

## Planning for Healthy Babies Extension Request

### **Section I- Historical Narrative Summary**

Georgia's Planning for Healthy Babies (P4HB<sup>®</sup>) Program, an 1115 Demonstration Waiver, is now in its fourth year of implementation. A reduction in our low birth weight rate continues to be this waiver's main focus.

In April of 2009, the Georgia Department of Community Health (DCH), in collaboration with numerous community and agency partners, initiated the Improving Birth Outcomes Workgroup to reduce Georgia's low birth weight (LBW) rate from 9.5% to 8.6% over a five year time span. For calendar year 2010 (CY 2010), the year prior to implementation of the P4HB program, the statewide LBW rate was 9.8%, higher than it was for CY 2009 (9.5%). Within the Medicaid population, the LBW rate was 8.0% in CY 2010, up from 7.1% documented for CY 2009. The statewide very low birth weight (VLBW) rate also increased in CY 2010 to 1.9% from its steady rate of 1.8% in 2009. LBW is defined as a birth weight less than 2500 grams (5 pounds, 8 ounces) and VLBW is defined as a birth weight less than 1500 grams (3 pounds, 5 ounces).

Per the original concept paper, Drs. Alfred Brann of the Emory University Woodruff Health Sciences Center and Brian McCarthy of the Centers for Disease Control and Prevention presented results of their ongoing birth outcomes research in November 2009 to Georgia's Perinatal Center Directors. Their findings were that:

- Georgia's infant mortality declined by 50% from 1975 to 1996, primarily due to improved survival of low birth weight infants.
- The largest contributor to Georgia's infant mortality rate is the birth of LBW and VLBW infants.
- Births of VLBW infants are approximately 2% of all births but account for 50% of all infant deaths.
- Survival of VLBW infants has significantly improved in the last 25 years, but the prevalence of cerebral palsy has not changed.
- No obstetrical or prenatal assessment or intervention has been successful in predicting or preventing a woman's first preterm/LBW delivery.
- The single best predictor of a preterm/VLBW infant is a history of a previous preterm/VLBW delivery.
- For women who have had a VLBW delivery:
  - There is a substantial prevalence of unrecognized and/or poorly managed chronic diseases;

- Reproductive tract infections, iron-deficiency anemia, and substance abuse are common following a VLBW delivery; and
- The receipt of health care services for themselves is less of a priority than is securing income/employment and this influences their health care seeking behaviors.
- A review of the costs of initial (delivery) hospitalization for ten (10) live born infants less than 2500 grams conceived within 18 months of a VLBW delivery revealed:
  - A birth weight range of 730 – 2430 grams (mean weight of 1733 grams);
  - Initial hospitalization : 2 – 137 days (mean stay of 29.9 days); and
  - Cost of initial (delivery) hospitalization per live born infant less than 2500 grams of \$55,576

There is no single solution to low birth weights and research has shown that family planning and preconception health services that allow screening for health problems may reduce the incidence of low birth weight. Pregnancy is often too late to initiate preventive care for a mother who has previously delivered a very low birth weight infant. Research has also shown that the lowest risks for adverse perinatal outcomes are infants conceived 19 – 23 months after a previous live birth. Numerous sources affirm that reducing unintended pregnancy begins by increasing access to family planning services.

Because of this research and the high LBW rate in Georgia, Georgia requested and received approval from CMS to implement the P4HB<sup>®</sup> program effective January 1, 2011. The program provides family planning services to women ages 18 through 44 years who are at or below 200 percent of the most current federal poverty level (FPL) and provides inter-pregnancy care services to women at or below 200 percent of the most current FPL who previously delivered a very low birth weight baby. Family Planning Services have included medically necessary services and supplies related to birth control and pregnancy prevention. The program offers contraceptive management with a variety of methods, patient education, counseling and referral as needed to other social services and health care providers. Inter-pregnancy care (IPC) services have included all family planning services plus primary care and primary care case management (including Resource Mother’s outreach) services for women who delivered a VLBW infant. Eligibility for the program is re-determined on an annual basis and women eligible for the family planning component of the Demonstration may continue receiving family planning services for as long as the Demonstration is authorized by CMS. Women eligible for inter-pregnancy care services may continue receiving those services for two years from the date of initial enrollment into the program or until conception of the next infant (the goal for the IPC component is to delay conception for 18 to 23 months from conception of the index very low birth weight infant).

A unique aspect of Georgia’s Demonstration has been that services are delivered through the Georgia Families Care Management Organizations (CMOs) and their networks of providers. Three CMOs - AMERIGROUP, WellCare of Georgia, and Peach State Health Plan – participate in the Georgia Families program and receive a capitated per member per month (PMPM) payment for

each Demonstration participant. These capitation rates were approved by CMS and serve as the basis for calculating the expenses in the quarterly budget neutrality worksheets submitted to CMS. The CMOs' provider networks provide clinical, laboratory, pharmacy and other Demonstration services to the P4HB participants and each of the three CMOs has nurse case managers and Resource Mothers who provide the case management services for the IPC participants.

The PMPM payments to the CMOs totaled \$1,346,387 for the first program year. This amount included \$1,328,989 for family planning only (FP) services, \$16,320 for IPC services, \$1,078 for Resource Mother Only services, and administrative funds that were incorporated into these PMPM payments. The PMPM payments to the CMOs totaled \$14,776,647 for the second program year. The Year 2 total included \$14,528,929 for FP services, \$211,200 for IPC services, and \$36,518 for Resource Mother Only services. The Year 2 expenditures reflected a growth in enrollment during that period and represented a ten-fold increase in total spending during Year 2 when compared with the expenditures for the first year of the program (\$1,346,387). The PMPM payments to the CMOs totaled \$18,373,944 for the third year of the program. The Year 3 total included \$17,811,781 for FP only services, \$386,160 for IPC services, and \$176,003 for Resource Mother only services. Administrative funds were also incorporated into these PMPM payments.

The implementation of the P4HB program followed a multi-pronged communication plan (see **Appendix A**) during Years 1 and 2 with engagement of the Georgia Families CMOs, professional associations, the Georgia Department of Public Health (DPH), as well as direct engagement of consumers via printed and other media. Despite multiple engagement efforts by DCH and providers in the community, there was a lower than expected take-up of the program and even lower take-up of the program's benefits although participation rates increased in the second and third years. After Year 2, funding was no longer available for mass media marketing. Outreach activities from that point included a web presence, outreach to NICU staff, Right From the Start (RSM) Outreach worker activities, education provided by public health personnel at the time of the presumptive eligibility determination for pregnant women, and outreach activities conducted by DCH program staff and the Georgia Families CMOs.

The initial key goals for the P4HB Demonstration were to:

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

Program Objectives were to:

- Improve access to family planning services by extending eligibility for family planning services to all women aged 18 through 44 years who were at or below 200% of the FPL during the term of the demonstration;

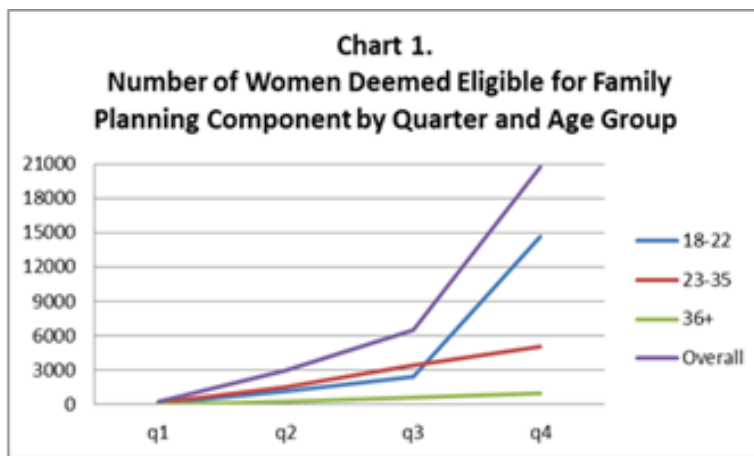
- Provide access to inter-pregnancy primary care health services for eligible women who previously delivered a very low birth weight infant;
- Decrease unintended and high-risk pregnancies among Medicaid eligible women
- Decrease late teen pregnancies by reducing the number of repeat teen births among Medicaid eligible women;
- Decrease the number of Medicaid-paid deliveries beginning in the second year of the project, thereby reducing annual pregnancy-related expenditures;
- Increase child spacing intervals through effective contraceptive use to foster reduced low birth weight rates and improved health status of women;
- Increase consistent use of contraceptive methods by 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 who in need of services but who were not receiving them; and
- Estimate the overall savings in Medicaid spending attributable to this project.

The program’s initial goals and objectives were established to be achieved over a five year time span and initial projections included increasing enrollment and participation rates for each year of the program as shown in the table below. The initial demonstration application was approved for three (3) years and since the initial approval, we have received two temporary extensions that allowed a Year 4 of the Demonstration.

At the time of the original Demonstration application, the estimate of women eligible (18 – 44 years, uninsured, <200 FPL) to participate in the waiver program was 276,548 based on data from the Georgia Health Policy Center’s 2008 Georgia Population Survey. We used information from the South Carolina Family Planning Waiver Program to estimate program enrollment and participation and based on their experience, we estimated that at best 50% of eligible women would enroll and of those, 50% would actually use services. Our original enrollment projections were:

Year	Enrolled	Projected to Use Services	% of total eligible population
1	110,620	33,186	12%
2	124,447	49,779	18%
3	138,274	69,137	25%
4	152,102	76,051	27%
5	165,929	82,965	30%

**Year 1** - Our actual program experience was far different from the projections. While there was continued interest in the program as evidenced by calls to the P4HB call center during the first year of the P4HB program, enrollee applications and the number of women deemed eligible for the program by RSM staff increased very slowly during Year 1. The number of women deemed eligible for the family planning only component of P4HB grew from less than 3,000 by the end of the second quarter of Year 1 to approximately 21,000 by the end of the fourth quarter. While there was a steady increase in the number of women in the 23 - 35 year age range deemed eligible, the growth in the last quarter was among those ages 18 - 22. Significant growth occurred as demonstrated by the quarterly patterns shown in Chart 1 below. The actual number of women enrolled, by the end of the year, in the family planning component of P4HB fell far short of the 20,976 deemed eligible and was less than 10% of the projected Year 1 enrollment of 110,620. Only 7,543, less than half of those who had been deemed eligible, were actually enrolled in the FP component by the end of the year.



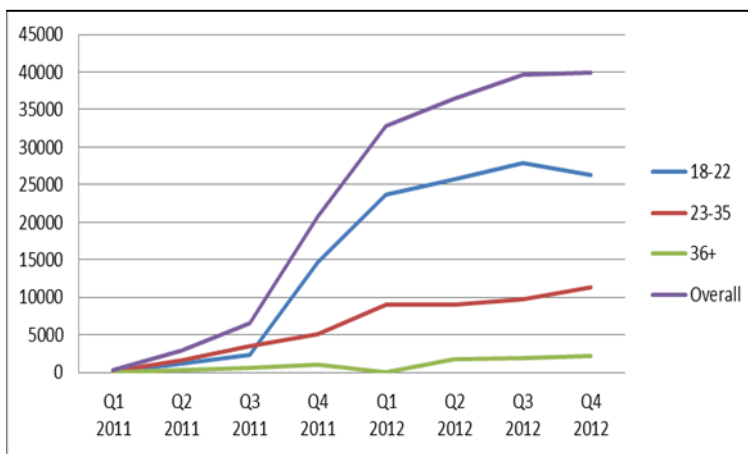
The number of women deemed eligible for the IPC component of the Demonstration also grew slowly during Year 1 - a pace much slower than that of the family planning component. By the end of the year, there were only 19 women deemed eligible for the IPC component of the Demonstration. The projected enrollment was 2,500. The women deemed eligible for the IPC component were largely in the 23-35 year age range and all 19 of them were actually enrolled in the IPC component by the end of the year. The number of women enrolled in the Resource Mother only component was similarly low - only four women were enrolled in this component of P4HB by year end.

In an effort to engage more women in the P4HB program, DCH implemented a process, in December 2011, to auto-enroll women who had delivered babies under the RSM eligibility criteria into the P4HB program. These RSM women were automatically eligible for the family planning or IPC component of the Demonstration. IPC enrollment, however, required provider attestation of the birth of a live born, very low birth weight infant. This process also allowed auto enrollment of young women as they 'aged out' of Medicaid and the PeachCare for Kids<sup>®</sup> program - Georgia's stand-alone CHIP program. RSM and PeachCare for Kids<sup>®</sup> women received a letter informing them about the P4HB program, their option to opt out of the program and their option to select a CMO, if they had not been enrolled in Medicaid managed care, or a new CMO if they had been

enrolled in Medicaid managed care. If a new CMO was not chosen, the women would remain in their current CMO to receive their P4HB services. These women did not need to submit a new application for the program because they were considered a Continued Medicaid Determination. As will be discussed later in the extension request, auto-enrollment into the FP component of the program was discontinued in June of 2013.

**Year 2** - The number of women deemed eligible for the family planning only component of P4HB grew substantially during Year 2 of the program, due in part to the auto-enrollment process. This growth continued through the end of the third quarter of 2012 and then leveled off at just below 40,000 – see **Chart 2** below.

**Chart 2** – Number of Women Deemed Eligible for Family Planning Component by Quarter and Age Group



Toward the end of Year 2, there was a slight decline in women ages 18-22 deemed eligible. This number peaked at almost 28,000 in the third quarter and declined to a little over 26,000 in the fourth quarter. The only age group for which there was continued growth in the numbers deemed eligible was the 23-35 year old group. This group grew from 9,023 in the first quarter to 11,316 in the last quarter of 2012.

By the end of Year 2, 39,889 women were deemed eligible for the FP component of P4HB but only 34,184 were actually enrolled in one of the CMOs to receive family planning only services. Approximately 124,000 women were projected to be enrolled by the end of Year 2.

There was significant growth in the number of women deemed eligible for and actually enrolled in the IPC component during Year 2. In fact, over 80 percent of the Demonstration participants deemed eligible for the IPC component were actually enrolled in a CMO by the end of the year (144 of 173 deemed eligible). All of these enrolled women were in the 21-44 age range. We attributed much of this growth to the implementation of the auto-enrollment process in April 2012 for the IPC component. To implement this process, our CMOs were asked to submit reports of women delivering very low birth weight infants to DCH. This information was shared with the



DCH enrollment broker for the P4HB program who then enrolled these women into the IPC component. As with the auto-enrollment process for the FP component, letters were sent to these women informing them about the program, their option to choose a new CMO, and that they would be auto-enrolled into the IPC component after their pregnancy eligibility status ended.

**Year 3** - By the end of Year 3, there were 32,561 women deemed eligible for the FP component of the Demonstration and 285 women deemed eligible for the IPC component. Actual enrollment in the CMOs was slightly less with 31,690 in the FP component and 253 in the IPC component. 12,403 of the FP only women were in the 18 – 20 age group and 19,287 were in the 21 – 44 age group. Of the IPC women, 17 were in the 18 – 20 age group and 236 were in the 21 – 44 age group. These Year 3 actual enrollment figures represent 23% of the projected enrolled population for Year 3.

Following implementation of the P4HB program, there was a drop in the statewide LBW rate to 9.4% in CY 2011 and the 9.4% rate held steady through CY 2012 (the last year for which statewide data is available). Within the Medicaid population, the LBW rate climbed in 2011 to 8.5% then declined to 8.44% in 2012. The statewide VLBW rate dropped to 1.8% in CY 2011 and remained at that level in CY 2012.

**Program Evaluation** - Our Year 2 program evaluation, submitted to CMS in February 2014, identified the following:

1. If the estimated fertility rate (169 per 1,000 as documented in the P4HB Concept Paper) among women 18-44, <200% FPL, and uninsured was applied to all women actually enrolled in the P4HB program by the end of Years 1 and 2 (as reported in Georgia's MMIS data and referenced above), expected births would be 5,814 in Year 2. The number of actual births in Year 2 to participants fell far below that at 562 births. 'Averted' births are then estimated at 5,252 in Year 2 which indicates potential savings to the state from a lower-than-expected birth rate among those enrolled. It is also helpful to compare the P4HB experience to that of other states with family planning waivers. In a study of six study states (Bronstein, Adams and Edwards, 2003), states reported that births to participants in one to two years post the program implementation, ranged from a low of 11% (AR, SC) of the 'expected' number of births to as high as 80% (NM). The 562 births in 2012 among Demonstration participants in Georgia constitute about 10% of the number 'expected' which puts the P4HB program well at the lower end of the other states' experiences.
2. The percentage of Medicaid women with any family planning visits increased from about 36% in 2010 to almost 40% in 2011 and remained close to that in 2012. The number of visits per enrolled woman was higher in 2012 than in 2009 but there was not a consistent upward trend in this or in the percentage with a visit/service for birth control.
3. One method to affect the rates of unintended pregnancies and births is to move women using some form of birth control toward the use of more effective methods. Our evaluation data indicated a stable composition of usage across the four World Health Organization (WHO) tiers within both the Medicaid and Title X, non-Medicaid enrolled groups. With

respect to the use of long acting reversible contraceptive (LARC) methods, there was a decline among Medicaid enrolled women in 2009 - 2010 that was reversed after the P4HB program was implemented leaving the percentage of all users in Medicaid at 38.5% in 2012. The increased use of LARC methods, especially near the end of CY 2012, may mean that the effects of the P4HB program on reductions in unintended pregnancies and births will be even more evident in the coming years.

4. The percentage of P4HB participants who had any family planning visit was 30.1% in 2011 and 29.8% in 2012. The overall percentage with a visit/service for birth control remained low at almost approximately 9% in 2011 and 2012. There was a marked difference, however, in the utilization patterns for those auto and not auto-enrolled. Whereas 20.2% of those auto-enrolled had any family planning visit in 2012 and 5.4% had a visit/service for birth control, the corresponding percentages for those not auto-enrolled into P4HB were 44.8% with a family planning visit and 13.5% with a visit/service for birth control. Overall, from 35 - 37% of P4HB enrollees using a birth control method were using LARCs in 2011 and 2012. In 2012 this percentage was higher among those not auto-enrolled at 40.5% compared to approximately 27% among those auto-enrolled.
5. The percentage of FP only enrollees with at least three months of consecutive enrollment that had evidence of a pregnancy after enrollment was 6.6% with the not auto-enrolled slightly higher (7.3%) than the auto-enrolled (6.1%). There was also a higher percentage of the not auto-enrolled group with a delivery in 2012. The number of deliveries to these women equaled 484 or 2.8% of those not auto-enrolled while the 178 deliveries to the auto-enrolled equaled only 0.7%.
6. While the number of total IPC enrollees was small in 2012, the data indicated that 7.3% experienced a repeat pregnancy after enrollment and this was higher among the auto-enrolled versus not auto-enrolled. Two IPC participants experienced a repeat delivery. Both of these deliveries were among those women not auto-enrolled in the IPC component of P4HB.
7. The 2012 distribution of birth weight for the FP only participants was different from that of non-participants but in an unexpected direction. Whereas non-participants exhibited a rate of VLBW of 1.4% (the state's average is 1.8%), those participating in the FP only component of P4HB exhibited a higher percentage of infants with VLBW at 2.1%. The percentage of LBW infants among women in the FP component of P4HB, however, was lower at 4.5% compared to non-participants at 5.5%. The higher percentage of VLBW infants among P4HB participants may reflect a selection of women into the P4HB program who were at higher risk of poor birth outcomes.
8. The data indicated that IPC women had lower repeat pregnancies within six months (5.7% vs. 7.3%) of enrollment in IPC than the women in a random sample of RSM mothers (non-participants) within six months of losing their Medicaid coverage. When a 12 month window was used, IPC women again had lower rates of repeat pregnancies (7.3% vs. 13.6%) than the RSM (non-IPC) comparison group. Important to the goals of the P4HB



program, the live birth to the IPC participant was normal birth weight; however, for the repeat births to the RSM (non-IPC) comparison group, one was normal birth weight and one was very low birth weight.

9. Given the increased risk of repeating an adverse pregnancy outcome such as a VLBW delivery, the provision of IPC services for women at or below 200% of the FPL who deliver VLBW infants remains very important to the overall success of the P4HB program in lowering the state's rate of VLBW births.
10. The combined FP and IPC components of the P4HB program also provide positive influences on birth weight by expanding the use of effective birth control methods among women in this income range, thereby decreasing unintended pregnancies and lengthening interpregnancy intervals. In particular, the FP only component may prove to play a major role in influencing the birth weight distribution since the majority of very low birth weight births are first births, and this component of the Demonstration provides increased access to family planning for nulliparous women who would not otherwise be Medicaid eligible.

As a result of our progress to date, DCH is requesting a three year extension of our current Demonstration in order to continue this progress. Throughout the extension period, the program's goals will remain as initially described. We will continue to work toward a statewide LBW rate of 8.6% and continue to partner with our CMOs, public health departments and other stakeholders to achieve this goal.

### **Demonstration Extension Objectives**

The following objectives will be pursued during the extension period:

- Improve access to family planning services by extending eligibility for these services to women meeting the eligibility criteria during the three years of the extension of the Demonstration;
- Provide access to interpregnancy primary care health services for eligible women who deliver a VLBW infant during the Demonstration period;
- Decrease unintended and high-risk pregnancies among Medicaid eligible women;
- Decrease late teen pregnancies by reducing the number of first or repeat teen births among Medicaid eligible women;
- Decrease the number of Medicaid-paid deliveries from the number expected to occur in the absence of the Demonstration extension. This decrease has already been documented for the first and second years of the Demonstration as noted in the written evaluations of those periods;
- Increase child spacing intervals through effective contraceptive use to foster reduced LBW rates and improved health status of women;

- Increase consistent use of contraceptive methods by providing wider access to family planning services;
- Increase family planning utilization among Medicaid eligible women. DCH will implement a new public awareness program following approval of the extension for the P4HB program. This public awareness program and communication plan will strengthen our outreach activities in order to draw more eligible individuals to the program; and
- Decrease Medicaid spending attributable to unintended births and LBW and VLBW babies.

These objectives point to several quantifiable performance measures that are being tracked pre- and post- implementation of the Demonstration.

New projections for the population that would be eligible for the Demonstration expansion are provided in the table below. Our actual experience did not follow our original projections that were based on the South Carolina model. Slightly less than three percent (3%) of the eligible women actually enrolled during Year 1 of the program and by the end of Year 3 and with assistance from auto-enrollment, 11.5% of the eligible population was enrolled. Enrollment during the current year, Year 4, is significantly less than previous years when marketing efforts and auto-enrollment were in play. Based on current trends, we project that by the start of the extension phase of this Demonstration, enrollment will approximate 5% of the eligible population. With approval of the extension request, a new communication plan will be implemented and we expect enrollment to increase during Year 1 of the extension to 11% of the eligible population and remain at that level throughout the expansion. This equates to a Demonstration expansion population of approximately 27,180 FP and IPC enrollees. Using historical data, we project 1.5% of the Demonstration expansion’s population (408) will be enrolled in the IPC and Resource Mothers components of the Demonstration.

<b>Year</b>	2014	2015	2016	2017
<b>Females, 18-44, &lt;200%FPL Citizens and Uninsured</b>	276,038	247,105	216,887	216,887

Under the extension, eligibility requirements for the P4HB program will remain the same as those originally approved. If a woman becomes pregnant while enrolled during the extension period, she may be determined eligible for Medicaid under the State plan and will be disenrolled from the Demonstration. Women enrolled in a Medicaid State plan eligibility category will be eligible for the Demonstration’s Resource Mother Outreach services if they have delivered a VLBW infant on or after January 1, 2011. Claims will not be submitted under the Demonstration for any woman

found to be eligible under the Medicaid State plan except for those Medicaid eligible women who are also eligible for Resource Mother Outreach services.

Women who receive a sterilization procedure and complete all necessary follow-up procedures will be dis-enrolled from the Demonstration and women enrolled in the IPC component will be dis-enrolled after two (2) years of participation in that program component. At the time of their disenrollment from the IPC component, they may be eligible for the FP component of the Demonstration and if so, will be transitioned to that component. Eligibility redeterminations will be conducted at least every 12 months.

Providers of family planning services will make appropriate referrals to primary care providers as medically indicated and women enrolled in the Demonstration will receive information about how to access primary care services. As a result of the recent approval, by CMS, of Georgia's Family Planning SPA, GA-14-001, the family planning visit limit will change under the extension. Other benefits and the delivery system will remain the same as approved under the current Demonstration.

Nurse case management and Resource Mother Outreach services will be provided to women enrolled in the IPC component as well as to low income Medicaid and Medicaid-eligible women who are blind or disabled and have documentation of the delivery of a very low birth weight infant after program implementation.

During the extension time period, family planning services available through the P4HB program will include all family planning services covered by the Georgia Medicaid program as noted below:

- Comprehensive annual exam;
- Pap smear including follow-up testing with colposcopy as indicated, clinical breast examination;
- Follow-up contraceptive visits;
- Pregnancy testing;
- Provision of FDA-approved contraceptive methods and supplies, evaluation and management of contraceptive-related problems;
- Sterilization;
- Treatment of major complications of delivered services;
- Diagnostic treatment and follow-up of STIs;
- Drugs, supplies, devices related to women's health services (genital tract infections, UTI's, etc);
- Multivitamin with folic acid or folic acid;
- Hepatitis B and Td vaccinations for 19 and 20 year-olds;
- Education and counseling (with referral as needed) related to reproductive health, preventive and preconception care, pregnancy timing and spacing, risk reduction for sexually transmitted infections, tobacco and substance abuse, domestic violence, and benefits and risks of contraceptive methods; and
- Counseling and referrals to social services and primary health care providers.

The IPC component supports our goal to reduce the VLBW rate by delaying conception of the next pregnancy for 18 to 23 months from delivery of the index VLBW infant. This delay will allow for improvements in women's underlying health status by addressing their health and preconception needs and managing their chronic and other health conditions. IPC services include:

- Primary care visits (5 outpatient visits annually);
- Chronic disease management;
- Prescription medications for treatment of chronic diseases;
- Substance abuse treatment;
- Limited dental services;
- Resource Mother/Nurse case management (through CMO staff); and
- Non-emergency transportation.

Women enrolled in the IPC program have access to the CMOs' primary care and family planning providers as well as a nurse case manager and Resource Mother hired or contracted by each CMO. Nurse case managers and Resource Mothers take part in coordinating care for the women in the IPC and the Resource Mother only components of the program and linking them with community-based resources and programs.

Under our current structure, once a woman is deemed eligible for the Demonstration, she has 30 days in which to choose a CMO. If a CMO is not selected, a CMO is auto-assigned based on the auto-assignment algorithm in place for the Georgia Families program. Auto-assignment adds another 30 days to the woman's wait before she can access P4HB services. DCH expects to implement a new protocol, prior to the start date of the expansion, which will decrease the time between the eligibility determination and actual CMO enrollment for P4HB to no more than 31 days. This change will support earlier access to P4HB services.

Women already enrolled in a Georgia Families CMO, who are losing Medicaid or CHIP coverage, will be encouraged to enroll in the P4HB program. If they are deemed eligible, they may choose to stay with their current CMO or choose a new CMO.

## **Section II – List of Programmatic Waivers and Expenditures**

The following waivers and expenditure authorities are requested for the Demonstration Extension Period. These are the same waiver and expenditure authorities as those approved in the current Demonstration.

- Authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by Georgia for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period of this Demonstration, be regarded as expenditures under the State's title XIX plan. All requirements of the Medicaid statute will be applicable to such expenditure authorities (including adherence

- to income and eligibility system verification requirements under section 1137(d) of the Act), except those specified below as not applicable to these expenditure authorities.
- Demonstration Population 1: Expenditures for extending family planning and family planning-related services provided to:
    - Uninsured women, ages 18 through 44, losing Medicaid pregnancy coverage at the conclusion of 60 days postpartum, and who are not otherwise eligible for Medicaid or the Children's Health Insurance Program (CHIP); and
    - Uninsured women, ages 18 through 44, who have family income at or below 200 percent of FPL, and who are not otherwise eligible for Medicaid or CHIP.
  - Demonstration Population 2: Expenditures for extending family planning, family planning-related, and IPC services to women, ages 18 through 44, who deliver a VLBW baby on or after January 1, 2011, with family income at or below 200 percent of the FPL, and who are not otherwise eligible for Medicaid or CHIP. IPC services will be available for 2 years after enrollment.
  - Demonstration Services 1: Expenditures for extending Resource Mother Outreach services to women, ages 18 through 44, who deliver a VLBW baby on or after January 1, 2011, with family income at or below 200 percent of the FPL, who are eligible for Medicaid.
  - All Medicaid requirements apply, except the following:
    - Methods of Administration: Transportation Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53 to the extent necessary, to enable the State to not assure transportation to and from providers for Demonstration Population 1.
    - Eligibility Section 1902(a)(10)(A) - To the extent necessary to allow Georgia to not provide medical assistance for Demonstration Populations 1 and 2 until the individual has been enrolled in a managed care organization.
    - Amount, Duration, and Scope of Services (Comparability) Section 1902(a)(10)(8) - To the extent necessary to allow the State to offer Demonstration Population 1 a benefit package consisting only of family planning and family planning-related services and Demonstration Population 2 a benefit consisting only of family planning, family planning related services, and IPC services.
    - Freedom of Choice Section 1902(a)(23) - To the extent necessary to enable the State to limit freedom of choice of provider for Demonstration Populations 1 and 2. Individuals may be auto-enrolled into the care management organization they were enrolled in at the time of the delivery of their VLBW baby.
    - Retroactive Eligibility Section 1902(a)(34) - To the extent necessary to enable the State to not provide medical assistance to Demonstration Populations 1 and 2 for any time prior to when an application for the Demonstration is made.

