percent increase in processing timeliness from 2008.

From the start of the demonstration, eligibility staff has been checking the DSHS Bureau of Vital Statistics (BVS) site for birth records for in-state applicants in order to avoid pending WHP applications for missing documentation. Still, incomplete information or missing documentation has forced staff to pend a significant percentage of applications received. 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

<sup>5</sup> Source: Texas Medicaid and Healthcare Partnership (TMHP) Ad Hoc Query Platform Claims Universe (First year data retrieved on January 26, 2009; 2<sup>nd</sup> and 3<sup>rd</sup> year data retrieved on January 25, 2010.)

<sup>6</sup> The number of services received in the third year is approximate due to a lag in Medicaid claims data.

<sup>7</sup> Health and Human Services Commission TN-01 Report, January 2010.

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providers collect more of the required documentation—including encouraging the verification of citizenship at the time of the client's appointment—so that staff will pend fewer applications, will process applications more quickly, and will deny fewer women.

### *Provider Participation and Training*

Only Medicaid providers that perform family planning services within their scope of practice and that do not perform elective abortions are eligible to provide services under WHP.

HHSC staff trains eligible 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.

- In March and June 2009, HHSC and DSHS staff participated with providers from all over the state in a series of Family Planning Provider Partnership Project meetings in Austin hosted by the Women's Health and Family Planning Association of Texas. These sessions and meetings gave HHSC an opportunity to hear directly from family planning providers about the ways WHP and the DSHS family planning program impact providers and clients and to discuss how the programs could be improved.
- In September, HHSC staff participated in a speaker panel about women's health issues and provided an overview of WHP at the Texas Medical Association Fall Conference in Austin, Texas.
- In October, HHSC participated in the 2009 Annual Project Directors' Conference for DSHS family planning providers. 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.
- In November, HHSC and DSHS staff participated in the 2009 Annual Texas Association of Community Health Centers Conference and provided an overview of WHP and state family planning programs for Federally Qualified Health Centers.
- Also in November, HHSC participated in billing workshops for family planning providers conducted by the state's Medicaid claims administrator, Texas Medicaid and Healthcare Partnership (TMHP). Meetings were conducted in Dallas, Laredo, Midland, San Antonio, and Houston.

### *Client-Directed Outreach Activities*

HHSC used several approaches to reach out to WHP clients in the second year of the demonstration.

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- At the beginning of the year, HHSC sent approximately one million notices about WHP to women whose children receive Medicaid. These notices were included with their children's January Medicaid identification form. The bilingual notices, printed with English on one side and Spanish on the other side, included basic program information and directed potential clients to the WHP call center for more detailed information about the program and about how to apply. Also in January, Medicaid/CHIP staff reached out to community-based organizations (CBOs) contracted with HHSC to conduct outreach on a variety of programs and encouraged CBOs to continue efforts to educate potentially eligible women about the program.
- In April, HHSC published several articles in provider organization newsletters. The Texas Medical Association published an article about WHP on its website and sent it to the county medical societies for printing in county society newsletters, as well as to specialty societies. In addition, the Texas Nurses Association included the article in its April/May/June 2009 newsletter, with a circulation of 265,000. The Texas Osteopathic Medical Association also included information about WHP in its news briefing publication, which is sent to approximately 1,800 members. Some of the articles also included information about referring women to the Breast and Cervical Cancer Services program for cancer screening and Medicaid for Breast and Cervical Cancer Program for cancer treatment.
- Also in April, bilingual posters for the WHP program were updated, printed, and distributed. HHSC's Office of Community Collaboration and Border Affairs staff headed up the distribution initiative, targeting locations such as community colleges and other areas that potential clients might frequent.
- In addition, HHSC directed its Medicaid managed care contracted enrollment broker to implement outreach and education efforts to educate pregnant women receiving Medicaid about the availability of WHP after the women deliver their babies. These changes included: 1) updating the enrollment broker's outreach script to include information about WHP and referral information; and 2) distributing WHP flyers to clients during home visits and community presentations. These changes were made in April 2009.
- In May, DSHS approved a curriculum about WHP for certified community health worker training sites to offer. Community health workers, or *promotores*, can complete the training at certified training sites and earn three continuing education units. The training provides an overview of program benefits and eligibility and instructs health workers how to help women apply for the program.
- In August, HHSC printed 500,000 English and 300,000 Spanish full-color business card-sized pushcards with information about the program on one side

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and room for a provider to add their contact information on the opposite. These pushcards, which have proven popular with providers, were distributed in October 2009.

