

# **State of Texas**

## **1115(a) Research and Demonstration Waiver**

**Submitted by**

**Texas Health and Human Services Commission**

# Texas Women’s Health Program

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## TEXAS WOMEN'S HEALTH PROGRAM

### CHAPTER 1: INTRODUCTION AND OVERVIEW

#### Introduction

The Health and Human Services Commission (HHSC), under the authority of §1115(a) of the Social Security Act (the Act), is requesting that the Centers for Medicaid and Medicare (CMS) renew the Texas Medicaid Research and Demonstration Family Planning Waiver, also known as the Women's Health Program. HHSC requests that the renewal be effective January 1, 2012, through December 31, 2013.

The Women's Health Program covers family planning services for women ages 18 through 44 with incomes at or below 185 percent of the Federal Poverty Level. The goal of the program is to improve health outcomes for low-income women and babies and to reduce expenditures for Medicaid-paid births by increasing access to family planning services.

In 2009, Medicaid covered approximately 56 percent of all births in Texas.<sup>1</sup> The most recent Pregnancy Risk Assessment Monitoring System data, compiled by the Texas Department of State Health Services, indicates that approximately 47 percent of the live births in Texas in 2009—an estimated 183,950 births—were reported as unintended pregnancies.<sup>2</sup> Continuing the Women's Health Program will reduce the number of unintended pregnancies among low-income women by providing access to family planning counseling, contraception, and services.

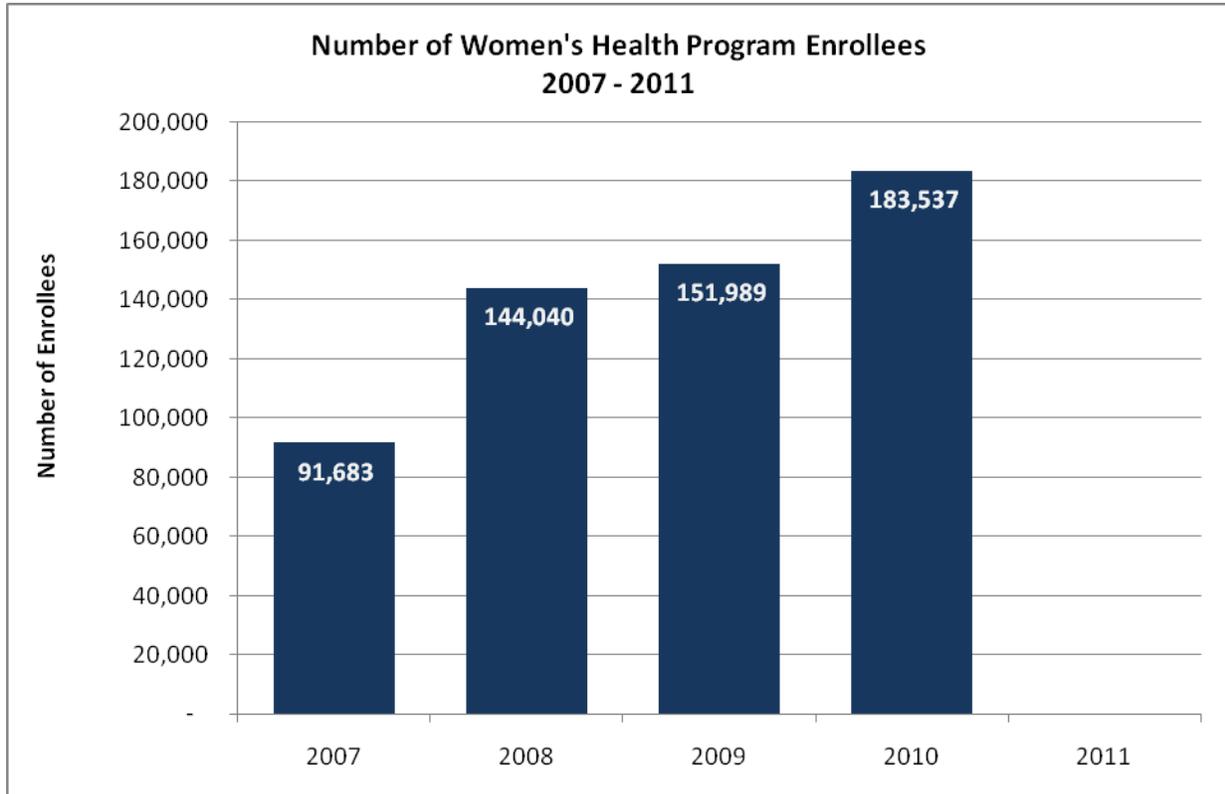
In the renewal, Texas also proposes to offer treatment for sexually transmitted diseases under the family planning waiver. The Women's Health Program already includes basic health screenings that identify the presence of specific diseases and health conditions. Currently, women who are diagnosed with a disease (e.g., a Sexually Transmitted Disease) at a family planning exam must be referred for medical treatment and appropriate follow-up. Texas proposes to enlarge the Women's Health Program to include sexually transmitted disease treatment so that a client with a Sexually Transmitted Disease can receive treatment from her regular family planning provider without being referred elsewhere. The Women's Health Program also will pay the costs associated with the treatment of clients' Sexually Transmitted Diseases.

#### Program Accomplishments

##### Increased Access

Since its implementation, the Women's Health Program has succeeded in increasing lower-income women's access to family planning services: as of the end of 2010, an unduplicated total of 292,680 women enrolled in the Women's Health Program. Women's Health Program

enrollment has increased every year from about 92,000 women in 2007 (the first full year of the Program's operation) to 183,537 women in 2010. The graph below shows Women's Health Program enrollment for each year of the demonstration through calendar year 2010. (Full enrollment figures for 2011 are not yet available.)



#### Reduced Medicaid Expenditures

Since the program began, using CMS-prescribed methodologies, HHSC estimates that from 2007 to 2009 the Women's Health Program averted 16,837 Medicaid-paid births and saved nearly \$183 million (all funds). (Data for births averted in 2010 and 2011 are not yet available.) After paying the costs associated with the program, the Women's Health Program, from 2007 through 2009, saved about \$121 million (all funds). The federal share of savings after paying the Women's Health Program expenditures totaled approximately \$63 million.

#### Increased Health Screenings

In addition to reducing expenditures for Medicaid-paid births, over 292,680 women have benefited from health screenings and family planning services they may not have been able to access if the Women's Health Program were not available. As one example, approximately 36% of women participating in the program were screened for a Sexually Transmitted Disease in calendar year 2010.<sup>3</sup> The Centers for Disease Control and Prevention estimated that from 2000 to 2009 about 10% of women age 20 - 24 years screened in a Texas family planning clinic test positive for Chlamydia.<sup>4</sup> This data suggests that increased access to screenings and family

planning services through the Women's Health Program plays an important role in improving health outcomes for low-income women in Texas.

## **Collaborating Agencies**

### HHSC Responsibility

HHSC is the single state agency designated to oversee administration of the Medicaid program under Title XIX of the Social Security Act and in compliance with title 42 of the Code of Federal Regulations § 431.10. HHSC has the primary responsibility for coordinating the renewal of the Women's Health Program 1115 waiver. HHSC will set policy relating to family planning benefits and determine eligibility and renewal for women participating in the Women's Health Program.

### Texas Department of State Health Services Responsibility

The Department of State Health Services is the state's public health agency. The Department of State Health Services has the primary responsibility for overseeing non-Medicaid family planning services and has a great deal of expertise and experience in family planning. The Department of State Health Services is a key partner in assisting HHSC to develop evidence-based family planning policy.

## **Key Elements of the Renewal**

- HHSC proposes to continue to offer family planning services under the Women's Health Program to women ages 18 to 44 with a net family income at or below 185 percent of the Federal Poverty Level.
- HHSC proposes to add treatment for sexually transmitted diseases to the services currently available through the Women's Health Program.
- HHSC requests approval of several regulatory exemptions under Section 1115 of the Act. The requested exemptions include Section 1902(a)(23) of the Act, and any other requirements that may need to be waived, to the extent necessary to allow the State to ensure that qualified providers participate in the Women's Health Program in accordance with State law. Chapter 3 of this application further describes HHSC's request for exemptions.

## **Evaluation and Program Performance Monitoring**

HHSC evaluated the first three years of the waiver, and is in the process of evaluating years four and five. In years six and seven, HHSC will monitor program performance to provide CMS with the information needed to evaluate the degree to which the Women's Health Program maintains its performance trends during its sixth and seventh years for women ages 18 through 44. Chapter 5 of this application provides additional details on HHSC's proposed performance monitoring activities.

## CHAPTER 2: BACKGROUND

### Texas Characteristics

#### Demographics

Texas has 254 counties and extends over 261,797 square miles, with a population density of 95 persons per square mile.<sup>5</sup> In 2009, roughly 87 percent of the state's 24.9 million residents lived in the 77 metropolitan counties, with the remaining 13 percent in the 177 non-metropolitan counties.

Texas' population has grown by an estimated 4 million between 2000 and 2009, to a total of 24.9 million, and the state's population is projected to continue to increase to an estimated 44.9 million people in 2040. The population projections for 2040 represent an increase of about 115 percent from the 2000 population.<sup>6</sup>

In 2009, Texas ranked 27th in the nation in per capita personal income (\$38,609), compared to \$39,635 for the U.S. as a whole, and had an overall poverty rate of 17.3 percent, the 7th highest poverty rate in the nation.<sup>7</sup> Thirteen percent of Texas' population received Medicaid-reimbursed services in 2009.<sup>8</sup>

In 2005, Texas became the 4th minority-majority state in the United States, with the total population of minorities comprising 50.2 percent of the total population.<sup>9</sup> By 2009, minorities represented 54 percent of the total population. Poverty affects minority populations in Texas at much higher rates. In 2009, 27 percent of the Hispanic population lived below the Federal Poverty Level, as did 20 percent of the African American population and 8 percent of Texas' white population.<sup>10</sup>

#### Women in Need

Approximately 60 percent of women ages 18 through 44 with incomes at or below 185 percent of the Federal Poverty Level in Texas (approximately 1.2 million women) were uninsured in 2009.<sup>11</sup> This lack of coverage contributes to high birth rates among low-income women, as the next section suggests.