- o Early and Periodic Screening, Diagnostic, and Treatment Section 1902(a)(43)(A) (EPSDT) - To the extent necessary to enable the State to not furnish or arrange for all EPSDT services to Demonstration Populations 1 and 2.

**Section III – Financial Data**

Since implementation, the P4HB program has provided CMS with budget neutrality documents demonstrating expenditures for each quarter of the Demonstration. These budget neutrality documents have been included in **Appendix B** along with projected expenditures for the first expansion year of the Demonstration (this is also provided in the narrative below.)

The Georgia State Legislature appropriated, for SFY 2015, state match funds to support P4HB enrollment levels seen during Year 3 of the program. In order to calculate cost for the expansion, the CMS approved capitation rates for the P4HB program were utilized and they are listed below.

Family Planning	Interpregnancy Care	Resource Mother
\$41.35	\$240	\$119.73

Using the 27,180 member total expansion population described in Section 1 for the first year of the Demonstration expansion and projecting that 1.1% of them will be IPC members and 0.4% will be RM members, we project a distribution of 26,772 FP members, 300 IPC members and 108 RM members by the end of the first year of the Demonstration expansion. These projections, combined with the current PMPM result in first year Demonstration cost of \$13,284,266 for FP only services; \$864,000 for IPC services; and \$155,170 for Resource Mother Only services for a total of \$14,303,436 for Year 1 of the expansion. 87.6% of the capitation rate for FP services is paid at the 90% FMAP and 13.4% of the IPC capitation rate is paid at the 90% FMAP rate. The spreadsheet containing the federal and state share calculations can be found in **Appendix C**. Total federal costs for Year 1 of the expansion are estimated to be \$12,866,753 and total state costs for Year 1 are estimated to be \$1,436,683. In addition to funds supporting the delivery of clinical services and supplies, DCH is requesting approval for \$150,000 per year to support outreach activities designed to increase enrollment into the P4HB program. These funds are being requested at the 50% match rate.

At the time of the initial approval for the P4HB program, CMS identified the federal FP Component budget limit calculated as the projected per member per month (PMPM) cost times the actual number of member months for “FP Benefits,” multiplied by the Composite Federal Share.

The initial projected PMPM (Federal share) FP only cost calculation per Demonstration Year is provided below. Over the course of the Demonstration, the FP PMPM paid to the CMOs has not exceeded the CMS approved capitation rate and therefore is well below the FP Benefit rate listed below.



	<b>Trend</b>	<b>DY 1</b>	<b>DY 2</b>	<b>DY 3</b>
<b>FP Benefits</b>	<b>2.7%</b>	<b>\$ 68.17</b>	<b>\$70.01</b>	<b>\$71.90</b>

The annual budget limit for the IPC component of the Demonstration was established by CMS as the estimated cost-savings of the VLBW and LBW births averted as described below:

- VLBW Birth Averted = Birth Averted \* Medicaid Costs for VLBW Infants up to 1 year of life
  - The Medicaid Cost of a VLBW Infant equals (the cost of VLBW infants up to 1 year of life)/ number of VLBW live births, where the costs and number of VLBW live births pertain to the Georgia Medicaid Program.
- LBW Birth Averted = Birth Averted \* Medicaid Costs for LBW Infants up to 1 year of life
  - The Medicaid Cost of a LBW Infant equals (the cost of LBW infants up to 1 year of life)/ number of LBW live births, where the costs and number of LBW live births pertain to the Georgia Medicaid Program.

The revised budget neutrality form for Year 1 of the P4HB program demonstrates significant savings from the original cost projections. It is included in **Appendix F**. All required data for calculating the first year of life infant costs was not available to populate the budget neutrality form for births that occurred to Demonstration participants in Year 2. We hope to include this information in the Year 3 Annual Evaluation Report.

#### **Section IV – Evaluation Report**

The Year 1 and Year 2 formal evaluations of the Demonstration have been included in **Appendix D and Appendix E** respectively. Because of the requirements for claims run-out and linkage to vital statistics data, we are unable to submit the annual formal evaluations of the P4HB program to CMS within the April timeframe described in the current Demonstration. Our experience has been that it takes twelve (12) months from the close of the calendar year before the annual evaluation report can be completed.

The Demonstration’s evaluation process has used a quasi-experimental design to test for changes pre and post the Demonstration in the following performance measures:

- Total family planning visits per poor and near poor woman;
- Use of contraceptive services/supplies per poor and near poor woman;
- Use of interpregnancy care services (primary care and outreach) by women with a VLBW delivery;
- Average interpregnancy intervals for poor and near poor women;
- Average interpregnancy intervals for women with a VLBW delivery;
- Teen and repeat teen births for poor and near poor 18 and 19 year olds;

- Rate of LBW and VLBW deliveries among the Medicaid population with comparisons to the statewide rates for LBW and VLBW deliveries;
- Rate of LBW and VLBW deliveries<sup>1</sup> among poor and near poor women and among Medicaid enrolled women compared to other populations within the state;
- Rate of infant mortality among the Medicaid population with a comparison to the statewide rate for infant mortality;
- Rate of infant mortality<sup>2</sup> among poor and near poor women and among Medicaid enrolled women compared to other populations within the state.

The objectives of the evaluation are to test not only for changes in the performance measures pre and post P4HB but to assess whether there is evidence of a causal pathway through the expanded access the P4HB program provides. When sufficient numbers of eligible women enroll in the program such that there is an increase in the overall use of family planning services and supplies among low-income women or an increase in consistent use of more effective contraceptive methods than would otherwise occur, use of methods of higher effectiveness should lead to reduced rates of unintended pregnancies, unintended births among this population of women, and improved interpregnancy intervals. Since teens are at high risk of unintended pregnancies, the rate of unintended births and repeat teen births should also fall as a result of the Demonstration.

A key hypothesis for the P4HB concept was that the above mentioned changes would be sufficient to lower the number of overall Medicaid paid pregnancies, deliveries, and births and hence costs, such that the state and federal government would ultimately realize a net cost savings despite increased spending on family planning and interpregnancy care related services. The focus of the budget neutrality test for the P4HB program is whether there is an overall shift in the distribution of infants across birth weight categories. If the Demonstration causes changes such that there are relatively fewer low birth weight and very low birth weight infants born to Medicaid enrolled women in Georgia, total expenditures should be lowered for the state and federal government. The budget neutrality document in **Appendix F** suggests the first year of the Demonstration proved the hypothesis to be true.

## **Section V- Public Notice**

DCH provided a thirty day public notice and comment period for this extension request as required. A copy of the Public Input Announcement is attached in **Appendix G**. The announcement contains all required components: a comprehensive description of the extension; the program description, goals, and objectives to be extended under the Demonstration including the beneficiaries who will be impacted; the health care delivery system and the eligibility requirements, benefit coverage; an estimate of the expected enrollment and expenditures including historic enrollment and budgetary data; the hypothesis and evaluation parameters of the

<sup>1</sup> While we include assessment of the rate of very low birth weight deliveries as a performance measure, we note that our power to detect differences will be limited due to the smaller number of IPC participants, the relatively short time period of the Demonstration over which these downstream outcomes can be observed, and potentially low participation rates.

<sup>2</sup> While we include assessment of the rate of infant mortality as a performance measure, our power to detect differences in this outcome will be limited by its relatively low incidence.

Demonstration; the specific waiver and expenditure authorities; the location and Internet address where copies of the Demonstration extension application are available for public review and comment; postal and Internet email addresses where written comments may be sent and reviewed by the public and; the minimum thirty day time period in which the comments will be accepted; the location, date and time of at least two public hearings convened by the state to seek public input on the Demonstration extension application. One of the public hearings will be a telephonic and/or Web conference.

**Appendix A**  
**P4HB Communication Plan**

**Communication Plan (Revised for Year 2)**

Phase	Activities	Status
<p><b>Phase 1: Educate Providers and CMOs</b> Focuses on educating health care providers and CMOs about P4HB. These are the major stakeholders identified through the Communication Plan as having “the most potential to positively influence and impact the behaviors of patients through preventative care measures.”</p>	<ol style="list-style-type: none"> <li>1) Introducing a revised P4HB Communication Plan to the Work Group and the CMOs;</li> <li>2) Develop a page on the DCH website for the P4HB program that provides specific information about the program, benefits, provider network, client eligibility and enrollment and program application; and</li> <li>3) Introduce the P4HB program and program-related materials to the CMOs (including program logo, poster and postcards).</li> <li>4) Added CMOs’ handbooks to the DCH P4HB website.</li> <li>5) Update DCH P4HB website to include additional program information.</li> </ol>	<p>1) through 3). Completed initial education. Re-education is ongoing. Web page developed and updated as needed. CMOs utilizing program-related materials. Handbooks (#4) added to P4HB website in June 2012. P4HB website updated in June 2012 (#5).</p>
<p><b>Phase 2: Leverage the Strengths &amp; Assets of Partners</b> Purpose is to use local experts to champion LBW prevention by encouraging eligible women in their respective communities to enroll in the P4HB program</p>	<p>The Improving Birth Outcomes Work Group will identify local experts at the district level. Additional organizations and providers also identified as potential collaborators, including MCH staff, WIC staff, family practice providers, pediatricians, faith community leaders, nursing and medical schools, nurse midwives, health care professionals, OBGYNs, policymakers, media representatives, civic and cultural leaders, and tobacco program coordinators.</p>	<p>Ongoing meetings with the Improving Birth Outcomes Work Group now held bi-monthly. Communication is ongoing with providers, MCH staff, pediatricians and public health staff. Outreach occurring via the RSM Outreach Project staff</p>
<p><b>Phase 3: Implement Consumer-Based Outreach (Statewide and Locally)</b> Purpose is to inform consumers and providers about P4HB using media, messaging, and an organized set of communication activities</p>	<ol style="list-style-type: none"> <li>1) Introduce campaign to 18 public health districts</li> <li>2) Outline marketing proposal and estimated costs</li> <li>3) Determine overall budget and process in which marketing materials will be purchased</li> <li>4) Buy billboards, radio and print ads. Advertisement will occur in 2 phases over the course of the program, and counties with highest LBW rates will be targeted first for billboard ads.</li> </ol>	<p>1) through 12). Completed. The RSM Outreach Project staff from the Department of Family and Children Services has been instrumental in our “grassroots” outreach efforts within the 18 public health districts.</p>

Phase	Activities	Status
	<ol style="list-style-type: none"> <li>5) Finalize copy for poster/postcard design</li> <li>6) Replace postcard with brochure in summer 2011.</li> <li>7) Obtain approval of printing cost for brochures, posters/postcards; obtain shipping addresses</li> <li>8) Provide RSM, PH departments, and DFCS officials with notice that postcards/posters and brochures will be distributed and guidance about how to use them.</li> <li>9) Draft/distribute press release announcing launch of P4HB program.</li> <li>10) Pitch background sessions to identified reporters from the Atlanta Journal &amp; Constitution.</li> <li>11) Begin brainstorming a newsworthy event for Summer 2011</li> <li>12) Other activities: theater ads, health fairs, participating in cause-related charitable events, articles in provider organization newsletters; news releases, media advisories, op-eds, podcast messages placed on PH4B website, Face Book and Twitter pages. In addition, the Plan calls for media advisories, op-eds and conducting “background sessions” with area reporters to discuss the state’s efforts to reduce its LBW rate.</li> </ol>	
<p><b>Phase 4: Use Existing Resources for Support and Coaching</b> Goal is to use current available resources in Georgia to promote prenatal care, healthy lifestyles before and during pregnancy, and smoking cessation.</p>	Reach out to WIC staff and Georgia Quit Line team and inform them of P4HB and that P4HB will reference them on the P4HB website and possible future marketing materials.	Completed.
<p><b>Phase 5: Annual Campaign Evaluation</b> To analyze on an annual basis the strengths and weakness of the P4HB program. Four types</p>	<ol style="list-style-type: none"> <li>1) Assess the strengths and weaknesses of campaign materials and strategies</li> <li>2) Measure effort and the direct outputs of campaign</li> </ol>	Ongoing. Emory University is assisting with the evaluation.

Phase	Activities	Status
<p>of evaluation are suggested: 1) formative; 2) process; 3) outcome: and 4) Impact</p>	<p>3) Examine the campaign's implementation and how the activities involved are working</p> <p>4) Measure effect and changes that result from the campaign. (Assess outcomes in the target populations or communities that come about as a result of the campaign's strategies and activities; measure policy changes.)</p> <p>5) Measure community-level changes that are achieved as a result of the campaign's aggregate effects on individuals' behavior and the behavior's sustainability. Attempts to determine whether the campaign caused the effects.</p> <p>6) Make recommendations for Year 2 of the campaign based on data gained from the annual evaluation; implement necessary changes in Year 2</p>	



# Appendix B

## Budget Neutrality Worksheets

Georgia's P4HB Budget Neutrality Worksheet for: FEDERAL COST 2011		Quarter 1	Quarter 2	Quarter 3	Quarter 4	TOTAL
<b>WITHOUT DEMONSTRATION - All P4HB Participants (FP and IPC) - FP and associated services (Effective FP?)</b>						
<i>FP and FP-Related Services for All P4HB Pop - 90:10 and reg</i>	FP Enrollee Member Months	41	2,005	10,639	19,428	32,113
<i>FMAP rates (multivits, immunizations, admin., etc)</i>	IPC Enrollee Member Months	-	3	19	46	
	PMPM for FP Members FP related Services	\$36.32	\$36.22	\$35.96	\$35.96	\$36.11
	PMPM for IPC Members FP related Services	\$28.95	\$28.95	\$28.95	\$28.95	
	<b>Total</b>	<b>\$ 1,489</b>	<b>\$ 72,707</b>	<b>\$ 383,091</b>	<b>\$ 699,894</b>	<b>\$ 1,159,669</b>
<b>First Year Infant Costs for VLBW Babies &lt; 1,500 grams (all Medicaid paid births)</b>						
	Estimated Persons					2,117
	Cost per Person	\$ -	\$ -	\$ -	\$ -	\$ 94,800.00
	<b>Total</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 200,691,600</b>
<b>First Year Infant Costs for LBW Babies 1,500 to 2,499 grams (all Medicaid paid births)</b>						
	Estimated Persons					\$ 5,768
	Cost per Person	\$ -	\$ -	\$ -	\$ -	\$ 54,908.00
	<b>Total</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 316,709,344</b>
<b>TOTAL WITHOUT- DEMONSTRATION COSTS</b>		<b>\$ 1,489</b>	<b>\$ 72,707</b>	<b>\$ 383,091</b>	<b>\$ 699,894</b>	<b>\$ 518,560,613</b>
<b>WITH DEMONSTRATION - IPC SERVICES excl. Resource Mothers Only Participants Only</b>						
<i>Interpregnancy Care Services at the FMAP rate</i>	Member Months	-	3	19	46	68
	PMPM	\$ 150	\$ 146	\$ 136	\$ 136	\$ 141.94
	<b>Total</b>	<b>\$ -</b>	<b>\$ 439</b>	<b>\$ 2,580</b>	<b>\$ 6,246</b>	<b>\$ 9,265</b>
<b>First Year Infant Costs VLBW Infants &lt; 1,500 grams (all Medicaid paid births adjusted for effect of IPC services)</b>						
	Persons					-
	Cost per Person	\$ -	\$ -	\$ -	\$ -	
	<b>Total</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	
<b>First Year Infant Costs for LBW Babies 1,500 to 2,499 grams (all Medicaid paid births adjusted for effect of IPC Services)</b>						
	Persons	0	0	0	0	0
	Cost per Person					
	<b>Total</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	
<b>First Year Infant Costs for Normal Weight &gt; 2,500 grams only for women who participated in the IPC</b>						
	Persons	0	0	0	0	0
	Cost per Person					
	<b>Total</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>
<b>TOTAL WITH DEMONSTRATION COSTS</b>		<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 9,265</b>
<b>DIFFERENCE</b>						<b>\$ 518,551,349</b>

Georgia's P4HB Budget Neutrality Worksheet for: FEDERAL COST 2012		Quarter 1	Quarter 2	Quarter 3	Quarter 4	TOTAL
<b>WITHOUT DEMONSTRATION - All P4HB Participants (FP and IPC) - FP and associated services (Effective FP?)</b>						
<i>FP and FP-Related Services for All P4HB Pop - 90:10 and reg</i>	FP Enrollee Member Months	52,572	86,082	103,073	109,638	351,365
<i>FMAP rates (multivits, immunizations, admin., etc)</i>	IPC Enrollee Member Months	65	91	290	434	880
	PMPM for FP Members FP related Services	\$36.00	\$36.00	\$36.00	\$35.97	\$35.99
	PMPM for IPC Members FP related Services	\$28.95	\$28.95	\$28.95	\$28.95	\$28.95
	<b>Total</b>	<b>\$ 1,894,427</b>	<b>\$ 3,101,510</b>	<b>\$ 3,718,932</b>	<b>\$ 3,956,055</b>	<b>\$ 12,671,596</b>
<b>First Year Infant Costs for VLBW Babies &lt; 1,500 grams (all Medicaid paid births)</b>						
	Estimated Persons					2,117
	Cost per Person	\$ -	\$ -	\$ -	\$ -	\$ 94,800.00
	<b>Total</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 200,691,600</b>
<b>First Year Infant Costs for LBW Babies 1,500 to 2,499 grams (all Medicaid paid births)</b>						
	Estimated Persons					\$ 5,768
	Cost per Person	\$ -	\$ -	\$ -	\$ -	\$ 54,908.00
	<b>Total</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 316,709,344</b>
<b>TOTAL WITHOUT- DEMONSTRATION COSTS</b>		<b>\$ 1,894,427</b>	<b>\$ 3,101,510</b>	<b>\$ 3,718,932</b>	<b>\$ 3,956,055</b>	<b>\$ 530,072,540</b>
<b>WITH DEMONSTRATION - IPC SERVICES excl. Resource Mothers Only Participants Only</b>						
<i>Interpregnancy Care Services at the FMAP rate</i>	Member Months	65	91	290	434	880
	PMPM	\$ 138	\$ 138	\$ 138	\$ 136	\$ 137.19
	<b>Total</b>	<b>\$ 8,938</b>	<b>\$ 12,513</b>	<b>\$ 39,876</b>	<b>\$ 59,135</b>	<b>\$ 120,461</b>
<b>First Year Infant Costs VLBW Infants &lt; 1,500 grams (all Medicaid paid births adjusted for effect of IPC services)</b>						
	Persons					-
	Cost per Person	\$ -	\$ -	\$ -	\$ -	
	<b>Total</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	
<b>First Year Infant Costs for LBW Babies 1,500 to 2,499 grams (all Medicaid paid births adjusted for effect of IPC Services)</b>						
	Persons	0	0	0		0
	Cost per Person					
	<b>Total</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	
<b>First Year Infant Costs for Normal Weight &gt; 2,500 grams only for women who participated in the IPC</b>						
	Persons	0	0	0	0	0
	Cost per Person					
	<b>Total</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>
<b>TOTAL WITH DEMONSTRATION COSTS</b>		<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 120,461</b>
<b>DIFFERENCE</b>						<b>\$ 529,952,079</b>

Georgia's P4HB Budget Neutrality Worksheet for: FEDERAL COST 2013		Quarter 1	Quarter 2	Quarter 3	Quarter 4	TOTAL
<b>WITHOUT DEMONSTRATION - All P4HB Participants (FP and IPC) - FP and associated services (Effective FP?)</b>						
<i>FP and FP-Related Services for All P4HB Pop - 90:10 and reg</i>	FP Enrollee Member Months	104,043	108,251	119,846	98,617	430,757
<i>FMAP rates (multivits, immunizations, admin., etc)</i>	IPC Enrollee Member Months	429	373	285	522	1,609
	PMPM for FP Members FP related Services	\$35.97	\$35.97	\$35.97	\$35.99	\$35.97
	PMPM for IPC Members FP related Services	\$28.95	\$28.95	\$28.95	\$28.95	\$28.95
	<b>Total</b>	<b>\$ 3,754,668</b>	<b>\$ 3,904,401</b>	<b>\$ 4,318,906</b>	<b>\$ 3,564,071</b>	<b>\$ 15,542,218</b>
<b>First Year Infant Costs for VLBW Babies &lt; 1,500 grams (all Medicaid paid births)</b>						
	Estimated Persons					2,117
	Cost per Person	\$ -	\$ -	\$ -	\$ -	\$ 94,800.00
	<b>Total</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 200,691,600</b>
<b>First Year Infant Costs for LBW Babies 1,500 to 2,499 grams (all Medicaid paid births)</b>						
	Estimated Persons					\$ 5,768
	Cost per Person	\$ -	\$ -	\$ -	\$ -	\$ 54,908.00
	<b>Total</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 316,709,344</b>
<b>TOTAL WITHOUT- DEMONSTRATION COSTS</b>		<b>\$ 3,754,668</b>	<b>\$ 3,904,401</b>	<b>\$ 4,318,906</b>	<b>\$ 3,564,071</b>	<b>\$ 532,943,162</b>
<b>WITH DEMONSTRATION - IPC SERVICES excl. Resource Mothers Only Participants Only</b>						
<i>Interpregnancy Care Services at the FMAP rate</i>	Member Months	429	373	285	522	1,609
	PMPM	\$ 136	\$ 136	\$ 136	\$ 137	\$ 136.45
	<b>Total</b>	<b>\$ 58,454</b>	<b>\$ 50,823</b>	<b>\$ 38,833</b>	<b>\$ 71,527</b>	<b>\$ 219,636</b>
<b>First Year Infant Costs VLBW Infants &lt; 1,500 grams (all Medicaid paid births adjusted for effect of IPC services)</b>						
	Persons					-
	Cost per Person	\$ -	\$ -	\$ -	\$ -	
	<b>Total</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	
<b>First Year Infant Costs for LBW Babies 1,500 to 2,499 grams (all Medicaid paid births adjusted for effect of IPC Services)</b>						
	Persons	0	0	0		0
	Cost per Person					
	<b>Total</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	
<b>First Year Infant Costs for Normal Weight &gt; 2,500 grams only for women who participated in the IPC</b>						
	Persons	0	0	0	0	0
	Cost per Person					
	<b>Total</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>
<b>TOTAL WITH DEMONSTRATION COSTS</b>		<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 219,636</b>
<b>DIFFERENCE</b>						<b>\$ 532,723,526</b>

## Appendix C

### Family Planning Total projected CY 15 cost

	90% Federal FP	10% State FP	Total FP	65.93% Federal Other	34.07% State Other	Total Federal	Total State	
	\$13,284,266	\$10,473,315.31	\$178,009.16	\$10,651,324.48	\$1,735,898.34	\$897,043.18	\$12,209,213.66	\$1,075,052.34

### IPC Projected CY 15 cost

	\$864,000.00	\$104,198.40	\$75,686.40	\$179,884.80	\$451,037.15	\$233,078.05	\$555,235.55	\$308,764.45
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### RM Projected CY 15 cost

	\$155,170.00				\$102,303.58	\$52,866.42	\$102,303.58	\$52,866.42
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### Grand Total

**\$12,866,752.79    \$1,436,683.21**

## **Appendix D**

# **Year 1 P4HB Evaluation Report**



**Annual Report**

**Planning for Healthy Babies Program<sup>®</sup> (P4HB<sup>®</sup>) 1115  
Demonstration in Georgia**

**YEAR 1**

**FINAL**

**Submitted to the Centers for Medicare and Medicaid Services  
by:**

**The Georgia Department of Community Health (DCH)**

**And their Outside Contractor:**

**Emory University, Rollins School of Public Health  
Department of Health Policy and Management**

**December 26, 2012**

## TABLE OF CONTENTS

<b>Executive Summary</b> .....	<b>i</b>
<b>Overview of Planning for Healthy Babies Program<sup>®</sup> Demonstration</b> .....	<b>1</b>
Demonstration Objectives .....	3
Demonstration Evaluation Objectives .....	4
<b>Summary of First Year Activities</b> .....	<b>6</b>
Communication, Outreach and Marketing .....	6
DCH Supported Activities.....	6
CMO Supported Activities.....	10
Major Changes In Year .....	11
<b>Enrollment and Participation</b> .....	<b>11</b>
Enrollment Process .....	11
Enrollment Trends.....	13
Participation Rates.....	15
<b>Member and Provider Surveys</b> .....	<b>16</b>
CMO Member Survey Results.....	17
CMO Provider Survey Results .....	23
<b>Data on Deliveries and Infants</b> .....	<b>27</b>
Counts of Deliveries and Costs .....	28
Counts of Infants and Costs .....	31
Birth Weight Distribution.....	33
<b>Service Use, Costs and Budget Neutrality</b> .....	<b>35</b>
Services Use .....	35
Costs.....	37
Demonstration Costs .....	37
IPC Demonstration Costs .....	38
Averted Births and Budget Neutrality .....	38
<b>Conclusions and Recommendations</b> .....	<b>40</b>
<b>Appendix A: P4HB<sup>®</sup> Communication Plan</b> .....	<b>A1</b>
<b>Appendix B: Schematic of Enrollment Process</b> .....	<b>B1</b>
<b>Appendix C: CMO Surveys</b> .....	<b>C1</b>
<b>Appendix D: CMO Action Plan Post Surveys</b> .....	<b>D1</b>

## **Executive Summary**

The Planning for Healthy Babies Program<sup>®</sup> (P4HB<sup>®</sup>), the 1115 Demonstration approved by the Centers for Medicare and Medicaid Services (CMS) for the Georgia Department of Community Health (DCH), expands the provision of family planning services to uninsured women, ages 18 through 44, who have a family income at or below 200 percent of the federal poverty level (FPL) and who are not otherwise eligible for Medicaid or the Children's Health Insurance Program (CHIP). In addition, the Planning for Healthy Babies Program<sup>®</sup> provides Interpregnancy Care (IPC) services to women who meet the same eligibility requirements above and who deliver a very low birth-weight (VLBW) infant (less than 1,500 grams) on or after January 1, 2011. Women ages 18 through 44 who have a family income at or below 200 percent of the FPL, who have a VLBW delivery on or after January 1, 2011, and who qualify under the Low Income Medicaid (LIM) Class of Assistance or the Aged, Blind and Disabled (ABD) Classes of Assistance under the Georgia Medicaid State plan are eligible for the Resource Mothers Outreach component of the IPC services as these services are not currently available under the Georgia Medicaid State plan. With this Demonstration, Georgia expects to achieve the following to promote the objectives of title XIX:

- Reduce Georgia's low birth weight (LBW) and VLBW rates;
- Reduce the number of unintended pregnancies in Georgia;
- Reduce Georgia's Medicaid costs by reducing the number of unintended pregnancies by women who otherwise would be eligible for Medicaid pregnancy-related services;
- Provide access to IPC health services for eligible women who have previously delivered a VLBW infant; and,
- Increase child spacing intervals through effective contraceptive use.

A unique aspect of Georgia's Demonstration is that services are delivered through the Georgia Families Care Management Organizations (CMOs) and their networks of providers. Three CMOs - AMERIGROUP, WellCare of Georgia, and Peach State Health Plan – participate in the Georgia Families program and receive a capitated per member per month (PMPM) payment for each Demonstration participant. These monthly rates were approved by CMS and serve as the basis for calculating the expenses in the quarterly budget neutrality worksheets. The CMOs' provider networks provide clinical, laboratory, pharmacy and other Demonstration services to

the P4HB<sup>®</sup> participants and each of the three CMOs has nurse case managers and Resource Mothers who provide the case management services for the IPC participants.

