Annual Report

Planning for Healthy Babies Program® (P4HB®)

1115 Demonstration in Georgia

January-December 2021

Submitted by:

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And their Outside Contractor

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March 31, 2022

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I. Summary and Background

Georgia's Planning for Healthy Babies Program® (P4HB®), section 1115(a) Medicaid Demonstration Project expanded the provision of family planning services to 1) residents of Georgia who are U.S. citizens, otherwise uninsured, and not eligible for Medicaid; 2) 18 through 44 years of age; 3) not pregnant but able to become pregnant; and 4) with incomes at or below 200 percent of the Federal Poverty Level (FPL) residing in the state. (With the state's use of the MAGI income measure, this threshold became 211% FPL as of April 2017.) The P4HB program, initially approved for a three-year period from January 1, 2011, through December 31, 2013, was granted multiple *temporary* extensions through August 28, 2019 and then renewed for ten years through December 31, 2029.

In addition to the family planning only (FP only) component the P4HB program provides a unique Interpregnancy Care (IPC) component. In this component, services include nurse case management/Resource Mother (RM) outreach, to women who meet the above eligibility criteria and who recently delivered a very low birth weight (VLBW) infant (<1500 grams or < 3 pounds 5 ounces). In addition, the program offers nurse case management/Resource Mother outreach services to women enrolled in the Georgia LIM (Low Income Medicaid) or ABD (Aged, Blind and Disabled) Medicaid programs who recently delivered a VLBW infant. The P4HB program provides these women (RM only) services through P4HB.

The approved renewal of the waiver is based on the determination that the continuation of the demonstration is likely to promote the objectives of Title XIX by "improving access to high-quality, person-centered family planning services that produce positive health outcomes for individuals. It is also likely to lead to positive health outcomes through its unique program component of Interpregnancy Care (IPC) which provides targeted benefits for physical and behavioral health services to otherwise uninsured women that have delivered very low birth weight (VLBW) infants in Georgia.

The goals of the demonstration and related objectives are listed below.

Demonstration Goals:

- **Primary**: Reduce Georgia's LBW and VLBW rates;
- **Secondary:** Reduce the number of unintended pregnancies in Georgia;
- **Tertiary**: Reduce Georgia's Medicaid costs by reducing the number of unintended pregnancies by women who otherwise would be eligible for Medicaid pregnancy-related services.

Demonstration Objectives

- Improve access to family planning services by extending eligibility for these services to newly eligible women.
- Increase consistent use of contraceptive methods by providing wider access to family planning services and incorporating care coordination and patient-directed counseling into family planning visits.
- Increase family planning utilization among Medicaid eligible women by using an outreach and public awareness program designed with input from family planning patients and providers as well as women needing but not receiving services.
- Increase child spacing intervals through effective contraceptive use.
- Provide access to interpregnancy primary care health services for eligible women who deliver a VLBW infant.
- Decrease unintended and high-risk pregnancies among Medicaid eligible women.
- Decrease Medicaid spending attributable to unintended births and LBW and VLBW babies.
- Decrease the number of Medicaid-paid deliveries from the number expected to occur in the absence of the Demonstration beginning in the second year.
- Decrease late teen pregnancies by reducing the number of first or repeat teen births among Medicaid eligible women ages 18-19 years.

Key Accomplishments

In the first *eight and a half years* of the P4HB demonstration, the key accomplishments relative to the primary goals stated above were:

- A decrease in: 1) unintended pregnancies; 2) teen births; 3) very short (<6 months) interpregnancy intervals; and an increase in 4) age at first birth among women eligible for pregnancy Medicaid with implementation of P4HB.

- Among those enrolling in the FP only component and *using* services, compared to those not using services, there was 1) a lower percentage with a short interpregnancy interval (<6 months, 12 months, 18 months) among those experiencing a pregnancy after enrollment and 2) a higher rate of birth of normal birthweight infants among those using long-acting reversible contraceptives (LARCs) and experiencing a pregnancy after enrollment.

- Among those enrolling in the IPC component, compared to those eligible but not enrolling, there was 1) a lower likelihood of a clinically inappropriate interpregnancy interval (< 12 or 18 months), a repeat pregnancy or repeat delivery within 18 months of enrollment and 2) a lower likelihood of an adverse outcome (fetal death, stillbirth, VLBW or LBW infant) in repeat deliveries within 18 months among those experiencing a pregnancy after enrollment.

However, some goals were not met:

- Enrollment in the FP only component has consistently lagged behind expectations.

- Implementation of P4HB has not been associated with overall reductions in LBW and VLBW births in Georgia.

- While IPC/Resource Mother only women received interpregnancy care services, including contraceptive methods and management of hypertensive and diabetes disorders, the rates of utilization could be improved.

Key Accomplishments in Renewal Period:

- The percent of uninsured women eligible in the community enrolled into the FP only component in this program year increased to ~32% from 27% in the previous year, even as the number of uninsured women increased during the pandemic.

- The percent of women eligible for IPC or RM only services who were enrolled in this program year increased to ~24% from 17% in the prior program year.

- The percentage of FP only enrollees using long-acting reversible contraceptives (LARCs) held steady at 18% in this program year.

- Repeat pregnancies within 18 months were 6.9 percentage points lower among RSM women eligible for P4HB FP only and participated by using any family planning service compared to those eligible that did not enroll.

- Half (50.3%) of women enrolled in IPC used some type of contraceptive method by one year postpartum and 13.2% used LARCs.

- A similar percentage of women enrolled in RM only used some type of contraceptive method by one year postpartum (47.2%) and 11% used LARCs.

- Repeat pregnancy within 18 months of an index VLBW delivery was 8.4 percentage points lower among women eligible for P4HB IPC and participated by using any family planning services compared to those eligible that did not enroll.

- Repeat pregnancy within 18 months of an index VLBW delivery was 11.1 percentage points lower among women eligible for RM only and participated by using any family planning services compared to those eligible that did not enroll.

- Fully 78% of women enrolled in IPC and RM only with evidence of diabetes or hypertension received services to manage these conditions in their postpartum period.

- Adverse outcomes in subsequent deliveries were 4 percentage points lower for women eligible for IPC who enrolled compared with those eligible that did not enroll.

- Enrollees who accepted case management by a RM but had no face-to-face or phone contact for case management were more likely to use a more effective method of contraception (10%) at the end of the period than those declining case management (5%).

II. Operational Updates

Unexpected Trends –COVID-19. The onset of the COVID-19 pandemic in 2020 had an unexpected impact on the Medicaid program in general and possibly, on enrollment of eligible women in the community into the P4HB FP only program component. The pandemic also likely increased the number of women eligible (uninsured and < 211% FPL) for P4HB in Georgia's communities. Using data from the American Community Survey (ACS) for these years we estimate the number of uninsured increased from 179,161 in 2019 to 194,126 in 2020. Since the COVID-19 public health emergency (PHE) meant that women delivering on Georgia's Right from the Start Medicaid (RSM) eligibility were retained in full Medicaid coverage, this could lower the enrollment of these new mothers into the FP only component of P4HB. Both women in Georgia's RSM and Low Income Medicaid (LIM) eligibility categories with a very low birth weight infant are eligible for the IPC component of P4HB along with retention in full Medicaid under the PHE, but there may have been and continue to be confusion among providers and women regarding these additional RM services. We note that the use of family planning services among FP only enrollees declined from 20% with any family planning visit to ~17% during the COVID-19 period and contraceptive use among FP only enrollees also declined.

Merger of CMOs. The women in the FP only and IPC/RM components of P4HB have been enrolled in four Care Management Organizations (CMOs) serving Medicaid enrollees throughout most of the demonstration period. These CMOs are: Amerigroup, CareSource, PeachState, and WellCare. As of May 1, 2021, WellCare merged with PeachState and all P4HB enrollees were brought into PeachState for service provision. As noted in our prior Semi-Annual report for P4HB, this change meant that the highest share of FP only enrollees (~46%) was now in the PeachState CMO. We report later on changes in total enrollment in all components of P4HB as well as their distribution across the three CMOs that remain in the Georgia Medicaid market.

Legislative Updates. On April 16, 2021, the Center for Medicare and Medicaid Services (CMS) approved implementation of the Georgia Postpartum Extension beginning statewide effective July 1, 2021 and continuing through March 31, 2026. This waiver will extend postpartum Medicaid coverage to women with incomes up to 220 percent of the Federal Poverty Level (FPL), from a previous period of 60 days to one hundred and eighty (180) days, or six months. Prior to the Georgia Postpartum Extension, the Georgia Department of Community Health (DCH) administered Georgia's RSM eligibility group with this income criteria throughout a woman's pregnancy and through a 60-day postpartum period. This waiver will incorporate the Resource Mother (RM) component of the P4HB demonstration waiver.

There have been several extensions of the State of Georgia's public health emergency (PHE), which was originally set to expire on July 1, 2021, at 12:00 AM. In response to the State's experience of ongoing emergency due to the impacts of COVID-19 on the economy, supply chain, and healthcare infrastructure, on June 30, 2021, Governor Kemp declared a State of Emergency for Continued COVID-19 Economic Recovery in the State via Executive Order on June 30, 2021. Governor Kemp renewed the Economic State of Emergency continuously through March 27, 2022, through various Executive Orders (January 18, 2022, and February 18, 2022). Since the PHE led to retention of Medicaid enrollees in all eligibility groups, there is an impact on teens (age 18) in PeachCare (Georgia's Children's Health Insurance Program) and older women in Medicaid eligibility categories that may have otherwise moved into one of the components of the P4HB demonstration when their Medicaid coverage ended.

Public Forum. P4HB Public Forum was held on August 18, 2021 as a part of the Medical Care Advisory Committee (MCAC). This was a virtual meeting via Microsoft Teams from 11:00 a.m. to 12:30 p.m. There were no public comments made regarding P4HB in this meeting.

III. Performance Metrics

Impact of the Demonstration. For the P4HB to have an impact on the performance metrics outlined above, the enrollment of those eligible for the FP only and other components of the program is the first step. We note the progress made relevant to the metrics in the sections that follow. Since enrollment is key to the first metric, we discuss some background on the P4HB enrollment process.