#### Medicaid Births

In 1986, Medicaid coverage for pregnant women and infants up to 100 percent of the Federal Poverty Level became a state option. This option became mandatory in 1988, and the eligibility level was raised to 133 percent of the Federal Poverty Level in 1989. Texas increased coverage to include pregnant women up to 185 percent of the Federal Poverty Level in December 1991. Eligibility has remained at that income level ever since except between 2003 and 2004, when, due to state fiscal constraints, eligibility was 158 percent of the Federal Poverty Level.

In 2006, the year before Texas implemented the Women's Health Program, the percentage of Texas births paid by Medicaid was 51.6 percent or one of every two births in Texas. The number of total births has steadily increased since 2006. Medicaid-funded births also have

increased as a proportion of total births; by 2009, Medicaid-funded births constituted approximately 56 percent of all births in Texas.<sup>12</sup> (See table below.)

**Percentage of All Births Paid by Medicaid**

	2003	2004	2005	2006	2007	2008	2009
Births	377,374	381,441	385,537	399,309	407,453	405,242	402,011
% Medicaid Paid	51.60%	53.50%	55.80%	55.90%	56.00%	55.25%	56.21%

Decreasing Medicaid-funded births translates into cost savings at both the state and federal levels as Medicaid covers not only costs associated with prenatal care, delivery, and postpartum care for the mother, but also covers, in most cases, first year medical costs for infant care and additional years of medical costs for disabled infants. Averted births also lead to cost savings through decreased participation in related assistance programs, such as the Supplemental Nutrition Assistance Program.

The Women’s Health Program has reduced expenditures for Medicaid-paid births. Since the program began, using CMS-prescribed methodologies, HHSC estimates that from 2007 to 2009 the Women’s Health Program averted 16,837 Medicaid-paid births and saved nearly \$183 million (all funds). The federal share of savings after paying the Women’s Health Program expenditures was \$63 million.

**Family Planning in Texas**

Before HHSC implemented the Women’s Health Program, women ineligible for regular Title XIX Medicaid could obtain publicly funded family planning and related preventive services in Texas only through programs administered by the Texas Department of State Health Services, funded primarily under Titles V and XX of the Act and Title X of the Public Health Service Act. The Department of State Health Services has contracted with public and private nonprofit agencies across the state to provide family planning services through these programs. (All Department of State Health Services family planning contractors also must be enrolled as Title XIX Medicaid providers.)

The recent economic downturn and the resulting decreased state revenue have reduced the funds available for family planning services in Texas. The Department of State Health Services currently is restructuring its family planning programs in response to the reduction in funds. Thus, the Women’s Health Program will play an increasingly critical role in providing health services to low-income women in Texas.

Women eligible for Medicaid may obtain family planning services through the state’s Medicaid program.

**Conclusion**

The Women's Health Program provides much needed health services, including access to family planning services, to low-income women lacking health insurance. Providing family planning services and preventive healthcare through the Women's Health Program will reduce unintended pregnancies and improve health outcomes among low-income women statewide.

## **CHAPTER 3: PROPOSED WAIVER**

The Women's Health Program will, if it is renewed, continue to provide family planning services for uninsured, low-income women in Texas, including screenings for preventable health conditions. In addition to renewing the existing program, HHSC seeks to extend the Women's Health Program to offer to all clients treatment for sexually transmitted diseases. HHSC also seeks several regulatory exemptions under Section 1115 of the Act.

Because family planning visits are often the single point of contact many women have with a healthcare provider, services such as disease screenings, treatment for sexually transmitted diseases, health assessments, and counseling decrease preventable health conditions prevalent among women.

### **Covered Populations**

The target population for the Women's Health Program consists of women ages 18 to 44 with a net family income at or below 185 percent of the Federal Poverty Level. Women must be United States citizens or qualified aliens, as well as Texas residents. More detailed information on eligibility and enrollment procedures can be found in the following chapter.

### **Eligible Services**

Women participating in the Women's Health Program will receive the following services:

- Comprehensive health history and evaluation;
- Physical examination;
- Screening for and treatment of sexually transmitted diseases;
- The full range of allowable Medicaid family planning services, including screenings for diabetes, hypertension, elevated serum cholesterol level, anemia, vaginal infection, and tuberculosis, as well as breast and cervical cancer;
- Assessment of health risk factors;
- Client-centered counseling and education regarding:
  - Basic human reproductive anatomy and physiology;
  - Sexual abstinence as the only 100 percent effective method of preventing pregnancy or infection with sexually transmitted diseases (including Human Immunodeficiency Virus, or HIV);
  - Promotion of abstinence as the preferred choice of behavior related to all sexual activity for unmarried persons;
  - Reduction of health risks;
  - All Food and Drug Administration-approved methods of contraception, except emergency contraception; and
  - Individualized counseling on any contraceptive method selected by the client, except emergency contraception;
- Provision of a contraceptive method, except emergency contraception, based on client choice and absence of medical contraindications;

- Information on potential resources for the treatment of non-covered health conditions identified by Women’s Health Program services; and
- Referral of non-covered medical problems to appropriate specialty health providers.

A participant who is identified as at-risk for cardiovascular disease and diabetes will receive preventive counseling at the initial family planning visit and any follow-up family planning visits to ensure that her preferred method of contraception is suitable to her current condition or risk factors, which may include:

- Hypertension;
- Elevated cholesterol;
- Obesity/Overweight (as measured by Body Mass Index);
- Smoking;
- Alcohol abuse; and
- Low physical activity.

Clients of the Women’s Health Program will receive information both orally and in writing during a family planning visit on how to access primary care services at the nearest Federally Qualified Health Center or other primary care provider. Provider education materials will include information on how to refer clients to Federally Qualified Health Centers and other primary care services. Referrals of medical problems for participating clients in the Women’s Health Program are limited to health practitioners that do not perform or promote elective abortions, nor contract or affiliate with entities that perform or promote elective abortions.

### **Requested Medicaid Exemptions under Section 1115 of the Act**

#### Current Exemptions<sup>13</sup>

1. Amount, Duration, and Scope of Services (Comparability) - Section 1902(a)(10)(B) of the Act  
*To the extent necessary to allow the State to offer the demonstration population a benefit package consisting only of approved family planning services.*
2. Early and Periodic Screening, Diagnostic, and Treatment - Section 1902(a)(43)(A) of the Act  
*The State will not furnish or arrange for Early and Periodic Screening, Diagnostic, and Treatment services to the demonstration population.*
3. Retroactive Coverage - Section 1902(a)(34) of the Act  
*Individuals enrolled in the family planning demonstration will not be retroactively eligible.*
4. Prospective Payment for Federally Qualified Health Centers and Rural Health Centers and Rural Health Clinics - Section 1902(a)(15) of the Act  
*The State will establish reimbursement levels to these clinics that would compensate them solely for family planning services.*

#### New Exemption Request to Implement as of the Waiver Renewal

- ”Freedom of Provider Choice” - Section 1902(a)(23) of the Act (and any other exemptions needed)

*To the extent necessary to allow the State, under Section 1115 of the Act, to ensure that qualified providers participate in the Women's Health Program in accordance with State law.*

## Background and Explanation for Requested Exemption from Freedom of Provider Choice Requirement(s)

The State does not believe a waiver of section 1902(a)(23) is necessary in light of Congress' delegation of authority to the states to establish qualifications of Medicaid providers.<sup>14</sup> Nonetheless, HHSC submits this request in the event that CMS believes a waiver is necessary.

Section 1902(a)(23) premises the freedom of choice on the participation of *qualified* providers. The Texas Legislature has established the qualifications for providers that are eligible to participate in the Women's Health Program. Since the Texas Legislature first directed HHSC to establish the Women's Health Program as a five-year demonstration project in 2005, the state has required, as a qualification for provider participation, that a provider neither perform or promote elective abortions nor be an affiliate of an entity that performs or promotes elective abortions.<sup>15</sup> Specifically, subsection (h) of Human Resources Code section 32.0248, which became effective September 1, 2005, prohibited the payment of Women's Health Program funds to providers that choose to perform or promote elective abortions or that choose to be affiliates of entities that perform or promote elective abortions. Although section 32.0248 expired on September 1, 2011, Human Resources Code section 32.024(c-1), as added in June 2011 and effective on September 28, 2011, continues this qualification.<sup>16</sup> HHSC has proposed rules to implement section 32.024(c-1). The rules implementing the subsection are expected to become effective as of January 1, 2012, to coincide with the start date of the waiver renewal. Texas law thus makes clear that a provider that performs or promotes elective abortions or is an affiliate of an entity that performs or promotes elective abortions is unqualified to participate as a Women's Health Program provider.

HHSC has determined that application of the provider qualifications established under state law will not detrimentally affect women's access to Women's Health Program services. Furthermore, HHSC will work with all women whose current providers will be unqualified to participate in the Women's Health Program to ensure that all of them have access to an alternative, qualified provider.

### **Eligible Providers**

Eligible providers for this waiver include all enrolled Medicaid providers except for providers that choose to perform or promote elective abortions or that choose to be affiliates of entities that perform or promote elective abortions. The following provider types may bill services under the Women's Health Program:

- Physician;
- Physician assistant;
- Advanced nurse practitioner;
- Clinical nurse specialist;
- Certified nurse midwife;

- Federally Qualified Health Center;
- Family planning agency;
- Freestanding ambulatory surgical center;
- Hospital-based ambulatory surgical center; and
- Laboratory.