- In October, DSHS Birth Defects and Epidemiology Surveillance (BDES) staff began a new WHP outreach effort utilizing approximately 50 DSHS BDES staff, located throughout the state, who collect birth defects data from hospital birth records. Because the BDES staff have a unique relationship with regional hospitals and providers, staff are able to provide the hospitals with WHP brochures and pushcards. In 2009, BDES staff provided information about WHP to 43 providers' offices and hospitals and distributed information to the Central Texas March of Dimes Programs Committee.
- In November, the HHSC Office for Prevention of Developmental Disabilities and the DSHS Substance Abuse Program began distributing WHP informational materials to contractors who deliver alcohol and substance abuse education and treatment services to women throughout the state.
- Throughout the year, HHSC and DSHS regional staff, HHSC-contracted CBOs, and TMHP promoted WHP at multiple 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 essential but challenging to bring these women into the demonstration project.

All outreach materials are available in Spanish, but in 2009, HHSC specifically targeted the Hispanic population with a bilingual billboard campaign in South and Central Texas. The billboard campaign was launched in February in Travis County (Central Texas) and in Cameron and Willacy Counties (South Texas), each of which has a large Spanish-speaking/Hispanic population and a lower percentage of eligible women enrolled in WHP compared to the rest of the state. A total of 20 billboards were posted throughout these counties advertising WHP: 11 billboards were printed in Spanish and nine billboards were printed in English. HHSC experienced a slight increase in call volume and applications from these areas during the month of February, but it is uncertain how much of the increase was directly due to the billboards.

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.

### **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.

##### *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. This goal was omitted based on an agreement between CMS and HHSC.

**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.

#### *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, 2009, through December 31, 2009. It also updates the 2008 data that, due to data lags, were finalized after the 2008 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 birth spacing, 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 a preliminary birth record is available through BVS.

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The annual performance measures are based on the data available at the end of the demonstration year. This report on the third year of the demonstration addresses all of the current performance goals except increasing birth spacing (Goal 7), reducing the number of low-birth-weight deliveries (Goal 8), and reducing the number of premature deliveries (Goal 9). These goals require the use of BVS birth records data that are not yet available. Goals 5, 6, and 10, based on Medicaid claims for births, are addressed for the second year of the demonstration.<sup>8</sup> 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 addressed in the Third Quarter 2010 report.

### **Goal 1: Increase access to Medicaid family planning services.**

At the end of 2009, 97,468 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 2009 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 HHSC anticipates that the number will increase as eligibility data becomes available.

**Table 1: Women's Health Program Enrollment**

<b>Month</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
January	9,424	89,081	85,628
February	18,850	81,630	85,783
March	28,532	80,212	86,684
April	37,150	80,427	87,841
May	45,636	80,346	88,806
June	52,750	80,436	90,693
July	58,803	80,865	92,448
August	65,155	81,682	94,224
September	70,585	82,669	96,653
October	76,590	83,615	98,629
November	81,037	84,397	100,308
December	84,899	85,125	97,468

Source: Texas Medicaid and Healthcare Partnership (TMHP) Ad Hoc Query Platform Client Universe (2007 data retrieved on January 22, 2009; 2008 and 2009 data retrieved on January 18, 2010).

<sup>8</sup> As noted previously, Goal 4 was omitted based on an agreement between HHSC and CMS.

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

At the end of 2009, 48,476 Hispanic women were enrolled in WHP. The enrollment of Hispanic women in WHP also indicates an increase in their access to Medicaid family planning because they were not eligible for these services prior to implementation of WHP.