The implementation of the P4HB<sup>®</sup> program by the DCH followed a multi-pronged communication plan, with engagement of the CMOs, professional associations, and the Georgia Department of Public Health (DPH) as well as direct engagement of consumers via printed and other media. DCH projected (based on 2008 survey data) that 276,548 women would be eligible for services under the Demonstration and that by the end of Year 1, 110,620 of those women would be enrolled and 33,186 would be using services. Despite multiple engagement efforts, only 7,566 women or 6.8% of the 110,620 women projected to be enrolled were actually enrolled with one of the Georgia Families CMOs for the P4HB<sup>®</sup> program. Of this 7,566 total enrolled population, 19 women were enrolled in the IPC component of P4HB<sup>®</sup>, four (4) women were enrolled in the Resource Mother only component, and 7,543 women were enrolled in the Family Planning (FP) component. DCH originally projected that 2,500 women would be enrolled in the IPC component of P4HB<sup>®</sup> however, less than 1% of the expected population was actually enrolled in IPC at the end of Year 1. If the number of women uninsured and in the income range eligible for P4HB<sup>®</sup> was based on 2009 data from the American Community Survey (ACS) including only citizens and was adjusted for the percentage of women ‘in need’ of family planning services, the percentage enrolled decreases from 6.8% to 5.3%.

The PMPM payments to the CMOs totaled \$1,346,386.57 for the first program year. This amount included \$1,328,989 for family planning only services, \$16,320 for IPC services, and \$1,077.57 for Resource Mother Only services with the administrative load amount of approximately 13% incorporated into these PMPM payments. The evaluation team is in the process of estimating the amount and types of services used by women enrolled in the FP only component. Service utilization claims among women enrolled in the IPC component show that women sought care for chronic and acute conditions, contraceptive needs, and preventive and maintenance health care. Survey data from the CMOs’ providers and program enrollees support that both providers and potential enrollees need more information about the availability of the

P4HB<sup>®</sup> program, eligibility criteria, services covered, and the importance of covered services for improving Georgia's rates of unintended pregnancy and adverse pregnancy outcomes.

Data for Medicaid deliveries in CY2011 support that Georgia has a substantial number of Medicaid paid deliveries (a total of 78,229 including live births, stillbirths and fetal deaths), which cost Medicaid approximately \$365 million. The costs for the live born deliveries equaled \$353 million for the mother and another \$291 million for infants born live with these deliveries. The estimated low birth weight rate was 8.4% but this was based on only a subset of the 72,122 live born infants with birth weight data on their claims. There is a clear pattern of higher costs for both the mother and the infant if the infant is born either low birth weight or very low birth weight. Very low birth weight infants average \$73,861 at delivery and \$8,169 in their first year of life while infants born of normal birth weight average \$2,247 at delivery and \$1,617 in their first year of life. As noted above, Georgia expects the P4HB<sup>®</sup> program to lower the adverse outcomes and their related costs by expansion of services to those reproductive age women otherwise uninsured and eligible for Medicaid if they become pregnant.

To begin the full evaluation process, DCH and its contractor will link the administrative claims and enrollment data with the State's Vital Records in order to more accurately measure the birth weight distribution among births paid by Medicaid not only in 2011 but in 2009 and 2010, two years prior to the demonstration. As more data are accumulated about enrollees, their service utilization, and their subsequent outcomes as well as hypothesis testing about the impact of the P4HB<sup>®</sup> can be performed.

The numbers we present in this first annual report are based on claims and encounter data and are subject to change once these records are linked to the Georgia vital records for CY2011. The Georgia Department of Public Health projects the CY2011 Georgia vital records data will be available for linkage with Georgia Medicaid claims data during late spring 2013. We recognize the lack of standardization in the definition of 'Medicaid-financed births' across states and hope that our effort in Georgia will contribute toward a common set of definitions and standards for

computing these measures using Medicaid claims data, vital records, and once completed, linked claims-vital records.



## **I. OVERVIEW OF THE PLANNING FOR HEALTHY BABIES PROGRAM<sup>®</sup> (P4HB<sup>®</sup>)**

In response to the persistent high rate of low birth weight (LBW) and very low birth weight (VLBW) infants born to women in Georgia, the DCH designed an 1115 Demonstration and was granted authority by CMS to expand access to family planning services under the P4HB<sup>®</sup> program. This program became available in January 2011 to women ages 18 through 44 years who were above the state's LIM income eligibility level but at or below 200% of the Federal Poverty Level (FPL). The Demonstration requires women to be U.S. citizens, residents of Georgia, not pregnant but able to become pregnant (no tubal ligation or hysterectomy) and otherwise uninsured for family planning (FP) services.

The Planning for Healthy Babies Program<sup>®</sup> (P4HB<sup>®</sup>) is scheduled to end December 31, 2013. Given DCH's goal to reduce the rates of low and very low birth weight births, the P4HB<sup>®</sup> program also provides Interpregnancy Care (IPC) services to women at or below 200% of the FPL who deliver a very low birth weight (VLBW) infant. Resource Mother Outreach services are also provided to these women as well as to LIM or ABD women who delivered a very low birth weight infant on or after January 1, 2011. DCH identified the following as goals for this Demonstration:

- 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.

Pregnancies among the near-poor group of women made newly eligible for family planning services under P4HB<sup>®</sup> are likely to be paid for by the Georgia Medicaid program as pregnant

women at or below 200% FPL qualify under Georgia's pregnancy ("Right from the Start") Medicaid eligibility criteria. A key objective of the Demonstration, as noted, is to reduce the proportion of unintended pregnancies/births and increase inter-pregnancy intervals among this 'targeted' group of near-poor women. Given the increased risk of repeating an adverse pregnancy outcome such as a VLBW delivery, the provision of IPC services for women at or below 200% of the FPL who deliver a VLBW infant is important to the success of P4HB<sup>®</sup> in lowering the state's rate of VLBW births. The FP and IPC components of P4HB<sup>®</sup> may also provide positive influences on birth weight by expanding the use of effective birth control methods thus decreasing the occurrence of unintended pregnancy and short interpregnancy intervals. In particular, the FP component may play a major role in influencing birth weights since the majority of very low birth weight births are first births and this component of the Demonstration provides increased access to family planning for nulliparous women.

Family planning services available through the P4HB<sup>®</sup> program include all family planning services covered by the Georgia Medicaid Program as noted below:

- Comprehensive annual exam;
- Pap smear including follow-up testing with colposcopy as indicated;
- Clinical breast examination;
- Follow-up contraceptive visits (4 per year);
- Pregnancy testing;
- Provision of FDA-approved contraceptive methods and supplies, evaluation and management of contraceptive-related problems;
- Sterilization;
- Treatment of major complications of delivered services;
- Diagnostic treatment and follow-up of sexually transmitted infections (STIs);
- Drugs, supplies, devices related to women's health services (genital tract infections, UTI's, etc);
- Multivitamin with folic acid or folic acid;
- HepB and Td vaccinations for 19 and 20 year-olds;
- Education and counseling (with referral as needed) related to reproductive health, preventive and preconception care, pregnancy timing and spacing, risk reduction for sexually transmitted infections, tobacco and substance abuse, domestic violence, and benefits and risks of contraceptive methods; and
- Counseling and referrals to social services and primary health care providers.

The expansion of eligibility for family planning services under P4HB<sup>®</sup> should increase low-income women's access to this full spectrum of family planning services by permitting women within a higher income range to have coverage and by allowing access through private health care providers as well as county health departments and community health centers. In addition to family planning services, the IPC component of P4HB<sup>®</sup> also covers:

- Primary care visits (5 outpatient visits annually);
- Chronic disease management;
- Prescription medications for treatment of chronic diseases;
- Substance abuse treatment;
- Limited dental services;
- Resource Mother/Nurse case management (through CMO staff); and
- Non-emergency transportation.

The IPC services under the P4HB<sup>®</sup> program are available for eligible women following delivery of a live born, very low birth weight (< 1,500 grams or 3 pounds, 5 ounces) infant for twenty-four (24) months (as long as the woman remains eligible for P4HB<sup>®</sup>). The goals of this program component are to delay conception of the women's next pregnancy for 18 to 23 months from delivery of the index VLBW infant and to improve the women's underlying health status by addressing their health and preconception needs and managing their chronic and other health conditions. The Resource Mother/Nurse case management component of the Demonstration is also available to the LIM and ABD groups if they have a VLBW infant on or after January 1, 2011.

A unique aspect of the P4HB<sup>®</sup> program is that participants are required to select a CMO with its affiliated provider network that provides the family planning and IPC services. Once deemed eligible for the Demonstration, women have 30 days in which to choose a CMO. Women already enrolled in a Georgia Families CMO, who are losing Medicaid or CHIP coverage, may choose to stay with their current CMO or choose a new CMO if desired. Women enrolled in the IPC component of P4HB<sup>®</sup> have access to the CMOs' primary care and family planning providers as well as a nurse case manager and Resource Mother hired or contracted by each CMO. Nurse case managers and Resource Mothers take part in coordinating care for the women in the IPC

and the Resource Mother only components of the program and linking them with community-based resources and programs.

### **Demonstration Objectives**

The primary goal of the Demonstration is to reduce Georgia's low birth weight and very low birth weight rates. The following objectives were identified to effect achievement of the goals of the Demonstration:

- Improve access to family planning services by extending eligibility for these services to the newly eligible women noted above during the three years of the Demonstration.
- Provide access to interpregnancy primary care health services for eligible women who deliver a very low birth weight infant during the three year term of the Demonstration.
- Decrease unintended and high-risk pregnancies among Medicaid eligible women.
- Decrease late teen pregnancies by reducing the number of first or repeat teen births among Medicaid eligible women ages 18-19 years.
- Decrease the number of Medicaid-paid deliveries from the number expected to occur in the absence of the Demonstration beginning in the second year.
- Increase child spacing intervals through effective contraceptive use to foster reduced low birth weight rates and improved health status of 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.
- Decrease Medicaid spending attributable to unintended births and low and very low birth weight babies.

These objectives point to several quantifiable performance measures that will be gauged pre- and post- implementation of the demonstration as discussed in the next section.

### **Demonstration Evaluation Objectives**

The demonstration evaluation will use a quasi-experimental design in most of the analysis to test for changes pre and post the demonstration in the following performance measures:

- Total family planning visits per poor and near poor woman;
- Use of contraceptive services/supplies per poor and near poor woman;
- Use of inter-pregnancy care services (primary care and outreach) by women with a very low birth weight delivery;
- Average inter-pregnancy intervals for poor and near poor women;
- Average inter-pregnancy intervals for women with a very low birth weight delivery;
- Teen and repeat teen births for poor and near poor 18 and 19 year olds;
- Rate of low birth weight and very low birth weight deliveries among the Medicaid population with comparisons to the statewide rates for low birth weight and very low birth weight deliveries;
- Rate of low birth weight and very low birth weight deliveries<sup>3</sup> among poor and near poor women and among Medicaid enrolled women compared to other populations within the state;
- Rate of infant mortality among the Medicaid population with a comparison to the statewide rate for infant mortality;
- Rate of infant mortality<sup>4</sup> among poor and near poor women and among Medicaid enrolled women compared to other populations within the state.

The objectives of the evaluation are to test not only for changes in the performance measures but to assess whether there is evidence of causation. In order for DCH to achieve significant changes in these measures, the P4HB<sup>®</sup> program must enroll sufficient numbers of women and increase the overall use of family planning services/supplies among low-income women or promote more consistent use of effective contraceptive methods among program users. Since the Demonstration targets the income range of women who would qualify for Medicaid ‘if’ they become pregnant, increased use of contraceptives among the Demonstration participants should lead to reduced unintended pregnancies and in turn, unintended births among this population of women (as well as improved inter-pregnancy intervals). Since teens are at high risk of unintended pregnancies, a related effect should be that the rate of unintended births and repeat teen births falls post the demonstration.

A key hypothesis is that these changes will be sufficient to lower the number of overall Medicaid paid pregnancies and deliveries/births and hence, costs, such that the state and federal

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<sup>3</sup> While we include assessment of the rate of very low birth weight deliveries as a performance measure, we note that our power to detect differences will be limited due to the smaller number of IPC participants, the relatively short time period of the Demonstration over which these downstream outcomes can be observed, and potentially low participation rates.

<sup>4</sup> While we include assessment of the rate of infant mortality as a performance measure, our power to detect differences in this outcome will be limited by its relatively low incidence and the issues noted above.

government will ultimately realize a net cost savings despite increased spending on family planning and inter-pregnancy care related services. Since Medicaid birth rates are highly variable and can be affected by external factors (such as unemployment, wage/income changes) estimates of ‘averted births’ used in budget neutrality tests in most states’ demonstration programs are based in part, on births actually observed within the demonstration enrollee or participating (users) group of women. While the evaluation will include this measure, the focus of the budget neutrality test for the P4HB<sup>®</sup> program is whether there is an overall shift in the distribution of infants across birth weight categories. If the Demonstration causes changes such that there are relatively fewer low birth weight and very low birth weight infants born to Medicaid enrolled women in Georgia, total expenditures should be lowered for the state and federal government.

## **II. SUMMARY OF FIRST YEAR ACTIVITIES**

### **Communication, Outreach and Marketing**

During Demonstration Year 1, there were several major events that involved communication, outreach, and marketing. Each of these activities was initiated to increase awareness of the P4HB<sup>®</sup> program as well as encourage participation by both consumers and providers. We summarize these activities below.

### **DCH Supported Activities**

Before the implementation of the P4HB<sup>®</sup> program, the DCH developed a multi-pronged communication plan which incorporated five (5) specific phases for the marketing of P4HB<sup>®</sup> throughout the state: 1) educate providers and CMOs; 2) leverage strengths and assets of partners; 3) implement consumer-based outreach; 4) use existing resources for support and coaching; and 5) annual evaluation. Each of these phases is described in the table in Appendix A and discussed below. The DCH link for the P4HB<sup>®</sup> program is: <http://dch.georgia.gov/planning-healthy-babies>.

**Educate Providers and CMOs.** During Year 1, DCH provided extensive provider education and outreach throughout the state. These related activities included distributing numerous educational and training materials to the CMOs (including a training webinar on the role and duties of the Resource Mother), the Georgia Family Planning Program’s (Georgia Title X Grantee) staff, and numerous provider organizations throughout the state. DCH also provided several direct trainings and hosted webinars with all 18 public health districts. In addition, DCH worked with each of the CMOs to develop and implement a provider survey that helped inform the DCH as well as the CMOs about their network providers’ knowledge and understanding of the P4HB<sup>®</sup> program and potential barriers that existed in the first year of the program. The results of this first survey are discussed in section IV of this report.

DCH also developed a Provider Outreach Information brochure and Provider Manual addendum for P4HB<sup>®</sup>. The Provider Outreach Information brochure and Provider Manual addendum provide written descriptions of the P4HB<sup>®</sup> program in terms of the benefits and scope of services, reimbursement, eligibility requirements, and enrollment procedures. The brochure indicates that providers will receive training about P4HB<sup>®</sup> through the CMOs, and specifically, that the CMOs will provide “ongoing training to all providers of family planning and family planning related services”.

**Leverage Strengths and Assets of Partners.** DCH provided additional training and educational materials (blast fax, P4HB<sup>®</sup> materials) to the following provider organizations: Georgia Primary Care Association; Georgia Association of Family Physicians (GAFF); Georgia Chapter of the American Academy of Pediatrics (G-AAP); and the Georgia Obstetrical and Gynecologic Society (GOGS). In addition, DCH hosted a webinar for the Georgia Hospital Association on April 5, 2011. DCH has maintained regular communication about P4HB<sup>®</sup> with Georgia’s Title X program as well. DCH provided video information conferencing system (VICS) training to all public health district Title X sites as well as provided them with all of the P4HB<sup>®</sup> outreach materials that had been developed (i.e. postcards, applications, provider FAQs).

DCH directly distributed P4HB<sup>®</sup> materials to various independent provider associations for use during face-to-face visits and hosted eight (8) webinars for all 18 health districts. Information was distributed to the six Regional Perinatal Centers (RPCs) and to their discharge planners. When the RPCs requested materials, DCH contacted the Right from the Start Medicaid Outreach Project (RSM) staff who provided the materials (i.e., posters and post cards) to the RPCs. In addition, professional champions notified their respective professional societies (Georgia OB/GYN Society, Georgia Academy of Family Physicians) about the P4HB<sup>®</sup> program and disseminated information about the P4HB<sup>®</sup> program in their professional societies' newsletters. The Georgia Academy of Family Physicians hosted an information session about the P4HB<sup>®</sup> program during its summer membership meeting in June 2011. The Georgia OB/GYN Society presented information on P4HB<sup>®</sup> at their annual Provider Golf Tournament and offered information at their annual meeting in August 2011.

**Consumer-Based Outreach.** DCH conducted extensive client outreach during 2011. RSM staff made over 700 presentations about the P4HB<sup>®</sup> program to interested individuals throughout the state. P4HB<sup>®</sup> client outreach activities ranged from health fairs, to radio public service announcements, to church meetings and visits to children's hospitals and youth development centers. RSM staff made one-on-one presentations as well as presented at large-scale group information sessions. Attendance at most outreach activities was high, with several activities being attended by over 1,000 people. Examples include:

- September 2011: RSM workers promoted P4HB<sup>®</sup> to over 1,000 people at both "Paint the Town Pink" and "Troup Family Day" in LaGrange county;
- October 2011: RSM workers promoted P4HB<sup>®</sup> to over 2,000 people at both a Lions Club Fair in Jones County and at the First Baptist Church in Cherokee County.

A detailed list of all DCH specific outreach activities has been included in the quarterly reports submitted during Year 1 to CMS. Examples of additional outreach activities that occurred during Year 1 include:

- On site face-to-face assistance with completion of P4HB<sup>®</sup> applications and educational information targeting IPC members in three regions;
- Case management (CM) education to high risk OB members about P4HB<sup>®</sup> including education and instructions on how to apply for the program;



- Telephonic outreach: 1) to alert providers of their newly assigned members; 2) to postpartum members to provide education on the P4HB<sup>®</sup> program and how to apply; 3) to newly enrolled P4HB<sup>®</sup> members to educate them on benefits and services; 4) to members with VLBW babies admitted to the NICU to provide education on the P4HB<sup>®</sup> program and how to apply;
- Mass mailed applications to postpartum members who had recently delivered to educate them about P4HB<sup>®</sup>;
- Distribution of Provider Toolkits to new physicians during their CMO orientation;
- Trained Department of Family and Children Services (DFCS) supervisors and administrators on the P4HB<sup>®</sup> program. Distributed one P4HB<sup>®</sup> poster in each Georgia county DFCS office lobby along with an ample supply of P4HB<sup>®</sup> applications and postcards;
- Trained staff in Georgia's Public Health District 7 (16 counties) on the P4HB<sup>®</sup> program.

**Using Existing Resources for Support and Coaching.** The goal of this activity was to use current and available resources in Georgia to promote prenatal care, healthy lifestyles before and during pregnancy, and smoking cessation. DCH accomplished this goal by contacting Georgia's WIC program as well as POWERLINE, a telephone resource sponsored by Georgia's Healthy Mothers, Healthy Babies program, to inform them about the P4HB<sup>®</sup> program. DCH also included these resources on the P4HB<sup>®</sup> program's website and other marketing materials.

**Annual Evaluation.** The purpose of the annual evaluation is to analyze, on a yearly basis, the strengths and weakness of the P4HB<sup>®</sup> outreach program. Four types of evaluations were originally suggested: 1) formative; 2) process; 3) outcome; and 4) impact. The evaluation would: 1) assess the strengths and weaknesses of outreach materials and strategies; 2) measure effort and the direct outputs of outreach; 3) examine the roll-out of the outreach activities and how the activities were working; 4) measure effect and changes that result from the outreach (assess outcomes in the target populations or communities that come about as a result of the outreach strategies and activities and measure policy changes); 5) measure community-level changes that are achieved as a result of the aggregate effects of the outreach on individuals' behavior and the behavior's sustainability (attempts to determine whether the outreach caused the effects); and 6) make recommendations based on data gained from the annual evaluation. At the end of Year 1, DCH had moved forward to prepare for the overall evaluation of the Demonstration (inclusive of

the evaluation of the effectiveness of the marketing activities) since resources were limited for evaluating the effectiveness of the marketing and outreach activities as a distinct exercise.

**Marketing.** Prior to the start of the Demonstration, DCH received a commitment of funding in the amount of \$150,000 from the Department of Public Health (DPH) to conduct marketing for P4HB.® A marketing budget was created to facilitate the consumer outreach activities detailed in Phase 3 of the DCH Communication Plan for P4HB®. The P4HB® Marketing Plan budget was divided into 2 phases, Phase 1 (January-June 2011) and Phase 2 (July-December 2011).

A total of \$20,169 was expended in Phase 1 of the marketing plan for the printing of applications (204,500 in English; 142,000 in Spanish), 32,500 postcards, and 1,000 posters and for the associated shipping, translation and proofreading/editing of the translated Spanish documents. In Phase 2, \$127,750 was spent, the balance of the committed funds from DPH in support of the Demonstration. Funds were expended for radio advertisements that ran for six weeks via Radio One, bus and bus shelter advertisements that ran for three months, additional printing and shipping of over 5,000 English and Spanish brochures and posters, translation of Spanish materials, and billboards strategically placed in 10 counties with the highest LBW rates in the state (Benn Hill, Crisp, Spalding, Dougherty, Bibb, Lowndes, Walker, Muscogee, Richard, and Tift). Fifty-five billboards were rented for a period of six months. Additionally, a full-page, four-color advertisement was placed in the Expectant Mother's Guide for six months (August 2011 to January 2012). This Guide was available in Fulton, DeKalb, Gwinnett and Cobb Counties.

### **CMO Supported Activities**

The CMOs individually developed their Provider Education Action Plans that detailed the education activities related to P4HB®. Major tasks included: developing and distributing the Provider Manual Addendums relative to P4HB®; sending initial DCH outreach materials to all large provider groups/IPAs and facilities; posting DCH outreach materials on each CMO's provider portal; sharing information and training their provider relations representatives to

conduct community outreach (they provided education to providers at their offices) about P4HB<sup>®</sup>; conducting joint webinar trainings for providers and health care managers; and creating a quick reference card for P4HB<sup>®</sup>.

To date, the Georgia CMOs have posted information about P4HB<sup>®</sup> on their respective websites (<https://www.myamerigroup.com/English/Medicaid/GA/Pages/P4HB.aspx>; <http://georgia.wellcare.com/member/p4hb>; [http://www.pshpgeorgia.com/2011/02/18/planning-for-healthy-babies-program-p4hb-effective-january-1-2011/langswitch\\_lang/es/](http://www.pshpgeorgia.com/2011/02/18/planning-for-healthy-babies-program-p4hb-effective-january-1-2011/langswitch_lang/es/)). Also, all three CMOs have mailed informational letters and brochures directly to providers. Each of the CMO's Provider Manual addendums has been approved and posted on their CMO provider portals.

### **Major Changes in the Year**

In December 2011, DCH implemented a system to auto-enroll women who had delivered babies under the RSM eligibility criteria into P4HB<sup>®</sup>. These RSM women were automatically eligible for the family planning and/or IPC component of the Demonstration (although provider attestation of the birth of a live born, very low birth weight infant is still required). This system also began auto enrolling 19 year olds as they 'aged out' of the PeachCare for Kids<sup>®</sup> program – Georgia's stand- alone CHIP program. RSM and PeachCare for Kids<sup>®</sup> women received a letter informing them about P4HB<sup>®</sup>, their option to opt out of the program and their option to select a new CMO. If a new CMO was not chosen, the women would remain in their current CMO to receive their P4HB<sup>®</sup> services. Based on January 2012 statistics, this auto-enrollment process expanded knowledge of the P4HB<sup>®</sup> program and increased enrollment as women did not need to submit a new application but were considered a Continued Medicaid Determination. Auto-enrollment will be an ongoing component of the P4HB<sup>®</sup> enrollment process and work has been initiated to allow auto-enrollment into the IPC component for those women who deliver VLBW infants and meet P4HB<sup>®</sup> eligibility requirements.

### **III. ENROLLMENT AND PARTICIPATION**

Before discussing the patterns of enrollment in the first year, it is important to understand the P4HB<sup>®</sup> enrollment process and the barriers to enrollment as well as the auto-enrollment process described above.

#### **Enrollment Process**

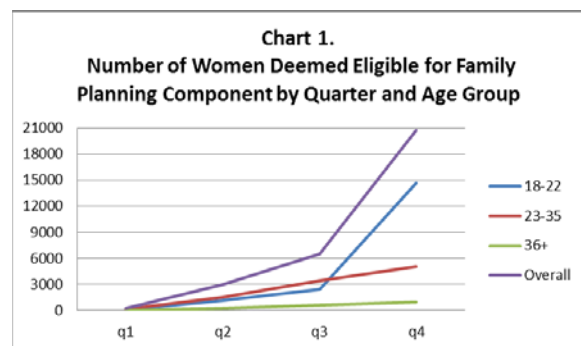
A diagram reflecting the enrollment process is provided in Appendix B along with a diagram indicating the auto-enrollment process for RSM enrollees that was implemented at the end of Year 1. To enroll in P4HB<sup>®</sup>, women must complete an application (paper or a web-based). Paper applications could be found at all of the 159 county health departments and DFCS offices within the state and at some private provider offices. Web-based applications were available at the DCH P4HB<sup>®</sup> website (<http://www.p4hb.org/Static/Guidelines.aspx>). To accompany the applications, women had to comply with Medicaid eligibility rules and provide proof of citizenship, age, income, and provider confirmation of a VLBW delivery (if applicable). County health department, county DFCS staff and RSM staff were responsible for verifying this documentation. Once the applications were completed by the prospective Demonstration participants, they were forwarded via mail or electronically to Policy Studies Incorporated (PSI) for processing. PSI would verify that all required information for the application was complete and if it was not, they would reach out to the prospective Demonstration participants for the additional required information. When all information was verified, PSI would upload the verified information into their system and notify the RSM staff that the application was ready for the eligibility determination. If the RSM staff determined that additional information was needed, they would alert PSI to conduct additional follow up. Otherwise, the RSM staff would determine whether the prospective Demonstration participant was eligible or not for the P4HB<sup>®</sup> program. Reasons for denial of the application included: not a US citizen, did not meet the income requirements, prior sterilization, eligibility for another Medicaid program, etc. If the application was approved, PSI would send the approval data to the DCH Medicaid Management Information System (MMIS) which would trigger the enrollment broker to contact the potential Demonstration participant in order for them to select a CMO. If the potential Demonstration

participant failed to select a CMO within 30 days, they were auto-assigned to a CMO operating within their county of residence. The CMO was then sent a file from the MMIS identifying the Demonstration participants who would be served by the CMO's provider network. The CMO would then: contact the new members and welcome them to the CMO and to the P4HB<sup>®</sup> program; send them a new member packet that detailed their benefits under the P4HB<sup>®</sup> program; and send them a membership card which identified their benefits.

During Year 1, data obtained from DCH's P4HB<sup>®</sup> tracking reports indicated that the average number of days from application to referral to RSM increased from 12.5 days in January to 16.4 days in December. The range of processes that could contribute to delays between application and enrollment (See Appendix B) include: women's provision of required documentation; verification of documents by designated agencies; women's selection of a CMO and communication of that selection to the Medicaid agency; and administrative processing of the application and enrollment. To expedite the process of verification, DCH educated local public health offices that, as a qualified Medicaid provider, they could view original identity verification documents, copy, and indicate by signing the copy that the originals had been viewed. Despite repeated efforts to educate local public health offices about their ability to accelerate the enrollment process, the average time from application to referral in Year 1 did not decline. The auto-enrollment process was implemented in December 2011 to further expedite enrollment for RSM women who would otherwise be disenrolled from Medicaid 60 days post-partum, and for young women aging out of the PeachCare for Kids<sup>®</sup> program.

## Enrollment Trends

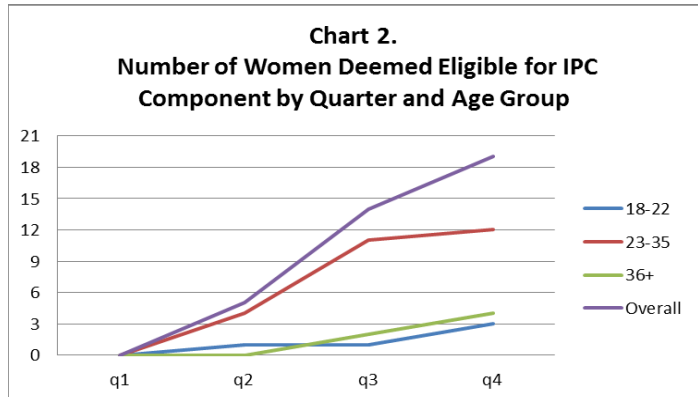
During the first year of the P4HB<sup>®</sup>, there was continued interest in the program as evidenced by calls to the call center, enrollee applications and the number of women deemed eligible by RSM staff. Significant growth occurred despite the somewhat lengthy enrollment process. It is



perhaps easiest to see this growth by looking at the quarterly patterns of the number of women deemed eligible overall and by age group as shown in the accompanying charts.