Women’s Health Program services are provided and reimbursed on a fee-for-service basis.

Under this demonstration program, no funds may be used to perform or promote elective abortions. Additionally, HHSC may not, for purposes of the Women’s Health Program, contract with entities that perform or promote elective abortions or are affiliates of entities that perform or promote elective abortions. Promotion of elective abortions includes advocating the choice of, or popularizing (by advertising or publicity) elective abortions.<sup>17</sup>

### **Program Standards**

Women’s health services will be delivered in accordance with current standards for family planning services. The standards cover the following elements of service:

*Informed Consent:* Providers must obtain from each program client informed consent to receive family planning services. The consent must be requested in a language the client understands, and the consenting client must document that consent in writing. This informed-consent requirement will include documentation of consent by women who opt to receive family planning services only, even though they may be eligible for comprehensive benefits under regular Medicaid.

*Confidentiality:* Services must be provided in a manner that respects the client’s privacy. Each client must be informed that the services are confidential and must be assured that her identity will not be revealed to anyone, including her partner, without her written permission, except as required by law.

*Availability of Contraceptive Options:* Each provider must make available to Women’s Health Program clients all Food and Drug Administration-approved contraceptive methods, except for emergency contraception, and their applications, consistent with recognized medical practice standards. A provider that is unable to provide specific services or methods must refer clients who request those services or methods to another qualified provider. All appropriate counseling and care options must be provided in an unbiased manner, allowing the client full freedom of choice.

*Linguistic and Cultural Competence:* Providers must perform all services in a culturally sensitive manner and must communicate in a language the particular client understands. Print and audiovisual materials must be appropriate in terms of the client’s language and literacy level.

*Access to Care:* Services must be provided without cost to eligible clients. Appointments for established clients must be available within a reasonable time, generally less than three weeks. New clients who cannot be seen within this timeframe must be referred to other qualified providers. Referrals to local resources must be made available to clients.

**Outreach**

HHSC has conducted and, under a waiver renewal, will continue to conduct a number of activities throughout the five-year demonstration to increase awareness of the Women's Health Program and enrollment. These activities include the following: creation and maintenance of a website that provides useful information about the Women's Health Program to clients such as eligibility criteria, covered services, instructions on how to apply for the program, and assistance in locating a provider; distribution of brochures and posters; publication of articles in provider organization newsletters; outreach and education through the managed care enrollment broker to educate pregnant women receiving Medicaid about the availability of the Women's Health Program after the women deliver their babies; participation in community-based outreach events; and campaigns specifically targeted to low-income Hispanic women.

In addition to consumer outreach, HHSC conducts and will continue to conduct provider outreach and education. For example, HHSC includes information about the Women's Health Program during statewide on-site trainings for Medicaid providers. HHSC also conducts statewide provider trainings and updates on the eligibility, benefits, and procedure requirements of this waiver, as needed.

## CHAPTER 4: ELIGIBILITY, ENROLLMENT, AND CLAIMS PROCESSING

### Eligibility

To participate in the Women's Health Program, a woman must be between the ages of 18 and 44 years (inclusive), a United States citizen or qualified alien, a Texas resident, and have income at or below 185 percent federal poverty level. Women who are or become pregnant and women who have been sterilized are not eligible for the Women's Health Program and are determined ineligible when they apply for Program benefits, when they are diagnosed as pregnant, or when their sterilization procedure is completed.

A woman is screened for eligibility for the Women's Health Program at the point of service delivery. If she does not meet the Program's income or citizenship requirements, she is screened for eligibility for a family planning program administered by the Texas Department of State Health Services.

If a woman is screened and presumed eligible for the Women's Health Program, the woman completes a one-page, simplified application that requires the client's signature. The provider's office staff faxes the application and documentation of income, identity, and citizenship or alien status to Texas state eligibility workers. State eligibility workers check to see if the woman is currently certified on any other program, such as regular Medicaid or the Children's Health Insurance Program. If she is currently receiving benefits under regular Medicaid or the Children's Health Insurance Program, her Women's Health Program application is denied. If she is not receiving another health benefit, the state eligibility workers certify or deny the woman's application within 45 days and then send the paperwork on to the eligibility contractor for inclusion in the eligibility system.

Women may be income-eligible for the Women's Health Program if a provider can determine adjunctive eligibility—through either the participation of a family member, within the required degree of relationship, or their own participation—in other “gateway programs” administered by the state with an income limit at or below 185 percent of the Federal Poverty Level. These gateway programs include financial assistance programs and medical assistance programs (e.g., Children's Medicaid), as well as other state-administered programs with the requisite income limit (e.g., the Supplemental Nutrition Assistance Program and the Women, Infants and Children program). Most means-tested programs in Texas have a maximum income limit of 185 percent of the Federal Poverty Level, which facilitates adjunctive eligibility.

Many women receive services the day they submit their application. If a provider submits a claim for a woman prior to her certification for the Women's Health Program, the claim is denied because the woman will not yet be determined eligible. HHSC will continue to educate providers on the risk of providing services to women who have not yet been certified by the state. If a woman is denied Women's Health Program eligibility after receipt of services, the provider bills the woman, not the state of Texas, for services rendered.

**Enrollment**

Women requesting services under this program enroll using a specific state application form which is processed through the Texas Integrated Eligibility Redesign System. The Texas Integrated Eligibility Redesign System is a browser-based system that integrates the application process for more than 50 health and human service programs. The Texas Integrated Eligibility Redesign System was the first online query system in the nation to receive permission to securely connect to the Social Security Administration. Because Texas is able to verify social security numbers and participation in other means-tested programs using this system, the state has improved data collection, timeliness, and reduced fraud.

Texas family planning programs take several steps to preserve client confidentiality. Women are not contacted by mail unless they have provided a safe address, and telephone communications do not contain any sensitive information about the woman or the services accessed. To protect confidentiality, HHSC modified the Women's Health Program application to include a clarifying statement about providing an allowable, safe address at which to receive communications about the program and how to renew enrollment. HHSC collects all necessary information required for Medicaid certification, including Social Security numbers.

Participating providers screen potential waiver clients to verify identification, income eligibility, citizenship or eligible immigration status, and adjunctive eligibility. If a potential client provides sufficient documentation (such as a child's Medicaid card), and the provider has applications available, the provider may fax copies of the completed application and documentation to the eligibility office. Applications are available to all women, whether or not they are eligible adjunctively.

Self-declaration is acceptable for establishing Texas residency and providing a social security number. Citizenship is verified in the same method that is used for all of Texas Medicaid, in compliance with the Deficit Reduction Act of 2005. Women are eligible from the month of their eighteenth birthday through the month of their forty-fifth birthday, and age needs to be verified only if it is in doubt. Identity must be confirmed at the initial application, and income level must be proven and verified at the time of both application and renewal. Information on other health insurance also must be gathered at the time of both application and renewal.

All applicants for the Women's Health Program are eligible for certification or denial no later than 45 calendar days following the initial file date. Denial of coverage occurs only if the information provided indicates the applicant is not eligible or not enough information is provided to determine eligibility. If missing information is provided, applications are re-opened within 60 days of the initial file date. The date any missing information is provided will be the new file date, and the process begins again.

**Eligibility Duration**

Once they are determined eligible, women are enrolled for 12 months of continuous eligibility. Loss of eligibility under this waiver will occur only upon death of the recipient, relocation to another state, or if a woman becomes pregnant or opts for sterilization. However, if the agency learns that the household failed to report required information at the time of the application and

that the newly discovered information renders the woman ineligible, the case is denied and a fraud referral may be sent to the Office of the Inspector General.

### **Renewal**

Women enrolled in the Women's Health Program have their eligibility re-determined every 12 months. A renewal packet, including an application that must be completed, signed, and returned along with any required verification, is sent to the client's safe address. The renewal application is the same as the initial application, but is pre-populated with the name of the client and the current mailing address on record.

## CHAPTER 5: PROGRAM PERFORMANCE MONITORING

As noted previously, analyses to determine the cost neutrality of the first three years of the Women's Health Program indicate that the program decreased the number of Medicaid-paid births to program participants and resulted in federal and state savings.<sup>18</sup> These findings are consistent with the results of family planning waivers in other states.<sup>19</sup>

A multidisciplinary team of HHSC researchers, led by HHSC's internal evaluation group, has been examining the Women's Health Program since 2007. This team plans to implement a performance monitoring system designed to provide CMS with the information needed to monitor whether the Women's Health Program maintains its performance trends during its sixth and seventh years.

The proposed monitoring system would measure performance on four goals, each of which addresses a critical aspect of the program: enrollment, participation, cost of services, and disenrollments due to pregnancy. The Program will achieve the greatest savings if it meets all four goals.<sup>20</sup>

### **Performance Goal 1: Maintain or increase the number of women enrolled in the Women's Health Program.**

#### Performance Measure: Women's Health Program annual enrollment

A decrease in the Women's Health Program enrollment would be unlikely to jeopardize the cost neutrality of the program. However, in the absence of offsetting changes, a decrease in enrollment would be likely to result in a decrease in the federal and state savings resulting from the program. Therefore, HHSC plans to maintain or increase Women's Health Program enrollment in the sixth and seventh years of the program. Annual enrollment would be examined in the context of annual enrollment from the beginning of the program.

### **Performance Goal 2: Maintain the Women's Health Program annual participation rate.**

#### Performance Measure: The Women's Health Program annual participation rate (the proportion of enrollees with at least one paid Women's Health Program claim for a service provided to her during that year)

During each of the first three years of the program, approximately 60 percent of the Women's Health Program enrollees participated in the program.<sup>21</sup> A decrease in the Women's Health Program annual participation rate would be unlikely to jeopardize the cost neutrality of the program, but it would be likely to decrease the federal and state savings resulting from the program. Therefore, HHSC plans to maintain the participation rate in the sixth and seventh years of the program. This performance measure would be examined in the context of the annual participation rate from the beginning of the program.