The enrollment of Hispanic women in WHP from January 2007 to December 2009 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 HHSC anticipates that the number will increase as eligibility data becomes available.

**Table 2: Hispanic Women's Health Program Enrollment**

<b>Month</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
January	5,013	45,305	43,456
February	10,099	41,192	43,356
March	15,200	40,437	43,615
April	19,707	40,539	44,059
May	24,057	40,516	44,469
June	27,548	40,614	45,353
July	30,381	40,858	46,275
August	33,478	41,385	46,991
September	36,216	41,960	48,075
October	39,228	42,497	49,058
November	41,400	42,966	49,884
December	43,241	43,284	48,476

Source: Texas Medicaid and Healthcare Partnership (TMHP) Ad Hoc Query Platform Client Universe (2007 data retrieved on January 22, 2009; 2008 and 2009 data retrieved on January 18, 2010).

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

An unduplicated total of 88,491 women had a paid Medicaid claim for WHP services received in 2009. Therefore, 58.2 percent of the unduplicated total of 151,989 women enrolled in WHP in 2009 received WHP services in the third year of the demonstration.<sup>9,10</sup>

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

<sup>9</sup> Medicaid claims data for 2009 are incomplete.

<sup>10</sup> Enrollment periods overlap demonstration years. For example, some of the 2009 WHP enrollees were also enrolled and received WHP services in 2007 and 2008.

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HHSC expects that the numbers will increase substantially as claims data becomes available.

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

Month	2007	2008	2009
January	5,867	12,866	14,577
February	6,932	11,248	12,946
March	8,259	11,819	14,238
April	9,198	12,946	14,881
May	10,200	11,862	13,476
June	9,668	12,278	14,468
July	9,851	12,912	15,052
August	10,901	11,953	14,290
September	9,672	12,864	15,107
October	11,846	13,882	15,398
November	10,384	11,849	11,491
December	10,326	12,925	9,160

Source: Texas Medicaid and Healthcare Partnership (TMHP) Ad Hoc Query Platform Claims Universe (2007 data retrieved on January 26, 2009; 2008 and 2009 data retrieved on January 25, 2010).

**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 is negotiating with CMS to have this goal omitted.

**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, HHSC used the methodology prescribed by CMS to compare the birth rate of Demonstration Year 2 (DY2) 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 FPL and ineligible for Medicaid except for pregnancy).<sup>11</sup> The base year birth rate was adjusted to reflect the age and ethnicity distribution of DY2 participants. The adjusted base year birth rate was 11.5 percent. The DY2 participant birth rate was 4.3 percent. These birth rates demonstrate a reduced number of births to DY2 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.

<sup>11</sup> Appendix D provides definitions of the variables used in these calculations.

**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, HHSC used the methodology prescribed by CMS to compare the birth rate of DY2 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 eligible for WHP (i.e., family income at or below 185 percent of FPL and ineligible for Medicaid except for pregnancy). The base year birth rate was adjusted to reflect the age distribution of Hispanic DY2 participants. The adjusted base year birth rate for Hispanic women was 10.1 percent. The DY2 birth rate for Hispanic participants was 4.8 percent. These birth rates demonstrate a reduced number of births to Hispanic DY2 participants.

Thus Hypothesis 2—that Hispanic WHP participants will have a lower birth rate than would have been expected without WHP—is correct. Appendix F presents the details of these calculations.

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

HHSC has determined that DSHS BVS data are needed for this analysis. DSHS is one of the five agencies under the HHSC umbrella. BVS data for 2007 and 2008 are not final, but they may provide a reasonably accurate assessment of this goal for DY2 participants. However, HHSC recently determined that it will need to go through the DSHS Institutional Review Board to obtain the necessary BVS data. HHSC anticipates being able to provide CMS with the results of this analysis as an attachment to the Third Quarter 2010 report.

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

As with Goal 7, HHSC has determined that BVS data are needed for this analysis. HHSC expects to obtain permission to use the data and to provide CMS with the results of this analysis as an attachment to the Third Quarter 2010 report.