Since the implementation of the Georgia Gateway System in July 2017, enrollment in Medicaid and hence, the components of P4HB, have been centralized. The Georgia Gateway System is the state's integrated web portal that clients can use to apply for, check and renew their benefits. Through a series of screening questions, the system determines client eligibility across multiple benefits programs, including the various Medicaid programs as well as the Supplemental Nutrition Assistance Program, the Special Supplemental Nutrition Program for Women, Infants, and Children, and Temporary Assistance for Needy Families, and Childcare and Parent Services. Applicants are screened for various Medicaid eligibility categories through a 'cascading process' and P4HB is provided as an option if the applicant is not eligible for full-scope Medicaid. The FP only, IPC and RM only enrollees have access to a subset of Medicaid services specific to each P4HB component. In this section we report on the reach of P4HB in terms of enrolling those eligible.

Objective: Improve access to family planning services by extending eligibility for these services to newly eligible women.

Outcome: The percentage of eligible women in the community successfully enrolled in the FP only component of P4HB lagged behind expectations in earlier program years but increased with the implementation of the Georgia Gateway System in 2017. **Table 1**, shows the numbers and percentage of women eligible for the FP only and IPC/Resource Mother only components, enrolled and hence, made newly eligible for services, in the 2019 and 2020 time period.

Table 1. Enrollment of P4HB Population Eligible in the Community 2019 and 2020

Demonstration Group	Enrolled in 4th Quarter	Population Eligible in Community[1,2]	Percent Eligible Enrolled
2019 P4HB Enrollment/Participation			
FP Only 2019[3]	48,556	179,651	27.0%
FP Only 2019[4]	48,556	97,910	49.6%
IPC/Resource Mother Only	542	3,193	17.0%
2020 P4HB Enrollment/Participation			
FP Only 2020[3]	61,348	194,126	31.6%
FP Only 2020[4]	61,348	105,799	58.0%
IPC/Resource Mother Only	762	3,119	24.4%

[1]Those eligible for family planning only benefits are uninsured female citizens ages 18-44 with income ≤ 211% FPL and residing in Georgia. The number of uninsured women in this age and income range was estimated using the ACS 1-year PUMS for 2011 – 2020 as shown in column 3.
[2]Those eligible for IPC include uninsured women 18-44 with income ≤ 211% FPL residing in Georgia with a live born infant under 1500 grams at delivery. We use women with a VLBW infant born on Medicaid in the past two years as the denominator for this calculation in each year. Those eligible for Resource Mother only include LIM and ABD Classes of Eligibility women with a VLBW infant. We combine the enrollment counts for IPC and Resource Mother for the numerator and use all Medicaid paid VLBW births in 2019 and 2020 (2019 n = 1,610 and 2020 n = 1,509) as the denominator in 2020. [3]*We use the numbers enrolled as of the 4th quarter of 2020 (and reported in our 4th Quarter 2020 Report) for consistency with the earlier parts of this report.* [4] *This denominator adjusts for women in need of family planning services based on a report from the Guttmacher Institute. Their estimate is that 54.5% of women in the age group 13-44 needed family planning services; they count women who are sexually active, able to get pregnant but not currently pregnant or trying to get pregnant. See:* http://www.guttmacher.org/pubs/win/contraceptive-needs-2008.pdf. *We multiplied the "in the community" population by .545 to get the 155,830 for 2012, 156,535 for 2013, 126,831 for 2014, 113,341 for 2015, 102,101 for 2016, 109,373 for 2017, 107,694 for 2018, 97,910 for 2019, and 105,799 for 2020 as shown in column 3.*

The number of women enrolled in the FP only component increased from 48,556 in 2019 to 61,348 in 2020 which meant the percentage of those eligible in the community increased slightly from 27% to almost 32% in this reporting period. This is despite the increase of 8% of women eligible for FP only in the community, likely due to the loss of jobs and employer sponsored insurance during COVID-19. There was also an increase in the percentage of those eligible and estimated to be in need of family planning services (see footnote to Table 1) enrolled in the FP only component from ~50% in 2019 to 58% in 2020.

Objective: **Provide access to interpregnancy primary care health services for eligible women who deliver a VLBW infant.**

Outcome: The number of women enrolled in the IPC and RM only components increased from 542 in 2019 to 762 in 2020 and this represents an increase in the percentage of women eligible for these components from 17% to 24%. Those eligible for IPC or RM only actually declined slightly from 3,193 to 3,119 over this period which reflects a decline in the number of VLBW births of 1,620 in 2019 to 1,509 in 2020 (see note to **Table 1**) paid by Medicaid. While the increase in enrollment of those eligible is an accomplishment, the percentage of eligible women

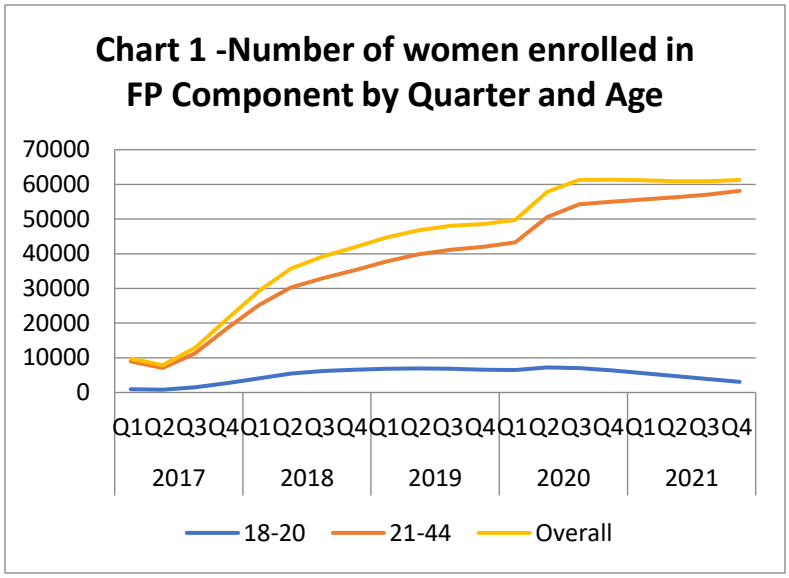
being enrolled and hence, offered IPC and RM only services, could be improved from the <25% level shown.

Once enrolled in P4HB, access to services for women in each of the P4HB components is through the CMO provider network that the enrollees choose or are assigned to. As noted above, the number of CMOs serving Georgia Medicaid clientele was reduced from four to three in July 2021. Total enrollment in 2021 in each component of P4HB by CMO are shown in **Table 2** below.

Table 2. Growth in Enrollment of P4HB Population by CMO and Age Group in 2021

ENROLLMENT BY CMO AND AGE GROUP FOR Q2 AND Q4 2021												
	Amerigroup			Caresource			Peachstate/Wellcare			Overall		
	Q2	Q4	Growth	Q2	Q4	Growth	Q2	Q4	Growth	Q2	Q4	Growth
Family Planning Only												
18-20	1400	957	-31.6%	1124	766	-31.9%	2165	1383	-36.1%	4689	3106	-33.8%
21-44	16411	17166	4.6%	14107	14986	6.2%	25747	25989	0.9%	56265	58141	3.3%
Total	17811	18123	1.8%	15231	15752	3.4%	27912	27372	-1.9%	60954	61247	0.5%
% Total	29.2%	29.6%		25.0%	25.7%		45.8%	44.7%				
Inter-Pregnancy Care												
18-20	4	2	-50.0%	4	2	-50.0%	6	1	-83.3%	14	5	-64.3%
21-44	74	64	-13.5%	115	114	-0.9%	97	73	-24.7%	286	251	-12.2%
Total	78	66	-15.4%	119	116	-2.5%	103	74	-28.2%	300	256	-14.7%
% Total	26.0%	25.8%		39.7%	45.3%		34.3%	28.9%				
Resource Mother Outreach												
18-20	6	3	-50.0%	6	7	16.7%	13	12	-7.7%	25	22	-12.0%
21-44	88	87	-1.1%	151	199	31.8%	253	213	-15.8%	492	499	1.4%
Total	94	90	-4.3%	157	206	31.2%	266	225	-15.4%	517	521	0.8%
% Total	18.2%	17.3%		30.4%	39.5%		51.5%	43.2%				
All Programs												
18-20	1410	962	-31.8%	1134	775	-31.7%	2184	1396	-36.1%	4728	3133	-33.7%
21-44	16573	17317	4.5%	14373	15299	6.4%	26097	26275	0.7%	57043	58891	3.2%
Total	17983	18279	1.6%	15507	16074	3.7%	28281	27671	-2.2%	61771	62024	0.4%
% Total	29.1%	29.5%		25.1%	25.9%		45.8%	44.6%				

There was a stable level of enrollment in the FP only component with a total of 61,348 at the end of Quarter 4 2020 compared to 61,247 by the end of Quarter 4, 2021. The age distribution of FP only enrollees continues to shift toward older women. Across all CMOs there was almost a 34% decline in the number of FP only enrollees 18-20 years of age. While there was growth in the number aged 21-44, it was only a 3.3% increase, resulting in the stable FP only enrollment level noted. The upward trend in enrollment of women ages 21-44 in the FP only component occurred earlier in the demonstration (see **Chart 1**), in 2017, as the Georgia Gateway enrollment system was implemented for Medicaid and other benefit programs. While that upward trend has continued, the slight upward trend for the 18-20 year-old women that began in 2017 did not continue. Their enrollment numbers stabilized in 2018-2019 but started to decline in 2020 perhaps due to the pandemic. The PHE retention in Medicaid eligibility was not extended to teens in Georgia's Children's Health Insurance Program (CHIP), called PeachCare in Georgia, but teens aging out of PeachCare are made aware of their possible eligibility for P4HB.