The data gathered for the annual participation rate will also be used to monitor enrollees' access to care. HHSC does not expect the change regarding the affiliates of elective abortion providers to limit enrollees' access to care. While any decrease in the participation rate could not be directly attributable to this change, it would indicate a need for further investigation.

### **Performance Goal 3: Maintain the “Per Member per Month” cost of the Women’s Health Program services**

Performance Measure: Per Member per Month cost of the Women’s Health Program services

HHSC plans to maintain the Per Member per Month cost of the Women’s Health Program services. Minimal increases are expected due to Medicaid inflation (approximately one to three percent each year) and due to the proposed addition of treatment for sexually transmitted diseases (approximately 0.8 percent each year). These small increases would not likely jeopardize the program’s cost neutrality.<sup>22,23,24</sup>

HHSC and CMS have agreed that, if this application is approved, CMS would tell HHSC what calculation to use when reporting Per Member per Month. HHSC expects to have the data needed to calculate the Per Member per Month for the first five years of the program. The Per Member per Month for years six and seven of the project would then be examined within the context of the Per Member per Month for the first five years of the program.<sup>25</sup>

As previously noted, the proposed expansion of services to include treatment for sexually transmitted diseases is projected to increase the Per Member per Month slightly. To show the additional cost of providing sexually transmitted diseases treatment, the Per Member per Month cost would be divided into two service components: family planning and treatment of sexually transmitted diseases. The annual number of the Women’s Health Program participants treated for a sexually transmitted disease would be reported to provide additional context for the Per Member per Month cost of treating sexually transmitted diseases.

### **Performance Goal 4: Maintain the proportion of the Women’s Health Program participants disenrolled due to pregnancy**

Performance Measure: Proportion of the Women’s Health Program participants disenrolled due to pregnancy

A Women’s Health Program participant who becomes pregnant is disenrolled from the Women’s Health Program as soon as she enrolls in a Medicaid for Pregnant Women program or HHSC otherwise learns of the pregnancy. A small increase in the proportion of the Women’s Health Program participants disenrolled due to pregnancy would be unlikely to jeopardize the cost neutrality of the program, but, in the absence of offsetting changes, it would be expected to decrease the federal and state savings resulting from the program. A large increase in the proportion of the Women’s Health Program participants disenrolled due to pregnancy could result in the Women’s Health Program costing more than it saves. Therefore, HHSC plans to

maintain the proportion of the Women’s Health Program participants disenrolled due to pregnancy. The annual rate of disenrollments due to pregnancy would be presented in the context of the comparable annual rates from the beginning of the program.

**Reporting**

Program Performance Monitoring results for each goal would be reported according to the following schedule.

<b>Deliverable</b>	<b>Program Year</b>	<b>Due Date</b>
Annual Report	Year 6 (2012)	March 2013
Annual Report	Year 7 (2013)	March 2014

HHSC also would continue to provide the Women’s Health Program cost data on the quarterly CMS 64 report.

**Projected Caseloads, Births Averted, and Savings**

In its first three years, the Women’s Health Program caseload grew to about 152,000 enrollees. The program averted approximately 17,000 Medicaid births and resulted in estimated net savings of over \$120 million, including both federal and state funds (see table below).<sup>26</sup>

**Women’s Health Program Caseloads, Births Averted, and Net Savings: Years 1, 2, and 3<sup>a</sup>**

	<b>Year 1 2007</b>	<b>Year 2 2008</b>	<b>Year 3 2009</b>
<b>Caseload</b>	91,683	144,040	151,989
<b>Estimated Number of Medicaid Births Averted</b>	4,390	5,726	6,721
<b>Estimated Net Savings<sup>b</sup></b>	<b>\$32,138,392</b>	<b>\$42,382,931</b>	<b>\$46,102,362</b>

<sup>a</sup> Data from Women’s Health Program annual reports submitted to CMS.

<sup>b</sup> Savings after paying the costs of the program.

In years six and seven, the Women’s Health Program is expected to have a caseload of over 250,000 enrollees per year and save a total of almost \$160 million, including both federal and state funds (see table below).<sup>27</sup> These projections include the cost of expanding Women’s Health Program services in years six and seven to provide treatment for sexually transmitted diseases.

**Projected Women’s Health Program Caseloads, Births Averted, and Net Savings: Years 6 and 7**

	<b>Year 6 CY2012</b>	<b>Year 7 CY2013</b>
<b>Projected Caseload</b>	256,138	267,756
<b>Projected Number of Medicaid Births Averted</b>	11,258	11,769
<b>Projected Net Savings<sup>a</sup></b>	<b>(\$77,677,278)</b>	<b>(\$81,217,354)</b>

<sup>a</sup> Savings after paying the costs of the program.

**Conclusion**

The waiver is expected to be budget neutral for the life of the demonstration project, including years six and seven, and save a total of almost \$160 million (all funds).<sup>28</sup> These projections include the costs of providing treatment for sexually transmitted diseases. The Women’s Health Program is expected to have a caseload of over 250,000 enrollees per year. Improving access to contraception and counseling on the spacing of births minimizes the overall number of births paid for by Medicaid. Assessing risk factors for preventable diseases and screening for gender-specific health conditions is vital to prevent morbidity and mortality. The continued success of the Women’s Health Program plan depends on the state’s ability to enroll newly eligible women who are not currently in the Medicaid system and to further develop strategies to facilitate access to services.

APPENDICES

**Appendix A. Women’s Health Program Caseloads, Births Averted, Costs, and Savings:  
Years 1, 2, and 3<sup>29</sup>**

Table A1. Women’s Health Program Caseloads, Participants, and Births Averted: Years 1, 2, and 3

	<b>Year 1 2007</b>	<b>Year 2 2008</b>	<b>Year 3 2009</b>
<b>Caseload</b>	91,683	144,040	151,989
<b>Unduplicated Number of Participants</b>	58,534	78,939	92,783
<b>Estimated Number of Medicaid Births Averted</b>	4,390	5,726	6,721

Table A2. Women’s Health Program Costs: Years 1, 2, and 3

	<b>Year 1 2007</b>	<b>Year 2 2008</b>	<b>Year 3 2009</b>
<b>Family Planning Services Costs</b>	\$12,382,209	\$20,485,104	\$29,017,802
<b>Administrative Costs</b>	\$75,000	\$100,000	\$100,000
<b>Total Costs</b>	\$12,457,209	\$20,585,104	\$29,117,802

Table A3. Women’s Health Program Savings: Years 1, 2, and 3

	<b>Year 1 2007</b>	<b>Year 2 2008</b>	<b>Year 3 2009</b>
<b>Estimated Savings from Medicaid Births Averted<sup>a</sup></b>	\$44,595,601	\$62,968,035	\$75,220,164
<b>Total Costs</b>	\$12,457,209	\$20,585,104	\$29,117,802
<b>Estimated Net Savings<sup>b</sup></b>	\$32,138,392	\$42,382,931	\$46,102,362

<sup>a</sup> Includes prenatal care, delivery, postpartum care, and first year of life costs for infant.

<sup>b</sup> Savings after paying the costs of the program.

**Appendix B. Projected Women’s Health Program Caseloads, Births Averted, Costs, and Savings: Years 6 and 7<sup>30</sup>**

**Table B1. Projected Women’s Health Program Caseloads, Participants, and Births Averted: Years 6 and 7<sup>a</sup>**

	<b>Year 6 CY2012</b>	<b>Year 7 CY2013</b>
<b>Projected Caseload</b>	256,138	267,756
<b>Projected Number of Participants</b>	156,362	163,454
<b>Projected Number of Medicaid Births Averted</b>	11,258	11,769

<sup>a</sup> Projections by HHSC Forecasting Division.

**Table B2. Projected Women’s Health Program Costs: Years 6 and 7<sup>a</sup>**

	<b>Year 6 CY2012</b>	<b>Year 7 CY2013</b>
<b>Projected Family Planning Costs</b>	\$47,827,622	\$49,984,601
<b>Projected Sexually Transmitted Disease Treatment Costs</b>	\$395,283	\$413,212
<b>Projected Administrative Costs</b>	\$100,000	\$100,000
<b>Total Projected Costs</b>	<b>\$48,322,905</b>	<b>\$50,497,813</b>

<sup>a</sup> Projections by HHSC Forecasting Division.

**Table B3. Projected Women’s Health Program Net Savings: Years 6 and 7**

	<b>Year 6 CY2012</b>	<b>Year 7 CY2013</b>
<b>Total Projected Costs</b>	\$48,322,905	\$50,497,813
<b>Projected Savings from Medicaid Births Averted<sup>a</sup></b>	(\$126,000,183)	(\$131,715,167)
<b>Projected Net Savings<sup>b</sup></b>	<b>(\$77,677,278)</b>	<b>(\$81,217,354)</b>

<sup>a</sup> Includes prenatal care, delivery, postpartum care, and first year of life costs for infant.

<sup>b</sup> Savings after paying the costs of the program.

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<sup>1</sup> TX Health and Human Services Commission, Center for Strategic Decision Support data.

<sup>2</sup> Texas PRAMS 2009, prepared by: DSHS OPDS, August 16, 2011.

<sup>3</sup> Prepared by Strategic Decision Support, Health and Human Services Commission, 08/18/2011.

<sup>4</sup> Centers for Disease Control and Prevention, found at: <http://www.cdc.gov/std/chlamydia2009/stateB.htm>. Retrieved 9/21/2011.

<sup>5</sup> Texas State Data Center at the University of Texas at San Antonio. Population Estimates and Projections Program. Population Projections for 2009 for Texas Counties. Office of the State Demographer. Institute for Demographic and Socioeconomic Research. February 2009. Data compiled and analyzed by: Strategic Decision Support Department. Texas Health and Human Services Commission. May 2011.