**Goal 9: Reduce the number of premature deliveries.**

As with Goal 7, HHSC has determined that BVS data are needed for this analysis. HHSC expects to obtain permission to use the data and to provide CMS with the results of this analysis as an attachment to the Third Quarter 2010 report.

**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 DY2 WHP participants, HHSC used the adjusted base year birth rate to project the number of births DY2 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 the costs of pregnancy, prenatal care, delivery, postpartum care, and the first year of infant care) is considered to be Medicaid savings due to births averted.

DY2 results indicate that approximately 5,726 births were averted, and HHSC estimates the reduction in total federal and state Medicaid costs to be about \$63 million. After paying the costs associated with the program, WHP services provided in DY2 saved about \$42 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 DY2. Based on the methodology prescribed by CMS, DY2 WHP expenditures were approximately 33 percent of the estimated savings due to births averted.

#### **IV. Assessment of Eligibility Determinations**

##### **Design**

###### *Management and Coordination*

A WHP-dedicated unit of eligibility advisors within HHSC Office of Eligibility Services processes WHP initial applications and renewal applications. In addition, eligibility advisors in HHSC field offices may process WHP applications. To evaluate the integrity of WHP eligibility determinations, HHSC Office of Family Services Quality Assurance (QA) audits a sample of determinations each month. Auditors evaluate whether the determination to grant, sustain, or deny benefits was correct, and if incorrect, the error's root cause.

###### *Assessment Plan*

Each month, HHSC QA audits a total of 80 WHP case actions. 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 from a database of all WHP case actions that occurred in the month a random sample of 40 positive case actions and 40 negative case actions.

- Positive case actions are determinations to grant or sustain WHP benefits. They include applications and renewals that are certified and reported changes that

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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 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*

HHSC Office of Family Services QA began collecting data collection for WHP eligibility determinations on the first day of the WHP demonstration and will continue throughout the demonstration. Results of audits from January 2007 through November 2009 for both the positive and negative samples are included below.

### **Analysis**

#### *WHP Benefits Granted or Sustained (Positives)*

WHP met its goal every month for the positive actions that were assessed in 2009. The errors that occurred did not necessitate corrective action.

<b>Month</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
January	15.0%	15.0%	2.5%
February	2.5%	5.0%	0.0%
March	12.2%	2.5%	0.0%
April	1.0%	12.5%	2.5%
May	2.5%	5%	2.5%
June	0.0%	10%	0.0%
July	17.5%	2.5%	2.5%
August	25.0%	5%	0.0%
September	5.0%	0%	0.0%
October	15.0%	0%	0.0%
November	7.5%	2.5%	2.5%
December	5.0%	0.0%	-

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### *WHP Benefits Denied or Terminated (Negatives)*

WHP did not meet its goal for the sample. This increase in errors is due in part to changes in staffing, as HHSC has hired many new eligibility case workers for the WHP-dedicated eligibility unit and for local eligibility field offices.

The leading causal factors for errors were:

- 1) incorrect denial for failure to allow an applicant the full ten days to provide requested verification;
- 2) incorrect denial for failure to provide information that is not required to determine eligibility; and
- 3) incorrect address on the form sent to applicants requesting additional information/verification.

January 2009 was the 12<sup>th</sup> consecutive month in which the error rate exceeded ten percent, requiring corrective action. Corrective action was not required from April 2009 through September 2009. However, October 2009 was the third consecutive month in which the error rate exceeded ten percent following the months of a sustained lower error rate. Corrective action has been required through the remainder of the year.

<b>Month</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
January	4.7%	45.0%	27.5%
February	2.5%	27.5%	25%
March	5.0%	30.0%	17.95%
April	5.0%	22.5%	10%
May	5.0%	45.0%	27.5%
June	2.5%	55.0%	8.57%
July	5.0%	40.0%	10%
August	15.0%	25.5%	10.26%
September	25.0%	40.0%	15%
October	17.5%	22.5%	17.5%
November	10.0%	35.0%	10.26%
December	47.5%	35%	-

### *Summary of Corrective Action Plan*

The corrective action plan was in place on January 1, 2009, and was implemented again on October 1, 2009. HHSC management staff continues to reinforce and review policy on reporting changes and determining eligibility with all WHP eligibility advisors. HHSC management staff also conducts random case reading samples to ensure that eligibility 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. Additionally, it is possible that a defect in the eligibility determination system may be contributing to the errors, particularly that of not

allowing the full ten days for the applicant to provide verification before denying the case. To remedy this problem, HHSC has filed two system defects with the contractor that manages the eligibility determination system in order to ensure that the system is denying cases in accordance with policy.