The CMOs reported on changes in enrollment among younger age groups along with strategies for improving education and outreach to eligible women. One CMO speculates that more young members may not have met the eligibility criteria for P4HB and may have enrolled in another Medicaid eligibility group. Another CMO suggested that young members moved home during the pandemic and could have been placed back on their parent's insurance for coverage. This CMO also acknowledged other reasons for the decline in enrollment among 18-20 year old members, including difficulty enrolling through Gateway, and experiencing challenges in accessing health care not covered by P4HB, thus being dissatisfied with the program and

choosing not to renew or enroll. To address these problems, the CMOs have indicated they are implementing enhanced provider and member education.

The number of women enrolled in the IPC and RM only component of P4HB increased only slightly from 762 in 2019 to 777 in 2020. We see a decline in all age groups in the IPC component but only a decline among the 18-20 year-old women in the RM only component. As noted earlier (footnote, Table 1), there was a decline in the number of women with a VLBW infant born on Medicaid and hence, eligible for IPC or RM only services. It may also be that retention in full Medicaid benefits under the PHE has kept women from enrolling in these P4HB components even though they would receive the additional benefit of the RM services.

Access through CMOs**.** Access to services and their specific modes of service delivery will vary across the CMOs based on their provider networks. As the data in Table 2 show, the PeachState/WellCare merger resulted in the largest percentage (~45%) of the FP only enrollees being in the PeachState CMO by the end of the 4th quarter of 2021. While this means that PeachState also has the largest percentage of all P4HB enrollees at this point in time, CareSource serves the largest percentage of IPC (~45%) and RM only (~40%) enrollees at the end of 2021. All CMOs experienced the decline across all age groups in the IPC component of P4HB over the 2021 period. The CareSource CMO, however, experienced an increased enrollment in the RM only component of P4HB from the beginning to the end of 2021, while the other two CMOs saw declines in enrollment in this component.

Objective: Increase family planning utilization among Medicaid eligible women by using an outreach and public awareness program designed with input from family planning patients and providers as well as women needing but not receiving services.

Outcome: Table 3, has information from each CMO regarding their outreach activities from January-December 2021. Data for WellCare reflect outreach activities only for Quarter 1 (January-March 2021) since the CMO merged with Peach State in May 2021.

Table 3: CMO Outreach, January-December 2021		
CMO	**All Outreach Activities**	**IPC Specific Outreach**
Amerigroup	• Virtual conferencing in place of face-to-face visits. • 74 virtual and drive-through baby showers/diaper days with 2,104 participants • New member mailings and welcome calls • Recertification reminders to new moms • Loss of benefit notifications • AGP Baby Kit Delivery bags to top hospitals • Marking initiative centered around OB providers	• Reminder letters and phone calls • 283 total successful welcome calls made to IPC and RM participants • 23 virtual face-to-face visits were completed. All physical F2F visits and unannounced visits are on hold until further notice.
CareSource	• Welcome calls and postcards to all P4HB enrollees within 30 days of being eligible. • Mailings sent to help enrollees navigate the CareSource website, ID cards, New Member and Provider survey, and P4HB member handbook. • New member mailings and ID cards were mailed to all P4HB enrollees.	• Welcome calls to IPC and RM participants • Reminder letters and phone calls • A total of 6,386 calls were attempted by CareSource to IPC and RM members. Of these calls, 2,459 calls were successful. • Due to the COVID-19 pandemic, no home visits were made.
Peach State	• During Q1 and Q2, 11,764 new enrollees received a call from PS about the P4HB benefits and services, and the same number of new enrollee packets were mailed to new members. No call activity was documented for Q3 and Q4 2021. • Hosted 18 virtual events during Q1 and Q2 with P4HB enrollees to discuss program services. Hosted a "paint and chat" virtual event in Q4 2021 with 7 enrollees. No virtual events were held in Q3 2021. • During Q1 and Q2, 270 enrollees (both new and existing PSHP members) received educational materials resulting in a phone call to the plan to inquire about P4HB. No new outreach events were conducted in Q3 "due to delays with the system that notifies targeted audience." • A total of 11,705 educational packets were mailed in 2021 to members who were within 60 days of delivering a baby. • Starting in Q3, PSHP's Healthy Start team shifted to a cultural competency initiative based on a recent DRAGG analysis. Because of this analysis, their team has a new focus on African American women in targeted regions that are least likely to complete their postpartum visit. • PSHP has also focused its outreach to educate members about the new Medicaid post-partum waiver and the importance of the member completing their postpartum visit within six weeks.	• A total of 2,165 phone contacts were made in 2021. • Peach State initiated porch visits with IPC and RM enrollees, with a total of 95 completed by the end of the year. Virtual visits continued as well.

Table 3: CMO Outreach, January-December 2021		
CMO	**All Outreach Activities**	**IPC Specific Outreach**
WellCare (Q1 2021 only)	• Due to the COVID-19 pandemic, most community outreach has transition to virtual activities. • P4HB mailings sent to 964 information packets to potential members.	• Resource Mothers completed 45 virtual events and educated 493 Georgians to the P4HB program. • Members who delivered a VLBW baby received outreach and education in order to build rapport and reduce gaps in care through the loss of insurance. • Resource Mothers conducted telephone outreach to 464 enrollees. Of these, 145 (31.3%) were educated on Plan benefits.

Objective: Increase consistent use of contraceptive methods by providing wider *access* to family planning services and incorporating care coordination and patient-directed counseling into family planning visits.

Outcome: These activities targeted new and prospective enrollees across the CMOs and ranged from telephone calls, mailings, and virtual face-to-face visits. Most outreach activities in 2021 were limited or conducted virtually due to the continuation of the COVID-19 pandemic. Notably, PSHP has initiated porch visits with its RM and IPC enrollees. Additionally, this CMO's outreach and educational efforts address the new Medicaid post-partum waiver with members and encourages them to complete their six-week postpartum visit.

We note that the access measures used in this and the following sections, reflect the Andersen framework.[1] This framework posits that *access* can be measured as 'potential' (having a usual source of care) or 'realized' (actual use of services) access. The framework used by this author also links the use of services to desired health outcomes as a reflection of *quality*. In this and following sections, we use the linked enrollment and claims data for women in the several components of P4HB to measure their utilization of covered services and in turn, outcomes reflective of the quality of services received.

Women in the FP only component of P4HB gain access to a family planning initial exam and annual exam; family planning and related services including contraceptives and supplies; sterilization; follow-up family planning visits; pregnancy tests and pap smears; testing for

Sexually Transmitted Infections (STIs); treatment and follow-up for all STI(s) except HIV/AIDS and hepatitis. Services also include counseling and referrals to social services and primary health care providers; family planning pharmacy visits; vitamins/folic acid; select immunizations for participants ages 18 through 20.[2]

Table 4 shows the percentage of women in the FP only component who had 1) a family planning visit, 2) number of visits, and 3) a visit for a contraceptive method in their first 6 months of enrollment in P4HB. As these data show, only 20% had any family planning visit in their first 6 months of enrollment in 2019 and this dropped to 17% in 2020.

Table 4. Use of Family Planning Services within Six Months of Enrollment among P4HB Family Planning only Enrollees, 2019-2020

Demonstration Year	Use Among P4HB Women FP Only			
	N	Any Family Planning Visit in First 6 Months	Mean Visits Per User in First 6 Months	Any Visit /Service for Contraceptive Method in First 6 Months
2019	24448	20.0%	2.13	13.7%
2020	22509	17.1%	2.02	10.8%

Denominator is all women ages 18-44 started in P4HB during the year.

In both years, the number of family planning visits averaged two per enrollee. There was also a decline in the percentage of FP only enrollees having a visit/service for a contraceptive method in those first 6 months. This percentage declined from almost 14% in 2019 to around 11% in 2020. Some of these declines could be related to the COVID-19 pandemic and the overall lower utilization of health care services.

While the use of family planning services and contraceptives is a personal one, the relative effectiveness of alternative types of contraceptives in preventing unintended pregnancies and lengthening interpregnancy intervals is well known. As noted in the footnote to **Table 5**, the World Health Organization (WHO) categorizes contraceptive methods by their relative effectiveness if preventing unintended pregnancy from Tier 1 (implants, intrauterine devices, sterilization) to Tiers 3 or 4 (condoms, diaphragms, fertility awareness methods, spermicides).

Table 5. Distribution of Contraceptive Methods among Users within Six Months of Enrollment, P4HB Family Planning only Enrollees, 2019-2020

Demonstration Year	% of Contraceptive Methods Paid by Medicaid According to Tier of Effectiveness: P4HB – FP Only					
	N	Tier 1	Tier 2	Tier 3/4	Tier Not Spec	LARC
2019	3908	19.5%	74.1%	0.7%	5.7%	18.1%
2020	2442	19.8%	71.1%	0.7%	8.4%	18.3%