<sup>6</sup> Texas State Data Center at the University of Texas at San Antonio. Population Estimates and Projections Program. Population Projections for 2009 for Texas Counties. Office of the State Demographer. Institute for Demographic and Socioeconomic Research. February 2009. Data compiled and analyzed by: Strategic Decision Support Department. Texas Health and Human Services Commission. May 2011.

<sup>6</sup> Ibid.

<sup>7</sup> US Census Bureau, March 2010 Current Population Survey (CPS). Data compiled and analyzed by: Strategic Decision Support Department. Texas Health and Human Services Commission. May 2011.

<sup>8</sup> Texas Health and Human Services Commission. Texas Medicaid in Perspective, 7<sup>th</sup> Edition. Available online at: <http://www.hhsc.state.tx.us/medicaid/reports/PB8/PDF/TheMedicaidNumbers.pdf> - and at: <http://www.hhsc.state.tx.us/medicaid/reports/PB8/PinkBookTOC.html>.

<sup>9</sup> Texas State Data Center at the University of Texas at San Antonio. Population Estimates and Projections Program. Population Projections for 2009 for Texas Counties. Office of the State Demographer. Institute for Demographic and Socioeconomic Research. February 2009. Data compiled and analyzed by: Strategic Decision Support Department. Texas Health and Human Services Commission. May 2011.

<sup>10</sup> US Census Bureau, March 2010 Current Population Survey (CPS). Data compiled and analyzed by: Strategic Decision Support Department. Texas Health and Human Services Commission. May 2011.

<sup>11</sup> Ibid.

<sup>12</sup> TX Health and Human Services Commission, Center for Strategic Decision Support data.

<sup>13</sup> Centers for Medicaid and Medicare Services, “Special Terms and Conditions,” December 31, 2008.

<sup>14</sup> *See Kelly Kare, Ltd. v. O’Rourke*, 930 F.2d 170, 172 (2d Cir. 1991).

<sup>15</sup> *See* Act of May 27, 2005, 79th Leg., R.S., ch. 816, § 1, 2005 Tex. Gen. Laws 2816, 2816–18, *codified at* Tex. Hum. Res. Code § 32.0248 (expired).

<sup>16</sup> *See* Act of June 27, 2011, 82d Leg., 1st C.S., S.B. 7, § 1.19(b).

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<sup>17</sup> The State will comply with current federal law and will not exclude providers under this demonstration who perform abortion if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.

<sup>18</sup> See Appendix A. Although the data needed to assess the cost neutrality of the fourth and fifth years of the demonstration are not yet available, the program is expected to have had similar results in those years.

<sup>19</sup> See Gold, R. B., Sonfield, A., Richards, C.L., & Frost, Jennifer J. (2009). *Next Steps for America's Family Planning Program: Leveraging the Potential of Medicaid and Title X in an Evolving Health Care System*, New York: Guttmacher Institute, 19-20. Retrieved from <http://www.guttmacher.org/pubs/NextSteps.pdf> . Last accessed August 17, 2011.

<sup>20</sup> This statement assumes that there is not a disproportionately large decrease in the cost of a Medicaid-paid birth (including the first year of infant care).

<sup>21</sup> The participation rate varied from 55 percent to 64 percent.

<sup>22</sup> Cost neutrality projections are presented in Appendix B.

<sup>23</sup> The increase in the cost of services due to inflation would not be expected to affect the cost neutrality of the program because the cost of a Medicaid birth (including the first year of infant care) would also be expected to increase due to inflation.

<sup>24</sup> If CMS approves HHSC's proposal to add treatment for sexually transmitted diseases, projections indicate that adding those services would be expected to increase the Per Member per Month slightly (approximately 0.8 percent). This estimate assumes that the CMS-preferred method of calculating the Per Member per Month does not differ substantially from the method HHSC Strategic Decision Support uses to calculate Per Member per Month.

<sup>25</sup> Due to the 3-month lag in Medicaid claims data, claims data for the last quarter of the project year are incomplete when the annual report for that year is prepared. Calculating the PMPM based on the incomplete data would artificially reduce the PMPM for the project year. Therefore, an annual report for a project year would include the PMPM calculation for the previous project year.

<sup>26</sup> Estimates are based on the cost neutrality analysis methodology prescribed by CMS. A more detailed presentation of these results is available in Appendix A. Year 4 results, which include births through September 2011, will be available in the WHP 2011 Annual Report.

<sup>27</sup> A more detailed presentation of projected results for years six and seven is available in Appendix B.

<sup>28</sup> Estimates are based on the cost neutrality analysis methodology prescribed by CMS. A more detailed presentation of these results is available in Appendix A. Year 4 results, which include births through September 2011, will be available in the WHP 2011 Annual Report.

<sup>29</sup> Data from 2009, 2010, and 2011 annual reports submitted to CMS. All costs and savings include both federal and state funds.

<sup>30</sup> All projections by HHSC Strategic Decision Support except as noted. All costs and savings include both federal and state funds.

Approved: December 31, 2008

Mr. Chris Traylor  
State Medicaid Director  
Texas Health and Human Services Commission  
P.O. Box 13247  
Austin, TX 78751

Dear Mr. Traylor:

We are pleased to inform you that Texas' request to amend the Texas Women's Health Waiver section 1115 demonstration has been approved in accordance with section 1115(a) of the Social Security Act, and is effective as of the date of this approval letter through December 31, 2012. Specifically, you requested to modify the demonstration by adding Current Procedural Terminology (CPT) codes to the list of services provided through this demonstration. Specifically, the new codes are:

- 99201 New Client Office Visit
- 76856 Ultrasound, pelvic (nonobstretic), real time with image documentation, complete
- 76857 Ultrasound, pelvic (nonobstretic), real time with image documentation, Complete, limited or follow-up (eg, for follicles)
- 76880 Ultrasound, extremity, nonvascular, real time with image documentation
- J7307 Implantable contraceptive rod device
- 11975 Insertion, implantable contraceptive capsules
- 11976 Removal, implantable contraceptive capsules
- 11977 Removal with reinsertion, implantable contraceptive capsules
- 84443 Thyroid stimulating hormone test
- 86695 Herpes simplex type 1
- 86696 Herpes simplex type 2
- 87252 Tissue culture inoculation, observation, and presumptive identification by cytopathic effect
- 58565 Hysteroscopy, surgical, with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants
- 74740 Hysterosalpingography, radiological supervision and interpretation
- E1399 Occlusive sterilization device
- 58340 Catheterization and introduction of saline or contrast material for saline infusion sonohysterography or hysterosalpingography

In addition, Attachment A (formerly Attachment B) to the enclosed Special Terms and Conditions (STCs) has been updated to reflect additional approved services and the

corresponding Federal Medical Assistance Percentage rate at which these services will be reimbursed.

Please be aware that by including those individuals who are eligible for family planning services under this waiver, the State is expanding the number of instances in which pharmacists, physicians, and other health care professionals would be protected by 42 U.S.C. section 300a-7(d) which provides:

No individual shall be required to perform or assist in the performance of any part of a health service program or research activity funded in whole or in part under a program administered by the Secretary of Health and Human Services if his performance or assistance in the performance of such part of such program or activity would be contrary to his religious beliefs or moral convictions.

Our approval of this demonstration project amendment is subject to the limitations specified in the expenditure authorities. The State may deviate from Medicaid State plan requirements to the extent those requirements have been listed as inapplicable to expenditures for the demonstration population.

The approval is also conditioned upon continued compliance with the enclosed STCs, defining the nature, character, and extent of anticipated Federal participation in the project. The award is subject to our receiving your written acknowledgement of the award and acceptance of the STCs and expenditure authorities within 30 days of the date of this letter.

Your contact for this demonstration is Lane Terwilliger, Esquire, who may be reached at (410) 786-2059. Ms. Terwilliger is available to answer any questions concerning the scope and implementation of your demonstration project. Communications regarding the program matters and official correspondence concerning the demonstration should be submitted to her at the following address:

Centers for Medicare & Medicaid Services  
Center for Medicaid and State Operations  
7500 Security Boulevard  
Mail Stop: S2-01-16  
Baltimore, MD 21244-1850  
Facsimile: 410-786-8534  
E-mail: Lane.Terwilliger@cms.hhs.gov

Official communications regarding program matters should be submitted simultaneously to Ms. Terwilliger and Mr. Bill Brooks, Acting Associate Regional Administrator, in the Dallas Regional Office. Mr. Brooks' address is:

Centers for Medicare & Medicaid Services  
Office of the Regional Administrator  
1301 Young Street, Room 833  
Dallas, TX 75202

We extend our congratulations to you on this award and look forward to working with you during the course of the demonstration.

Sincerely,

//s//

Kerry Weems  
Acting Administrator

Enclosures

Page 4 – Mr. Chris Taylor

cc:

Bill Brooks, Acting ARA, Dallas Regional Office

**CENTERS FOR MEDICARE & MEDICAID SERVICES  
EXPENDITURE AUTHORITY**

**NUMBER:** 11-W-00232/6

**TITLE:** Texas Women’s Health Waiver

**AWARDEE:** Texas Health and Human Services Commission

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by Texas for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period of this Demonstration, be regarded as expenditures under the State’s title XIX plan. All requirements of the Medicaid statute will be applicable to such expenditure authorities (including adherence to income and eligibility system verification requirements under section 1137(d) of the Act), except those specified below as not applicable to these expenditure authorities.

The following expenditure authority shall enable Texas to operate its section 1115 Medicaid “Texas Women’s Health Waiver” demonstration. The demonstration extends Medicaid eligibility for family planning services to women from the age of 18 to 44 with a net family income up to 185 percent of the Federal poverty level who are not otherwise eligible for Medicaid, the State Children’s Health Insurance Program, Medicare, or have creditable health insurance coverage.