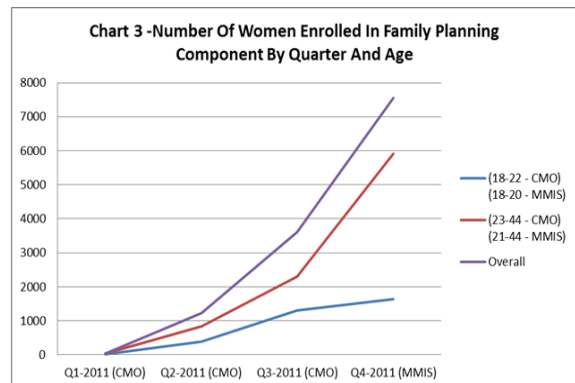
The number of women deemed eligible for the family planning only component of P4HB<sup>®</sup> grew from less than 3,000 by the end of the second quarter to a total of almost 21,000 by the end of the fourth quarter of Year 1 (See Chart 1).

While there was a steady increase in the number of women in the 23-35 year age range deemed eligible, the growth in the last quarter was really focused among those ages 18-22, perhaps reflecting the auto-enrollment of PeachCare for Kids<sup>®</sup> women turning 19 years of age.



The number of women deemed eligible for the IPC component of the Demonstration also grew during the year but at a slower pace than the family planning component. By the end of Year 1, there were only 19 women deemed eligible for this important part of the Demonstration. The trends in Chart 2 highlight that the women deemed eligible for the IPC component were largely in the 23-35 year age range but growth in the other two age groups was also trending upward by the end of Year 1. All 19 of those deemed eligible for IPC were actually enrolled in IPC by the end of CY2011. The numbers enrolled in the Resource Mothers only component of the Demonstration were similarly low. By the end of CY2011, there were four women enrolled in this component of P4HB<sup>®</sup>.

The number of women enrolled in the family planning component of P4HB<sup>®</sup> by the end of the first year fell short of the 20,976 deemed eligible for this component. As shown in Chart 3, the total number enrolled in this component by the end of the fourth



quarter was 7,543, less than half of those who had been deemed eligible for this part of P4HB<sup>®</sup>. We note that the DCH fourth quarter P4HB<sup>®</sup> report sent to CMS in February 2012, listed 7,403 women enrolled by the end of that quarter. The difference is due to a change in reporting made toward the end of the Demonstration's first program year; DCH staff created new report specifications for the MMIS so that it would accurately reflect the Demonstration's membership. The data contained in this new reporting system was used for the first Quarter 2012 Demonstration Quarterly Report sent to CMS in May 2012 and was used for the fourth quarter numbers shown in Chart 3.

Regardless of the source of data, the patterns of enrollment indicate an upturn in the fourth quarter for all age groups. The steep increase for the 21-44 age group [in the MMIS files] drives the overall increase in the fourth quarter but enrollments among those 18-20 [in the MMIS files] also increased in this last quarter. The significant gap between the number of women deemed eligible and the number enrolled in the family planning component of P4HB<sup>®</sup> may indicate the lack of awareness and knowledge of P4HB<sup>®</sup> among women and women's health care providers, as indicated by the CMO member and provider surveys, or possible problems with the range of processes that could contribute to delays between application and enrollment, as discussed earlier. As noted, DCH tried to address these barriers in several ways including the use of auto-enrollment. Auto-enrollment likely accounts for some of the enrollment increase in the fourth quarter.

## **Participation Rates**

In order to fully assess the rate of enrollment that occurred in Year 1 for the P4HB<sup>®</sup> program, we have to consider the total number of women likely eligible for P4HB<sup>®</sup> in the communities across Georgia. Since the program targeted women ages 18-44 not otherwise insured and under 200% FPL, we used data from the American Community Survey (ACS) for 2009 to estimate the number of uninsured women in the age and income range targeted. This number excludes women who are non-citizens and hence, not eligible for the Demonstration. (The ACS was not the source used in the projections of the number of women eligible for the Demonstration



mentioned previously and included in DCH’s application for the Demonstration.) While some of these uninsured women are likely eligible for traditional Medicaid in Georgia (and apparently not taking up these benefits), they are eligible for family planning only benefits under P4HB<sup>®</sup>. An shown below in Table 1 using the ACS data, the P4HB<sup>®</sup> program enrolled less than 3% of the total number of women estimated to be eligible and in the community based on income, age and citizenship (257,895--data from the American Community Survey). However, not all of these women may be ‘in need’ of family planning services. As noted by the Alan Guttmacher Institute, only women who are sexually active, can become pregnant and are not now pregnant or intending to become pregnant should be considered ‘in need’ of family planning. If we use their adjustment of 54.5% of women meeting these criteria, the number of women eligible for the Demonstration and in need of services is 140,522 and Georgia enrolled a little over 5% in Year 1. We also note that a large number of women continue to be served by the Title X program. In the process of the evaluation we will estimate unduplicated counts of family planning visits in both Title X and Medicaid in order to assess whether the Demonstration increased the total number of visits across the two programs.

**Table 1. Enrollment of Population Eligible in the Community**

Demonstration Group	Enrolled in 4 <sup>th</sup> Quarter 2011	Population Eligible in Community <sup>1,2</sup>	Percent Eligible Enrolled
FP Only <sup>3</sup>	7,543	257,895	2.9%
FP Only <sup>3</sup>	7,543	140,522 <sup>4</sup>	5.3%
IPC/Resource Mother Only	23	1,420	1.6 %

<sup>1</sup>Those eligible for family planning only benefits are uninsured female citizens ages 18-44 with income < 200% FPL and residing in Georgia. The estimated number of uninsured women in this age and income range is 257,895 for 2009. Since this number has likely grown since 2009, our estimate of this eligible population is likely understated.

<sup>2</sup>Those eligible for IPC include uninsured women 18-44 with income < 200% FPL residing in Georgia with a live birth infant under 1500 grams at delivery. Women enrolled in RSM with a VLBW infant should be the denominator for this calculation. 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 (n = 1,420 in Table 14) as the denominator.

<sup>3</sup>The count of women ever enrolled in the FP only component of the Demonstration includes the number reported earlier even though some of these women would have been disenrolled during the first three months of the Demonstration. We use the 7,543 number for consistency with the early parts of the report.

<sup>4</sup> 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 were actually in need of family planning services. We multiplied the “in the community” population by .545 to get the 140,522 in row 2, column 3. See: <http://www.guttmacher.org/pubs/win/contraceptive-needs-2008.pdf>.



These very low participation rates among the eligible population of women suggest the need for far more intensive education and outreach as well as significant efforts to make the application process more user-friendly and accessible in the community.

#### **IV. MEMBER AND PROVIDER SURVEYS**

As part of the P4HB<sup>®</sup> program, the CMOs, in collaboration with the DCH, monitor member and provider overall knowledge and understanding of P4HB<sup>®</sup> bi-annually through an analysis of member and provider surveys. These analyses serve to help the CMOs and DCH better understand and improve member and provider experiences with the P4HB<sup>®</sup> program, as it is important to both the CMOs and DCH to identify any area that could negatively impact the satisfaction of their members and providers who participate in the program. We briefly describe the survey methods used by the CMOs below and include in Appendix C the provider and member surveys.

The CMOs distributed surveys to their P4HB<sup>®</sup> members and providers at the end of Year 1 (on December 05, 2011, and January 05, 2012, respectively). All members identified by the CMOs as being enrolled in P4HB<sup>®</sup> during the period of February 2011 through August 2011 were mailed a survey. All contracted providers that participated in the program during CY 2011 and with a valid e-mail address, were sent the provider survey via the online “Survey Monkey” tool. The CMOs, in collaboration with DCH, reviewed the results of the surveys to identify any areas where there was a demonstrated lack of understanding of the P4HB<sup>®</sup> program. Any area that did not meet the CMOs’ performance goal was analyzed for barriers and opportunities for improvement; the action plan agreed upon by the CMOs and DCH is shown in Appendix D. Although there are concerns with the low response rates for the surveys and the lack of information on representativeness of the respondents, these surveys provide DCH with their first ‘view’ of member and provider involvement with the P4HB<sup>®</sup> program and the remaining barriers to greater awareness and involvement in the program

## CMO Member Survey Results

A total of 3,202 members met the selection criteria for the CMO survey and 169 of those eligible members participated in the survey, for a 5.3% participation rate. The 169 respondents to the member survey were represented across the CMOs with the following percentages: 29 (17%) from Amerigroup, 120 (71%) from Peach State and 20 (12%) from WellCare. The overall low response rate may reflect that there were no incentives provided by the CMOs for survey participation. The CMOs also could not provide the roster they used to send out the surveys, therefore, an analysis of the representativeness of the respondents could not be completed.

In the following tables we have summarized what the surveys revealed about the P4HB<sup>®</sup> program as reported by the 169 members responding. It is apparent that a substantial number of members report enrolling in P4HB<sup>®</sup> to receive primary care services such as routine check-ups and care for illness (as asked about in the survey) rather than, or in addition to, birth control or family planning services (Table 2). For many women the annual check-up provided for family planning purposes is the woman's primary care check-up.

**Table 2. Enrollment and Utilization of Services in P4HB®**

	<b>Responses N (%)</b>
<b>Enrollment in P4HB® to get...</b>	
Birth control or family planning services	122 (72%)
Pregnancy testing	46 (28%)
Testing or treatment for sexually-transmitted infections	56 (33%)
Primary care (such as routine check-up, care for an illness)	135 (80%)
Other	18 (11%)
<b>Have used these P4HB® services...</b>	
Birth control or family planning services	83 (49%)
Pregnancy testing	34 (20%)
Testing or treatment for sexually-transmitted infections	56 (33%)
Primary care (such as routine check-up, care for an illness)	92 (54%)
Other	25 (15%)
<b>Before enrolling in P4HB®, had trouble getting...</b>	
Birth control or family planning services	85 (50%)
Pregnancy testing	57 (34%)
Testing or treatment for sexually-transmitted infections	59 (35%)
Primary care (such as routine check-up, care for an illness)	107 (63%)
Other	19 (11%)
<b>Types of problems prior to P4HB®:</b>	
I did not have a way to get to appointments	12 (5%)
I could not pay for services	74 (34%)
I could not pay for birth control method	86 (40%)
I could not find a doctor or nurse that would treat me	18 (8%)
I could not get time off from work for appointments	2 (1%)
I had no one to take care of my children	11 (5%)
I was too sick to get to the doctor, nurse or clinic	3 (1.4%)
Other	10 (4%)
<b>Changes P4HB® made for the participant...</b>	
I am going to a different doctor or nurse for family planning services or birth control	60 (36%)
I am going to a different doctor or nurse for primary care	46 (27%)
I have started using a birth control method	82 (49%)
I have changed the birth control method I use	43 (25%)
I have more choice of birth control methods	83 (49%)
I do not have to use my own money for family planning services or birth control	91 (54%)
I am able to get preventive care (such as Pap smears) and family planning counseling	140 (83%)
With the Purple Card (IPC), I am able to get care for illnesses	5 (3%)
With the Purple Card (IPC), I am able to get medicines for illnesses when I need them	34 (20%)
Other	1 (0.6%)

For example, of those responding, 122 (72%) of the respondents said ‘yes’ to birth control or family planning as the reason for enrollment while 135 (nearly 80%) said ‘yes’ to enrolling for primary care (such as check-ups or physicals). Yet, only around half (49%) of those responding said they had used P4HB® for birth control/family planning or primary care (54%). The member responses do indicate that these two types of services were difficult to access by these women

prior to enrolling and in turn, the largest change due to enrollment in P4HB<sup>®</sup> reported by these women (83%) was their ability to obtain preventive and primary care due to the P4HB<sup>®</sup> program. About half of the women reported being able to start using a birth control method (49%) and having more choice (49%) of method due to enrollment in the P4HB<sup>®</sup> program.

The data in Table 2 also provides key information regarding the knowledge that women had about the P4HB<sup>®</sup> program with respect to:

- Eligibility criteria for the specific components of P4HB<sup>®</sup>; and
- Services covered under specific components of P4HB<sup>®</sup>.

Of the 169 responding to the survey, large percentages of CMO members enrolled in the Demonstration were clear on the eligibility criteria for the family planning only (which has a ‘pink’ enrollment card) component of P4HB<sup>®</sup>. The percentage responding correctly to the eligibility criteria for this component of the P4HB<sup>®</sup> ranged from 61% to 92% as shown below in the right hand column of Table 3.

However, correct responses for eligibility for the IPC component of the Demonstration (which has a ‘purple’ enrollment card) were less than 26% for all items; this reflects perhaps, that all women were asked these questions rather than following the skip pattern in the survey so as to ask women in each program component the questions specific to her component (e.g. FP, IPC, Resource Mother).

Responses regarding the services covered under specific components of P4HB<sup>®</sup> indicate that a large percentage (approximately 70%) of respondents understood that birth control services and methods as well as Pap tests and pelvic exams were covered and just over half (52%) recognized that STI testing was provided under the ‘Pink Card’. However, far smaller percentages were aware of the coverage of other family planning and related services. For example, only 26% reported being aware of coverage for vitamins with folic acid or treatment for major problems related to family planning services. Only 21% were aware of coverage for some vaccinations and less than half were aware that treatment for STIs was available through the program. There

was very little understanding of the coverage afforded under the “Purple Card” but again, this may have been due to women not following the intended ‘skip’ pattern in the survey.

**Table 3. Knowledge of Members about P4HB®**

Knowledge of...	Correct Responses N (%)
<b>Services available through the “Pink Card”...</b>	
Birth control services and methods	118 (70%)
Pap smear and pelvic exam	116 (69%)
Tubal Ligation (tubes tied)	11 (7%)
Pregnancy testing	37 (22%)
Screening for sexually transmitted infections	88 (52%)
Follow-up of an abnormal Pap smear	59 (35%)
Treatment for sexually transmitted infections	77 (46%)
Treatment for major problems related to family planning services	44 (26%)
Vitamins with folic acid	44 (26%)
Some vaccinations	36 (21%)
Non-emergency transportation	4 (8%)
<b>Services available through the “Purple Card”...</b>	
Primary care services (up to 5 visits per year)	9 (5%)
Treatment for medical problems like high blood pressure and diabetes	7 (4%)
Medicines for medical problems like high blood pressure and diabetes	6 (4%)
Care for drug and alcohol abuse (such as rehab programs)	2 (1%)
Some dental services	10 (6%)
Non-emergency transportation	7 (4%)
Nurse case management/Resource Mother	6 (4%)
Primary care services (up to 5 visits per year)	9 (5%)
<b>Eligibility for ‘Pink Card’</b>	
Be between 18-44 years of age	155 (92%)
Be a resident of Georgia	147 (87%)
Be a U.S. Citizen	144 (85%)
Have a household income that is at or below 200% of the federal poverty level	126 (75%)
Not be eligible for Medicaid or the Children’s Health Insurance Program (PeachCare)	103 (61%)
Other	1 (0.6%)
<b>Eligibility for ‘Purple Card’</b>	
Be between 18-44 years of age	44 (26%)
Be a resident of Georgia	42 (25%)
Be a U.S. Citizen	40 (24%)
Have a household income that is at or below 200% of the federal poverty level	35 (21%)
Not be eligible for Medicaid or the Children’s Health Insurance Program (CHIP)	27 (16%)
Not otherwise insured for health care services	0
Delivered a baby weighing < 3 pounds 5 ounces since January 1, 2011	17 (10%)
Other	5 (3%)

In Table 4 below we summarize the members’ responses to the problems they had encountered with the P4HB® program since enrollment.

**Table 4. Problems Encountered by Members Enrolled in P4HB®**

<b>Problems Under P4HB®</b>	<b>Responses N (%)</b>
I cannot get the family planning services I want	38 (22%)
I cannot get referrals or follow-up for care I need	31 (18%)
I cannot find a doctor or nurse willing to take P4HB clients	30 (17%)
I don't want to leave my current doctor or nurse	23 (13%)
I have to wait too long to get services	20 (12%)
I do not have transportation	19 (11%)
I cannot get to the doctor or nurse when they are open	10 (6%)
My P4HB doctor or nurse will not prescribe the birth control method I want to use	9 (5%)
Other	6 (3%)

The three most prevalent problems experienced were not getting the family planning services that were needed (22%), not getting the referrals or follow-up care that was needed (18%), and not being able to find a doctor or nurse willing to take P4HB® clients (17%) – all of which imply some level of difficulty in accessing needed services despite enrollment in P4HB®. As there was not a follow-up ‘probe’ question in the survey that enabled members to describe the services that they felt were lacking, we do not have further information on this point. Smaller percentages of members noted some concern about leaving their current provider (13%), having to wait a long time for services (12%), and lack of transportation (11%).

Three additional tables (Tables 5-7) reveal the following key findings:

- The largest percentage of members learned about P4HB® from the doctors, nurses, and staff at the local health departments or WIC offices (Table 5);
- Substantial percentages of members reported a need for more information about where members should go to obtain services and which services were covered (Table 6);
- Although members appeared to understand a lot of the coverage available to them, 46% reported they found it somewhat or very hard to understand ‘what I can get from P4HB®’ (Table 7).

**Table 5. Ways in Which Members Learned About P4HB®**

Source of Information	Responses N (%)
Mailings	45 (22%)
E-mail	1 (0.5%)
CMO websites	2 (1%)
CMO telephone calls	4 (2%)
Georgia Department of Community Health websites	17 (8%)
Georgia Department of Community Health meetings	9 (4%)
Doctors, nurses, or other staff at health department or WIC office	57 (28%)
Doctors, nurses, or other staff at the hospital	9 (4%)
Doctors, nurses, or other staff at my doctor's office	13 (6%)
Friends or family members	28 (14%)
Postings on billboards and public transportation	5 (2%)
Other	13 (6%)

**Table 6. Information Needs About P4HB®**

Type of Information	Needs More Information	
	Some More N (%)	Much More N (%)
Where to go for service	15 (9%)	62 (37%)
Services available with the Pink Card	56 (33%)	52 (31%)
Services available with the Purple Card	33 (20%)	49 (29%)
Cost of services	53 (31%)	32 (19%)

**Table 7. Areas of P4HB® that Were Hard for Members to Understand**

Area	Hard to Understand	
	Somewhat N (%)	Very N (%)
Who can get P4HB	27 (16%)	2 (1%)
Whether I can get P4HB	34 (20%)	3 (2%)
Complete the paper work to sign up for P4HB	15 (9%)	5 (3%)
Complete the web form to sign up for P4HB	16 (9%)	2 (1%)
Get the required documents to sign up for P4HB	20 (12%)	7 (4%)
Pick a Care Management Organization (CMO)	31 (18%)	10 (6%)
Pick a provider	31 (18%)	14 (8%)
Understand what I can get from P4HB	55 (33%)	22 (13%)
Other	4 (2%)	2 (1%)

## CMO Provider Survey Results

A total of 1,140 providers met the selection criteria for the survey; 62 of these eligible providers participated in the survey for a 5.4% participation rate. As with the member survey, there were no incentives for providers' participation in the survey, which may account for the low response rate. The 62 respondents to the health care provider survey represented the range of Medicaid program affiliations (with providers being affiliated in most cases with multiple CMOs): 49 (79%) Amerigroup, 50 (81%) Peach State, 59 (95%) WellCare, and 52 (84%) Fee-for-service Medicaid. (Note that providers can be involved in multiple networks).

Among the responding providers, the provider type included 32 (52%) MD/DO's, 28 (45%) other health care providers, one (1.6%) advanced practice nurse, and one (1.6%) registered nurse. Respondents' reported the following areas of specialization (with the option of selecting one or more specialty areas of practice): 23 (22%) obstetrics/gynecology, 15 (14%) women's health, 17 (16%) family practice or primary care, 14 (13%) family planning, 12 (11%) pediatrics, six (6%) general practice, five (5%) internal medicine, 12 (11%) other. The majority of respondents (58%) reported they provided health care services in private practice, but substantial percentages reported providing services in community health clinics or federally-qualified health centers (17%), public health departments (17%), or other settings (8%).

Among the responding providers, 50 (81%) indicated they were accepting new Medicaid patients and 44 (71%) indicated they were providing family planning or primary care services to women of reproductive age (ages 18-44 years). Only 38 (61%) reported being aware of the Georgia P4HB<sup>®</sup> program despite the CMOs sending the survey to those they believed to be participating providers.

Of the 38 provider respondents who were aware of the P4HB<sup>®</sup> program, they reported learning of the program in the following ways: 16 (42%) mailings from the CMOs, 16 (42%) e-mails from the CMOs, 10 (26%) meetings hosted by DCH, 9 (24%) from information initiated by



DCH, 5 (13%) telephone calls with CMOs, 4 (11%) websites of the CMOs, 3 (8%) patients asking about the program.

Thirty (79%) of the 38 respondents who were aware of the P4HB<sup>®</sup> program indicated they were providing these services to CMO members. However, it is important to note that seven (7) providers were unsure if they were providing services under P4HB<sup>®</sup> and 23 providers skipped this question, indicating that it was unclear from about half of the providers responding to the survey if they were actually providing direct services to P4HB<sup>®</sup> members despite the CMOs' perception that they were participating providers.

In the following tables (Tables 8-12) we report on other key results of the provider survey. As found for the member clients, there was some lack of clarity surrounding P4HB<sup>®</sup> for providers. In particular, at the end of Year 1 it appeared that providers did not have adequate knowledge of:

- The availability of the P4HB<sup>®</sup> program;
- Eligibility criteria for the specific components of P4HB<sup>®</sup>; or
- Services covered under their CMO contract for P4HB<sup>®</sup>.

When asked about who was eligible for the program under the 'Pink Card' and 40% or fewer providers responded correctly to all but two items. The highest percentage of correct responses (59%) was for the eligibility criterion of having a household income at or below 200% FPL, correctly reporting that women had to be income eligible, whereas the second highest percentage of correct responses (42%) was the criterion for being a resident of Georgia.

**Table 8. Provider Understanding of Eligibility Criteria for P4HB<sup>®</sup>**

Eligibility Criteria for P4HB <sup>®</sup>	Correct Responses by Category of P4HB <sup>®</sup>	
	Family Planning N (%)	Interpregnancy Program N (%)
Between 18-44 years of age	25 (40%)	17 (27%)
Resident of Georgia	26 (42%)	20 (32%)
U.S. Citizen	24 (39%)	18 (29%)
Household income at or below 200% FPL	19 (59%)	16 (26%)
Not otherwise eligible for Medicaid or the Children's Health Insurance Program (CHIP-PeachCare)	19 (31%)	16 (26%)
Not otherwise insured for family planning services	16 (26%)	15 (24%)
Delivered a very low birth weight infant since January 1, 2011	3 (5%)*	15 (24%)
Other	2 (3%)	2 (3%)

*\*\* Note: Three respondents correctly identified that having delivered a very low birth weight infant since January 1, 2011, was not a criterion for the Family Planning component.*

There is even less understanding of eligibility for the ‘Purple Card’ or IPC component of P4HB<sup>®</sup>. For the IPC component, correct responses regarding eligibility were generally 30% or less.

In addition to understanding eligibility criteria, it is important that providers understand the services that will be reimbursed by the program. As shown in Table 9 below, providers’ understanding of the family planning services covered under P4HB<sup>®</sup> ranged from 23% correct for follow-up of an abnormal Pap smear, to 44% correct for contraceptive services and methods. Less than half of the providers (40%) recognized that basic family planning visits were covered by the program. Important to detecting STIs or early cervical cancers, less than a third realized that screening and treatment of STIs were covered and follow-up for an abnormal Pap test, including colposcopy, was reimbursed under P4HB<sup>®</sup>.

Providers knowledge of the IPC Services available under P4HB<sup>®</sup> was as low as 5% correct for detoxification and outpatient rehabilitation for substance abuse.

**Table 9. Providers’ Knowledge of Services Covered Under their P4HB<sup>®</sup> Contract**

Services Covered Under P4HB <sup>®</sup>	Correct Responses N (%)
Family planning initial and follow-up exams	25 (40%)
Contraceptive services and methods	27 (44%)
Tubal ligation	17 (27%)
Pregnancy Testing	21 (34%)
Screening for sexually transmitted infections	19 (31%)
Follow-up of an abnormal Pap smear, including Colposcopy	14 (23%)
Treatment for sexually transmitted infections	18 (29%)
Treatment for major complications related to family planning services	10 (16%)
Multivitamins with folic acid	16 (26%)
Hepatitis B and Tetanus-Diphtheria vaccines	13 (21%)
Primary care services (up to 5 outpatient visits per year)	12 (19%)
Management and follow-up of chronic diseases	6 (9%)
Prescription medications for chronic diseases	5 (8%)
Detoxification and outpatient rehabilitation for substance abuse	3 (5%)
Limited dental services	4 (6%)
Nurse case management and Resource Mother outreach for health and social service coordination and support of health behaviors	10 (16%)
Non-emergency transportation	5 (8%)

The survey also asked providers what they perceived as barriers to participation in the P4HB<sup>®</sup> program. The key responses from providers were:

- The waiver does not cover the full range of family planning services;
- The waiver does not cover referrals or follow-up care;
- The waiver does not cover complications of family planning services.

Yet, some follow-up care is indeed covered by the Demonstration including, as noted above, treatment for major complications related to family planning services. Less than 20% of the providers reported any of these as major barriers.

**Table 10. Providers' Perception of Barriers for P4HB<sup>®</sup> Participation**

Factor	Perceived as Barrier	
	Major Barrier N (%)	Minor Barrier N (%)
Waiver does not cover the full range of family planning services	8 (13%)	8 (13%)
Waiver does not cover referrals or follow-up care	12 (19%)	5 (7%)
Waiver does not cover complications of family planning service	11 (17%)	5 (7%)
Your practice is full	2 (3%)	2 (3%)
Other	1 (1.6%)	0

The CMOs and the DCH were interested in what information providers need and how they prefer to receive information regarding the P4HB<sup>®</sup> program. A summary of the findings is shown in Tables 11 and 12.

**Table 11. Providers' Information Needs**

Type of Information	Need More Information	
	Some More N (%)	Much More N (%)
Enrollment eligibility criteria	12 (19%)	9 (15%)
Covered services for those enrolled in the Family Planning component	14 (23%)	8 (13%)
Covered services for those enrolled in the Interpregnancy Care component	14 (23%)	9 (15%)

All responding providers preferred to receive information via web-based resources and 34%

to 38% reported they wanted either some or much more information on eligibility, covered services and in particular, covered services for those enrolled in the IPC component of P4HB<sup>®</sup>.

**Table 12. Providers' Preference for Receipt of Information**

<b>Preferred Route of Receiving Information</b>	<b>Response N (%)</b>
Direct mailings	20 (32%)
E-mails to your practice	21 (34%)
Websites of the CMOs	62 (100%)
Telephone calls to your practice	2 (3%)
Website of the Georgia Department of Community Health	11 (18%)
Meetings hosted by the Georgia Department of Community Health or CMOs	9 (15%)
Professional conferences or practice staff meetings	6 (10%)
Colleagues	2 (3%)
Posting on billboards and public transportation	0

Taken together, these results indicate that, at the end of Year 1 of the P4HB<sup>®</sup> program, a great deal more education was needed for those already involved in the P4HB<sup>®</sup> program – whether as clients or providers – to truly understand its nature, coverage and potential to affect outcomes. As other components of the Annual Report also make clear, DCH, the CMOs and other public health personnel need to increase outreach to those women who are eligible and not enrolling due to lack of understanding of the program and of their eligibility for the program or who lack access to provider sites.

## **V. DATA ON DELIVERIES AND INFANTS**

In order to assess the impact of the P4HB<sup>®</sup> program on the intended objectives as listed in Section I of this report, DCH needed to assemble data on the counts and Medicaid costs for all deliveries, counts and costs of all infants at delivery and costs of infants in their first year of life on Medicaid. The P4HB<sup>®</sup> program goes beyond other state family planning waivers by including IPC services for mothers of very low birth weight infants. A key objective of P4HB<sup>®</sup> as noted, is

to increase child spacing through effective contraceptive use which will foster reduced low birth weight rates. Hence, DCH also needed data over the pre/post P4HB<sup>®</sup> time period on the distribution of infants born on Medicaid by birth weight. These data are also needed by the eligibility category of the mother in order to ascertain the number of unintended outcomes among women enrolled in P4HB<sup>®</sup>.