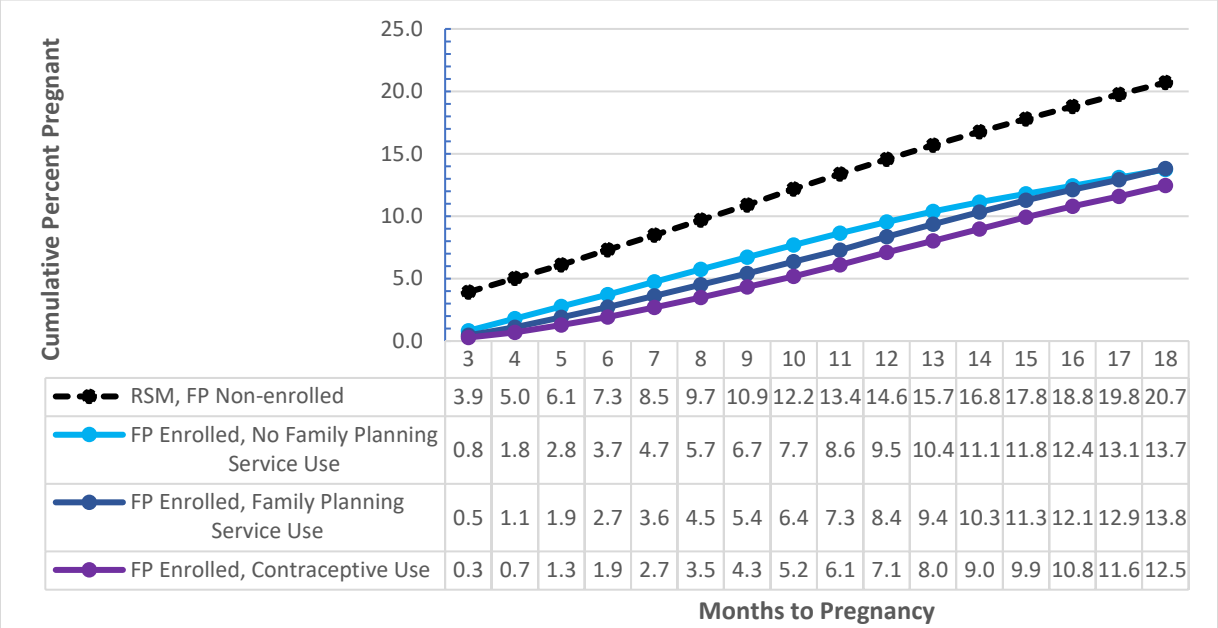
Notes: WHO Tiers of contraceptive effectiveness: Tier 1(High effectiveness): implants, intrauterine devices, sterilization; Tier 2 (Medium effectiveness): injectable methods, patch, pills, and vaginal ring; Tier 3 and 4 (Low effectiveness): condoms, diaphragms, fertility awareness methods, spermicides; Long-acting reversible contraceptive methods (LARC) are a subset of Tier 1 methods that are reversible and include implants and intrauterine devices. Tier not specified indicates that the tier of the method could not be assigned based on the claims codes

During both 2019 and 2020, the most commonly used contraceptive methods were those in Tier 2 (injectable methods, patch, pills, and vaginal ring). During both 2019 and 2020, approximately 20% of contraceptive methods paid by Medicaid among FP enrollee users were highly effective, those in Tier 1, with nearly all of these being long-acting reversible contraceptives (LARCs).

Objective: Increase child spacing intervals through effective contraceptive use.

Outcome: The data in **Chart 2** (below) indicate the impact of enrollment in the FP only component and in turn, use of services, on a repeat pregnancy insured by Medicaid**.** The broken line shows months to pregnancy for RSM women who do not enroll in P4HB while the colored lines show months to pregnancy for those enrolling and not using services (light blue line); for those enrolling and using any family planning services (dark blue line); and those specifically using contraceptive services (purple line).

Chart 2. Cumulative Months to Subsequent Pregnancy for Women Who Recently Delivered on RSM According to P4HB Enrollment and Service Use for 2011 through 2019

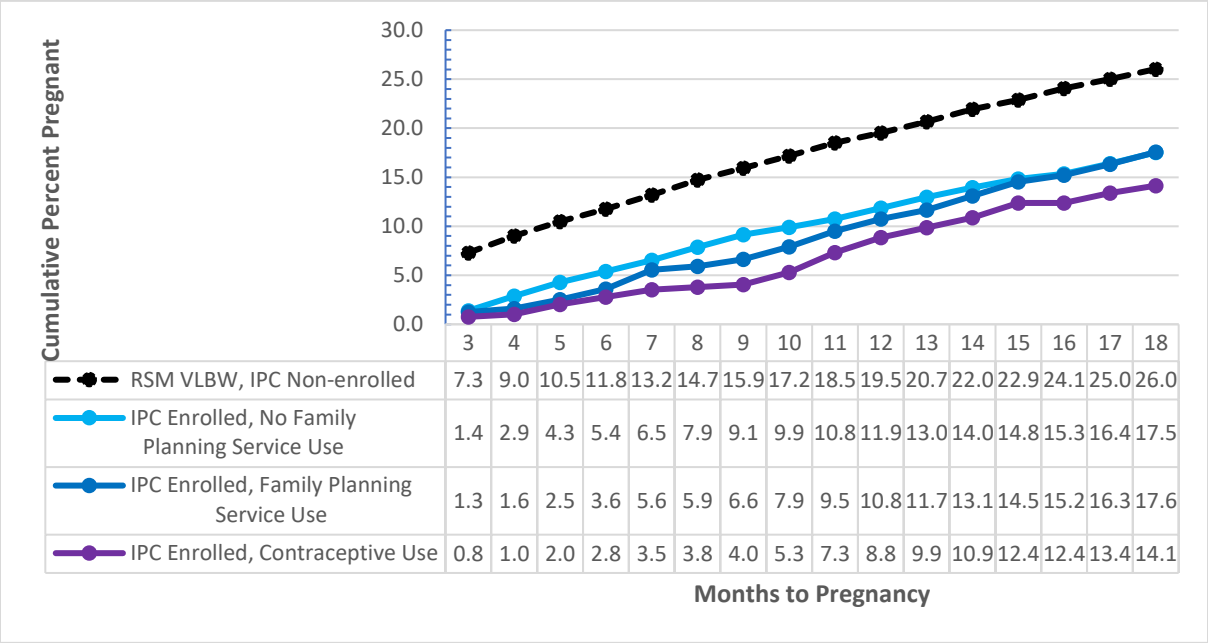


	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
RSM, FP Non-enrolled	3.9	5.0	6.1	7.3	8.5	9.7	10.9	12.2	13.4	14.6	15.7	16.8	17.8	18.8	19.8	20.7
FP Enrolled, No Family Planning Service Use	0.8	1.8	2.8	3.7	4.7	5.7	6.7	7.7	8.6	9.5	10.4	11.1	11.8	12.4	13.1	13.7
FP Enrolled, Family Planning Service Use	0.5	1.1	1.9	2.7	3.6	4.5	5.4	6.4	7.3	8.4	9.4	10.3	11.3	12.1	12.9	13.8
FP Enrolled, Contraceptive Use	0.3	0.7	1.3	1.9	2.7	3.5	4.3	5.2	6.1	7.1	8.0	9.0	9.9	10.8	11.6	12.5

Approximately 7% of the RSM women who choose not to enroll have a very short interpregnancy interval of 6 months or less; in comparison, less than 3% of those enrolling in P4HB and only 1.3% of those enrolling and using contraceptives have this very short interval. The percentage with a repeat pregnancy within one year is halved (from 13.4% to 6.1%) for women enrolling and using contraceptive services within the FP only component of P4HB. By 18 months almost 21% of the RSM not enrolling in P4HB are again pregnant and back in the Medicaid program. Among those enrolling, this is lower at almost 14% while among those enrolling and using contraceptives, it is lower still at 12.5%.

Access to and use of effective contraceptives to prevent and/or delay another pregnancy is particularly important for the IPC and RM only women who have recently had a VLBW infant and may have higher clinical needs of their own. In the following charts we show the percentage of IPC enrollees (**Chart 3**) and RM only enrollees (**Chart 4**) who have a repeat pregnancy within the 18 months following their delivery of a VLBW infant and as above, we distinguish this outcome for women eligible and enrolled versus not-enrolled and among enrollees, those using family planning or contraceptive services made available through P4HB.

Chart 3. Cumulative Months to Subsequent Pregnancy for Women Who Recently Delivered a VLBW Infant on RSM According to IPC Enrollment and Service Use for 2011 through 2019



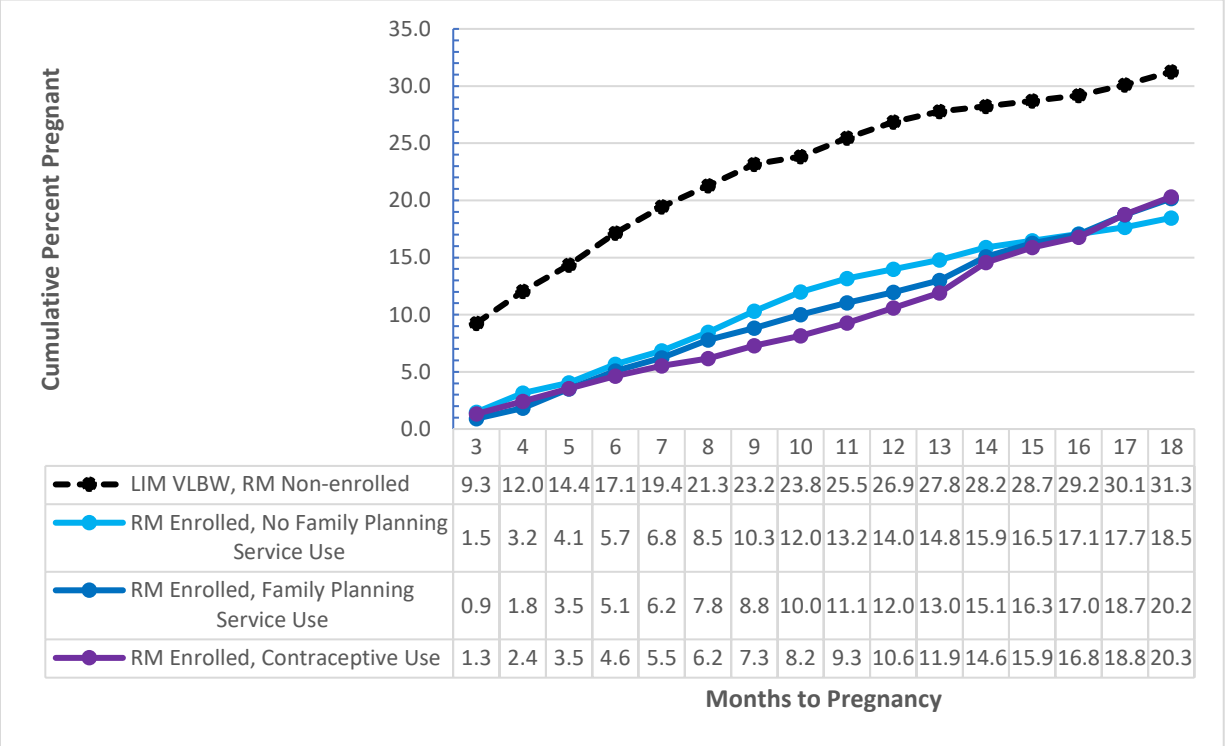
Months to Pregnancy	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
RSM VLBW, IPC Non-enrolled	7.3	9.0	10.5	11.8	13.2	14.7	15.9	17.2	18.5	19.5	20.7	22.0	22.9	24.1	25.0	26.0
IPC Enrolled, No Family Planning Service Use	1.4	2.9	4.3	5.4	6.5	7.9	9.1	9.9	10.8	11.9	13.0	14.0	14.8	15.3	16.4	17.5
IPC Enrolled, Family Planning Service Use	1.3	1.6	2.5	3.6	5.6	5.9	6.6	7.9	9.5	10.8	11.7	13.1	14.5	15.2	16.3	17.6
IPC Enrolled, Contraceptive Use	0.8	1.0	2.0	2.8	3.5	3.8	4.0	5.3	7.3	8.8	9.9	10.9	12.4	12.4	13.4	14.1