**Medicaid Requirements Not Applicable to the Medicaid Expenditure Authorities:**

All Medicaid requirements apply, except the following:

**1. Amount, Duration, and Scope of Services (Comparability)-Section 1902(a)(10)(B)**

To the extent necessary to allow the State to offer the demonstration population a benefit package consisting only of approved family planning services.

**2. Early and Periodic Screening, Diagnostic, and Treatment -Section 1902(a)(43)(A) (EPSDT)**

The State will not furnish or arrange for EPSDT services to the demonstration population.

**3. Retroactive Coverage-Section 1902(a)(34)**

Individuals enrolled in the family planning demonstration will not be retroactively eligible.

**4. Prospective Payment for Federally Qualified Health Centers and Rural Health Centers and Rural Health Clinics – Section 1902(a)(15)**

The State will establish reimbursement levels to these clinics that would compensate them solely for family planning services.

**CENTERS FOR MEDICARE & MEDICAID SERVICES  
SPECIAL TERMS AND CONDITIONS  
(Amendment Effective Date: XX XX, 2008)**

**NUMBER:** 11-W-00232/6

**TITLE:** Texas Women's Health Waiver

**AWARDEE:** Texas Health and Human Services Commission

**I. PREFACE**

The following are the Special Terms and Conditions (STCs) for the Texas Women's Health Waiver Program section 1115(a) Medicaid Demonstration (hereinafter "Demonstration"). The parties to this agreement are the Texas Health and Human Services Commission (State), and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of Federal involvement in the Demonstration and the State's obligations to CMS during the life of the Demonstration. The STCs are effective the date of approval, unless otherwise specified. All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below. This Demonstration is approved through December 31, 2011.

The STCs have been arranged into the following subject areas: Program Description and Objectives; General Program Requirements; Eligibility; Benefits and Delivery Systems; General Reporting Requirements; General Financial Requirements; Monitoring Budget Neutrality; Evaluation of the Demonstration; and the Service Code List, Attachment A.

**II. PROGRAM DESCRIPTION AND OBJECTIVES**

The Texas Women's Health Waiver section 1115(a) Medicaid Demonstration expands the provision of family planning services to women of childbearing age with a net family income up to 185 percent of the Federal poverty level (FPL), who do not have creditable coverage for family planning services, and who are not otherwise eligible for Medicaid, or State and Children's Health Insurance Program (SCHIP). The objective of the program is to decrease the number of Medicaid paid deliveries which will result in a decrease in annual Medicaid expenditures for prenatal, delivery, newborn and infant care, and increase the proportion of clients who receive assistance with accessing primary care services and comprehensive health coverage.

**III. GENERAL PROGRAM REQUIREMENTS**

- 1. Compliance with Federal Non-Discrimination Statutes.** The State agrees that it must comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid programs expressed in law, regulation, court order, and policy statement not expressly waived or identified as not applicable in the waiver and expenditure authority documents of which these terms and conditions are part, must apply to the Demonstration.
3. **Changes in Medicaid Law, Regulation, and Policy.** The State must, within the timeframes specified in law, regulation, court order, or policy directive, come into compliance with any changes in Federal law, regulation, court order, or policy affecting the Medicaid programs that occur during this Demonstration approval period, unless the provision being changed is explicitly waived under the STCs herein governing the Demonstration.
4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy Statements.**
  - a) To the extent that a change in Federal law, regulation, final court order, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this Demonstration, the State must adopt, subject to CMS approval, a modified budget neutrality agreement for the Demonstration as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change.
  - b) If mandated changes in the Federal law require State legislation, the changes must take effect on the day such State legislation becomes effective, or on the last day such legislation was required to be in effect under the law.
5. **Changes Subject to the Amendment Process.** Demonstration provisions related to eligibility, enrollment, benefits, delivery systems, and cost sharing covered under this Demonstration; evaluation design, sources of non-Federal share of funding, budget neutrality, and other comparable program elements in these STCs must be submitted to CMS as amendments to the Demonstration. Changes to the Service Code List, Attachment A, also require an amendment. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Social Security Act (the Act). The State must not implement changes to these elements without prior approval by CMS. Amendments to the Demonstration are not retroactive and FFP will not be available for changes to the Demonstration that have not been approved through the amendment process set forth in paragraph 6 below. The State will notify CMS of proposed Demonstration changes at the quarterly monitoring call, as well as in the written quarterly report, to determine if a formal amendment is necessary.
6. **Amendment Process.** Requests to amend the Demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. Amendment requests must be reviewed by the Federal Review Team and must include, but are not limited to, the following:
  - a) An explanation of the public process used by the State consistent with the requirements of paragraph 14 to reach a decision regarding the requested amendment;

- b) A data analysis which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality expenditure cap. Such analysis must include current “with waiver” and “without waiver” status on both a summary and detailed level through the current extension approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the “with waiver” expenditure total as a result of the proposed amendment which isolates (by Eligibility Group) the impact of the amendment;
  - c) A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and
  - d) If applicable, a description of how the evaluation design must be modified to incorporate the amendment provisions.
7. **Extension of the Demonstration.** States that intend to request demonstration extensions must submit to CMS a complete application at least **6 months prior** to the expiration of the current section 1115(a) extension period. Upon submission, the State will work with CMS to identify specific updates necessary to the submission based on significant programmatic changes (such as changes in State law, population demographics, or expenditures).
8. **Demonstration Phase Out.** The State may suspend or terminate this Demonstration in whole or in part at any time prior to the date of expiration. The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date. In the event the State elects to phase out the Demonstration, the State must submit a phase-out plan to CMS at least 6 months prior to initiating phase-out activities. Nothing herein should be construed as preventing the State from submitting a phase-out plan with an implementation deadline shorter than 6 months when such action is necessitated by emergent circumstances. The phase-out plan is subject to CMS approval. If the project is terminated or any relevant waivers suspended by the State, FFP must be limited to normal closeout costs associated with terminating the Demonstration, including services and administrative costs of disenrolling participants.
9. **Enrollment Limitation During Demonstration Phase-Out.** If the State elects to suspend, terminate, or not renew this Demonstration as described in paragraph 8, during the last 6 months of the Demonstration, individuals who would not be eligible for Medicaid under the current Medicaid State plan must not be enrolled unless the Demonstration is extended by CMS. Enrollment may be suspended if CMS notifies the State in writing that the Demonstration will not be renewed.
10. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the Demonstration, in whole or in part, at any time before the date of expiration, whenever it determines following a hearing that the State has materially failed to comply with the terms of the project. CMS must promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date.
11. **Finding of Non-Compliance.** The State does not relinquish its rights to challenge CMS’ finding that the State materially failed to comply.

12. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waiver or expenditure authorities at any time it determines that continuing the waiver or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS must promptly notify the State in writing of the determination and the reasons for the withdrawal, together with the effective date, and must afford the State an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the Demonstration, including services and administrative costs of disenrolling participants.
13. **Adequacy of Infrastructure.** The State will ensure the availability of adequate resources for implementation and monitoring of the Demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements to the extent they apply; and reporting on financial and other Demonstration components.
14. **Public Notice and Consultation with Interested Parties.** The State must continue to comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) when any program changes to the Demonstration, including, but not limited to, those referenced in paragraph 6 are proposed by the State.
15. **FFP.** No Federal matching funds for expenditures for this Demonstration will take effect until the effective date identified in the Demonstration approval letter.
16. **Citizenship and Identity Documentation Requirements.** The State shall only enroll individuals into the Texas Women's Health Waiver that meet Medicaid citizenship and identity documentation requirements set forth at 42 CFR section 435.407.

#### **IV. ELIGIBILITY**

17. **Eligibility Requirements.** The State shall enroll only individuals meeting all of the following eligibility criteria in the Demonstration.
  - Individuals who do not have creditable coverage for family planning services;
  - Individuals who are ages 18 to 44;
  - Individuals who have net family incomes up to 185 percent of the FPL; and
  - Individuals who have not been sterilized.
18. **Implementation Plan.** Within 30 days from the date of approval of a demonstration amendment the State shall submit an implementation plan. To the extent that an amendment affects the evaluation design, the State must also submit a revised evaluation plan.
19. **Redeterminations.** The State will ensure that redeterminations of eligibility for the demonstration are conducted at least every 12 months. The process for eligibility redetermination shall not be passive in nature, but will require that an action be taken by the recipient. Texas may satisfy this requirement by having the recipient sign and return a renewal form to verify the current accuracy of the information previously reported to the State.

20. **Integrity.** Within 60 days of approval of the demonstration renewal, the State will provide to CMS for approval, an appropriate methodology for ensuring the integrity of initial eligibility determinations and redeterminations of individuals covered under the family planning program.
- The State will use this methodology to conduct reviews of the eligibility determination process on at least an annual basis.
  - As part of the submission, the State will also develop an eligibility determination error rate computation methodology.
  - The State's error rate will be included in the annual report as specified in paragraph 31.
  - If the error rate is beyond the State established threshold, the State will develop a corrective action plan for CMS approval.
21. **Disenrollment.** A woman who loses family planning eligibility due to pregnancy or due to sterilization shall be disenrolled effective the first of the month following confirmation of the condition. A woman who is enrolled in another Medical Assistance eligibility category will be disenrolled on the day prior to the date of enrollment in another eligibility category for the subsequent month.
22. **Primary Care Referral.** The State assures CMS that providers of family planning services will make appropriate referrals to primary care providers as medically indicated. The State also assures that individuals enrolled in this Demonstration receive materials about how to access primary care services. The State must evaluate the impact of providing such referrals for primary care services in the evaluation referenced in paragraph 44.