## V. Conclusion

### *Successes*

In its third year, WHP has succeeded at expanding access to Medicaid family planning services to uninsured women in Texas. Since implementation on January 1, 2007, an unduplicated total of 217,377 women have been enrolled in WHP at some point. WHP has provided family planning services to at least 88,491 clients from January 2009 through December 2009. WHP also has successfully expanded access to Medicaid family planning services to Hispanic women. By the end of 2009, half of all women enrolled in WHP were Hispanic.

Due to gestation and the lag in Medicaid claims data, this report examines WHP birth data and the cost neutrality for the second year of the demonstration (DY2). Analyses indicate that three of the 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.
- The lower birth rate among WHP participants reduced Medicaid expenditures for prenatal, delivery, postpartum, and the first year of infant care.

Data to test the other HHSC hypotheses were not available in time for this report. Results of those analyses will be included in the Third Quarter 2010 report.

In DY2, WHP was estimated to have averted approximately 5,726 births. The reduction of federal and state Medicaid costs was estimated to be about \$63 million. After paying the costs associated with the program, WHP services provided in DY2 saved about \$42 million. The WHP program was cost neutral in DY2: WHP expenditures were approximately 33 percent of the estimated savings due to births averted.

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

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While any Medicaid provider may participate in WHP, most WHP clients are seen at more than 300 publicly funded clinic sites that receive family planning funding through DSHS. Although 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 made. WHP and DSHS's family planning programs generally cover the same services, but each covers a few benefits the other does not. Consequently, in 2009, HHSC and DSHS implemented new benefits for both programs to more closely align the two programs.

In 2009, HHSC gathered input from stakeholders on ways WHP could be improved through Family Planning Community Participation meetings hosted by DSHS and Family Planning Partnership Project meetings hosted by the Women's Health and Family Planning Association of Texas. 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 2009, HHSC investigated opportunities to market WHP through public advertisements. HHSC piloted WHP billboard advertisements in specific regions of the state with low program enrollment and a high Spanish-speaking/Hispanic population. In 2010, 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 2010, 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.
- HHSC will continue to offer in-person and web-based training to educate providers about WHP eligibility and benefits.
- HHSC will continue to work with provider associations to identify ways to improve provider participation, especially among providers who do not contract with DSHS for Title V, Title X, and Title XX.

These 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	2009
1 <sup>st</sup>	17,115	30,905	36,088
2 <sup>nd</sup>	24,140	31,889	37,216
3 <sup>rd</sup>	25,989	32,001	38,510
4 <sup>th</sup>	27,979	33,206	31,259

\* Unduplicated within each quarter but not across quarters.

Source: Texas Medicaid and Healthcare Partnership (TMHP) Ad Hoc Query Platform Claims Universe (2007 data retrieved on January 26, 2009; 2008 and 2009 data retrieved on January 25, 2010).

### Appendix B: Women's Health Program Services Used Most Frequently in 2009

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	A4267	Condom
6	J1055	Depo-Provera
7	87591	Gonorrhea Screening
8	87491	Chlamydia Screening
9	88142	Pap Test
10	81002	Urine Screening Test

Source: TMHP Ad Hoc Query Platform Claims Universe retrieved on January 25, 2010.