Among those eligible for IPC but not enrolling, the percentage with a very short interpregnancy interval of 6 months or shorter was high at almost 12% (**Chart 3**). This compares to less than 4% of those enrolling and using any family planning service and less than 3% of those using any contraceptive method. Within 12 months of the index VLBW delivery, those not enrollng were more likely to have a repeat pregnancy at almost 20% and was almost half at 11% among users and reduced to ~9% among those enrollling and using contraceptives. Within 18 months of the index VLBW delivery, fully 26% of non-enrollees had a repeat pregnancy while only 14% of those enrolling and using contracpetives did.

In **Chart 4** we show these patterns for the Low-Income Medicaid (LIM) women eligible for RM only services due to having a VLBW delivery. Among those eligible for RM only services but not enrolling, the percentage with a very short interpregnancy interval of 6 months or shorter was even higher than for IPC women at almost 17%. This compars to 5.7% for those enrolling and not using family planning services, 5.1% for those enrolling and using family planning services, and 4.6% among those enrolling and using contraceptives. Within 12 months of the index VLBW delivery, those not enrollng were substantially more likely to have a repeat pregnancy in

Medicaid (at nearly 27%) compared to those enrolling and using family planning services (12%) and in particular, those enrolling and using contraceptives (~11%). Within 18 months of the index VLBW delivery, fully 31% of non-enrollees had a repeat pregnancy in Medicaid, compared to ~18-20% of those enrolling, whether using or not using services.

Chart 4. Cumulative Months to Subsequent Pregnancy for LIM Women with VLBW Delivery According to RM Only Enrollment and Service Use for 2011 through 2019



	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
LIM VLBW, RM Non-enrolled	9.3	12.0	14.4	17.1	19.4	21.3	23.2	23.8	25.5	26.9	27.8	28.2	28.7	29.2	30.1	31.3
RM Enrolled, No Family Planning Service Use	1.5	3.2	4.1	5.7	6.8	8.5	10.3	12.0	13.2	14.0	14.8	15.9	16.5	17.1	17.7	18.5
RM Enrolled, Family Planning Service Use	0.9	1.8	3.5	5.1	6.2	7.8	8.8	10.0	11.1	12.0	13.0	15.1	16.3	17.0	18.7	20.2
RM Enrolled, Contraceptive Use	1.3	2.4	3.5	4.6	5.5	6.2	7.3	8.2	9.3	10.6	11.9	14.6	15.9	16.8	18.8	20.3

Objective: Decrease unintended and *high-risk* pregnancies among Medicaid eligible women

Outcome: The women in the IPC and RM only components have recently delivered a VLBW infant who has high medical needs, and these women themselves also likely have high medical needs that indicate that a repeat pregnancy is a high-risk pregnancy. All mothers need a postpartum visit but these women's needs may also include care related to the management of chronic health conditions, such as diabetes mellitus and/or hypertension, as well as screening for and management of cardiovascular risk factors following the occurrence of cardio metabolic complications of pregnancy, such as gestational diabetes and gestational hypertension, which place a woman at risk for the future development of these conditions.[3]

The services available to the IPC women include all of the family planning services offered in the FP only component noted earlier[2] as well as primary care visits, limited dental services, non-emergency transportation, prescription drugs (non-family planning), substance abuse and mental health treatment and substance use detoxification (inclusive of intensive outpatient rehabilitation), case management (inclusive of care planning, referrals, and assessment of risk factors) and Resource Mother outreach (inclusive of mentoring, help with personal and social problems, nutrition guidance, referrals to community resources),but fall short of the full Medicaid benefits available to the RM only enrollees.

Table 6 shows realized access to services following the index VLBW delivery for the subset of IPC and RM only women with evidence of chronic hypertension or diabetes mellitus or gestational hypertension or diabetes, and continuously enrolled 90, 180 or 360 days postpartum. Higher rates of service receipt among these high-risk women indicate higher service quality within P4HB.

Table 6. Receipt of Post-Partum Visit and Interpregnancy Care Services among IPC and RM only Women with VLBW Delivery Enrolling through June 2020 and Evidence of Chronic Hypertension or Diabetes Mellitus or Gestational Hypertension or Diabetes

	IPC			RM Only		
	Delivery to 90-Days Post (RSM)	**Delivery to 180-Days Post (IPC)**	**Delivery to 360-Days Post (IPC)**	**Delivery to 90-Days Post (RSM)**	**Delivery to 180-Days Post (RM)**	**Delivery to 360-Days Post (RM)**
N Continuously Enrolled in Medicaid	557	419	339	502	452	417
Postpartum Service						
Postpartum care visit	45.8%	46.3%	47.5%	46.2%	45.6%	45.3%
Receipt of cervical cancer screening	12.2%	12.4%	22.7%	15.1%	18.1%	29.7%
Family planning counseling	7.0%	9.3%	13.3%	8.8%	11.5%	16.1%
Dental care**	5.7%	7.2%	9.4%	5.2%	8.6%	16.5%
Any diabetes or hypertension related	77.9%	75.7%	78.5%	75.1%	75.9%	77.7%
Any mental health or substance abuse related	19.2%	22.9%	25.4%	24.9%	29.2%	36.5%

Contraceptive Method						
Tier 1	25.0%	26.3%	28.3%	30.5%	32.7%	34.3%
Tier 2	23.0%	26.3%	29.2%	21.9%	23.0%	25.4%
Tier 3/4	0.2%	0.2%	0.3%	0.0%	0.0%	0.0%
Tier Unspecified	1.1%	1.4%	2.7%	1.6%	2.0%	2.2%
Any Method	49.2%	54.2%	60.5%	54.0%	57.7%	61.9%
Subsets of Tier 1						
LARC	12.0%	12.2%	15.0%	12.7%	12.8%	14.6%
Sterilization	12.9%	14.1%	13.3%	17.7%	19.9%	19.7%

***Denominator is IPC, RM only women with delivery of VLBW infant and enrolling in demonstration years 2011 through June 2019. Contraceptive Tiers have been identified in other tables in this report. Tier 1, 2, 3/4, and Unspecified are mutually exclusive. If claims for more than one type during post-partum period, categorized into most effective method. ** Dental care includes those services covered for IPC and RM only women.*

Less than half (46-48%) of IPC and RM only women with chronic or gestational hypertension or diabetes receive a postpartum visit even among those continuously enrolled through one year. Their receipt of cervical cancer screening (~23% to ~30%) and dental care (~8% ~16%) is even lower but we do not know if they are due for these cancer screens or have needs for the dental care in this time period. Their very low receipt of family planning counseling at ~13% to ~16% during their postpartum period, puts them at risk of an unintended pregnancy or an intrapartum interval that is too short.

However, receipt of services for the management of and/or screening for chronic conditions are high. Among women with chronic or gestational hypertension or diabetes, approximately 78% received diabetes or hypertension related services during their full 360 days post-delivery. Among the IPC women with these chronic or gestational conditions, the receipt of any mental health or substance abuse related service was 25% and among RM only women, this rate was almost 37%. Again, we do not have good information on their need for these types of services but the utilization among the RM only women increased over the 90 to 360-day period as they perhaps found access to a Medicaid participating provider over this longer period.

The receipt of any contraceptive method and again, the distribution of users by the WHO Tiers of effectiveness, matters for reducing high-risk pregnancies. Overall, the rates of use of any contraceptive method among these high-risk women is high at 49% to 54% in the first 90 days. We see again, an increase in the use of any contraceptive method the longer these women are

enrolled. For the IPC women, this increase was from 49.2% to 60.5% and for the RM only women the increase was from 54% to almost 62%. By 360 days post-delivery the RM only enrollees were more likely to be using Tier 1 contraceptives (34.3%) than were the IPC enrollees (28.3%). Within Tier 1, the IPC and RM only women were similar in their use of LARCs at ~15% while RM only enrollees with evidence of chronic or gestational hypertension or diabetes had higher rates of sterilization (~20%) than the IPC enrolled women (~13%).

For both IPC and RM only high-risk women, the potential of the P4HB program to connect them to needed services goes beyond these services to needed social support services within their communities through their Recourse Mothers. The CMOs track aspects of this case management and we report on their files through the 4th quarter of 2021. Among 3,574 unique women ever enrolled in IPC or RM only 2017-2021, 1612 (45%) accepted case management, 221 (6%) declined case management, and for 1741 (49%) information about acceptance or declination of case management was either missing or pending. The declination of case management varied according to whether the woman was enrolled in IPC (4%) or RM only (7%) (**Table 7**) and across the CMOs (**Table 8**). The highest level of declination of contact was among the 1429 in the PeachState CMO.