In this section we report on the total counts of deliveries and infants by birth weight of the baby as derived from the administrative claims/encounter data provided by DCH to Emory through its data sharing agreement. In the footnotes of the following tables, we show the specific billing codes found within the Medicaid claims data that were used to define deliveries (unduplicated using the mother's ID), to categorize them by live born, stillborn ( $\geq 22$  weeks' gestation) or fetal deaths ( $<22$  weeks' gestation) and to further categorize live born infants (unduplicated using the infant's ID) according to the birth weight categories as found on the infants' records. We were not able to capture information on the birth weight of all infants from the administrative records and hence, can only categorize those deliveries for which we had a linkage between the mother and infant (by SSN of the household) by birth weight. As the P4HB<sup>®</sup> program and its evaluation moves forward, these administrative records will be linked to data from the DPH vital records unit for confirmation of birth weight and gestational age and for additional information on the mother (sociodemographics, evidence of chronic health conditions and complications of the pregnancy, smoking, etc) that will be used in the pre/post analysis of the effects of the P4HB<sup>®</sup> program on the stated objectives.

### **Counts of Deliveries and Costs**

The data in Table 13 below show that there were a total of 78,229 Medicaid paid deliveries occurring in CY2011 based on the claims data. We note that this count omits an additional 2,520 deliveries for which there was an indicator of third party liability (including Medicare) for the delivery costs. (See the notes to Table 13 for the detail on which codes were used to identify deliveries and to classify them as live born, stillborn, etc).

As shown below, based on the count of deliveries paid fully by Medicaid, 69,638 of the total 78,229 could be categorized as live born deliveries while 7,352 or 9.4 % of the total, were coded as fetal deaths of < 22 weeks gestation; another 1,239 were coded as stillborn deliveries. The 69,638 live born deliveries paid fully by Medicaid were estimated to cost the Georgia Medicaid program almost \$365 million with an average cost of \$4,663 per delivery. Since the great majority of infants receive their own Medicaid ID at birth, these Medicaid amounts paid are largely representative of those expenses incurred for care of the mother at the time of the delivery hospitalization. In addition to the costs for the deliveries with live born infants, Georgia Medicaid incurred costs totaling just over \$12 million for deliveries ending in fetal death or stillborn infants for mothers whose deliveries were paid by the program in CY2011 as shown in Table 13.

**Table 13. Medicaid Deliveries for Calendar Year 2011 (CY2011)**

MEASURE	Counts	Total \$ Paid Mother	Average \$ Paid Mother
<b>All Medicaid Deliveries<sup>1</sup></b>			
Total Deliveries <sup>2</sup>	78,229	\$364,806,937	\$4,663 <sup>(6)</sup>
Live born deliveries	69,638	\$352,769,025	\$5,066 <sup>(6)</sup>
Stillborn deliveries (>= 22 weeks) <sup>1</sup>	1,239	\$4,493,957	\$3,627 <sup>(6)</sup>
Fetal deaths < 22 weeks <sup>1</sup>	7,352	\$7,543,955	\$1,026 <sup>(6)</sup>
<b>Deliveries<sup>1</sup> to Demonstration</b>			
<b>Entire Demonstration population</b>			
Total Deliveries	6	\$450	\$75
Live born deliveries	0	0	0
Stillborn deliveries (>= 22 weeks) <sup>1</sup>	0	0	0
Fetal deaths < 22 weeks <sup>1</sup>	6	\$450	\$75
<b>FP only<sup>3</sup></b>			
Live born deliveries	0	0	0
Stillborn deliveries (>= 22 weeks) <sup>1</sup>	0	0	0
Fetal deaths < 22 weeks <sup>1</sup>	6	\$450	\$75
<b>IPC and FP<sup>4</sup></b>			
Live born deliveries	0	0	0
Stillborn deliveries (>= 22 weeks) <sup>1</sup>	0	0	0
Fetal deaths < 22 weeks <sup>1</sup>	0	0	0
<b>Resource Mother only<sup>5</sup></b>			
Live born deliveries	0	0	0
Stillborn deliveries (>= 22 weeks) <sup>1</sup>	0	0	0
Fetal deaths < 22 weeks <sup>1</sup>	0	0	0

<sup>1</sup> 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
- **Deliveries of Stillbirths** were identified by using ICD-9 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)].
- **Deliveries associated with Fetal deaths** < 22 weeks were identified by using ICD-9 codes 632 (missed abortion) and 634.xx (spontaneous abortion).
- 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.

<sup>2</sup> This count of total deliveries omits those with private third party liability or Medicare coverage (n = 2,520). If these records were included the number of deliveries would be 80,749 with 71,717 live born deliveries, 1,276 stillbirths and 7,756 fetal deaths.

<sup>3</sup> Family planning only participants were identified using Aid Eligibility Code = 181; all deliveries that occurred to these women were after their fourth month of enrollment in the P4HB<sup>®</sup> program. Women who came into the program pregnant were disenrolled within three months of their enrollment. These pregnancies were conceived prior to enrollment in the program and were not counted.

<sup>4</sup> IPC participants were identified using Aid Eligibility Code = 180. Only the deliveries and births to IPC women **subsequent** to their enrollment are reported in these tables.

<sup>5</sup> Participants in the Demonstration with Resource Mother only benefits are LIM and ABD classes of eligibility with a delivery and VLBW birth weight infant in the year. They were identified using Aid Eligibility Codes 182 (LIM) and 183 (ABD). Only the deliveries and births to women with LIM and ABD classes of eligibility **subsequent** to their enrollment are reported.

<sup>6</sup> A total of 46 records with zero amounts paid are included in this average; for fetal deaths there were 5, stillborn 2 and live born 39 deliveries with zero amount paid by Georgia Medicaid.

In the bottom portion of Table 13 we show the counts and costs of any deliveries observed for women enrolled in the family planning or other components of P4HB<sup>®</sup>. Since these data reflect only the first year of the Demonstration and many women were not enrolled until the second and third quarters of CY2011, we anticipated no live born deliveries to Demonstration participants. While there were no live born deliveries or stillbirths observed for the P4HB<sup>®</sup> participants, there were 6 fetal death deliveries (< 22 weeks' gestation) observed among women enrolled in the family planning only component of P4HB<sup>®</sup>. The costs of this outcome totaled only \$450 or \$75 per woman; this indicates that these women became pregnant even while enrolled in the family planning only component of P4HB<sup>®</sup>. They were eligible for a wide range of family planning services and either did not use them or used them ineffectively.

### **Counts of Infants and Costs**

In Table 14 below we show the counts of infants identified with their own Medicaid ID and categorized as a live birth or stillbirth. Note that the number of live born infants (72,122) is greater than the number of live born deliveries (69,638) due to multiple gestations, whereby deliveries result in more than a single birth. Of the total 72,122 live born infants, only 67,108 had evidence of a birth weight within the claims/encounters data and were grouped into birth weight categories. The footnotes to Table 14 indicate what DRG or other codes were used to identify live born infants and to categorize the infants by birth weight. We note that there were a total of 5,014 infants for which we could not determine birth weight using the claims/encounter data. We have examined the characteristics of these records and do not observe systematic differences for them from the other infant records for which we observe birth weight. We will continue to assess why a DRG or other code indicating their birth weight is not recorded for them. This highlights the importance of linking the administrative files to the vital records as planned.



Of the 67,108 live births with evidence of birth weight, a total of 1,420 or 2.1% were categorized as very low birth weight (VLBW) and 8.4% (1,420 plus 4,243) were categorized as low birth weight (LBW). This percentage is lower than expected and lower than reported in PRAMS data for 2008; in these data 9.7% of women with Medicaid at any time during her pregnancy were recorded as LBW. Since this information is critical to the evaluation of the P4HB<sup>®</sup> program and since we were not able to categorize all live born infants using the administrative claims/encounter data, we do not want to place a large emphasis on the percentage estimate at this time. Moreover, as noted earlier, the P4HB<sup>®</sup> program could not have affected the birth weight distribution in this first Demonstration year.

The data in Table 14 do indicate that the costs of all live births were approximately \$291 million and averaged to \$4,031 per infant (Column 5); these costs are for the delivery hospitalization of the infant. We do see the anticipated pattern of higher costs for those infants born low or very low birth weight relative to those born normal weight. Average costs for infants of normal weight were estimated to be \$2,247 (Column 5) while for those infants born of low birth weight, costs were estimated at \$10,389. Infants born at VLBW averaged \$73,861 at their delivery hospitalization.

In Table 14, we also include data for the delivery costs of the mothers by the birth weight category of their infant for those mothers who could be linked to an infant based on the SSN of the head of the household. We note that only 48,101 of the 67,108 (72%) live born infants with evidence of birth weight data within the claims/encounter data were linked to their mothers using the SSN of the head of the household, and hence, estimates of the mother's costs by birth weight of her infant are based on only this subset of deliveries. We do see, however, that the delivery costs for the mother also follow the pattern of higher costs for LBW and VLBW infants at the delivery hospitalization. The mother's cost at a delivery of a normal BW baby was estimated at \$5,100 while the mother's cost at delivery of a VLBW delivery was estimated at \$7,131.

**Table 14. Infant Counts and Costs for Mother and Infant at the Delivery Hospitalization Calendar Year 2011 (CY2011)**

MEASURE	Counts	Average \$ Paid Mother <sup>4</sup>	Total \$ Paid Infant Delivery Hospitalization	Average \$ Paid Infant Delivery Hospitalization
All Medicaid Live births <sup>2</sup>	72,122	\$5,148	\$290,712,470	\$4,031
VLBW	1,420	7,131	104,882,489	73,861
LBW	4,243	5,780	44,081,469	10,389
Normal BW	61,445	5,100	138,078,020	2,247
Other – Not Categorized	5,014	4,762	3,670,492	732
All Medicaid Stillbirths <sup>3</sup>	133	5,821	370,290	2,784

<sup>1</sup> We note that there were no live births or stillbirths for women enrolled in the family planning only component of the Demonstration nor were there live births for women enrolled in the IPC or Resource Mother only components of the Demonstration subsequent to the delivery/birth which qualified them for the program.

<sup>2</sup> Live born infants were identified and further categorized according to infant birth weight as very low birth weight (VLBW) < 1500 grams, low birth weight (LBW) 1500 – 2499 grams, and normal birth weight >= 2500 grams). Birth weight categories for live-born infants were then defined using Georgia DRG codes in the encounter data as follows:

- VLBW (< 1500 grams): GA DRG = 602 through 608 OR ICD-9 = 764.xx or 765.xx or V21.3 that pertain to weight < 1500 grams
- LBW (1500 – 2499 grams): GA DRG = 609 through 621 OR ICD-9 = 764.xx or 765.xx or V21.3 that pertain to weight 1500 = 2499 grams
- NBW (≥ 2500 grams): GA DRG = 622 through 630 OR ICD-9 = 764.xx or 765.xx or V21.3 that pertain to weight ≥ 2500 grams

<sup>3</sup> Stillborn infants were identified using Georgia DRG code 600.

<sup>4</sup> Amounts paid for mothers at the time of delivery were summarized for all deliveries in Table 13 and are summarized here by birth weight of the infant for the subset of mothers (n =48,101 ) who could be linked to an infant based on the SSN of the head of the household.

In Table 15 we provide the estimated costs to the Georgia Medicaid program of infants in their first year of life in the program. These costs are counted beginning with the claim/encounters with the first service date occurring after their delivery hospitalization discharge date in order to isolate the delivery versus first year of life costs. While the data in Table 15 provide estimates of these costs categorized by the infants' birth weight, we note that we could only analyze those 35,756 infants born in the first six months of 2011 due to the lag in claims data. We used the average costs for this cohort of 35,756 infants born in the first part of 2011 to extrapolate to an annual estimate for CY 2011. Also, as the costs are based on claims paid through June of 2012, estimates may not be complete even for these 35,756 infants.

The total amount paid for infants regardless of their birth weight was estimated at almost \$134 million; note that this estimate is extrapolated based on the averages just quoted, applied to the infants born in the second half of the year based on their birth weight category and added to the actual total for those born in the first six months. There was very little change in the average per infant costs when we adjusted for their disenrollment from Medicaid (due to death or other causes); these are estimated for the 32,727 alive and continuously enrolled as of December 31, 2011 and are shown in the last column of Table 15.

As the data show, there is the expected pattern of higher costs for infants of lower birth weight continuing into their first year of life. Whereas the estimated average first year costs equaled \$1,851 for all infants born in the first six months of CY2011, the costs for normal birth weight infants was estimated at \$1,617 while costs for LBW infants was estimated at \$2,581 and for VLBW infants, at \$8,169. These are estimated based on the infants regardless of their disenrollment or death. Averages estimated on those infants who are continuously enrolled (i.e., not disenrolled due to death or other reasons) are similar to these, as shown in the far right column.

**Table 15. Infant Costs for Medicaid Live Births During First Year of Life (Post-Delivery Hospitalization)**

MEASURE	Infants <sup>1</sup> Born on Medicaid in First 6 Months of CY2011	1 <sup>st</sup> Year of Life Post-Delivery Hospitalization			
		Average \$ Paid per Infants <sup>2</sup> Born in First 6 Months of CY2011	Total \$ Paid <sup>3</sup> Extrapolated to All Infants <sup>4</sup> from those Born in First 6 Months	Total \$ Paid Extrapolated to Continuously Enrolled Infants <sup>5</sup>	Average \$ Paid per Continuously Enrolled Infants <sup>5</sup>
Medicaid Livebirths <sup>1</sup> in First 6 Months of 2011	35,756	\$1,851	\$ 133,616,439	\$126,383,720	\$1,916
VLBW	522	8,169	11,571,990	9,621,761	8,264
LBW	2,019	2,581	11,035,354	10,407,916	2,708
Normal BW	30,932	1,617	99,372,735	95,086,465	1,691
Not Categorized	2,283	2,320	11,636,360	11,267,578	2,392

<sup>1</sup> The 35,756 live born infants born in the first six months of CY2011 were categorized as very low birth weight (VLBW) < 1500 grams, low birth weight (LBW) 1500 – 2499 grams, and normal birth weight >= 2500 grams) as noted in Table 14.

<sup>2</sup> Costs for all infants born in the first six months of CY2011 are included regardless of their disenrollment or death.

<sup>3</sup> Dollars paid for services for infants in their first year of life were counted beginning with the first service date occurring after their delivery hospitalization discharge date. Paid claims for infants born in CY2011 were complete through June of 2012; expenses paid after this date will not be counted in their first year costs.

<sup>4</sup> Costs for the full first year of the infant's life were only available for those infants born in the first six months of 2011 (and based on claims paid only through June 2012). We used the average costs for this cohort of infants born in the first part of 2011 (n = 35,756) to extrapolate to an annual estimate for CY 2011.

<sup>5</sup> Costs for all infants born in the first six months of CY2011 are included only for those 32,727 alive and continuously enrolled (data on enrollment were only available through December 31, 2011). We used the average costs for this cohort of infants (n = 32,727) to extrapolate to an annual estimate for CY 2011 as shown in the far right column.

## **VI. SERVICE USE AND COSTS**

### **IPC Service Use**

A key goal of the IPC component of the Demonstration is to help these mothers maintain or improve their health by providing access to the expanded set of services noted earlier. The administrative data can be used to ascertain the types of conditions for which these women are seeking and receiving care under the P4HB<sup>®</sup> program. Among the IPC component's participants, the claims data indicated that almost all (16) of the 19 enrolled in this component of the P4HB<sup>®</sup> utilized some services. We note that the claims used in this part of the report are for claims paid through June 2012 in order to capture utilization of IPC women enrolled in the latter part of 2011. An additional three (of the four enrolled) members in the 'Resource Mother only' component utilized services. The ICD-9 diagnosis codes that appear in the claims data for these members are summarized below, separately for the IPC and Resource Mother only participants.

According to ICD-9 diagnosis codes within the Medicaid claims data, the use of services by women enrolled in the IPC component reflected the receipt of care for the following: preventive services; acute gynecologic conditions or other gynecologic testing; other acute conditions; contraceptive services; or chronic health conditions. Examples of preventive health care included routine gynecologic exams and routine medical check-ups. An array of acute gynecologic

conditions was seen among these women utilizing services, including pelvic inflammatory disease, vaginitis, abnormal Pap smear and cervical dysplasia, as well as screening for sexually transmitted infections. Examples of other acute conditions for which care was sought include abnormal weight gain, abdominal pain, anemia, cystitis and fatigue. Six of the 19 enrolled IPC women received contraceptive management while three had an intrauterine device (IUD) inserted.

Table 16 below summarizes the ICD-9 codes reflecting chronic health conditions that were present in the Medicaid claims data for IPC and Resource Mother only participants. While the 19 members enrolled in the IPC component of P4HB<sup>®</sup> had a total of 59 ICD-9 diagnosis codes reflected in the Medicaid claims data, only three of these 19 members had an ICD-9 diagnosis code reflecting a chronic health condition: two members had an ICD-9 diagnosis code reflecting chronic pain with long-term monitoring of opiate use; and one member had ICD-9 diagnosis codes reflecting several chronic conditions including hypertension, obstructive sleep apnea, narcolepsy, and restless leg syndrome.

**Table 16. ICD-9 Diagnostic Codes for Chronic Conditions for IPC and Resource Mother Only Participants**

Component of Program	Chronic Health Condition Evident from Claims Data
Interpregnancy Care (3 of 19 members with evidence of chronic condition)	Chronic pain with chronic opiate use (2) Hypertension (1) Narcolepsy (1) Obstructive sleep apnea (1) Restless leg syndrome (1)
Resource Mother Only (2 of 4 members with evidence of chronic condition)	Depression (1) Diabetes mellitus (1) Obesity (1)

Among the three members enrolled in the ‘Resource Mother’ only component and using some services in the follow-up period, there were a total of 17 ICD-9 diagnosis codes reflected in the Medicaid claims data. Two of these members had an ICD-9 diagnosis code reflecting a chronic health condition; one member with diabetes mellitus (with an episode of diabetic ketoacidosis and coding for non-compliance with care) and obesity, and another with depression. Both of these members had ICD-9 codes reflecting maintenance care for their health (long-term use of anticoagulation, long-term use of insulin, therapeutic drug monitoring). All three of the

Resource Mother only members had one or more ICD-9 diagnosis codes reflecting an acute condition (deep venous thrombosis [2], otitis media, acute sinusitis, cough, urinary tract infection, vaginitis, dyspareunia).

**Costs**

**Demonstration Costs.** In Table 17 below we report on the total amounts paid for services provided to all Demonstration enrollees and in turn, for IPC enrollees. The total amount paid for services received in CY2011 by all categories of Demonstration enrollees equaled \$943,868; this averaged out to \$278 per woman enrolled. The great majority of these costs were for the family planning only enrollees; a total of \$942,662 was spent on family planning enrollees.

**Table 17. Total and Mean Costs for the Services Provided to All Demonstration Enrollees and IPC Enrollees**

<b>Demonstration Participants</b>	<b>Total Annual Costs</b>	<b>Average Annual Costs/Woman</b>
All Enrollees	\$943,868	\$278.34
Family Planning Only Enrollees	\$942,662	\$278.89
IPC Enrollees	\$1,206	\$120.58

**IPC Costs.** When the IPC enrollees are examined as a separate group, total costs identified via the claims/encounters were only \$1,206 or around \$121 per IPC enrollee. There were no amounts paid for services received by Resource Mother only enrollees in CY2011. Because there are no claims/encounters for the nurse/Resource Mother case management, the \$121 per IPC enrollee does not reflect the total costs of care for these Demonstration participants.

These dollar amounts do not represent the full costs for the Demonstration enrollees, however, since services are delivered through the CMOs, which are paid on a per member per month (PMPM) basis. The PMPM includes dollars for service delivery as mentioned above along with dollars paid to the CMOs for claims processing, outreach activities, etc. The total amounts paid by DCH to the CMOs through the end of CY 2011 equaled \$1,346,387 for all enrollee groups. Thus, the costs for services actually provided to those enrolled were more than covered by the PMPM payments made to CMOs in the first Demonstration year. We anticipate that service use

and related costs will increase in the second year of the Demonstration as women and providers become more aware of the service coverage and benefits of the P4HB<sup>®</sup>.

### **Averted Births and Budget Neutrality**

**Averted Births.** The P4HB<sup>®</sup> program in Georgia has a budget neutrality requirement that is based on a ‘shifting’ of the birth weight distribution such that the total costs to the Medicaid program supported by the federal matching rate is lowered from what it would otherwise be by lowering the percentage of all Medicaid births which are low and very low birth weight. This shifting of the distribution should occur from the increased use of family planning services by those brought into the family planning component of the Demonstration as well as the management of contraceptive use among those women in the IPC and Resource Mother only components of the Demonstration. Better family planning among these women with a very low birth weight baby should lengthen their interpregnancy interval. Additionally, the treatment of acute and management of chronic conditions of women enrolled in the IPC component should lead to better health of the women, and in turn better birth outcomes, if they become pregnant.

While the count of ‘averted’ births is therefore not central to the calculation of budget neutrality on a quarterly or annual basis under P4HB<sup>®</sup>, we present in Table 18 below an estimate of the number of births that would have been expected among participants in the family planning only component of the Demonstration.

**Table 18. An Estimate of Averted Births Among Family Planning Only Demonstration Population**

<b>Year</b>	<b>Number of ‘Expected’ Births Among Participants<sup>1</sup></b>	<b>Number of Births to Participants</b>	<b>Number of ‘Averted’ Births</b>
2011	1312	0	1312

<sup>1</sup>[Based on fertility rate of 174 per 1,000 from the concept paper developed in the application process: http://dch.georgia.gov/sites/dch.georgia.gov/files/imported/vgn/images/portal/cit\\_1210/33/52/156793595PlanningforHealthyBabiesProgram121709Final.pdf](http://dch.georgia.gov/sites/dch.georgia.gov/files/imported/vgn/images/portal/cit_1210/33/52/156793595PlanningforHealthyBabiesProgram121709Final.pdf)

We would not expect births in the first year of the Demonstration among participants due to the usual length of gestation periods and the disenrollment of those coming into P4HB<sup>®</sup> if already pregnant. Based on the concept paper submitted to CMS in the application process, the fertility rate among women 18-44, < 200% FPL and uninsured in this first year of the Demonstration was estimated at 174 per 1,000. If this expected rate is applied to all women enrolled (and not coming in pregnant) in the family planning only component of the Demonstration (7,543), the number of expected births would be 1,312 as noted in Table 18. We count all of these as ‘averted’ births in the above table although we note there were six of the family planning enrollees who became pregnant and experienced a fetal death (< 22 weeks). It is also possible other family planning enrollees have become pregnant and their delivery/birth will not be captured until Year 2. We also cannot contribute success to the Demonstration in regards to the prevention of unintended pregnancies until we know more about the use of family planning services among this group of women.

***Budget Neutrality.*** The budget neutrality requirement for Georgia’s P4HB<sup>®</sup> program, as noted, is based on the potential of the Demonstration to ‘shift’ the birth weight distribution. Specifically, the budget neutrality spreadsheet requires that the total federal costs for all low and very low birth weight babies plus normal birth weight babies born to IPC enrollees in each Demonstration year must be less than the total federal costs for all low and very low birth weight babies in the base year for the P4HB<sup>®</sup> program to be considered budget neutral. While we could compare the distribution and federal costs for infants born on Medicaid in 2011 (shown in Tables 14 and 15) and of low or very low birth weight to those in our budget neutrality spreadsheet for 2008, the 2008 cost estimates were derived in a slightly different manner than those presented here and again, there are no births to IPC women in Year 1 beyond the birth that made them eligible for the Demonstration. The birth weight distribution and related Medicaid costs will be derived for calendar years 2009 and 2010 in the same manner as those reported here for 2011. We anticipate that these cost data can be better used to gauge whether the Demonstration prevented enough unintended first births and through better management of the health of women with very low birth weight babies, enough repeat births among this group, such that the distribution of all



Medicaid births shifted away from the low and very low birth weight categories. However, we cannot attribute such an outcome to the Demonstration until we review the CY2012 data.

## **VII. CONCLUSIONS AND RECOMMENDATIONS**

The innovative P4HB<sup>®</sup> program was implemented in the state of Georgia during CY2011 with extensive efforts at both the DCH and local levels to market the benefits of this Demonstration. While the DCH used all available resources to make women and providers aware of the program across both the urban and rural areas of the state, the numbers expected to enroll in this first year did not materialize. In the concept paper submitted to CMS, Georgia anticipated that as much as half of those eligible might enroll. As shown in the data presented here (using the ACS data), the percent enrolling in the family planning component by the end of the first year was between 3 and 5%. As noted in the concept paper, other states' first year use of services is typically low at 1.5% to 20%; we do not yet know what percentage of the 7,543 family planning only program enrollees actually used family planning services once they were enrolled but utilization of effective contraceptive services will be important for the success of the program.

By the third quarter of 2011, DCH recognized the need to undertake efforts to increase enrollment and during the fourth quarter of CY2011 initiated auto-enrollment of all RSM as well as young women aging out of PeachCare for Kids<sup>®</sup> into P4HB<sup>®</sup>. The effect of this effort was reflected in the sharp increase in enrollment at the beginning of CY2012 and these increases should continue through CY2012. It will be important for the CMOs to ensure that those women who are auto-enrolled fully understand the benefits to which they are entitled and that they must seek these through the CMO to which they are assigned.

DCH did not elect to use presumptive eligibility in its P4HB<sup>®</sup> program and hence, has had to work more closely with providers to inform them of the eligibility and enrollment process and to engage them in the act of enrollment where possible. Despite repeated efforts to educate local public health offices about their ability to accelerate the enrollment process, the average time from application to referral in Year 1 did not decline and was 16.4 days at the end of the year.

While auto-enrollment will partially address this issue, there is still a very large group of uninsured women in the age and income range in Georgia's communities who are eligible for these valuable benefits but are not aware of their eligibility, are aware but not motivated to apply, or have applied and been discouraged by the enrollment process and have not secured a benefit card. The percentage of those applying and deemed eligible by the RSM workers or the DFCS staff who were actually enrolled in a CMO, was less than 50% by the end of CY2011. If DCH is to reach the goals laid out in the design of the P4HB<sup>®</sup> program, the percentage of those making application to the program who actually become enrolled needs to markedly increase from the levels seen during the first year.

Among those who did enroll, there was a significant amount of service usage, totaling over \$900,000 in costs to the DCH. These costs are almost entirely for the women enrolled in the family planning component of the Demonstration. We do not yet know how much of the services and costs for women in the FP only component were for family planning but among those in the IPC component of the Demonstration, many of the women did receive contraceptive management and other family planning related services in the short time they were enrolled during Year 1 of the Demonstration. We do observe some services related to care for chronic conditions among those enrolled in the IPC component of the Demonstration. The dollars are small in magnitude but the diagnosis codes do not indicate a high prevalence of hypertension, diabetes and obesity among the women at high-risk of delivering a repeat very low birth weight baby.

It is important to recognize that women who did enroll in P4HB<sup>®</sup> reported that they did so to access both birth control/family planning as well as primary care (such as check-ups or physicals) and that these services were difficult for them to obtain prior to enrolling. The largest change due to enrollment in P4HB<sup>®</sup> reported by these women was their ability to obtain annual family planning examinations (described by them as preventive and primary care) due to the P4HB<sup>®</sup> program while a smaller change reported was the ability to start using a birth control method and having more choice of method. While most women understand that birth control services and methods as well as Pap tests and pelvic exams are covered, there is less

understanding by women as well as providers of other services covered. Just over half (52%) of the women recognize that STI testing is provided and far smaller percentages are aware of treatment for STI coverage or coverage for vitamins with folic acid or treatment for major problems related to family planning services. A troubling finding is that less than half of the providers recognize that basic family planning visits are covered by the program and less than a third of providers realize that screening and treatment of STIs is covered or that follow-up for an abnormal Pap, including colposcopy is reimbursed under P4HB<sup>®</sup>. More effort needs to be made to assure that women and their providers are fully aware of eligibility, enrollment processes and of course, services that can be accessed through the program. We list below some specific recommendations in this regard.

## **Recommendations**

The majority of the recommendations that follow were implemented by DCH and the CMOs during CY2012.

