

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.¹ 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.² 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.

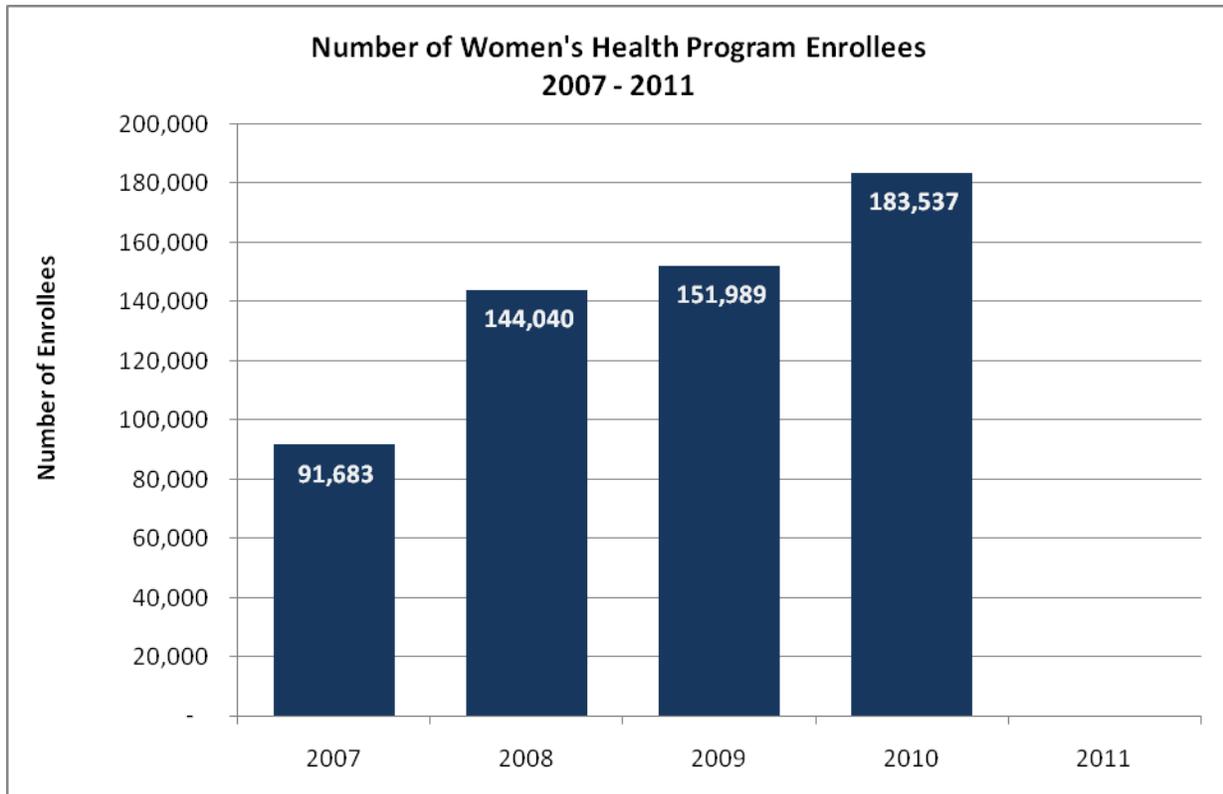
In the renewal, Texas also proposes to offer treatment for sexually transmitted diseases under the family planning waiver. The Women's Health Program already includes basic health screenings that identify the presence of specific diseases and health conditions. Currently, women who are diagnosed with 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 2010.³ 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.⁴ 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.⁵ 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.⁶

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.⁷ Thirteen percent of Texas' population received Medicaid-reimbursed services in 2009.⁸

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.⁹ 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.¹⁰

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 2009.¹¹ 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.¹² (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 Exemptions¹³

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.¹⁴ 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.¹⁵ 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.¹⁶ 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.¹⁷

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.¹⁸ These findings are consistent with the results of family planning waivers in other states.¹⁹

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.²⁰

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.²¹ 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.^{22,23,24}

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.²⁵

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.

Deliverable	Program Year	Due Date
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).²⁶

Women’s Health Program Caseloads, Births Averted, and Net Savings: Years 1, 2, and 3^a

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

^a Data from Women’s Health Program annual reports submitted to CMS.

^b 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).²⁷ 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

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

^a 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).²⁸ 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 3²⁹**

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

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

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

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

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

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

^a Includes prenatal care, delivery, postpartum care, and first year of life costs for infant.

^b Savings after paying the costs of the program.

Appendix B. Projected Women’s Health Program Caseloads, Births Averted, Costs, and Savings: Years 6 and 7³⁰

Table B1. Projected Women’s Health Program Caseloads, Participants, and Births Averted: Years 6 and 7^a

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

^a Projections by HHSC Forecasting Division.

Table B2. Projected Women’s Health Program Costs: Years 6 and 7^a

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

^a Projections by HHSC Forecasting Division.

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

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

^a Includes prenatal care, delivery, postpartum care, and first year of life costs for infant.

^b Savings after paying the costs of the program.

¹ TX Health and Human Services Commission, Center for Strategic Decision Support data.

² Texas PRAMS 2009, prepared by: DSHS OPDS, August 16, 2011.

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

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

⁵ 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.

⁶ 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.

⁶ Ibid.

⁷ 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.

⁸ Texas Health and Human Services Commission. Texas Medicaid in Perspective, 7th 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>.

⁹ 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.

¹⁰ 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.

¹¹ Ibid.

¹² TX Health and Human Services Commission, Center for Strategic Decision Support data.

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

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

¹⁵ 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).

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

¹⁷ 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.

¹⁸ 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.

¹⁹ 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.

²⁰ 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).

²¹ The participation rate varied from 55 percent to 64 percent.

²² Cost neutrality projections are presented in Appendix B.

²³ 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.

²⁴ 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.

²⁵ 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.

²⁶ 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.

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

²⁸ 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.

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

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