Table 7. Acceptance of Case Management Services by P4HB Enrollment Type, 2021

Enrollment Type	IPC N = 1334	Resource Mother Only N = 2240	Total N = 3574
Accepted	512 (38%)	1100 (49%)	1612 (45%)
Declined	56 (4%)	165 (7%)	221 (6%)
Missing/Pending	766 (57%)	975 (43%)	1741 (49%)

Table 8. Acceptance of Case Management Services by CMO, 2021

Case Management	Medicaid Care Management Organization			TOTAL N = 3574
	Amerigroup N = 735	CareSource N = 1410	Peach State N = 1429	
Accepted	69 (9%)	304 (22%)	1239 (87%)	1612 (45%)
Declined	5 (1%)	77 (5%)	139 (10%)	221 (6%)
Missing/Pending	661 (90%)	1029 (73%)	51(3%)	1741 (49%)

Among the 1612 women who accepted case management, 674 (42%) had at least one phone or face-to-face contact with the case manager during Q1 through Q4 2021, with substantial variation in the proportion of IPC and RM only enrollees having at least one phone or face-to-face contact with the case manager according to CMO assignment (**Table 9**).

Table 9. Interaction with Case Manager (Among those Accepting) by Medicaid CMO, 2021

Case Management	Medicaid Care Management Organization			TOTAL N = 1612
	Amerigroup N = 69	CareSource N = 304	Peach State N = 1239	
Face-to-face or telephone	15 (22%)	76 (25%)	583 (47%)	674 (42%)

Among the 674 enrollees who had at least one phone or face-to-face contact with the case manager, 312 (46%) reported a problem list. These lists included annual health exam, employment and job skills, high blood pressure, diabetes, other health conditions, community resources, housing, transportation, food and family and intimate relationships. For this group, 324 (48%) had care plans around healthy lifestyle changes, housing, safety, helping control risk factors and promote health, employment/job skills, transportation, connecting with community resources, drug and alcohol use assistance, and intimate relationships. In contrast, among the 938 enrollees who did not have at least one phone or face-to-face contact, only 115 (12%) had a problem list and yet those lists included many of the same problems. For this group of enrollees, 115 (12%) also had care plan goals, the most common of which focused on healthy lifestyle education and community resource education.

Across the three groups of enrollees, there were differences in the percentage who were using a more effective method of contraception during the quarter compared to the method they were using at the start of the quarter (**Table 10**). Approximately 5% of those declining case management were using a more effective method at the end of the quarter whereas 10% of those who accepted and had no face-to-face or phone contact with the case manager were and 4% of those who accepted and had at least one face-to-face or phone contact with the case manager were ($p<0.0001$). While these differences were statistically significant ($p<0.001$) they must be interpreted with caution given the high percentage of missing data on contraceptive method type, particularly among those who declined case management (91% missing) or who accepted case management but had no face-to-face or phone case management encounter (72% missing).

Table 10. IPC and RM Only Enrollees' Use of Birth Control According to Case Management Group

Contraceptive Outcome	Case Management Group			p-value inter-group comparison
	Declined N = 221	Accepted, No face-to-face or phone contact N = 938	Accepted, Face-to-face or phone contact N = 674	
Participant selected more effective method	11 (5%)	91 (10%)	26 (4%)	***<0.0001****
Contraceptive method used at end of the period:				
Sterilization	0	60 (6%)	16 (2%)	***<0.0001****
LARC	3 (1%)	39 (4%)	59 (9%)	
Injectable	8 (4%)	34 (4%)	55 (8%)	
Oral contraceptive pills	6 (3%)	69 (7%)	68 (10%)	
Condoms	0	25 (3%)	30 (4%)	
Other	0	0	0	
None	2 (1%)	34 (4%)	98 (14%)	
Unknown/Missing	202 (91%)	677 (72%)	348 (52%)	

** indicates statistically significant difference in proportion across the three case management groups.*

Pregnancy & Delivery Outcomes among High-Risk Women. A pregnancy conceived within 18 months of the index VLBW delivery, regardless of outcome, is indicative of a short interpregnancy interval and is an adverse outcome that the P4HB IPC and RM only components were designed to prevent. Earlier (**Chart 3**) we showed descriptive differences in the percentage of women in the 2011-2019 IPC enrollee cohort versus the RSM comparison cohort with repeat pregnancies in 18 months or less. In Table 12 we first test whether these differences are statistically significant. They are all significant ($p<.01$).

In **Table 11** we also show the percentage of women in the IPC and RSM cohort with a delivery within 18 months of their index VLBW delivery according to the outcomes of those deliveries. The percentage of IPC women experiencing a delivery within 18 months was significantly lower than for the RSM/VLBW comparison cohort (9.5% vs 17.2%). Moreover, the percentage experiencing an adverse pregnancy or birth outcome (fetal death, stillbirth, VLBW or LBW delivery) was significantly lower for the IPC enrollees than for the RSM women with an index VLBW infant who did not enroll (4.3% vs 7.6%, $p<0.01$).

Table 11. Number and Percent of Women with VLBW Infant with Repeat Pregnancy within Six, Twelve or 18 Months and Repeat Delivery within 18 Months, Among those Enrolled in the IPC Waiver Demonstration and Eligible but Not Enrolled

Timing of Repeat Pregnancy or Delivery	IPC 2011-2019 N =2,286	RSM – VLBW 2011-2019 N =4,842
Pregnant within 6 months	113 (4.9%)	528 (10.9%) ^^^
Pregnant within 12 months	265 (11.6%)	943 (19.5%) ^^^
Pregnant within 18 months	401 (17.5%)	1,264 (26.1%)^^^
	N = 2,195*	**N = 4,585***
Delivery within 18 months	209 (9.5%)	789 (17.2%)^^^
Fetal Deaths	26 (12.4%)	108 (13.7%)
Still Births	10 (4.8%)	34 (4.3%)
Very Low Birth Weight (<1500 g)	20 (9.5%)	62 (7.9%)
Low Birth Weight (1500-2499 g)	38 (18.2%)	146 (8.5%)
Normal Birth Weight (≥2500 g)	103 (49.3%)	380 (48.2%)
Unknown Weight	48 (23.0%)	189 (25.5%)
Adverse Delivery Outcome**	94 (4.3%)	350 (7.6%)^^^

IPC and RSM-VLBW index deliveries through 06/30/2019 **Sum of fetal deaths, still births, and low birth weight deliveries. Chi-Square: ^ P-value < 0.10, ^^ P-value < 0.05, ^^^ P-value <0.01 Notes: Repeat pregnancies were identified using the following set of claims codes: Repeat deliveries were defined as human conceptions ending in live birth, stillbirth (>= 22 weeks' gestation), or fetal death (< 22 weeks). Ectopic and molar pregnancies and induced terminations of pregnancy were NOT included.* ***Deliveries of Live births* *were identified in the claims by using: ICD-9 diagnostic codes 640-676 plus V27.x* ***OR*** *ICD-9 procedure codes 72, 73, or 74 plus V27.x* ***OR*** *CPT-4 codes 59400, 59409, 59410, 59514, 59515,59612,59614,59620, 59622 plus V27.x or Z37.x OR ICD-10 diagnostic codes O0 – O9 plus Z37.x or ICD-10 procedure codes 10A, 10D, or 10E plus Z37. x.* ***Deliveries of Stillbirths*** *were identified by using ICD-9 diagnostic code 656.4x (intrauterine fetal death >= 22 weeks gestation) OR specific V-codes [V27.1 (delivery singleton stillborn, V27.3 (delivery twins, 1 stillborn), V27.4 (delivery twins, 2 stillborn), V27.6 (delivery multiples, some stillborn), V27.7 (delivery multiples, all stillborn)] or ICD-10 diagnostic codes Z37.1, Z37.4, or Z37.7* ***Deliveries associated with Fetal deaths*** *< 22 weeks were identified by using ICD-9 diagnostic codes 632 (missed abortion) and 634.xx (spontaneous abortion) or ICD-10 diagnostic codesO03 or O02.1. In the case of a twin or multiple gestation, the delivery was counted as a live birth delivery if ANY of the fetuses lived. Costs were accumulated over the pregnancy and attributed to the delivery event if there was a fetal death (632) that preceded a live birth*

Since the characteristics of the participants and non-participants differ, we used regression analysis to assess the adjusted difference in the following outcomes: 1) probability of a repeat pregnancy within 18 months; 2) probability of a delivery within 18 months and 3) probability of an adverse delivery outcome with 18 months. We control for age, race, month of index birth, months enrolled in the 18 months over which we follow them and an indicator for urban/rural residence. The regression results are shown in **Table 12** below**.**

Table 12. Estimated Differences in Probability of Outcomes (Marginal Effects) for IPC Compared to RSM Women with VLBW Infants not Enrolling in IPC, Ages 18-44

Outcome	Marginal Effect
Repeat Pregnancy within 18 Months after Index Delivery	-11.99^^^
Repeat Delivery within 18 Months after Index Delivery	-9.31^^^
Adverse Delivery Outcome within 18 months after Index Delivery	-4.14^^^

^ P-value < 0.10, ^^ P-value < 0.05, ^^^ P-value <0.01

Estimated effects from logistic models are multiplied by 100 to provide percentage point changes in the dependent variable. Controlled for age, race, month of index birth, months enrolled in the 18 months over which we follow them and urban/rural residence.

After controlling for these factors there are significantly lower adverse outcomes among IPC participants. Specifically, the probability of a repeat pregnancy after the index delivery (VLBW) is almost 12 percentage points lower for IPC enrollees and the probability of a repeat delivery, 9 percentage points lower. Important to the quality of the IPC component the probability of an adverse outcome in a subsequent delivery is 4 percentage points lower for those eligible for IPC and participating.

Objective: Decrease Medicaid spending attributable to unintended births and LBW and VLBW babies.

Outcome: Table 13 shows the total capitated payments made to the CMOs for the FP only, IPC and RM only components. Along with the slower growth and declines in some components of P4HB noted earlier, total capitated payments to the CMOs declined slightly from the first half of 2021 (~$13 million) to the last half (~$10 million) of 2021. The total for all three components was just over $23 million by the end of 2021.