**Appendix C: Disenrollment from the Women's Health Program in 2009**

<b>Reason for Disenrollment</b>	<b>First Quarter (%)</b>	<b>Second Quarter (%)</b>	<b>Third Quarter (%)</b>	<b>Fourth Quarter (%)</b>	<b>Total (%)</b>
Certification period ended	15,378 (75%)	12,808 (71%)	11,935 (69%)	10,162 (55%)	50,283 (68%)
Individual ineligible, is pregnant	2,150 (10%)	2,385 (13%)	2,302 (13%)	2,270 (12%)	9,107 (12%)
Certified for Medicare, Medicaid, or State Children's Health Insurance Program	1,223 (6%)	1,498 (8%)	1,542 (9%)	1,478 (8%)	5,741 (8%)
Individual not certified, does not meet program requirement	688 (3%)	123 (1%)	81 (0%)	3,074 (17%)	3,966 (5%)
Other	657 (3%)	625 (3%)	746 (4%)	727 (4%)	2,755 (4%)
Voluntary withdrawal	443 (2%)	688 (4%)	589 (3%)	616 (3%)	2,336 (3%)
<b>Total</b>	<b>20,539</b>	<b>18,127</b>	<b>17,195</b>	<b>18,327</b>	<b>74,188</b>

Source: Disenrollment Interface from HHSC Eligibility Systems.

**Appendix D: Cost Neutrality Definitions**

**Demonstration Year 2 (DY2)** is calendar year 2008.

**WHP Participants in DY2** are WHP enrollees with at least one paid WHP claim for a service delivered in Demonstration Year 2.

**WHP Participants with Medicaid Births for DY2** are DY2 WHP participants with a Medicaid-paid birth where the pregnancy occurred in DY2 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 DY2. Some of these births occurred in DY3, but births after September 2009 were excluded because the pregnancy probably occurred in DY3.

**WHP Birth Rate for DY2** = DY2 WHP Participants with Medicaid Births / DY2 WHP Participants

**WHP Participant Proportions by Ethnicity and Age for DY2** = Number in Ethnicity and Age Group in DY2 / Total Number of DY2 WHP Participants

**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

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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 DY2 Participant Proportions** = Base Year Birth Rate \* DY2 WHP Participant Proportion. This adjustment weights the base year birth rate for each ethnicity and age group by the prevalence of that group among DY2 WHP participants so the total across all ethnicity and age groups equals a base year birth rate that reflects the ethnicity and age of DY2 WHP participants.

**Projected Births to DY2 WHP Participants If No WHP** = Number of DY2 WHP Participants \* Base Year Birth Rate Adjusted for DY2 Participant Proportions

**Births Averted** = Projected Births to DY2 WHP Participants - Actual Births to DY2 WHP Participants

**Average Cost of Medicaid Birth in DY2** 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 DY2 (*Target expenditure is the "break-even" point for cost neutrality*)

**Waiver Expenditures** = DY2 WHP Medicaid claims

**Administrative Expenditures** = DY2 Evaluation Expenditures + DY2 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 2**

<b>Ethnicity and Age Groups</b>	<b>WHP Participants – DY2</b>	<b>WHP Participants with Medicaid Births – DY2</b>	<b>WHP Birth Rate – DY2</b>	<b>WHP Participant Proportions by Ethnicity and Age – DY2</b>	<b>Base Year** Population</b>	<b>Base Year Women with Medicaid Births</b>	<b>Base Year Birth Rates by Ethnicity and Age</b>	<b>Base Year Birth Rates Adjusted for DY2 Participant Proportions</b>
<b>White</b>								
18-19	3676	154		4.66%	31,165	6,032	0.19	0.00901
20-24	8573	393		10.86%	120,274	17,224	0.14	0.01555
25-29	4735	158		6.00%	67,341	7,971	0.12	0.00710
30-34	1997	34		2.53%	58,889	3,572	0.06	0.00153
35-39	1255	10		1.59%	44,380	1,429	0.03	0.00051
40-44	657	2		0.83%	59,147	349	0.01	0.00005
<b>Black</b>								
18-19	2394	126		3.03%	13,182	2,904	0.22	0.00668
20-24	5547	295		7.03%	40,008	7,962	0.20	0.01398
25-29	3372	119		4.27%	34,474	3,878	0.11	0.00481
30-34	1656	37		2.10%	25,514	1,677	0.07	0.00138
35-39	917	8		1.16%	23,712	714	0.03	0.00035
40-44	465	0		0.59%	36,081	180	0.00	0.00003
<b>Hispanic</b>								
18-19	5675	364		7.19%	52,555	9,977	0.19	0.01365
20-24	15323	861		19.41%	176,147	23,955	0.14	0.02640
25-29	9704	462		12.29%	173,234	12,864	0.07	0.00913
30-34	5213	210		6.60%	165,526	6,880	0.04	0.00274
35-39	3370	62		4.27%	140,456	3,004	0.02	0.00091
40-44	2034	5		2.58%	113,724	722	0.01	0.00016
<b>Other</b>								
18-19	430	17		0.54%	3,786	193	0.05	0.00028
20-24	995	35		1.26%	14,402	650	0.05	0.00057
25-29	458	16		0.58%	11,627	538	0.05	0.00027
30-34	225	4		0.29%	10,066	496	0.05	0.00014
35-39	171	3		0.22%	10,162	217	0.02	0.00005
40-44	97	0		0.12%	10,038	57	0.01	0.00001
<b>Totals</b>	<b>78,939</b>	<b>3,375</b>	<b>0.042755</b>	<b>100%</b>	<b>1,435,890</b>	<b>113,445</b>		<b>0.11529</b>