For outreach to and facilitation of enrollment by women potentially eligible for the family planning component of P4HB<sup>®</sup> we recommend that DCH consider:

1. Partnering with the district health officers to find ways in which local health department staff can facilitate the placement of recruitment materials in the public health departments, inform potentially eligible women about the program and the application process (particularly when they are partaking in WIC and Title X services located within the local health departments), and potentially participate in the actual completion of the application process.
2. Increasing the placement of advertising materials on radio stations and printed materials in human service and public transportation venues. Materials could include pamphlets and brochures to reach eligible but not yet enrolled women. Also, to help enrolled women understand the benefits of the program, as well as to educate women not yet enrolled, the DCH website could also list the covered services for each component of the

program. Podcasts and videos on the DCH website are also options. In addition, listing the specific services on the back of the ‘Pink’ and ‘Purple’ cards which are sent to women once they are enrolled may help both enrolled women and their providers better understand the services they are eligible to receive. Education programs could also be completed with videos in the clinic setting. Text-based messaging, well received with this population, is also recommended as an additional outreach and education activity.

3. Working further with the CMOs to distribute (via mailings) pamphlets to fully inform enrolled women of the specific services for which they are eligible and the importance of those benefits for maintaining their reproductive health. This is particularly important for those women (and teens) who have recently been auto-enrolled into the P4HB<sup>®</sup> program. Working with the CMOs, DCH could develop text-based messaging to P4HB<sup>®</sup> members to inform them on a regular basis about specific services for which they are eligible and the importance of those benefits for maintaining their reproductive health. Other educational and informational materials may be developed via visual materials, such as podcasts, videos, and SMS text messaging.

For outreach to and facilitation of enrollment by women potentially eligible for the IPC and Resource Mother only components, we recommend that DCH consider:

1. Facilitating a webinar series with the Medical Directors and social workers of the Regional Perinatal Centers and other high-volume delivery hospitals with neonatal intensive care units to educate them about the IPC and Resource Mother only components of the Demonstration and their role in informing potentially eligible women (i.e., mothers of VLBW infants) about the program and the application process.
2. Engaging the CMOs’ OB Case Management staff to interface directly with women who deliver a VLBW infant while covered by Right from the Start Medicaid to facilitate the completion of the application process and the engagement of the woman in primary and maintenance health care. These OB Case Managers could be a powerful tool for motivating women to partake in the post-partum visit and other care-seeking behaviors

and to adopt positive self-care behaviors (such as continuation of folic acid supplementation and adherence to correct and consistent use of contraceptive methods).

For engagement of women enrolled in the IPC and Resource Mother only components:

1. Engage the contracted Resource Mothers to help in outreach to enroll women as well as encourage the CMOs to use other means of outreach (e.g., reminder letters sent to participants) to support and facilitate that women seek primary and maintenance health care for their chronic health conditions and for complications of their health that may have developed during the pregnancy that indicate the need for post-pregnancy risk reduction (such as gestational diabetes and preeclampsia).

For enhanced quality of services delivered to women enrolled in the family planning component, we recommend that DCH consider:

1. Supporting the CMOs in reaching out to their women's health care providers with specific educational materials or trainings, such as the CDC Medical Eligibility Criteria for Contraception Use and 'Method Match', made available by the Association of Reproductive Health Professionals, to ensure providers are familiarized with the range of contraception methods and their contraindication, advantage, and disadvantage profiles.

For enhanced quality of services delivered to women enrolled in the IPC and Resource Mother only components, we recommend that DCH consider:

1. Supporting the CMOs in reaching out to their women's health care providers with specific educational materials or training about the importance of and the recommended content of interconception care. In particular, the CMOs should assure that the Preconception Care Toolkit, as promoted by the Georgia Department of Public Health and Georgia's health care provider professional associations, is used by provider networks to support clinicians in the delivery of evidence-based preconception care services as part of the P4HB<sup>®</sup> program. The toolkit is available at:

[www.fpm.emory.edu/Preventive/projects/GAPCCToolkit.htm](http://www.fpm.emory.edu/Preventive/projects/GAPCCToolkit.htm)

2. Further supporting the CMOs in reaching out to their providers with evidence-based guidelines for post-partum care and post-pregnancy follow-up of common complications of pregnancy.

While the CMOs provide P4HB<sup>®</sup> information on their websites, they could also include podcasts of information sessions related to provider participation/contracting. DCH could engage with professional associations (G-AAP, GAFF, GOGS, public health nurse association) and hospital networks to deliver provider education about the P4HB<sup>®</sup> program (purpose, eligibility, covered services, means of enrollment). Care should be taken to clarify whether all services covered by P4HB<sup>®</sup> are included in provider contracts with all CMOs.

In conclusion, much progress has been made but much remains to be done to ensure that the innovative aspects of the P4HB<sup>®</sup> have their anticipated impact. DCH now has through June of 2013 to enroll women in the several components of the P4HB<sup>®</sup> program. While enrollments increased markedly due to auto-enrollment, it is imperative that both women and their providers understand the service coverage that is available under P4HB<sup>®</sup> in order for the Demonstration to reach its full potential in terms of improving the reproductive health of P4HB<sup>®</sup> participants and in particular, the IPC participants. An integral part of improving their reproductive health is supporting the efforts of women of all ages, and in particular the youth who are at high risk of their first unintended pregnancy, to decide on their pregnancy intentions and to use the most safe and effective birth control methods while also staying abreast of age-appropriate screens and other preventive services. The auto-enrollment of thousands of teens as they age out of Georgia's PeachCare for Kids<sup>®</sup> program provides an unprecedented opportunity for DCH to work with a cohort of teens as they enter their prime years to assure that their reproductive health is maintained and that they reach their goals regarding the timing and intendedness of their first pregnancy.

## Appendix A: P4HB<sup>®</sup> Communication Plan

Phase	Activities	Status
<p><b>Phase 1: Educate Providers and CMOs</b> Focuses on educating health care providers and CMOs about P4HB. These are the major stakeholders identified through the Communication Plan as having “the most potential to positively influence and impact the behaviors of patients through preventative care measures.”</p>	<p>6) Introducing a revised P4HB Communication Plan to the Work Group and the CMOs;            7) Develop a page on the DCH website for the P4HB program that provides specific information about the program, benefits, provider network, client eligibility and enrollment and program application; and            8) Introduce the P4HB program and program-related materials to the CMOs (including program logo, poster and postcards).</p>	<p>1) through 3). Completed initial education. Re-education is ongoing. Web page developed and updated as needed. CMOs utilizing program-related materials.</p>
<p><b>Phase 2: Leverage the Strengths &amp; Assets of Partners</b>            Purpose is to use local experts to champion LBW prevention by encouraging eligible women in their respective communities to enroll in the P4HB program</p>	<p>The Improving Birth Outcomes Work Group will identify local experts at the district level. Additional organizations and providers also identified as potential collaborators, including MCH staff, WIC staff, family practice providers, pediatricians, faith community leaders, nursing and medical schools, nurse midwives, health care professionals, OBGYNs, policymakers, media representatives, civic and cultural leaders, and tobacco program coordinators.</p>	<p>Ongoing meetings with the Improving Birth Outcomes Work Group now held bi-monthly. Communication is ongoing with providers, MCH staff, pediatricians and public health staff. Outreach occurring via the RSM Outreach Project staff</p>
<p><b>Phase 3: Implement Consumer-Based Outreach (statewide and Locally)</b>            Purpose is to inform consumers and providers about P4HB using media, messaging, and an organized set of communication activities</p>	<p>13) Introduce campaign to 18 public health districts            14) Outline marketing proposal and estimated costs            15) Determine overall budget and process in which marketing materials will be purchased            16) Buy billboards, radio and print ads. Advertisement will occur in 2 phases over the course of the program, and counties with highest LBW rates will be targeted first for billboard ads.            17) Finalize copy for poster/postcard design            18) Replace postcard with brochure in summer 2011.            19) Obtain approval of printing cost</p>	<p>1) through 12). Completed. The RSM Outreach Project staff from the Department of Family and Children Services has been instrumental in our “grassroots” outreach efforts within the 18 public health districts.</p>

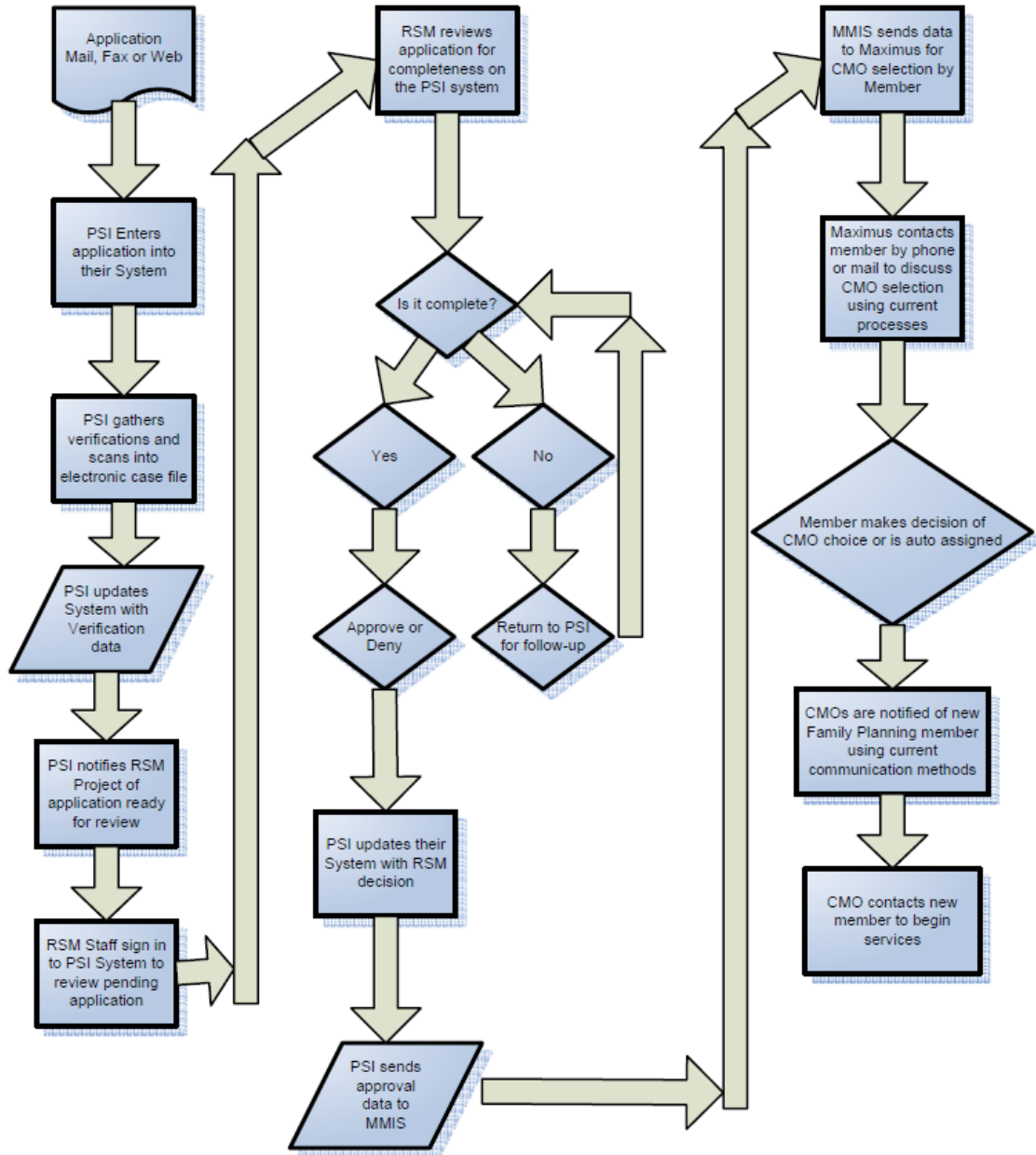
Phase	Activities	Status
	<p>for brochures, posters/postcards; obtain shipping addresses</p> <p>20) Provide RSM, PH departments, and DFCS officials with notice that postcards/posters and brochures will be distributed and guidance about how to use them.</p> <p>21) Draft/distribute press release announcing launch of P4HB program.</p> <p>22) Pitch background sessions to identified reporters from the Atlanta Journal &amp; Constitution.</p> <p>23) Begin brainstorming a newsworthy event for Summer 2011</p> <p>24) Other activities: theater ads, health fairs, participating in cause-related charitable events, articles in provider organization newsletters; news releases, media advisories, op-eds, podcast messages placed on PH4B website, Face Book and Twitter pages. In addition, the Plan calls for media advisories, op-eds and conducting “background sessions” with area reporters to discuss the state’s efforts to reduce its LBW rate.</p>	
<p><b>Phase 4: Use Existing Resources for Support and Coaching</b></p> <p>Goal is to use current available resources in Georgia to promote prenatal care, healthy lifestyles before and during pregnancy, and smoking cessation.</p>	<p>Reach out to WIC staff and Georgia Quit Line team and inform them of P4HB and that P4HB will reference them on the P4HB website and possible future marketing materials.</p>	<p>Completed.</p>
<p><b>Phase 5: Annual Campaign Evaluation</b></p> <p>To analyze on an annual basis the strengths and weakness of the P4HB program. Four types of evaluation are suggested: 1) formative; 2) process; 3) outcome: and 4)</p>	<p>7) Assess the strengths and weaknesses of campaign materials and strategies</p> <p>8) Measure effort and the direct outputs of campaign</p> <p>9) Examine the campaign’s implementation and how the</p>	<p>Ongoing. Emory University is assisting with the evaluation.</p>



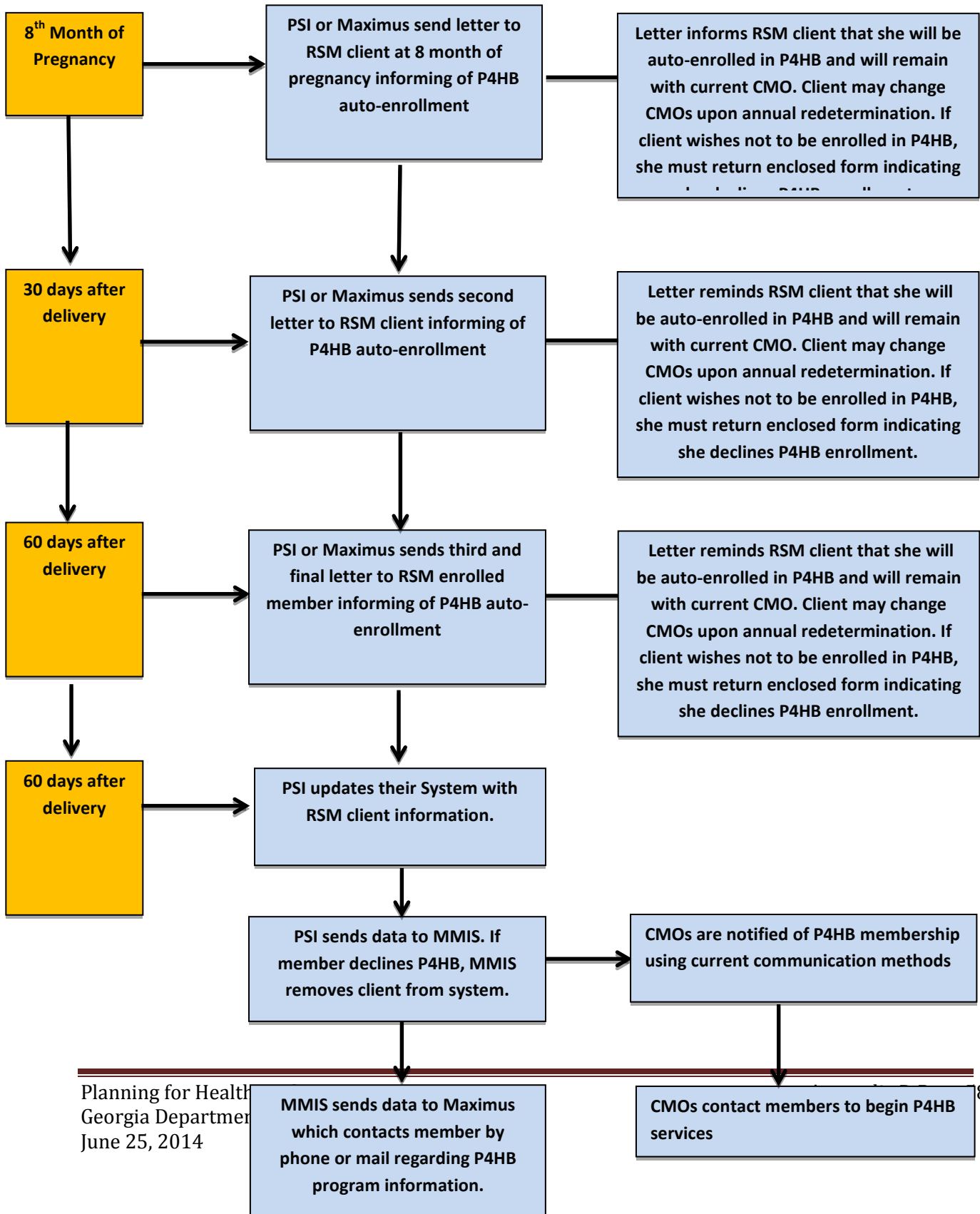
Phase	Activities	Status
Impact	<p>activities involved are working</p> <p>10) Measure effect and changes that result from the campaign. (Assess outcomes in the target populations or communities that come about as a result of the campaign's strategies and activities; measure policy changes.)</p> <p>11) Measure community-level changes that are achieved as a result of the campaign's aggregate effects on individuals' behavior and the behavior's sustainability. Attempts to determine whether the campaign caused the effects.</p> <p>12) Make recommendations for Year 2 of the campaign based on data gained from the annual evaluation; implement necessary changes in Year 2</p>	

## Appendix B: Schematic of Enrollment Process

Application Process flow for Planning for Healthy Babies Waiver



**Process of Auto Enrollment in Planning for Healthy Babies (P4HB)  
for Right from the Start (RSM) Enrollees**



## Appendix C: CMO Client and Provider Surveys



### Planning for Healthy Babies (P4HB) Client Survey

*The Georgia Department of Community Health Division of Medicaid needs your help to improve services for women in the P4HB Program. Please complete and turn in this survey. Thank you for your time!*

#### 1. Please tell us about your experience with the Planning for Healthy Babies (P4HB) Program:

Are you currently . . .	Yes	No	Don't Know Or Unsure
<b>a. Enrolled in these parts of P4HB:</b>			
Family Planning (Pink Card)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interpregnancy Care or IPC (Purple Card)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Resource Mother Only (Yellow Card)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<hr/>			
<b>b. Did you enroll in P4HB to get:</b>			
Family planning services?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy testing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Testing or treatment for sexually transmitted infections?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Primary care (such as check-ups or physicals, care for an illness)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please fill in): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<hr/>			
<b>c. Have you used any of these P4HB services:</b>			
Family planning ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy testing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Testing or treatment for sexually transmitted infections?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Primary care (such as routine check-ups, care for an illness)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please fill in): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<hr/>			
<b>d. Before you enrolled in P4HB, did you have problems getting:</b>			
Family planning services?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy testing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Testing or treatment for sexually transmitted infections?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Primary care (such as routine check-up, care for an illness)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please fill in): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b><i>If "Yes" to ANY part of 1d:</i></b>			
What types of problems did you have? (check all that apply)			
<input type="checkbox"/> I did not have a way to get to appointments			
<input type="checkbox"/> I could not pay for services			
<input type="checkbox"/> I could not pay for birth control methods			
<input type="checkbox"/> I could not find a doctor or nurse			
<input type="checkbox"/> I could not get time off from work for appointments			
<input type="checkbox"/> I had no one to take care of my children			
<input type="checkbox"/> I was too sick to get to the doctor or clinic			
<input type="checkbox"/> Other (please fill in) _____			

**2. Please tell us about the major changes that P4HB has made for you:**

Since enrolling in P4HB:	Yes	No	Don't Know Or Unsure
a. I am going to a different doctor or nurse for family planning services or birth control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. I am going to a different doctor or nurse for primary care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. I have started using a birth control method	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. I have changed the birth control method I use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. I have more choices of birth control methods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. I do not have to use my own money to get birth control methods or services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. I am able to get preventive care (such as Pap smears) and family planning counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. With the Purple Card (IPC), I am able to get care for illnesses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. With the Purple Card (IPC), I am able to get medicines for illnesses when I need them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Other (please fill in): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**3. Please tell us which services you can get with the Pink Card without having to pay:**

Services	Yes	No	Don't Know Or Unsure
a. Birth control services and methods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Pap smear and pelvic exam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Tubal Ligation (tubes tied)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Pregnancy testing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Screening for sexually transmitted infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Follow-up of an abnormal Pap smear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Treatment for sexually transmitted infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Treatment for major problems related to family planning services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Vitamins with folic acid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Some vaccinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**4. Please tell us which services you can get with the Purple Card without having to pay:**

Services	Yes	No	Don't Know Or Unsure
a. Primary care services (up to 5 visits per year)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Treatment of medical problems (such as high blood pressure or diabetes)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Medicines for medical problems (such as high blood pressure or diabetes)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Care for drug and alcohol abuse (such as rehab programs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Some dental services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Non-emergency transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Nurse case management/Resource Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**5. For a woman to qualify for the Pink Card she must: (Check all that apply)**

	Yes	No	Don't Know Or Unsure
a. Be between 18-44 years of age	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Be a resident of Georgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Be a U.S. Citizen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Have a household income at or below 200% of the federal poverty level (\$1,816 per month for a family of 1 or \$2,452 for a family of 2 )	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Not be eligible for Medicaid or the Children's Health Insurance Program (PeachCare)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Other (Please fill in) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**6. For a woman to qualify for the Purple Card she must: (Check all that apply)**

	Yes	No	Don't Know Or Unsure
a. Be between 18-44 years of age	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Be a resident of Georgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Be a U.S. Citizen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Have a household income at or below 200% of the federal poverty level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Not otherwise eligible for Medicaid or the Children's Health Insurance Program (CHIP)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Have delivered a very low birth weight infant since January 1, 2011	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Other (Please fill in) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**7. Under the P4HB Program, how much of a problem is each of the following:**

Potential Problems	Major Problem	Minor Problem	Not a Problem	Don't Know or No Opinion
a. I cannot get the family planning services I want	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. I cannot get referrals or follow-up for care I need	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. I cannot find a doctor or nurse willing to take P4HB clients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. I don't want to leave my current doctor or nurse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. I have to wait too long to get services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. I do not have transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. I cannot get to the doctor or nurse when they are open	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. My P4HB doctor or nurse will not prescribe my birth control methods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Other (Please fill in) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**8. Please check whether you have enough information or need more information about P4HB**

About P4HB ...	HAVE ENOUGH information	NEED SOME MORE information	NEED MUCH MORE information
a. Where to go for services			
b. Which services are available to me with the Pink Card	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Which services are available to me with the Purple Card	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

d. How much money I have to pay for services

**9. How did you learn about P4HB?** (check all that apply)

- Amerigroup, Peach State or WellCare (CMOs) mailings
- Amerigroup, Peach State or WellCare (CMOs) e-mails
- CMO websites
- CMO telephone calls
- Georgia Department of Community Health websites
- Georgia Department of Community Health meetings
- Doctors, nurses, or other staff at the health department or WIC office
- Doctors, nurses, or other staff at the hospital
- Doctors, nurses, or other staff at my doctor's office
- Friends or family members
- Postings on billboards and public transportation
- Other: \_\_\_\_\_

**10. How hard was it to:**

	VERY Hard	SOMEWHAT Hard	NOT Hard at all
a. Understand who can get P4HB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Understand whether I can get P4HB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Complete the paper work to sign up for P4HB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Complete the web form to sign up for P4HB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Get the required documents to sign up for P4HB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Pick a Care Management Organization (CMO)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Pick a provider	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Understand what I can get from P4HB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Other (please fill in) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*Thank you for your help!*



**Planning for Healthy Babies (P4HB)  
Provider Survey**

*The Georgia Department of Community Health Division of Medicaid requests your help to improve services for women eligible for the P4HB Program. Please complete and submit this survey. Thank you for your time!*

**1. Please tell us about you and your practice:**

Are you currently. . .	Yes	No	Don't Know Or Unsure
a. Accepting new Medicaid patients?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Providing family planning or primary care services to women of reproductive age?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Aware of Georgia's Planning for Healthy Babies (P4HB) Program?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*If "Yes" to 1c, please continue with the full survey:*

How did you learn about Georgia Planning for Healthy Babies (P4HB)? *(check all that apply below)*

- Mailings from the Care Management Organizations
- E-mails from the Care Management Organizations
- Websites of the Care Management Organizations
- Telephone calls with the Care Management Organizations
- Websites of the Georgia Department of Community Health
- Meetings hosted by the Georgia Department of Community Health
- Professional or staff meetings
- Colleagues
- Postings on billboards and public transportation
- Patients asked questions about P4HB

*If "No" to 1c, then → Skip to Question #7.*

d. Providing services to women enrolled in the Georgia Planning for Healthy Babies (P4HB) Program?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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**2. Please tell us about the services you believe are included in the Care Management Organization (CMO) contract for the Family Planning Component of P4HB?**

Services	Covered	Not Covered	Don't Know Or Unsure
a. Family planning initial and follow-up exams, including Pap smear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Contraceptive services and methods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Tubal ligation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Pregnancy testing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Screening for sexually transmitted infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Follow-up of an abnormal Pap smear, including Colposcopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Treatment for sexually transmitted infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Treatment for major complications related to family planning services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Multivitamins with folic acid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Hepatitis B and Tetanus-Diphtheria vaccines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



**3. Please tell us about the services you believe are included in the Care Management Organization (CMO) contract for the Interpregnancy Care Component of P4HB?**

Services	Covered	Not Covered	Don't Know Or Unsure
a. Primary care services (up to 5 outpatient visits per year)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Management and follow-up of chronic diseases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Prescription medications for chronic diseases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Detoxification and outpatient rehabilitation for substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Limited dental services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Nurse case management and Resource mother outreach for health and social service coordination and support of health behaviors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Non-emergency transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Multivitamins with folic acid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Hepatitis B and Tetanus-Diphtheria vaccines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**4. Please indicate the criteria that you believe a woman must meet to be eligible for the Family Planning Component of P4HB:**

Criteria. . .	Required	Not Required	Don't Know Or Unsure
a. Between 18-44 years of age	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Resident of Georgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. U.S. Citizen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Household income at or below 200% of the federal poverty level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Not otherwise eligible for Medicaid or the Children's Health Insurance Program (CHIP-PeachCare)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Other ( <i>Please fill in</i> ) _____			

**5. Please indicate the criteria that a woman must meet to be eligible for the Interpregnancy Care Component of the Georgia Medicaid Family Planning Waiver:**

Criteria. . .	Required	Not Required	Don't Know Or Unsure
a. Between 18-44 years of age	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Resident of Georgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. U.S. Citizen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Household income at or below 200% of the federal poverty level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Not otherwise eligible for Medicaid or the Children's Health Insurance Program (CHIP-PeachCare)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Delivered a very low birth weight infant since January 1, 2011	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Other ( <i>Please fill in</i> ) _____			

**6. Please indicate to what extent you believe the following are barriers for providers as they try to assure women receive appropriate reproductive health services under P4HB.**

Barriers to care . . .	Major Barrier	Minor Barrier	Not a Barrier	Don't Know Or No Opinion
a. Waiver does not cover the full range of family planning services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Waiver does not cover referrals or follow-up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

c. Waiver does not cover complications of family planning services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Payments to providers are not adequate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Problems or delays in receiving payments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Your practice is full	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Other (Please fill in) _____				

**7. Please indicate the extent to which you have adequate information or need more information about various aspects of P4HB in order to effectively provide care to women.**

Aspect of the Waiver . . .	HAVE ADEQUATE information	NEED SOME MORE information	NEED MUCH MORE information
a. Enrollment eligibility criteria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Determination of eligibility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Enrollment process	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Covered services for those enrolled in the Family Planning Component	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Covered services for those enrolled in the Interpregnancy Care Component	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Reimbursement rates	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**8. How do you prefer to receive information or learn about new Medicaid initiatives or programs?**

- Mailings from the Care Management Organizations
- E-mails from the Care Management Organizations
- Websites of the Care Management Organizations
- Telephone calls with the Care Management Organizations
- Websites of the Georgia Department of Community Health
- Meetings hosted by the Georgia Department of Community Health
- Professional or staff meetings
- Colleagues
- Postings on billboards and public transportation

*Thank you for your help!*

## Appendix D: CMO Action Plan Post Surveys

ACTION AREA	Action Proposals
<b>P4HB Education</b>	
Member Education	<p>CMOs: Distribute (via mailings) pamphlets to fully inform enrolled women of the benefits for which they are eligible and the importance of those benefits for maintaining their reproductive health.</p> <p>CMOs and DCH: Include more information about covered services on their respective websites.</p>
Provider Education	DCH: Engage with professional associations (G-AAP, GAFFP, SGOGS, public health nurse association) and hospital networks to deliver provider education about the P4HB program (purpose, eligibility, covered services, means of enrollment).
Involve Facility Providers (RSM, Case Workers, NICU social workers)	CMOs: Engage CMO-employed Resource Mothers and case workers to deliver outreach to NICU staff (including neonatologists, social workers, and case managers) who work in NICU's of the Perinatal Regional Network
<b>Outreach</b>	
Outreach to Eligible Population	DCH: Distribute educational pamphlets and signage to local public health departments and human services sites that inform potentially eligible women of the purpose of P4HB, benefits and covered services, and how to enroll in P4HB.
Target Schools	DCH: Distribute educational pamphlets and signage to school-based health clinics and nurses that inform teens and the on-site school providers of the purpose of P4HB, benefits and covered services, and how to enroll in P4HB.
Target Human Services Site (e.g. WIC, Food Stamp, Head Start, Title X Clinics, FQHCs)	DCH: Engage with DPH to deliver education about the P4HB program (purpose, eligibility, covered services, means of enrollment) and seek their participation in informing and helping enroll eligible women.
Follow-up With those Auto-Enrolled	CMOs: Engage CMO staff to outreach to auto-enrolled women via phone or other means of contact to ensure their understanding of P4HB and its benefits to them.
<b>Education Regarding Benefits from Family Planning</b>	

Target eligible population	DCH: Distribute educational pamphlets and signage to local public health departments and human services sites that inform potentially eligible women of the benefits of family planning and well-spaced and well-timed pregnancies
Target enrolled population	CMOs: Distribute (via mailings) pamphlets to fully inform enrolled women of the benefits for which they are eligible and the benefits of family planning and well-spaced and well-timed pregnancies.