Table 13. P4HB Capitation Payments First and Second Half and Total, 2021

	1st Half (1/1-6/30, 2021)		2nd Half (7/1-12/31, 2021)		Total Year (1/1-12/31, 2021)	
Program	**$**	**%**	**$**	**%**	**$**	**%**
FP Only	$12,132,250	93.2%	$9,145,822	91.0%	$21,278,072	92.2%
IPC	$387,487	3.0%	$403,865	4.0%	$791,352	3.4%
RMOC	$498,156	3.8%	$505,101	5.0%	$1,003,257	4.3%
Total	$13,017,893	100.0%	$10,054,787	100.0%	$23,072,680	100.0%

Source Georgia Department of Community Health, MMIS (Medicaid management Information System) Reports MGD-3610-W (MCHB Payment Activity Report), Covers January- December 2021, includes monthly expenditures and Year to Date totals for each program and overall.

As in earlier years, the FP only component is the most costly for Medicaid in terms of total capitated payments, accounting for 92% of the total. Payments to CMOs for women in this component declined from the first to the second half of 2021 by about $3 million; the total at the end of 2021 was just over $21 million.

Capitated dollar payments for IPC and RM only components of P4HB rose slightly over the first to second half of 2021. The IPC capitated payments equaled $791, 352 by the end of the year accounting for only 3.4% of the total. Capitated payments for women in the RM only component of P4HB were just over $1 million by the end of 2021 program year, accounting for only 4.3% of the total $23 million paid to CMOs.

IV. Summary of Member Surveys

Member Surveys. As part of the P4HB program, the CMOs, in collaboration with DCH, monitor member overall knowledge and understanding of the program once a year through an analysis of member survey responses. In the latest round of survey administration, the responses represent those from three CMOs, Amerigroup, CareSource, and Peach State. In previous years, the responses represented members from four CMOs, however, Peach State and WellCare merged in April 2021. The CMOs and DCH review the results of each wave of the survey to identify areas of member poor understanding about the P4HB program. Analyses of these survey data help the CMOs and DCH better understand and improve member experiences with the P4HB program, as it is important to both the CMOs and DCH to identify any area that could negatively affect the satisfaction of members who participate in the program. Any areas that do not meet the CMOs' performance goals are analyzed for barriers and opportunities for improvement. Although there are concerns with the low response rates for the survey and the lack of information on representativeness of the respondents, the survey results provide DCH with an overall 'view' of member involvement with the P4HB program and potential barriers to greater awareness and involvement in the program.

Survey Methods. To date, the member survey has been administered in seventeen waves. The most recent wave of the member survey was conducted from September through November of 2021. Members identified by the CMOs were contacted by internet, mail, and phone for the survey (9,000

participants). Of the 9,000 program participants contacted, 261 (2.9%) responded to the survey. The section below provides a summary of the responses from the most recent wave of the CMOs' member survey (17th wave).

CMO Member Survey Results. In this most recent 17th wave, each CMO selected a random sample of 3,000 members for a total of 9,000 members that met the selection criteria for inclusion in the member survey. For wave seventeen, the member response rates were: 2.4% (73/3,000) for Peach State, 3.3% (100/3,000) for Amerigroup, and 2.9% (88/3000) for CareSource. As before, we note these response rates are far below a desired level of survey response.

Data in **Table 14** summarizes the members' responses regarding the services they had trouble accessing prior to enrollment in P4HB and the changes made for the member since enrolling in P4HB. The most commonly reported service that respondents indicated that they had trouble accessing prior to enrolling in P4HB was primary care (~46% and ~25% in waves 16 and 17, respectively). A substantial percentage also reported having problems with accessing birth control or family planning services prior to enrolling in P4HB in both of the two most recent waves (~27% and ~21% in waves 16 and 17, respectively). Less commonly reported problems were in accessing testing or treatment for sexually transmitted infections (~25% and ~19% in waves 16 and 17, respectively) and pregnancy testing (~16% and ~9%, respectively).

A substantial number of respondents reported that the enrollment in P4HB made particular changes for them. The most frequently reported changes following enrollment in P4HB among respondents in both of the two most recent waves of the survey was that they had more choice of birth control methods (~51% and ~45% in waves 16 and 17, respectively), they did not have to use their own money for family planning (~51% and ~36% in waves 16 and 17, respectively), and that they started using a method of birth control (~39% and ~32% in waves 16 and 17, respectively). In addition, a substantial percentage reported that they began going to a different doctor or nurse for family planning services (~ 28% and 22% in waves 16 and 17, respectively) or to a different doctor or nurse for primary care (~25% in both waves 16 and 17). Approximately 16-17% in both of the two most recent waves of the survey indicated that they changed their birth control method under P4HB.

Table 14. Enrollment and Utilization of Services in P4HB®		
	16th Wave N=109 Responses n (%)	**17th Wave N=261 Responses n (%)**
Before enrolling in P4HB®, had trouble getting…		
Birth control or family planning services	29 (26.6%)	54 (20.7%)
Pregnancy testing	17 (15.6%)	23 (8.8%)
Testing or treatment for sexually- transmitted infections	27 (24.8%)	49 (18.8%)
Primary care (such as routine check-up, care for an illness)	50 (45.9%)	66 (25.3%)
Other (Finding Dentist/Provider)	19 (17.4%)	30 (11.5%)
Changes P4HB® made for the participant…		
I am going to a different doctor or nurse for family planning services or birth	31 (28.4%)	57 (21.8%)
I am going to a different doctor or nurse for primary care	27 (24.8%)	70 (26.8%)
I have started using a birth control	42 (38.5%)	83 (31.8%)
I have changed the birth control method I use	18 (16.5%)	45 (17.2%)
I have more choices of birth control methods	55 (50.5%)	117 (44.8%)
I do not have to use my own money for family planning services or birth control	55 (50.5%)	94 (36.0%)
I can get preventive care (such as Pap smears) and family planning counseling	84 (77.1%)	181(69.3%)
Other	6 (5.5%)	9 (3.4%)

In **Table 15** we summarize the members' responses to the problems they have encountered with the P4HB program since enrollment. The most frequent problem reported in both of the two most recent wave of the survey was not being able to find a doctor or nurse willing to take P4HB clients (~15% and ~23% in waves 16 and 17, respectively). Fewer than 20% reported any of the surveyed problems related to not being able to get services or referrals or to find a provider or clinic in both of the two most recent waves of the survey.

Table 15. Problems Encountered by Members Enrolled in P4HB®		
Problems Under P4HB®	**16th Wave N=109 Responses n (%)**	**17th Wave N=261 Responses n (%)**
I cannot get the family planning services I want	14 (12.8%)	50 (19.2%)
I cannot get referrals or follow-up for care I need	9 (8.3%)	49 (18.8%)
I cannot find a doctor or nurse willing to take P4HB clients	16 (14.7%)	59 (22.6%)
I do not want to leave my current doctor or nurse	5 (4.6%)	46 (17.6%)
I must wait too long to get services	8 (7.3%)	37 (14.2%)
I do not have transportation	6 (5.5%)	23 (8.8%)
I cannot get to the doctor or nurse when they are open	9 (8.3%)	21 (8.0%)

My P4HB doctor or nurse will not prescribe the birth control method I want to use	1 (0.9%)	25 (9.6%)
Other (Not Total Health Coverage/Cannot Use)	5 (4.6%)	28 (10.7%)

The member survey probed the following areas to assess whether key reproductive health assessments occurred during the encounter: whether the member was asked about key reproductive health topics during her last health care appointment (**Table 16**). Approximately half of respondents in the two most recent waves of the survey reported that a doctor or nurse asked them about whether they use birth control to prevent or space pregnancies during their last encounter, whether they use male or female condoms to prevent STIs, and about their sexual practices. For all other monitored reproductive health topics, 36% or fewer report that their doctor or nurse asked them about the topic during their last encounter, with the lowest percentage reporting being asked about thoughts or plans about timing or spacing pregnancies (~26% and ~36% during waves 16 and 17, respectively).

Table 16. Provider Inquiry about Reproductive Health Topics during Encounters

Reproductive Health Topic	**16th Wave N=109**	**17th Wave N=261**
Has a Doctor or Nurse Ever Talked With You About Any Of The Following…? n (%) Yes		
Your thoughts or plans about having or not having children in the future	51 (46.8%)	140 (53.6%)
Your thoughts or plans about timing or spacing pregnancies	28 (25.7%)	93 (35.6%)
Your sexual practices	56 (51.4%)	122 (46.7%)
The use of birth control to prevent or space pregnancies	61 (56.0%)	168 (64.4%)
The use of male or female condoms to prevent STIs	58 (53.2%)	161 (61.7%)
Your life plans or goals	39 (35.8%)	-------

During the 17th wave of the survey, participants were also asked additional questions that were not asked on prior waves of the survey. Specifically, participants were asked how they heard of the P4HB program with responses shown in **Table 17**. The most frequent source of information about the P4HB program was the health department (60.5%), followed by the P4HB letter from the health plan (39.5%), the provider office (22%) and others (22%), and through a flyer or advertisement (13%).

Table 17. How Did You Hear of the P4HB Program	
	17th Wave N=261
Health Department	158 (60.5%)
Providers Office	73 (28.0%)
P4HB Letter from your health plan	103 (39.5%)
Flyer / Advertisement	34 (13.0%)
Other (DFCS, Family/Friend, Hospital)	58 (22.2%)

Near the end of the survey, members were asked to rate their satisfaction level with the P4HB program on a 0-10 scale with zero being not at all satisfied and a ten being completely satisfied. The data in **Table 18** indicates that 69% of respondents were highly satisfied with P4HB, whereas 19.2% had moderate satisfaction, and 7.3% had low satisfaction.

Table 18. How Satisfied Are You With The P4HB Program?	
	17th Wave N=261
Low Satisfaction (0-3)	19 (7.3%)
Medium Satisfaction (4-7)	50 (19.2%)
High Satisfaction (8-10)	180 (69.0%)

The final question asked on survey wave seventeen was how we could improve the P4HB program. The most common responses addressed the need to cover more services including birth control and medications, as well as to have more providers who accept P4HB/Medicaid. Additionally, members asked for better communication and information regarding their program benefits, as well as the suggestion for a member portal that provides comprehensive information about P4HB and covered services.