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 November 18, 2009)

\* Demonstration Year 2 (DY2) is calendar year 2008

\*\* Base Year is 2003

**Appendix F: Calculation of Women's Health Program Demonstration Birth Rates for Hispanic Women in Demonstration Year 2**

Ethnicity and Age Groups	WHP Participants – DY2	WHP Participants with Medicaid Births – DY2	WHP Birth Rate – DY2	WHP Participant Proportions by Ethnicity and Age – DY2	Base Year** Population	Base Year Women with Medicaid Births	Base Year Birth Rates by Ethnicity and Age	Base Year Birth Rates Adjusted for DY2 Participant Proportions
Hispanic								
18-19	5,675	364		13.73%	52,555	9,977	0.19	0.02607
20-24	15,323	861		37.08%	176,147	23,955	0.14	0.05043
25-29	9,704	462		23.49%	173,234	12,864	0.07	0.01744
30-34	5,213	210		12.62%	165,526	6,880	0.04	0.00524
35-39	3,370	62		8.16%	140,456	3,004	0.02	0.00174
40-44	2,034	5		4.92%	113,724	722	0.01	0.00031
<b>Totals</b>	<b>41,319</b>	<b>1,964</b>	<b>0.04753</b>	<b>100.00%</b>	<b>821,642</b>	<b>57,402</b>		<b>0.10125</b>

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 November 18, 2009)

\* Demonstration Year 2 (DY2) is calendar year 2008

\*\* Base Year is 2003

**Appendix G: Calculation of Women’s Health Program Cost Neutrality for Demonstration Year 2\***

	<b>Total</b>	<b>Federal Share of Costs**</b>
<b>WHP Savings Due to Births Averted</b>		
Projected Births to DY2 WHP Participants If No WHP	9,101	
Actual births to DY2 WHP Participants	3,375	
Births Averted	5,726	
Average Cost of Medicaid Birth in DY2	\$10,996	\$6,892
Target Expenditure = Savings Due to Births Averted	\$62,968,035	\$39,467,183
<b>WHP Expenditures (defined by CMS)</b>		
Waiver Expenditures	\$20,485,104	\$18,435,872
Administrative Expenditures	\$100,000	\$50,000
Total WHP Expenditures	\$20,585,104	\$18,485,872
<b>Cost Neutrality</b>		
Total WHP Expenditures as a Percent of Target Expenditure	32.69%	46.84%
<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. Data in the table include error due to rounding.

\*\* For DY2, Medicaid birth expenditures had approximately a 62.68 percent Federal Medical Assistance Percentage (FMAP). This FMAP was derived by prorating the Texas FMAP for federal fiscal year 2008 and the Texas stimulus FMAP for federal fiscal year 2009. WHP Waiver Expenditures had approximately a 90 percent federal participation rate. WHP administrative expenses had a 50 percent federal participation rate.