# **Appendix E**

## **Year 2 P4HB Evaluation**

**Annual Report**

**Planning for Healthy Babies Program® (P4HB®)**

**1115 Demonstration in Georgia**

**YEAR 2**

**Submitted to the Centers for Medicare and Medicaid Services**

**By:**

**The Georgia Department of Community Health (DCH)**

**and**

**Emory University, Rollins School of Public Health (RSPH)**

**Department of Health Policy and Management (HPM)**

**REVISED FEBRUARY 28, 2014**

**Revised due to corrected data on month of enrollment in a CMO among P4HB enrollees and updated eligibility data.**

## TABLE OF CONTENTS

Executive Summary .....	iii
Overview of Planning for Healthy Babies Program® Demonstration .....	1
Demonstration Objectives .....	5
Demonstration Evaluation Objectives .....	6
Summary of Second Year Activities .....	8
Communication and Outreach .....	8
DCH Supported Activities .....	8
CMO Supported Activities .....	13
Major Changes In Year.....	14
Enrollment and Participation.....	15
Enrollment Trends .....	15
Participation Rates .....	19
Provider Surveys Rounds 1-3 .....	21
Summary of Provider Survey Results Rounds 1-3 .....	22
Data on Deliveries and Infants .....	26
Counts of Deliveries and Costs 2012 .....	27
Counts of Infants and Costs 2012.....	31
Service Use .....	35
IPC Service Use.....	35
Trends in Births, Averted Births, and Budget Neutrality.....	37
Family Planning Service Use.....	41
Births and Birth Outcomes Among Waiver Participants .....	49
Participants vs. Non-Participants.....	51
Pre/Post Analysis of RSM Women.....	54
XIII. Conclusions and Recommendations.....	55
Recommendations.....	56
Appendix A:Communication Plan.....	A1
Appendix B: Member and Provider Survey Responses.....	B1

## **Executive Summary**

The Planning for Healthy Babies Program<sup>®</sup> (P4HB<sup>®</sup>), Georgia's section 1115(a) Medicaid Demonstration, expands the provision of family planning services to uninsured women, ages 18 through 44, who have a family income at or below 200 percent of the federal poverty level (FPL), and who are not otherwise eligible for Medicaid or the Children's Health Insurance Program (CHIP). The Demonstration also provides Interpregnancy Care (IPC) services to women who meet the same eligibility requirements above and who deliver a very low birth weight (VLBW) infant (less than 1,500 grams) on or after January 1, 2011. In addition, women ages 18 through 44 with a family income at or below 200 percent of the FPL, who have a VLBW delivery on or after January 1, 2011, and who qualify under Georgia's Low Income Medicaid (LIM) Class of Assistance or the Aged, Blind and Disabled (ABD) Classes of Assistance are eligible for nurse case management/Resource Mothers Outreach only services under the Demonstration. Georgia expects to achieve the following with this Demonstration:

- Reduce Georgia's low birth weight (LBW) and VLBW rates ;
- Reduce the number of unintended pregnancies in the state;
- Reduce Medicaid costs by reducing the number of unintended pregnancies by women who otherwise would be eligible for Medicaid pregnancy-related services;
- Provide access to IPC health services for eligible women who have previously delivered a VLBW infant; and,
- Increase child spacing intervals through effective contraceptive use.



A unique aspect of Georgia's Demonstration is that services are delivered through the Georgia Families Care Management Organizations (CMOs) and their networks of providers. Three CMOs - Amerigroup, WellCare of Georgia, Inc., and Peach State Health Plan - participate in the Georgia Families program and receive a capitated per member per month (PMPM) payment for each Demonstration participant. These capitation rates were approved by CMS and serve as the basis for calculating the expenses in the quarterly budget neutrality worksheet. The CMOs' provider networks provide clinical, laboratory, pharmacy and other Demonstration services to the P4HB participants and each of the three CMOs has nurse case managers and Resource Mothers who provide the case management services for the IPC participants. Title X clinics, largely public health departments in Georgia, are also included in the CMOs' networks.

The implementation of the P4HB program followed a multi-pronged communication plan, with engagement of the CMOs, professional associations, and the Georgia Department of Public Health (DPH) as well as direct engagement of consumers via printed and other media. DCH projected (based on 2008 survey data) that 276,548 women would be eligible for services under the Demonstration and that by the end of Year 1, 110,620 of those women would be enrolled and 33,186 would be using services. Despite multiple engagement efforts by DCH and providers in the community, there has been a lower than expected take-up of the program and even lower take-up of the program's benefits although participation rates increased in this second year. Using an estimate from the American Community Survey of uninsured women < 200% FPL in Georgia in 2011, approximately 12% of this estimated eligible population was enrolled in the FP only component at the end of CY2012. If the number of eligible women is adjusted for the percentage of women 'in need' of family planning

services, the percentage enrolled in the family planning only component increases to 22.5%. This percentage includes the large number of women auto-enrolled into the family planning only component of the P4HB program; some of the data in this report indicate these auto-enrolled women had less interest in the program and tended to use services at a lower rate than those initiating their own enrollment.

The PMPM payments to the CMOs totaled \$14,776,646.80 for the second program year resulting in a total of \$16,123,033.37 across the two years since implementation of the P4HB program. The PY2 total included \$14,528,929.15 for FP only services, \$211,200 for IPC services, and \$36,517.65 for Resource Mother Only services. The PMPM for each of these program components included an administrative load amount of 13 %. These PY2 expenditures reflect a growth in enrollment during this period and represent a ten-fold increase in total spending during PY2 when compared with the expenditures for the first year of the program (\$1,346,386). As reported in the third quarter 2013 P4HB Quarterly Report to CMS, the member months for the FP only enrollees continued to increase through the second year while the number of participants enrolled, member months, and expenditures for the IPC component of the Demonstration began to decline. Some of this decline may have been the result of a finding identified in this PY 2 report that as many as 7% of the IPC enrolled women experienced a new pregnancy, one experienced a repeat live birth, and one experienced a still birth in 2012. Once the pregnancy determination was made, these women would have been transferred to a new eligibility category within the Georgia Medicaid program.

In preparation for this report, the evaluation team examined early effects of the P4HB program on: 1) use of family planning services among Medicaid enrolled women and among women in the income range targeted by P4HB; 2) trends in Medicaid paid births and birth weight distributions; 3) pregnancies and births among P4HB enrollees and birth weight outcomes; 4) comparisons of birth outcomes between P4HB participants and non-participants; 5) time to next pregnancy for Right from the Start Medicaid (RSM) enrollees with an index birth between 2009 and 2012; and 6) evidence of increased management of chronic conditions among IPC enrollees. As noted on the title page, this report uses corrected enrollment data for P4HB enrollees and update eligibility data. Since P4HB enrollees can only receive P4HB services once they are enrolled into a CMO this is the enrollment date that must be used for assessing subsequent outcomes such as pregnancies and/or births. Our outside evaluator did not have the CMO enrollment date in the data they originally used for the Annual Reports. This has now been corrected and the counts of P4HB enrollees used for assessing outcomes reflect this. This report presents data that support the following key findings:

### **Use of Family Planning:**

- Use of any family planning services at Title X clinics from the first quarter of 2009 to the first quarter 2013 increased among uninsured women in the income range targeted by P4HB (>25% but < 200% FPL);
- Use of contraceptives at Title X clinics shifted toward long-acting, reversible contraceptives (LARCs) based on descriptive and multivariate analysis;
- Use of family planning services among all Medicaid enrolled women ages 18-44 increased between 2009 and 2012;

- The growth in family planning services paid for by Medicaid or Title X did not increase enough to result in a growing percentage of all women < 200% FPL with a family planning or birth control visit over the 2009-2012 time period; but
- Users in both the Medicaid and Title X sectors shifted toward greater use of LARCs by 2012.

#### **Trends in Births/Costs:**

- Medicaid paid births were declining prior to implementation of the P4HB program and they have continued to decline through CY2011 but rose in CY2012 following overall patterns at the state level;
- Average paid amounts for infants at delivery increased only slightly from \$3,274 to \$3,889 over the 2009-2012 years;
- The percentage of very low birth weight infants remained close to 2.0% each year between 2009 -2012 based on Medicaid claims; and between 2009-2011 based on linked claims and vital records.

#### **Pregnancy/Birth Experiences of P4HB Enrollees:**

- An estimated 6.6% of FP only demonstration participants experienced a pregnancy after 3 months of continuous enrollment in P4HB and 1.5% had a delivery paid by Medicaid after enrollment;

- Total births to P4HB enrollees was 562 in 2012, still far less than expected given the fertility rates cited in the DCH Planning for Healthy Babies Concept Paper used in the application process<sup>5</sup>;
- Birth outcomes of infants born to the FP only demonstration participants included a somewhat higher percentage of VLBW infants but a higher percentage LBW infants, than those infants born to RSM women in 2012 who were not enrolled in P4HB;
- Two IPC enrollees experienced a delivery after enrolling in the P4HB program. One had a live born delivery and one had a still born delivery paid by Medicaid in CY2012;
- Repeat pregnancies among women with a VLBW birth on Medicaid in CY2012 equaled 13.6% within 12 months for those not participating in IPC but were lower at 7.3%, for those participating in IPC;
- There were no repeat VLBW births among the IPC enrollees but there was one repeat VLBW birth among women in a RSM comparison sample.

#### **Changes in Other Outcomes:**

- The percentage of all RSM enrollees with a repeat pregnancy within 6 months of the index birth ranged from 3.2% to 3.7% during the 2009-2011 time periods and was lower at 3.4% in 2012;
- Infant first year of life costs after their delivery hospitalization averaged \$2,355 in 2012 versus \$1,851 in 2011; and

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<sup>5</sup>[http://dch.georgia.gov/sites/dch.georgia.gov/files/imported/vgn/images/portal/cit\\_1210/33/52/156793595PlanningforHealthyBabiesProgram121709Final.pdf](http://dch.georgia.gov/sites/dch.georgia.gov/files/imported/vgn/images/portal/cit_1210/33/52/156793595PlanningforHealthyBabiesProgram121709Final.pdf)

- Small percentages of IPC women were using services in 2011 but this increased in 2012 with most of them using services for acute conditions. The use of services by IPC participants for chronic conditions increased and the most common service was for the management of hypertension.

The numbers we present in this second annual report are based on claims and encounter data from 2009-2012 with linkages to the Georgia vital records for CY2009-CY2011. As the updated 2011 and new 2012 extracts were delivered to the evaluation team, it was realized that DRG coding, as reported by the CMOs, was markedly less complete than in prior years. As these new data came in, Emory conducted comparisons of counts of infants/deliveries and birth weight distributions using ICD-9 versus DRG codes and, using the linked 2009-2011 claims and vital records, concluded that the agreement between claims and vital records was similar for ICD-9 and DRG coding. However, when using either coding system in comparison to the vital records, the claims data consistently demonstrated that: 1) a smaller percentage of infants were categorized as LBW; and 2) within those categorized as LBW, a larger percentage were categorized as VLBW than reported in the vital records for the same set of infants. Emory assigned the lowest birth weight observed in claims since, from a scientific viewpoint, this will provide a more conservative approach and if an effect is seen using this method we can be more confident it is a real/true effect. Ultimately, Emory will use the vital records data as the 'gold standard' for measuring birth weight once they are available and linked.

The evaluation team also noted that the claims led to an apparent undercount of infants in CY2011 and an undercount of deliveries in CY2012. The latter is most important for the measures reported here

since deliveries to women enrolled in P4HB in the first full year after the implementation year will be *understated*. This should be kept in mind as the results presented here are reviewed. We recognize the lack of standardization in the definition of ‘Medicaid-financed births’ across states and hope that our effort in Georgia will contribute toward a common set of definitions and standards for computing these measures using Medicaid claims data, vital records, and once completed, linked claims-vital records.

Based on the updated data with the corrected CMO enrollment dates, Emory found that significant number of women came into the program most likely already pregnant. Based on this and other outcomes presented in this report, Emory University makes the following recommendations to DCH:

- Based on some positive signs in Year 2, we encourage DCH to seek an extension of the P4HB program beyond its scheduled end. The patterns observed near the end of the second year indicate that P4HB may be reaching maturity in terms of achieving sustainable levels of enrollment, use of effective family planning methods, and management of women with very low birth weight infants. It is important for the state to strengthen these trends.
- Continue to work with Title X as an active partner in the enrollment of eligible women into the P4HB program and in the provision of family planning services to uninsured and under insured women who, if pregnant, are eligible for Medicaid coverage. A continued monitoring of the Title X quarterly data will inform DCH about the trends seen in the most recent quarters that indicate increased use of birth control methods and in turn, more use of LARCs. An added benefit of such a partnership is that these efforts can help Title X clinics ‘leverage’ Medicaid funds to increase revenues and allow for the use of Title X funding to further expand outreach,

access and the provision of more effective methods of birth control to non-Medicaid eligible individuals.

- Increase efforts to retain the auto-enrolled women. Many of them will be coming up for recertification throughout the coming year. These women have accounted for a large portion of the total number of women enrolled in the family planning only component.
- Continue working with the IPC enrollees to ensure their awareness and utilization of the range of services available to them and, in particular, the management of chronic conditions in addition to the family planning services intended to help them prevent a repeat pregnancy or birth within a short time period.
- Explore opportunities to decrease the time between the eligibility determination and actual CMO enrollment for P4HB. While most women who eventually come into a CMO for P4HB services do so within two months from the date of the eligibility determination, this is a time period when women do not have access to P4HB services so unintended pregnancies may occur. There were 1,043 pregnancies observed among women enrolled less than the three months required for inclusion in the full analysis. These can perhaps be seen as failures of women to understand the program and/or failure of the delivery system to get the women in for family planning counseling and services in a timely fashion.
- Consider a renewed marketing campaign for P4HB. The large number of women who appear to come into the program already pregnant is perhaps indicative of a misunderstanding of the preventive nature of the program. There were 1,035 pregnancies and 215 births among women who eventually enrolled in a CMO for three continuous months who apparently came into P4HB already pregnant and as noted above, an additional 1,043 pregnancies among those



enrolled in a CMO for less than two months. This campaign should target: media outlets (TV, radio) as well as social media (texts, Face Book, Twitter) and; eligible FP only enrollees as well as eligible IPC enrollees. In addition, a provider component of this renewed marketing campaign should be included that targets a broad range of provider types (OBGYN, family physicians, nurse practitioners, Title X women's health coordinators, neonatal ICU providers and social workers). Previously collected qualitative information indicated that providers were confused about the status of P4HB, with many believing the program was ending in December 2013. This renewed marketing campaign would clarify that P4HB is continuing and should include clear information about eligibility, enrollment, and program benefits.

## **II. OVERVIEW OF THE PLANNING FOR HEALTHY BABIES PROGRAM**

### **(P4HB)**

In response to the persistent high rate of low birth weight (LBW) and very low birth weight (VLBW) infants born to women in Georgia, the DCH designed a Section 1115(a) Demonstration and was granted authority by CMS to expand access to family planning services under the P4HB program. This program became available in January 2011 and eligible women must be: U.S. citizens and residents of Georgia who are otherwise uninsured and not eligible for Medicaid; 18 through 44 years of age; not pregnant but able to become pregnant; and with incomes at or below 200% of the Federal Poverty Level (FPL).

The P4HB program also provides Interpregnancy Care (IPC) services to women who meet the above eligibility criteria and who deliver a very low birth weight (VLBW) infant on or after January 1, 2011. The program also offers nurse case management and Resource Mother outreach services to women receiving IPC services and to women enrolled in the Georgia LIM or ABD (Aged, Blind and Disabled) Medicaid programs who deliver a very low birth weight infant on or after January 1, 2011. DCH identified the following as key goals for the P4HB Demonstration:

- **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.

When pregnancies occur among the near-poor group of women at or below 200% FPL they qualify under Georgia’s pregnancy (“Right from the Start”) Medicaid eligibility criteria. Since women in this income range are made newly eligible for family planning services under P4HB, it is possible that the costs of deliveries paid for by the Georgia Medicaid program under the RSM eligibility category will begin to decline. A key objective of the Demonstration, as noted, is to reduce the proportion of unintended pregnancies/births and increase interpregnancy intervals among this ‘targeted’ group of near-poor women. Given the increased risk of repeating an adverse pregnancy outcome such as a VLBW delivery, the provision of IPC services for women at or below 200% of the FPL who deliver a VLBW infant is important to the overall success of P4HB in lowering the state’s rate of VLBW births. The combined FP and IPC components of P4HB may also provide positive influences on birth weight

by expanding the use of effective birth control methods among women in this income range, thereby decreasing unintended pregnancies and lengthening interpregnancy intervals. In particular, the FP only component may play a major role in influencing the birth weight distribution since the majority of very low birth weight births are first births, and this component of the Demonstration provides increased access to family planning for nulliparous women who would not otherwise be Medicaid eligible.

Family planning services available through the P4HB program include all family planning services covered by the Georgia Medicaid program as noted below:

- Comprehensive annual exam;
- Pap smear including follow-up testing with colposcopy as indicated, clinical breast examination;
- Follow-up contraceptive visits (4 per year);
- Pregnancy testing;
- Provision of FDA-approved contraceptive methods and supplies, evaluation and management of contraceptive-related problems;
- Sterilization;
- Treatment of major complications of delivered services;
- Diagnostic treatment and follow-up of STIs;
- Drugs, supplies, devices related to women's health services (genital tract infections, UTI's, etc);
- Multivitamin with folic acid or folic acid;
- HepB and Td vaccinations for 19 and 20 year-olds;

- Education and counseling (with referral as needed) related to reproductive health, preventive and preconception care, pregnancy timing and spacing, risk reduction for sexually transmitted infections, tobacco and substance abuse, domestic violence, and benefits and risks of contraceptive methods; and
- Counseling and referrals to social services and primary health care providers.

While the expansion of eligibility for these family planning services under P4HB should increase low-income women's access to a full spectrum of family planning services by permitting women within a higher income range to have coverage and by allowing access through private health care providers as well as county health departments and community health centers, this expanded access depends in large part on enrollment of eligible women and in turn, encouraging their use of available services. These services are available to eligible women for twenty-four (24) months as long as the woman remains eligible for P4HB.

The IPC services under the P4HB program are also available (for twenty-four (24) months) to eligible women who deliver a live born, VLBW (< 1,500 grams or 3 pounds, 5 ounces) infant. The goals of this program component are to delay conception of the women's next pregnancy for 18 to 23 months from delivery of the index VLBW infant and to improve women's underlying health status by addressing their health and preconception needs and managing their chronic and other health conditions. Women qualifying for the IPC component of the Demonstration receive the following services in addition to family planning services:

- Primary care visits (5 outpatients visits annually);
- Chronic disease management;

- Prescription medications for treatment of chronic diseases;
- Substance abuse treatment;
- Limited dental services;
- Resource Mother/Nurse case management (through CMO staff); and
- Non-emergency transportation.

Resource Mother/Nurse case management (through CMO staff) outreach is available to Medicaid eligible women enrolled in the LIM and ABD classes of assistance who deliver a VLBW infant. All of their other service needs are met through their full Medicaid eligibility.

A unique aspect of the P4HB program is that participants must select a CMO, with its affiliated provider network, through which their family planning and IPC services are delivered. Once deemed eligible for the Demonstration, women have 30 days in which to choose a CMO. Women already enrolled in a Georgia Families CMO, who are losing Medicaid or CHIP coverage, may choose to stay with their current CMO or choose a new CMO if desired. Women enrolled in the IPC program have access to the CMOs' primary care and family planning providers as well as a nurse case manager and Resource Mother. Nurse case managers and Resource Mothers take part in coordinating care for the women in the IPC and the Resource Mother only components of the program and linking them with community-based resources and programs.

## Demonstration Objectives

The primary goal of the Demonstration is to reduce Georgia's LBW and VLBW rates. The following related objectives were identified to effect achievement of the goals of the Demonstration:

- Improve access to family planning services by extending eligibility for these services to the newly eligible women noted above during the three years of the Demonstration.
- Provide access to interpregnancy primary care health services for eligible women who deliver a VLBW infant during the three year term of the Demonstration.
- Decrease unintended and high-risk pregnancies among Medicaid eligible women.
- Decrease late teen pregnancies by reducing the number of first or repeat teen births among Medicaid eligible women ages 18-19 years.
- Decrease the number of Medicaid-paid deliveries from the number expected to occur in the absence of the Demonstration beginning in the second year.
- Increase child spacing intervals through effective contraceptive use to foster reduced LBW rates and improved health status of 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.
- Decrease Medicaid spending attributable to unintended births and LBW and VLBW babies.

These objectives point to several quantifiable performance measures that will be gauged pre- and post-implementation of the demonstration as discussed in the next section.

### **Demonstration Evaluation Objectives**

This Demonstration's evaluation uses a quasi-experimental design, where possible, to test for changes pre and post the Demonstration in the following performance measures:

- Total family planning visits per poor and near poor woman;
- Use of contraceptive services/supplies per poor and near poor woman;
- Use of interpregnancy care services (primary care and outreach) by women with a VLBW delivery;
- Average interpregnancy intervals for poor and near poor women;
- Average interpregnancy intervals for women with a VLBW delivery;
- Teen and repeat teen births for poor and near poor 18 and 19 year olds;
- Rate of LBW and VLBW deliveries among the Medicaid population with comparisons to the statewide rates for LBW and VLBW deliveries;
- Rate of LBW and VLBW deliveries<sup>6</sup> among poor and near poor women and among Medicaid enrolled women compared to other populations within the state;
- Rate of infant mortality among the Medicaid population with a comparison to the statewide rate for infant mortality;
- Rate of infant mortality<sup>7</sup> among poor and near poor women and among Medicaid enrolled women compared to other populations within the state.

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<sup>6</sup> While we include assessment of the rate of very low birth weight deliveries as a performance measure, we note that our power to detect differences will be limited due to the smaller number of IPC participants, the relatively short time period of the Demonstration over which these downstream outcomes can be observed, and potentially low participation rates.

The objectives of the evaluation are to test not only for changes in the performance measures pre and post P4HB but to assess whether there is evidence of a causal pathway through the expanded access P4HB provides. In order for P4HB to achieve significant changes in these measures, sufficient numbers of eligible women in the community must enroll such that there is an increase in the overall use of family planning services/supplies among low-income women or an increase in consistent use of more effective contraceptive methods than would otherwise occur. Increased use of contraceptives and, in particular, use of methods of higher effectiveness among the Demonstration's participants should lead to reduced rates of unintended pregnancies and in turn, unintended births among this population of women (as well as improved interpregnancy intervals). Since teens are at high risk of unintended pregnancies, another anticipated effect should be that the rate of unintended births and repeat teen births falls post the Demonstration.

A key hypothesis is that these changes will be sufficient to lower the number of overall Medicaid paid pregnancies and deliveries/births and hence, costs, such that the state and federal government will ultimately realize a net cost savings despite increased spending on family planning and interpregnancy care related services. Since Medicaid birth rates are highly variable and can be affected by external factors (such as unemployment, wage/income changes) estimates of 'averted births' used in budget neutrality tests in most states' demonstration programs are based in part, on births actually observed within the demonstration enrollee or participating (users) group of women. While the P4HB evaluation will include this measure, the real budget neutrality test for the P4HB program is whether there is an overall shift in the distribution of infants across birth weight categories. If the

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<sup>7</sup> While we include assessment of the rate of infant mortality as a performance measure, our power to detect differences in this outcome will be limited by its relatively low incidence and the issues noted above.



Demonstration causes changes such that there are relatively fewer low birth weight and very low birth weight infants born to Medicaid enrolled women in Georgia, total expenditures should be lowered for the state and federal government.

## **II. SUMMARY OF SECOND YEAR ACTIVITIES**

### **Communication and Outreach**

During the second program year of the Demonstration (PY2), DCH and each of the participating Care Management Organizations (CMOs) continued their efforts to increase awareness of the P4HB program as well as encourage participation by both consumers and providers. We summarize these communication and outreach efforts below.

### **DCH Supported Activities**

In PY2, DCH continued to follow its multi-pronged communication plan which incorporates five (5) specific phases for the marketing of P4HB throughout the state: 1) educate providers and CMOs; 2) leverage strengths and assets of partners; 3) implement consumer-based outreach; 4) use existing resources for support and coaching; and 5) annual evaluation. Two new activities related to provider education were added to Phase 1. Each of these phases is described in the table in Appendix A and discussed below. The DCH link for the P4HB program is: <http://dch.georgia.gov/planning-healthy-babies>.

- 1. Educate Providers and CMOs.** DCH continued to conduct provider education and outreach throughout the state. These related activities included distributing numerous educational and

training materials to the CMOs, the Georgia Family Planning Program's (Georgia Title X Grantee) staff, and numerous provider organizations throughout the state. In May 2012, DCH staff members made a presentation to the Medical Care Advisory Committee of DCH about P4HB. In June 2012, these same staff members presented an update regarding P4HB to the state's Title X Women's Health Coordinators during their meeting in Macon, Georgia. In addition, DCH added two new provider activities (Phase 1), including 1) adding the provider handbooks to the P4HB website and 2) updating the P4HB website to include additional program information.

In addition, DCH continued to work with the CMOs to refine and implement two additional provider surveys. These surveys, implemented in April and September 2012, helped to inform DCH and the CMOs about their network providers' knowledge and understanding of the P4HB program and potential barriers that existed in the first two years of the program. The results of the provider surveys are discussed in section IV of this report.

2. **Leverage Strengths and Assets of Partners.** DCH provided additional training and educational materials (blast fax, P4HB materials) to the following provider organizations: Georgia Primary Care Association; Georgia Association of Family Physicians (GAFP); Georgia Chapter of the American Academy of Pediatrics (GAAAP); and the Georgia Obstetrical and Gynecologic Society (GOGS). In May 2012, DCH staff members conducted site visits to view the CMOs' IPC case management tracking systems and discuss any concerns regarding the IPC component of the P4HB program. These visits were well received by the CMOs' staff members. DCH and Emory University also worked to develop and implement webinars for staff members of the NICUs in Georgia with the goal of encouraging them to inform eligible women about the IPC component and

facilitate their completion of program application materials. Each webinar described the P4HB program, the IPC services available through P4HB for women who deliver a VLBW infant, and the enrollment process with emphasis upon ways in which the NICU social workers and staff could facilitate eligible women's enrollment in the program. Three webinars were delivered during 2012.

3. **Consumer-Based Outreach.** DCH continued to conduct extensive client outreach during 2012. RSM staff made over 1,600 presentations about the P4HB program to interested individuals throughout the state. P4HB client outreach activities ranged from health fairs to radio public service announcements to church meetings and visits to children's hospitals and youth development centers. RSM staff made one-on-one presentations as well as presented at large-scale group information sessions. Attendance at most outreach activities was high, with several activities being attended by over 1,000 people. Examples include:

- RSM workers promoted P4HB in January 2012 at a Harlem Globetrotter Benefit Basketball game attended by over 1,000 people.
- In March 2012, RSM workers promoted P4HB to over 2,000 participants of the Belks KIDS FEST in Lowndes County.
- In April 2012, RSM workers promoted P4HB in Fulton County to 1,000 people at the Georgia Dome and at Atlanta Technical College.
- In May 2012, RSM workers promoted P4HB in Clayton County to 1,000 people at the Swing into Spring at Star Park event
- In July 2012, RSM workers promoted P4HB in Jeff Davis County to 1,300 people at the Back to School - Focus on the Family event.
- In August 2012, RSM workers promoted P4HB to 2,000 people at the Fannin County Rodeo.