V. Budget Neutrality and Financial Reporting

Objective: Decrease the number of Medicaid-paid deliveries from the number expected to occur in the absence of the Demonstration beginning in the second year.

Outcome: Demonstration of P4HB expenditures for January 1 through December 31, 2021 appears in the Budget Neutrality Report as submitted by DCH.

VI. Disenrollment, Service Denials, Provider Claims & Grievances

CMS requires that each semi-annual report show comparisons for *disenrollment; denials of service; provider counts; and complaints, grievances and appeals* for the current reporting period and comparison of these measures for the same period for the previous 2 years**.** These data were included in our prior semi-annual report; we report comparisons for two years prior (January – June and July-December 2019 & 2020) the current reporting period (January-June and July- December 2021).

Table 19 - Disenrollment, Denial of Service & Provider Claim Counts, 2019-2021

Reporting Period	Disenrollment	Denials of Service	Provider Claims
Jan-June 2019	750	161,778	35,784
Jan-June 2020	463	143,659	32,799
Jan-June 2021	*84*	104,833	32,096
July-Dec 2019	528	158,693	36,339
July-Dec 2020	406	156,708	34,539
July-Dec 2021	421	87,242	32,606

The data in the top rows of **Table 19** include the current reporting period, January-June 2021. The pattern in disenrollment of clients in the first six months of each of the years shown is clearly one of declining disenrollment. Some of the decline to only 84 total disenrollment in January-June of 2021 likely reflects the Covid-19 extension of eligibility for Medicaid enrollees. This number compares to 463 total disenrollment in the first six months of 2020 and to an even higher total disenrollment of 750 in the January-June 2019 comparison period.

In their reports, the CMOs noted that less disenrollment was due in part to the PHE and PP extension. For disenrollment among IPC women they noted reasons as :1) women did not meet the criteria of a recent delivery of VLBW infant; 2) woman had completed the 24 months postpartum coverage she was eligible for under IPC; and 3) woman was unable to be reached. They also noted that sometimes the woman declined the service coverage. Regarding reasons for disenrollment from the FP only component, they noted: 1) woman was aging out of eligibility; 2) woman had become pregnant; 3) woman was ineligible since she moved to another state or had moved to another insurance plan. Also, one CMO refers to disenrollment as “terminations”. Terminations often occur when clients fail to recertify.

Denials of service stood at 104,833 in the January-June 2021 period and reflects a significant decrease from the denials (143,659) reported in the January-June 2020 period and an even bigger decline from the number of denials (161,778) reported for this period in 2019. Reasons for the denials in 2021 from the CMOs related to several issues, including denials of services not covered, such as emergency department visits, lab draws, and outpatient visits for evaluation or management for low or moderate concerns.

Finally, the provider claim counts for the first six months of each year clearly show a decline from 2019 to 2021. In the January-June 2021 period the state reports an unduplicated count of providers submitting a P4HB claim of 32,096, down from the 32,799 in the first six months of 2020 which was also a decline from the 35,784 reported in the first six months of 2019.

Table 20 - Grievances Count By CMO 2019-2021

P4HB Grievance Count by CMO					
Reporting Period	**Amerigroup**	**CareSource**	**PeachState**	**WellCare**	**Total**
Jan-June 2019	12	0	0	0	12
Jan-June 2020	1	0	0	0	1
Jan-June 2021	21	2	0	15	38
Average 1st Half of Each Year	11.3	0.7	0	5.0	17.0
July-Dec 2019	6	0	0	0	6
July-Dec 2020	0	0	0	0	0
July-Dec 2021	13	13	9	0	35
Average 2nd Half of Each Year	6.3	4.3	3.0	0	13.7
Total (P4HB)	53	15	9	15	92

We discuss the data in **Table 20** on counts of grievances overall and by CMOs and discuss the following comparisons:

- July-December 2020 compared to July-December 2019; and
- January-June 2021 compared to January-June 2020 and January-June 2019.

In the July-December 2020 reporting period there were no grievances reported across the CMOs; this represents a decline from the 6 grievances reported for the July-December 2019 period and a larger decrease from the 21 reported for the Jan-June 2021 period. As noted in the table, the average number of grievances in the July-December periods of these years was 11.3. This is in

contrast to the lower average of 6.3 grievances in the July-Dec time period in these years. The bulk of the total 92 grievances were reported for Amerigroup (53). Both WellCare and CareSource had 15 grievances reported. Most grievances were described by the CMOs as having to do with administrative issues, access to care or denials for services, or related to provider issues.

We note that while Amerigroup has the largest number of grievances in all periods summarized in Table 22, they were the only CMO including this information in their most recent Quality Management (QM) reports. They noted most complaints were for either billing or related to care/benefits and importantly, their QM reports state that all grievances have been resolved.

VII. Evaluation Activities & Interim Findings

A key milestone in the P4HB Evaluation Design approved by CMS is the upcoming 2022 Interim Report. In that report we plan to address several research questions pertaining to access and utilization based on claims data but also using survey data for Georgia and comparison states. These specific questions (numbered 1, 2, 4 and 5 in the P4HB Evaluation Design) are:

- How did beneficiaries utilize covered health services?
- DidP4HB enrollees maintain coverage for 12 months or longer? How did sociodemographic, county, and economic factors affect the probability of disenrollment?
- Was P4HB associated with a reduction in the share of unintended pregnancies among Medicaid live births?
- Did P4HB reduce Georgia's Medicaid costs by reducing the number of unintended pregnancies by women who otherwise would be eligible for Medicaid pregnancy-related services?

Regarding the first question above, we have continued to report on the use of family planning and contraceptive services by women enrolled in the FP only, IPC and RM only components of P4HB. Several tables in this Annual Report show the data for 2019 and 2020 but these data have been compiled over the full demonstration period. The 2022 Interim Report will update these data through 2021. We have also made progress on assembling the Behavioral Risk Factor Surveillance System (BRFSS) data for Georgia and comparison states to analyze low-income women's access (e.g. a personal doctor) in Georgia pre and post the initiation of P4HB to other states in the nation that did not implement a family planning waiver or make other major changes

in access to these services. This can be seen as the 'short-run' effects of P4HB on these access measures. We will use more current BRFSS data through 2019, to provide a 'long run' assessment of P4HB for low-income women in Georgia compared to other states controlling for whether they expanded Medicaid under the ACA.

Regarding the second question above, we have merged data on numerous sociodemographic measures to the enrollment and claims data in order to analyze the role of county level factors related to access to health care (such as numbers of Ob/GYNs per women of reproductive age, FQHCs per capita) and that represent underlying social and economic conditions (such as residential segregation, percent uninsured, employment, poverty). This merger of data will allow us to test the role of these external measures along with maternal characteristics (age, race/ethnicity) on the probability of disenrollment from P4HB within a 12 month period. We have not begun these analyses due to the continued PHE which means women have not been disenrolled from Georgia Medicaid since its beginning. We will begin this analysis with the 2017-2019 data (when the Georgia Gateway system began and the PHE was not in place) and follow it through the PHE to the end of 2021. The earlier data will provide insight on the length of time P4HB enrollees maintain coverage and the factors affecting this; the analysis of the 2020-2021 data will shed light on how these patterns may have changed during the PHE. We note that earlier analysis indicated ~80% of postpartum women remained on Medicaid during the PHE so there has been some voluntary disenrollment even during this period.

Regarding the third and fourth questions listed above, we have continued with the analysis of the linked claims/vital records data for a period pre and post the implementation of P4HB. As we update these analyses we are estimating the models 1) using only the RSM women as those affected by P4HB; and 2) separately for non-Hispanic whites, non-Hispanic blacks and Hispanics. We have found differences in the effects of P4HB from other earlier analysis and differences on some of the outcomes measured by race/ethnicity.

Objective: Decrease late teen pregnancies by reducing the number of first or repeat teen births among Medicaid eligible women ages 18-19 years.

Outcome/Interim Findings:

- Age at first birth increased with the implementation of P4HB and this increase was great for non-Hispanic blacks that the other racial/ethnic groups.
- Teen births (ages 18-19) decreased with the implementation of P4HB.
- Repeat births (second or higher) decreased only for non-Hispanic blacks with the implementation of P4HB.
- No effects on preterm or birthweight outcomes based on analyses to date.

In doing this analysis we have used privately insured mothers with high school or less education as a comparison group for the RSM women. We have linked enrollment/claims and vital records data for both of these groups which allows us to compare outcomes pre and post P4HB. We are supplementing these analyses with data from the Pregnancy Risk Assessment Monitoring System (PRAMS) data for Georgia and comparison states. We have reported on these analyses earlier but are updating the data to a more current period and using a different and larger number of comparison states to increase the validity of the comparison. In deriving the comparison states we have carefully documented the changes these states made in their family planning and other Medicaid policies that can affect the outcomes of interest.

In order to analyze unintended pregnancy, we are using the Pregnancy Risk Assessment Monitoring System (PRAMS) survey. With this survey we can measure pre-conception use of family planning, intendedness of pregnancy, postpartum contraception and birthweight outcomes among women uninsured pre-pregnancy but insured by Medicaid at delivery. We are also analyzing these outcomes by race/ethnicity. Some preliminary findings indicate there were reductions in unintended pregnancies with the implementation of P4HB and effects varied by race/ethnicity. There is also an indication of a reduction in VLBW infant deliveries paid by Medicaid, a finding we have not seen to this point with the claims/enrollment data.

References

1. Andersen RM. Revisiting the behavioral model and access to medical care: does it matter? Journal of Health and Social Behavior. 1995 Mar;36(1):1–10. doi: 10.2307/2137284. Available from: http://dx.doi.org/10.2307/2137284.
2. Fact Sheet, Planning for Healthy Babies, P4Hb Overview. Georgia Department of Community Health. Planning4HealthyBabiesFY12_2.pdf (georgia.gov)
3. McKinney J, Keyser L, Clinton S, Pagliano C. ACOG Committee Opinion No. 736: optimizing postpartum care. Obstetrics & Gynecology. 2018 Sep 1;132(3):784-5.