## V. BENEFITS AND DELIVERY SYSTEMS

23. **Benefits.** Family planning services are medically necessary services and supplies related to birth control, pregnancy prevention, and preventive services listed in Attachment A, including:
- Approved methods of contraception;
  - Drugs, supplies, or devices related to women's health services described above that are prescribed by a physician or advanced practice nurse (subject to the national drug rebate program requirements);
  - Contraceptive management, patient education and counseling; and
  - Primary care referrals to other social service and health care providers as medically indicated, however the costs of those primary care services are not covered for enrollees of this Demonstration.
24. **Services.** Services provided through this Demonstration are paid on a fee for service (FFS) basis.

## VI. GENERAL REPORTING REQUIREMENTS

25. **General Financial Requirements.** The State must comply with all general financial requirements under title XIX of the Social Security Act, as set forth in section VII.

26. **Reporting Requirements Relating to Budget Neutrality.** The State shall comply with all reporting requirements for monitoring budget neutrality as set forth in section VIII.
27. **Annual Submission of Service Code Listing.** Texas will provide to CMS an updated list of Current Procedural Terminology (CPT) and Healthcare Common Procedural Coding Systems (HCPCS) codes covered under the Demonstration on January 31 of each Demonstration year (DY). The revised code list should reflect only changes due to updates in service codes for those services for which the State has already received approval and submitted on a template provided by CMS.
28. **Monitoring Calls.** CMS shall schedule quarterly conference calls with the State following the receipt of the quarterly reports unless CMS determines that more frequent calls are necessary to adequately monitor the Demonstration. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the Demonstration. Areas to be addressed include, but are not limited to, health care delivery, enrollment, quality of care, access, benefits, audits, lawsuits, financial reporting and budget neutrality issues, progress on evaluations, State legislative developments, and any Demonstration amendments the State is considering submitting. The State and CMS shall discuss quarterly expenditure reports submitted by the State for purposes of monitoring budget neutrality. CMS shall update the State on any amendments under review as well as Federal policies and issues that may affect any aspect of the Demonstration. The State and CMS shall jointly develop the agenda for the calls.
29. **Quarterly Operational Reports.** The State must submit progress reports no later than 30 days following the end of each quarter.

The intent of these reports is to present the State's data along with an analysis of the status of the various operational areas under the demonstration. These quarterly reports must include, but are not limited to:

- a) Expenditures including administrative costs.
  - b) The number of demonstration participants disenrolled because of pregnancy or sterilization. (Participants include all individuals who obtain one or more covered family planning services through the demonstration.)
  - c) Events occurring during the quarter, or anticipated to occur in the near future that affect health care delivery, benefits, enrollment, grievances, quality of care, access, pertinent legislative activity, eligibility verification activities, and other operational issues;
  - d) Action plans for addressing any policy and administrative issues identified; and
  - e) Evaluation activities and interim findings.
30. **Annual Report.** The annual report is due 90 days following the end of the fourth quarter of each demonstration year and must include:

- a) In each annual report the State shall report the average total Medicaid expenditures for a Medicaid-funded birth each year. The cost of a birth includes prenatal services and delivery and pregnancy-related services and services to infants from birth up to age 1. (The services should be limited to the services that are available to women who are eligible for Medicaid because of their pregnancy and their infants.)
- b) In each annual report the State shall report the number of actual births that occur to family planning demonstration participants. (Participants include all individuals who obtain one or more covered medical family planning services through the family planning program each year.)
- c) The eligibility error rate data referenced in paragraph 21.
- d) At the end of each DY, a DY fertility rate will be determined for Demonstration participants during that DY.

The base-year fertility rate and the DY fertility rate will be used to calculate a measure of births averted through the Demonstration using the following formula:

$$\text{Births Averted} = (\text{base-year fertility rate}) - (\text{fertility rate of Demonstration participants during DY}) \times (\text{number of Demonstration participants during DY})$$

The intent of the family planning program is to promote better birth outcomes for enrollees and avert unintended pregnancies for Demonstration participants.

- 31. **Final Report.** No later than 180 days prior to the end of the demonstration award period, Texas shall submit a draft final report to CMS for comments. The final report will incorporate all CMS comments and evaluation findings. The final report shall also contain a disclaimer that the opinions expressed are those of the State and do not necessarily reflect the opinions of CMS. The final report is due 90 days after the end of the demonstration award period.

## VI. GENERAL FINANCIAL REQUIREMENTS

- 32. **Reporting Expenditures Under the Demonstration.** In order to track expenditures under this Demonstration, Texas must report Demonstration expenditures through the Medicaid and State Children's Health Insurance Program (SCHIP) Budget and Expenditure System (MBES/CBES); following routine CMS-64 reporting instructions outlined in section 2500 and section 2115 of the State Medicaid Manual. All Demonstration expenditures claimed under the authority of title XIX of the Act must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the Demonstration project number assigned by CMS (including the project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). The State should report Demonstration expenditures on Forms CMS-64.9 Waiver and/or 64.9P Waiver as follows:

- a) Allowable family planning expenditures eligible for reimbursement at the State's Federal medical assistance percentage (FMAP) rate should be entered in Column (B) on the appropriate waiver sheets.
- b) Allowable family planning expenditures eligible for reimbursement at the enhanced family planning match rate should be entered in Column (D) on the appropriate waiver sheets.

**33. Extent of FFP for the Demonstration.** CMS shall provide FFP for CMS-approved services (including prescriptions) provided to women at the following rates and as described in Attachment A.

- a) For procedures or services clearly provided or performed for the primary purpose of family planning (i.e., contraceptive initiation, periodic or inter-periodic contraceptive management and sterilizations) and which are provided in a family planning setting, FFP will be available at the 90 percent Federal matching rate. Reimbursable procedure codes for office visits, laboratory tests, and certain other procedures must carry a primary diagnosis or a modifier that specifically identifies them as a family planning service. Note: The laboratory tests done during an initial family planning visit for contraception include a PAP smear, blood count and pregnancy test. Additional screening tests may be performed depending on the method of contraception desired and the protocol established by the clinic, program or provider. Additional laboratory tests may be needed to address a family planning problem or need during an inter-periodic family planning visit for contraception.
- b) In order for family planning-related services to be reimbursed at the enhanced FMAP rate they must be defined as those services generally performed as part of, or as follow-up to, a family planning service for contraception. Such services are provided because a "family planning-related" problem was identified/diagnosed during a routine/periodic family planning visit. Three kinds of family planning related services are recognized:
  - A colposcopy (and procedures done with/during a colposcopy) performed as a follow-up to an abnormal PAP smear which is done as part of a routine/periodic family planning visit. Only those colposcopies which can generally be performed in the office or clinic setting are covered as a family planning-related service under this Demonstration. No services/surgeries that are generally provided in an ambulatory surgery center/facility (except tubal ligations performed in an ambulatory surgery center/facility), a special procedure room/suite, an emergency room, an urgent care center or a hospital are not covered under these waivers as "family planning-related services."
  - Treatment/drugs for vaginal infections/disorders, other lower genital tract and genital skin infections/disorders in women, and urinary tract infections, where these conditions are identified/diagnosed during a routine/periodic family planning visit. Note: a follow-up visit/encounter for the treatment/drugs is not covered.

- Treatment for disorders/conditions such as hypertension, hypercholesterolemia, diabetes, or upper genital tract disorders are not covered under this demonstration because they are not considered “family planning-related,” even though they may be identified/diagnosed as a result of a family planning visit/encounter.
- c) FFP will not be available for the costs of any services, items, or procedures that do not meet the requirements specified above, even if family planning clinics or providers provide them.
- d) CMS will provide FFP at the appropriate 50 percent administrative match rate for general administration costs, such as, but not limited to, claims processing, eligibility assistance and determinations, outreach, program development, and program monitoring and reporting.
34. **Expenditures Subject to the Budget Agreement.** For purposes of this section, the term “expenditures subject to the budget neutrality agreement” must include all title XIX expenditures provided to individuals who are enrolled in this Demonstration. Participation in the Demonstration is described in paragraph 17 and expenditures are described in paragraph 33. All expenditures that are subject to the budget neutrality agreement are considered Demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and/or 64.9P Waiver.
35. **Administrative Costs.** Administrative costs will not be included in the budget neutrality agreement, but the State must separately track and report additional administrative costs that are directly attributable to the Demonstration. All administrative costs must be identified on the Forms CMS-64.10.
36. **Claiming Period.** All claims for expenditures subject to the budget neutrality agreement (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. All claims for services during the Demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the Demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the Demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.
37. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the Demonstration. The State must estimate matchable Demonstration expenditures (total computable and Federal share) subject to the budget neutrality expenditure cap and separately report these expenditures by quarter for each Federal fiscal year (FFY) on the Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS shall make Federal funds available based upon the State’s estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

- 38. Sources of Non-Federal Share.** The State certifies that matching the non-Federal share of funds for the Demonstration are State/local monies. The State further certifies that such funds shall not be used to match any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.
- a) CMS shall review the sources of the non-Federal share of funding for the Demonstration at any time. The State agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.
  - b) Any amendments that impact the financial status of the program shall require the State to provide information to CMS regarding all sources of the non-Federal share of funding.
- 39. State Certification of Funding Conditions.** The State must certify that the following conditions for non-Federal share of Demonstration expenditures are met:
- a) Units of government, including governmentally-operated health care providers, may certify that State or local tax dollars have been expended as the non-Federal share of funds under the Demonstration.
  - b) To the extent the State utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the State would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.
  - c) To the extent the State utilizes CPEs as the funding mechanism to claim Federal match for payments under the Demonstration, governmental entities to which general revenue funds are appropriated must certify to the State the amount of such tax revenue (State or local) used to satisfy Demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the State's claim for Federal match.
  - d) The State may use intergovernmental transfers to the extent that such funds are derived from State or local tax revenues and are transferred by units of government within the State. Any transfers from governmentally-operated health care providers must be made in an amount not to exceed the non-Federal share of title XIX payments. Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. Moreover, the State must certify that no pre-arranged agreements (contractual or otherwise) exist between health care providers and State and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, (including health care provider-related taxes), fees, business relationships with governmental entities that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

40. **Monitoring the Demonstration.** The State will provide CMS with information to effectively monitor the Demonstration, upon request, in a reasonable time frame.

## VII. MONITORING BUDGET NEUTRALITY

41. The following is the method by which budget neutrality will be monitored for the Texas section 1115 Family Planning Demonstration.

- a) Texas will be subject to a limit on the amount of Federal title XIX funding it will receive for extending Medicaid eligibility for family planning services during the demonstration extension period. This limit will be determined using a pre/post comparison of fertility rates for demonstration participants. Thus, Texas will be at risk for the cost of family planning services (including traditional family planning services at the enhanced match rate and ancillary services at the FMAP rate described in the STCs) that are not offset by the demonstration intervention.
- b) The demonstration will provide family planning services to uninsured women from the age of 18-44 with a net family income up to 185 percent of the FPL who are not otherwise eligible for Medicaid, the State Children's Health Insurance Program, Medicare, or have creditable health insurance coverage. The demonstration will not change the current division of Federal and State responsibility for costs of the current Medicaid program. CMS will confirm that the demonstration expenditures do not exceed the levels of expenditures that would have occurred in the absence of the demonstration.
- c) Annual Budget Limits  
To calculate the overall expenditure limit for the demonstration, separate budget limits will be calculated for each year, and will be on a DY basis. These annual estimates will then be added to obtain an expenditure estimate over the entire demonstration period. The Federal share of the estimate will represent the maximum amount of FFP that the State can receive during the expanded family planning services demonstration. For each DY, the Federal share will be calculated using the FMAP rate(s) for that 12-month period.
- d) The intent of the demonstration is to offset the cost of family planning services for demonstration participants in order to avert unintended pregnancies. During each year of the demonstration, the number of births averted (BA) will be estimated by the following equation:
  - $BA = (\text{base year fertility rate} - \text{fertility rate of demonstration participants during DY}) \times (\text{number of female demonstration participants during DY})$ , where fertility rates will be measured per thousand. The base year fertility rate will be adjusted for age groupings, using the age distribution of the actual demonstration participants and predetermined age-specific fertility rates. Participants are all women who obtain one or more covered medical family planning service(s) through the demonstration. At its option, the State may also adjust the fertility rates for ethnicity.

- The base-year fertility rate must reflect fertility rates during 2003 for individuals in families with income up to 185 percent of the FPL and ineligible for Medicaid except for pregnancy. The fertility rates will include births paid for by Medicaid.
- e) Application of the Budget Limit. The budget limit calculated above will apply to demonstration expenditures, as reported by the State on the CMS-64 forms. If at the end of the Demonstration period, the costs of the Demonstration services exceed the budget limit, the excess Federal funds will be returned to CMS.
- f) Base-Year Fertility Rate  
 The State will submit to CMS base-year fertility rates and a methodology for calculating the fertility rates. Preliminary base-year fertility rates must be submitted for approval within the first operational year of the demonstration and conform to the following requirements:
- They must reflect fertility rates during the Base Year, for women in families with income up to 185 percent of the FPL, and ineligible for Medicaid except for pregnancy.
  - They must be adjusted for the age of all potential demonstration participants.
  - The fertility rates will include births paid by Medicaid.
  - The State will be allowed up to 6 months after the end of the first demonstration year to finalize these preliminary rates. Following the conclusion of each year of the demonstration, a demonstration year fertility rate will be determined by computing an age-weighted average fertility rate during the DY, unless the State demonstrates that the age distribution is consistent with the prior demonstration year(s). The annual age distribution categories will correspond with the base-year age-specific fertility rates. At its option, the State may also adjust the fertility rates for ethnicity.
- g) Expenditure Review. CMS will enforce budget neutrality over the life of the demonstration, rather than annually. However, no later than 6 months after the end of each DY or as soon thereafter as the data are available, the State will calculate annual expenditure targets for the completed year. This amount will be compared with the actual claimed FFP for Medicaid. Using the schedule below as a guide, if the State exceeds these targets, it will submit a corrective action plan to CMS for approval. The State will subsequently implement the approved program.

<u>Year</u>	<u>Cumulative Target Expenditures</u>	<u>Percentage</u>
Year 1	Year 1 budget limit amount	+16 percent
Year 2	Years 1 and 2 combined budget limit amount	+8 percent
Year 3	Years 1 through 3 combined budget limit amount	+4 percent
Year 4	Years 1 through 4 combined budget limit amount	+2 percent
Year 5	Years 1 through 5 combined budget limit amount	+0 percent

- h) Failure to meet budget Neutrality Goals. The State, whenever it determines that the demonstration is not budget neutral or is informed by CMS that the demonstration is not budget neutral, shall immediately collaborate with CMS on corrective actions, which shall include submitting a corrective action plan to CMS within 21 days of the date the State is informed of the problem. While CMS will pursue corrective actions with the State, CMS will work with the State to set reasonable goals that will ensure that the State is in compliance.
- i) Definition of With and Without Waiver Demonstration Costs. The “with” and “without” demonstration costs (Federal share) follow. The “without” demonstration costs are estimates of the costs of births that would occur in the absence of the demonstration. The “with” demonstration costs are estimates of family planning services provided with the demonstration in effect.

**Total Costs:**

YEAR	WITHOUT DEMONSTRATION	WITH DEMONSTRATION	TOTAL SAVINGS
2007	\$1,315,825,939	\$1,330,982,043	(\$15,156,104)
2008	\$1,465,744,832	\$1,443,804,930	\$21,939,902
2009	\$1,632,520,080	\$1,576,049,380	\$56,470,700
2010	\$1,818,611,506	\$1,758,178,388	\$60,433,119
2011	\$2,025,933,509	\$1,960,870,461	\$65,063,048
TOTAL	\$8,258,635,866	\$8,069,885,202	\$188,750,665

**VI. PRIMARY CARE REFERRAL AND EVALUATION**

42. **Access to Primary Care Services.** The State shall facilitate access to primary care services for enrollees in the Demonstration. The State shall assure CMS that written materials concerning access to primary care services are distributed to the Demonstration participants. The written materials must explain to the participants how they can access primary care services. In addition, the State must evaluate the impact of providing referrals for primary care services, as described in the State’s demonstration evaluation design.

43. **Independent Evaluation.** Should CMS conduct an independent evaluation of the section 1115 family planning demonstration the State will cooperate fully with CMS or the independent evaluator selected by CMS, to assess the impact of the Medicaid demonstrations and/or to examine the appropriateness of the averted birth budget neutrality methodology. The State will submit the required data to CMS or its contractor.

44. **Final Evaluation Design.** A final evaluation design report must be submitted to CMS for approval within 30 days from the award of the demonstration extension. At a minimum, the evaluation design should include a detailed analysis plan that describes how the effects of the demonstration will be isolated from those of other initiatives occurring in the State. The report should also include an integrated presentation and discussion of the specific hypotheses (including those that focus specifically on the target population for the demonstration) that are being tested. The report will also discuss the outcome measures that will be used in evaluating the impact of the demonstration, particularly among the target population. It will also discuss the data sources and sampling methodology for assessing these outcomes. Finally, it will discuss how the referral process for primary care will be evaluated. The State must submit primary care materials to CMS with an evaluation of the effectiveness of those materials. The State must implement the evaluation design and report its progress in each of the demonstration's quarterly reports.
45. **Monitoring the Rate of Expenditure Growth.** Family planning expenditures under the Medicaid program have increased in recent years and CMS is interested in monitoring these expenditures. Thus, as part of the overall monitoring of the demonstration, CMS will also be monitoring the rate in expenditure growth for family planning services. This monitoring will be done on a per capita basis, using total expenditures recorded during the first year of the demonstration as a baseline. As a frame of reference the annual rate of growth of actual expenditures will be compared with the baseline amount trended forward using Consumer Price Index (CPI) Medical. The comparison of actual per capita expenditures over the life of the demonstration and per capita expenditures trended using CPI Medical will be considered if the State should seek an extension of their family planning demonstration.
46. **Federally Contracted Evaluation.** In addition, a federally-contracted evaluation will examine the appropriateness of the budget neutrality methodology of these demonstrations by assessing the births that have been averted as a result of the demonstrations, the data sources currently used to assess averted births and budget neutrality, and expenditures overall. Based on the evaluation findings and other information, CMS reserves the right to negotiate a new budget neutrality methodology, if CMS deems appropriate. Such a methodology change could range from a change in data sources used to determine budget neutrality, to a total change in methodology, such as incorporating a per capita cap like the one described above. Any and all changes to the budget will be made in full consultation with the State, including expenditure data used in the methodology.
47. **Interim Evaluation Reports.** In the event the State requests to extend the Demonstration beyond the current approval period under the authority of section 1115(a), (e), or (f) of the Act, the State must submit an interim evaluation report as part of the State's request for each subsequent renewal.
48. **Final Evaluation Plan and Implementation.**
- a) CMS shall provide comments on the draft designs within 60 days of receipt, and the State must submit a final plan for the overall evaluation of the Demonstration described in paragraph 45, within 60 days of receipt of CMS comments.

- b) The State must implement the evaluation designs and report its progress on each in the quarterly reports.
- c) The State must submit to CMS a draft of the evaluation report within 120 days after expiration of the Demonstration. CMS must provide comments within 60 days after receipt of the report. The State must submit the final evaluation report within 60 days after receipt of CMS comments.

49. **Cooperation with CMS Evaluators.** Should CMS conduct an independent evaluation of any component of the Demonstration; the State will cooperate fully with CMS or the independent evaluator selected by CMS. The State will submit the required data to the contractor or CMS.