- In October 2012, RSM workers promoted P4HB to over 10,000 people at the Paulding County Trick or Treat Village.
- In December 2012, RSM workers promoted P4HB in Jones County to 1,000 people at the Annual Christmas Parade celebration.

A detailed list of all DCH specific outreach activities has been included in the quarterly reports submitted during PY 2 to CMS. Examples of additional outreach activities that occurred during PY 2 include:

- **Maintained ongoing communication with family planning and OB/GYN providers:** DCH communicated with family planning and OB/GYN providers to inform them about P4HB.
- **Ongoing engagement of providers involved in High Risk Pregnancies:** The Georgia Families CMOs were continually encouraged to increase their outreach to their network providers who provided care for these high risk pregnant women.
- **Ongoing engagement of Georgia's Title X Family Planning Program:** Georgia's Title X Family Planning Program shared data on a quarterly basis with the P4HB evaluation team at Emory.
- **Ongoing collaborations with the Georgia Department of Public Health (DPH) and the Georgia Department of Human Services Division of Family and Children Services (DFCS):** These collaborations aimed to further outreach to teens and young women who were uninsured and either paying out of pocket for family planning services/supplies or going without needed services. Our partnerships helped us reach women in the local public

- health department clinics and the DFCS offices. Some of these efforts were reflected in the local meetings held by RSM workers across the state.
- **Develop and implement an interview/survey for the IPC enrollees:** DCH worked with Emory to develop interview questions for the IPC enrollees that focused on: reproductive health/birth spacing; birth control methods and barriers to getting them; nutrition; chronic conditions; protection from infections; management of stressors and social issues; substance abuse; and dental health. These questions were included in the 2013 surveys.
4. **Using Existing Resources for Support and Coaching.** The goal of this activity was to use current and available resources in Georgia to promote prenatal care, healthy lifestyles before and during pregnancy, and smoking cessation. DCH accomplished this goal by contacting Georgia's WIC program as well as POWERLINE, a telephone resource sponsored by Georgia's Healthy Mothers, Healthy Babies program, to inform them about the P4HB program. DCH also included these resources on the P4HB program's website and in other marketing materials.

### **CMO Supported Activities**

The CMOs individually developed their own client and provider education action plans related to P4HB. To date, the Georgia CMOs have posted information about the P4HB program on their respective websites (<https://www.myamerigroup.com/English/Medicaid/GA/Pages/P4HB.aspx>; <http://georgia.wellcare.com/member/p4hb>; [http://www.pshpgeorgia.com/2011/02/18/planning-for-healthy-babies-program-p4hb-effective-january-1-2011/langswitch\\_lang/es/](http://www.pshpgeorgia.com/2011/02/18/planning-for-healthy-babies-program-p4hb-effective-january-1-2011/langswitch_lang/es/)).

Major client-related outreach efforts included: new member welcome calls to all newly enrolled P4HB members; telephonic outreach to members with VLBW deliveries to educate them on the IPC program; mailing of program materials (including contraceptive benefit information) to all new and existing P4HB members; enhanced call scripting for call center staff to educate P4HB members on the importance of understanding their benefits and services; home visits to outreach members unable to be reached by phone; distribution of a postcard to new members that emphasized the importance of utilizing contraception and reporting such use on the member secure web portal; on hold messaging to include information about types of contraception covered in the plan; quarterly incentives to members to encourage them to report birth control methods; hiring new Resource Mothers to conduct expanded IPC outreach and enrollment; and baby showers held with community members to educate them about P4HB.

The CMOs' provider and community related outreach efforts included: telephonic outreach to providers to educate them on the P4HB program; local face to face outreach to community partners (DFCS, WIC, Health Departments, and Birthing centers); and collaboration with the March of Dimes for the Southeast region for outreach to NICU staff who would interface with the Medicaid eligible women delivering infants who were subsequently admitted to the NICU.

### **Major Changes in the Year**

In December 2011, DCH implemented a system to auto-enroll women who had delivered babies under the RSM eligibility criteria into the FP only component of P4HB. These RSM women were automatically eligible for the family planning only component of the Demonstration. This system also

began auto-enrolling 19 year olds as they ‘aged out’ of the PeachCare for Kids<sup>®</sup> program – Georgia’s stand-alone CHIP program. RSM and PeachCare for Kids<sup>®</sup> women received a letter informing them about P4HB, their option to opt out of the program and their option to select a new CMO. If a new CMO was not chosen, the women would remain in the current CMO to receive their P4HB services. In April 2012, DCH began auto-enrollment of IPC eligible women. Each of the three CMOs provided DCH quarterly data that reflected the women who had delivered a VLBW infant. Based on these monthly reports, DCH sent a letter to each IPC-eligible woman informing her that she would be auto-enrolled in P4HB unless she opted out.

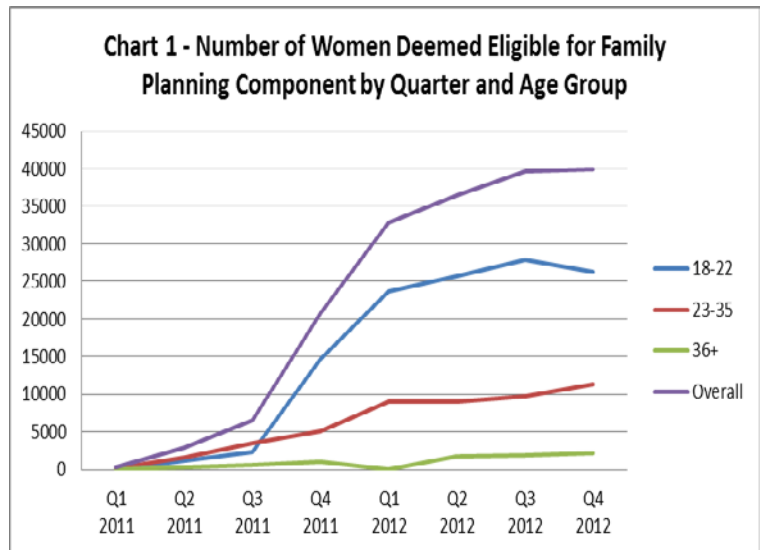
Based on our 2012 statistics, this auto-enrollment process expanded knowledge of the P4HB program and increased enrollments as women did not need to submit a new application for the P4HB program but instead their enrollment into the P4HB program was considered to be a Continued Medicaid Determination.

### **III. ENROLLMENT AND PARTICIPATION**

In our first year report, we provided a summary of the P4HB enrollment process and the barriers to enrollment that could occur as well as the auto-enrollment process. We note that the auto-enrollment of P4HB family planning only enrollees continued throughout the second year and hence, affected the numbers and patterns seen in the data presented here in the Year 2 Annual Report.

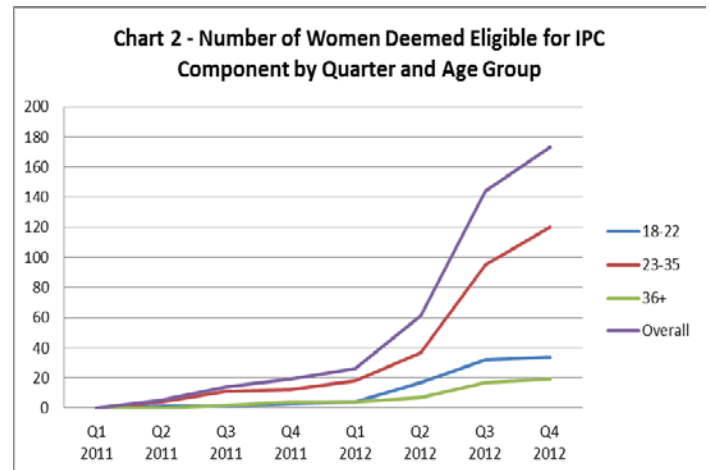
## Enrollment Trends

There was evidence of continued interest in the P4HB in the form of calls to the call center, enrollee applications and the number of women deemed eligible by RSM staff through the second year of the program. As shown in Chart 1, the number of women



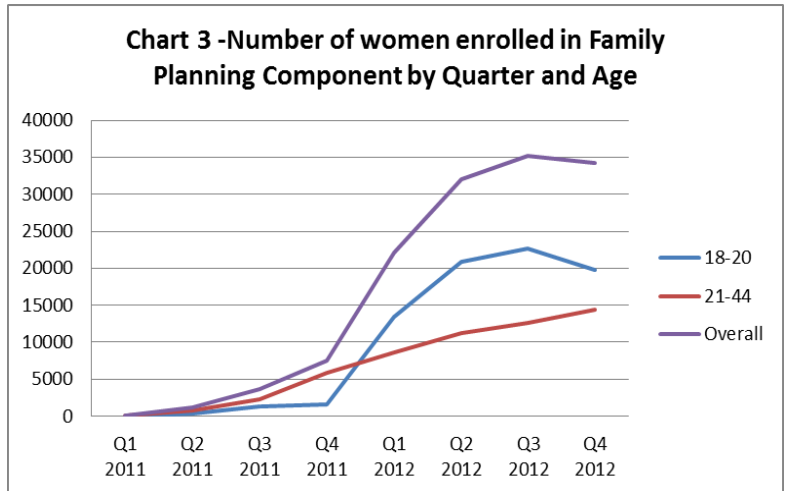
deemed eligible for the family planning only component of P4HB grew through the end of the 3<sup>rd</sup> quarter of 2012 and then leveled off at just below 40,000. Toward the end of PY2, there was a slight decline in women ages 18-22 deemed eligible; the number deemed eligible in this age range peaked at almost 28,000 in the 3<sup>rd</sup> quarter and declined to a little over 26,000 in the 4<sup>th</sup> quarter 2012. The only age group for which there was continued growth in numbers deemed eligible through the end of 2012 was the 23-35 year old group. This group grew from 9,023 in the 1<sup>st</sup> quarter 2012 to 11,316 in the last quarter.

The number of women deemed eligible for the IPC component of the Demonstration, as shown in Chart 2, grew markedly during the second year of P4HB and resulted in a total of 173 deemed eligible by the end of the second year. The great majority of these women were





in the 23-35 year old age group and their numbers grew from 18 in the first quarter of 2012 to 120 by the end of the 4<sup>th</sup> quarter 2012. There were a total of 34 women in the 18-22 year old age group and 19 in the oldest age group, deemed eligible for the IPC component of P4HB by the end of this second year.

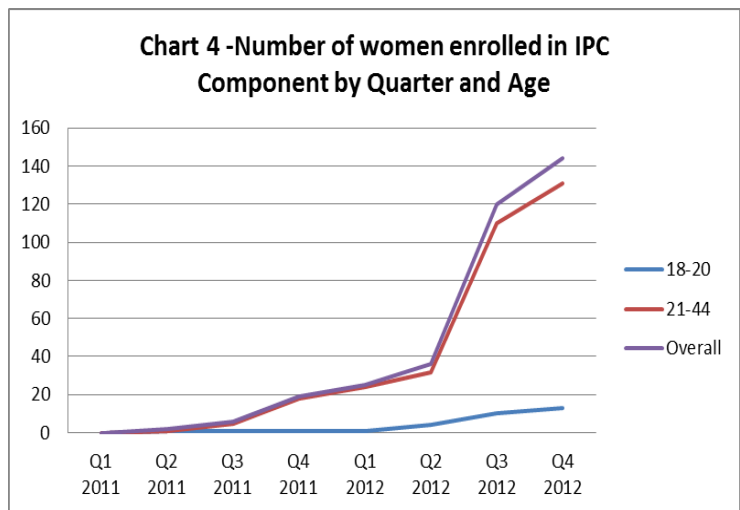


By the end of PY2, the number of women actually enrolled in one of the CMOs to receive family planning only services (34,184) was less than the 39,889 deemed eligible for this component as depicted in Chart 3 by age group. The data in this chart are shown for two age groups which reflect a change in reporting made toward the end of the Demonstration’s first program year. The original counts of women enrolled in the family planning and IPC components were generated from ad hoc and member services reports. Toward the end of CY 2011, DCH staff created new report specifications for the Medicaid Management Information System (MMIS) so that it would accurately reflect the Demonstration’s membership. The data contained in this new report was used for the fourth quarter 2011 Demonstration Report and all four quarterly reports for 2012.

As shown in Chart 3, the patterns of enrollment indicate an upturn in the fourth quarter of 2011 that continued for the 21-44 year old group through all of 2012. The steep increases in enrollment for those

in the 18-20 year old group continued through the 3<sup>rd</sup> quarter of 2012, peaking at 22,679. Unfortunately, those increases were not sustained and an enrollment decline was evident by the end of the 4<sup>th</sup> quarter 2012, with enrollment for this age group dropping to 19,831. The gap between the number of women deemed eligible and the number enrolled in the family planning component of P4HB seen in the first year was narrowed markedly. This trend will be monitored during the third year of the Demonstration to see if it continues. We also note that the overall increase in enrollment during the second year of P4HB was driven in part by the auto-enrollment policy. Using a list of study IDs for women auto-enrolled in the P4HB family planning only component at some point during 2011 or 2012, we found a total of 61% were auto-enrolled into the program during this time period. Given this high percentage, if these enrollees exhibit different behaviors regarding the use of family planning services or pregnancy during their time enrolled, the overall patterns among family planning only enrollees in P4HB will be affected. We therefore provide some separate statistics for these women at certain points in the remainder of this report.

Over 80% of the Demonstration participants deemed eligible for the IPC component were actually enrolled in a CMO by the end of 2012 (144 of 173 deemed eligible) as we see in Chart 4. All of the enrolled women were in the 21-44 age range and the overall growth



reflected the growth in enrolled women in this age group. Some of this growth was due to auto-

enrollment into the IPC component which was instituted as of April 1, 2012. This process involved the CMOs reporting on very low birth weight deliveries to DCH who then worked with its enrollment broker to enroll these women into the IPC component of P4HB. Letters were also sent to these women notifying them that they would be auto-enrolled once their pregnancy eligibility status ended.

The numbers enrolled in the Resource Mothers only component of the P4HB program totaled 77 by the end of PY2. Combined with the 144 women enrolled in the IPC component, there were 221 women who had delivered VLBW infants and were now receiving nurse case management and Resource Mother services, in addition to the primary care and other IPC services, by the end of PY2.

### **Participation Rates**

In order to fully assess the rate of enrollment that occurred in PY 2 for the P4HB program, we have to again consider the total number of women likely eligible for P4HB in the communities across Georgia. Since the program largely targeted women ages 18-44 not otherwise insured and under 200% FPL, we used data from the American Community Survey (ACS) for 2011 to estimate the number of uninsured women in this age and income range in PY 2. While some of these uninsured women were eligible for traditional Medicaid in Georgia (and apparently not taking up these benefits), they were only eligible for family planning only benefits under P4HB. This number excludes women who were non-citizens and hence, not eligible for the Demonstration. As shown below in Table 1, we estimated that the P4HB program enrolled less than 3% of the total number of women estimated to be eligible and in the community based on income, age and citizenship (256,979 from ACS) in 2011. The ACS data have been more readily available as the survey has grown in size and timeliness; using data from its three

year 2011 public use micro sample we estimate 279,308 uninsured women citizens in Georgia in the age and income group targeted by P4HB in 2012. Using this as the denominator, we estimate around 12% of the eligible population was enrolled in the family planning only component of P4HB in PY 2.

**Table 1 Enrollment of Population Eligible in the Community**

Demonstration Group	Enrolled in 4 <sup>th</sup> Quarter	Population Eligible in Community <sup>1,2</sup>	Percent Eligible Enrolled
FP Only 2011	7,543	256,979	2.9%
FP Only 2012 <sup>3</sup>	34,184	279,308	12.2%
FP Only 2012	34,184	152,223 <sup>4</sup>	22.5%
IPC/Resource Mother Only	221	1,522	14.5%

<sup>1</sup>Those eligible for family planning only benefits are uninsured female citizens ages 18-44 with income < 200% FPL and residing in Georgia. The estimated number of uninsured women in this age and income range was estimated at 256,979 for 2010 and 279,308 for 2011.

<sup>2</sup>Those eligible for IPC include uninsured women 18-44 with income < 200% FPL residing in Georgia with a live born infant under 1500 grams at delivery. Women enrolled in RSM with a VLBW infant should be the denominator for this calculation. 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 (n = 1,522 in Table 3 shown later) as the denominator.

We use the 34,184 number enrolled as of the 4<sup>th</sup> quarter for consistency with the earlier parts of the report.

<sup>4</sup> 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 were actually in need of family planning services. We multiplied the “in the community” population by .545 to get the 152,223 in row 3, column 3. See: <http://www.guttmacher.org/pubs/win/contraceptive-needs-2008.pdf>.

While this family planning only participation rate is not as high as desired, it does show significant improvement in terms of outreach and enrollment of eligible women as the percentage of eligible women enrolled quadrupled from around 3% to over 12% in this second year. When we consider that only an estimated 54.5% of the eligible population may be ‘in need’ of family planning services (sexually active, able to get pregnant, not currently pregnant or trying to get pregnant) the estimated percentage enrolled jumps to 22.5%. A caveat is that a larger percentage of these enrollees were auto-

enrolled, as noted earlier. We also note that a large number of women in need of family planning continue to be served by the Title X program in Georgia and we report on changes seen in this program pre and post implementation of the P4HB program in terms of Medicaid coverage, rates of use of contraceptives and types of contraceptives used. We also estimate unduplicated counts of family planning visits in both Title X and Medicaid in order to assess whether the P4HB program increased the use rates across the two programs as shown later.

The P4HB program also enrolled a much larger percentage of women with a VLBW infant into the IPC and Resource Mother only components of the program. Of the total 1,522 births estimated to be in the VLBW category (see Table 1) in Year 2, a total of 221 were enrolled in one of these two components. This means almost 15% of these women were enrolled, up from only 1.6% in Year 1. While this is a major improvement, there is still the need for intensive education and outreach to health care providers who care for or interface with women with a very low birth weight delivery (e.g., obstetrical care providers and nurses, neonatal care providers and nurses) as well as significant efforts to keep the application process user-friendly and accessible in the community.

#### **IV. PROVIDER SURVEYS ROUNDS 1-3**

As part of the P4HB program the CMOs, in collaboration with the DCH, monitored member and provider overall knowledge and understanding of P4HB approximately bi-annually through an analysis of member and provider surveys. Analyses of these surveys served to help the CMOs and DCH better understand and improve member and provider experiences with the P4HB program, as it is important

to both the CMOs and DCH to identify any area that could negatively impact the satisfaction of their members and providers who participate in the program. We briefly describe the survey methods used by the CMOs below and include in Appendix B the full set of responses to the provider and member surveys in each round. As of the end of 2012, the member and provider surveys had been administered in three waves -- in December 2011, April 2012, and September 2012. The CMOs administered the first two waves of surveys to their members and providers then contracted with The Myers Group to administer the third and subsequent waves of the surveys.

We note that the surveys continue to be affected by low response rates among both members and providers and that due to the lack of information regarding the rosters used by the CMOs and The Myers Group, we were not able to discern how many of the same members or providers were responding to the survey across all 3 waves. To the extent the same enrollees respond with each wave, the answers may be biased toward longer term enrollees. We also note that the second through third waves of the member surveys are affected by the large percentage of auto-enrolled members during the 2012 time period. We summarize here the key findings from these surveys for providers; we note that results for members were reported in the 2013 third Quarterly Report to CMS.

### **Summary of Provider Survey Results Rounds 1-3**

For each of the three waves of the survey administration, a total of 1140, 1140, and 1292 providers met the selection criteria for the survey; of those eligible, a total of 62, 104, and 31 participated in the survey for each of the three waves, respectively, for a participation rate of 5.4%, 9.1%, and 2.4% . The

respondents to the health care provider survey represented the range of CMO affiliations (with providers being affiliated in most cases with multiple CMOs): 79%, 80%, and 94% respectively, were affiliated with Amerigroup for each of the three waves of the survey; 81%, 82%, and 74% respectively with Peach State; 95%, 95%, and 94% respectively with WellCare; and 84%, 83%, and 71% with fee-for-service Medicaid. Among the responding providers, the provider type varied across the surveys. The percentage of responding providers who were MD/DOs were 52%, 59%, and 90% respectively, for each of the three waves of the survey. For the first and second wave of the survey, respondents reported the following areas of specialization (with the option of selecting one or more specialty areas of practice): 22% and 25% obstetrics/gynecology, 14% and 13% women's health, 16% and 17% family practice or primary care, 13% and 15% family planning, 11% and 8% pediatrics, 6% and 4% general practice, 5% and 4% internal medicine, 11% and 10% other. For survey waves 1 and 2, the majority of respondents reported they provided health care services in private practice (58% and 63%, respectively), but substantial percentages reported providing services in community health clinics or federally-qualified health centers (17% and 15%), public health departments (17% and 16%), or other settings (8% and 7%). The third wave of the survey did not ask providers about their provider type or site of practice.

For each of the three waves of the survey, 81%, 83%, and 90% of the responding providers, respectively, indicated they were accepting new Medicaid patients; and 71%, 78%, and 84% indicated they were providing family planning or primary care services to women of reproductive age (ages 18-44 years); however, only 61%, 64%, and 61% respectively, reported being aware of the Georgia

P4HB program despite the CMOs sending the survey to those they believed to be participating providers.

Only the first and second waves of the survey asked providers about how they learned about the program. Of the 38 and 67 provider respondents, respectively, who were aware of the P4HB program, they reported learning of the program in the following ways: 42% and 45% mailings from the CMOs, 42% and 39% e-mails from the CMOs, 26% and 21% meetings hosted by DCH, 24% and 24% from information initiated by DCH, 13% and 12% telephone calls with CMOs, 11% and 19% websites of the CMOs, and 8% and 7% patients asking about the program.

Key findings of the provider survey are summarized below, according to major themes explored by the survey:

Provider knowledge of eligibility criteria:

- For all three waves of the survey, fewer than half of all providers had correct knowledge about all of the eligibility criteria;
- From the first through the third waves of the survey, there were improvements in the percentages of providers correctly identifying the eligibility criteria of age between 18-44 years (from 40% to 45%), being a Georgia resident (from 42% to 48%), being a U.S. citizen (from 39% to 42%), not otherwise eligible for Medicaid or CHIP-PeachCare for Kids<sup>®</sup> (from 31% to 32%), and not otherwise covered for family planning services (from 26% to 32%).



- Less than one-third of responding providers knew that the delivery of a VLBW infant since January 1, 2011, is an eligibility criterion for the IPC component with some improvement across the three waves of the survey (24%, 21%, and 26% respectively).

Provider knowledge of covered services:

- From the first through the third surveys, there were improvements in the percentages of providers with knowledge of all of the covered family planning services;
- Provider knowledge of covered interpregnancy care services was more variable across the three waves of the survey:
  - 19%, 16%, and 23%, , respectively, for primary care services;
  - 9%, 11%, and 6%, respectively, for management and follow-up of chronic conditions;
  - 8%, 9%, and 10%, respectively, for prescription medications for chronic conditions;
  - 5%, 5%, and 3%, respectively, for detoxification and outpatient rehabilitation;
  - 6%, 7%, and 6%, respectively, for limited dental services;
  - 16%, 14%, and 19%, respectively, for nurse case management and resource mother outreach;
  - 8%, 6%, and 16%, respectively, for non-emergency transportation.

Provider perception of barriers:

- From the first through the third surveys, the percentage of providers reporting perceived barriers to client participation in the P4HB program increased:
  - 26%, 26%, and 35%, respectively, perceived lack of coverage of the full range of family planning services as a barrier;
  - 27%, 27%, and 39%, respectively, perceived lack of coverage of referrals or follow-up care;

- 26%, 26%, and 26%, respectively, perceived lack of coverage of complications of family planning services.

Provider information needs and preferences:

- Across the three waves of the survey, one-third to nearly two-thirds of providers reported a need for more information about enrollment eligibility criteria and covered services for the Family Planning and the Interpregnancy Care components;
- The most favored routes of receipt of information according to the first two waves of the survey (the questions were not included in the third wave of the survey) were websites of the CMO's (100% and 9%, respectively), e-mails to the practice (34%, and 37%, respectively), and direct mailings (32% and 28%, respectively).

## **V. DATA ON DELIVERIES AND INFANTS**

In this section we report on the total counts of deliveries and infants by birth weight category as derived from the administrative claims/encounter data provided by DCH to Emory through its data sharing agreement. We begin with the data for CY2012 to reflect the second year of the P4HB. As in our Year 1 Annual Report, we provide details of the methods in the footnotes of the following tables on the specific billing codes found within the Medicaid claims data that were used to define deliveries (unduplicated using the mother's ID), to categorize them by live born, stillborn ( $\geq 22$  weeks' gestation) or fetal deaths ( $<22$  weeks' gestation) and to further categorize live born infants (unduplicated using the infant's ID) according to the birth weight categories as found on the infants' records. We have changed, as noted in our Executive Summary, the codes used in this process. Specifically, we use

ICD-9 diagnosis codes predominantly through this process instead of DRGs as this coding was incomplete in the CMO encounters starting in 2011.

Again, we are not able to capture information on the birth weight of all infants from the administrative records and hence, can only categorize the birth weight of those deliveries for which we had a linkage between the mother and infant (provided by Truven Health Analytics). As the P4HB program and its evaluation has moved forward, these administrative records have been linked to data from the Department of Public Health's (DPH) vital records unit for 2009-2011 and used to confirm birth weight and gestational age and will be used to obtain additional information on the mother (socio-demographics, evidence of chronic health conditions and complications of the pregnancy, smoking, etc.). We report on trends in births and birth weight for the 2009-2011 time periods in later tables in this report.

### **Counts of Deliveries and Costs 2012**

The data in Table 2 below show that there were a total of 78,190 Medicaid paid deliveries occurring in calendar year 2012 based on the claims data; we note that this count omits an additional 3,176 deliveries for which there was an indicator of private third party liability (including Medicare) at time of delivery or the amount Medicaid paid was zero. Based on the count of deliveries paid fully by Medicaid, 69,643 of the total 78,190 could be categorized as live born deliveries while 7,505 or 9.6 % of the total were coded as fetal deaths of < 22 weeks gestation and 1,042 were coded as stillborn

deliveries. The 69,643 live born deliveries paid fully by Medicaid were estimated to cost the Georgia Medicaid program almost \$360 million with an average of \$5,175 per delivery.

**Table 2 Medicaid Deliveries for Calendar Year 2012 (CY2012)**

MEASURE	Counts	Total \$ Paid Mother	Average \$ Paid Mother
<b>All Medicaid Deliveries<sup>1</sup></b>			
Total Deliveries <sup>2</sup>	78,190	371,589,078	4,752
Live born deliveries	69,643	360,421,486	5,175
Stillborn deliveries (>= 22 weeks) <sup>1</sup>	1,042	4,091,650	3,927
Fetal deaths < 22 weeks <sup>1</sup>	7,505	7,075,942	943
<b>Deliveries<sup>1</sup> to Demonstration</b>			
<b>Entire Demonstration population</b>			
Total Deliveries	664	3,176,506	4,784
Live born deliveries	562	3,054,336	5,435
Stillborn deliveries (>= 22 weeks) <sup>1</sup>	12	34,603	2,884
Fetal deaths < 22 weeks <sup>1</sup>	90	87,567	973
<b>FP only<sup>3</sup></b>			
Live born deliveries	561	3,047,727	5,433
Stillborn deliveries (>= 22 weeks) <sup>1</sup>	11	32,874	2,989
Fetal deaths < 22 weeks <sup>1</sup>	90	97,567	973
<b>IPC<sup>4</sup></b>			
Live born deliveries	1	6,609	6,609
Stillborn deliveries (>= 22 weeks) <sup>1</sup>	1	1,729	1,729
Fetal deaths < 22 weeks <sup>1</sup>	0	0	0
<b>Resource Mother only<sup>5</sup></b>			
Live born deliveries	0	0	0
Stillborn deliveries (>= 22 weeks) <sup>1</sup>	0	0	0
Fetal deaths < 22 weeks <sup>1</sup>	0	0	0

<sup>1</sup> 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
- **Deliveries of Stillbirths** were identified by using ICD-9 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)].
- **Deliveries associated with Fetal deaths < 22 weeks** were identified by using ICD-9 codes 632 (missed abortion) and 634.xx (spontaneous abortion).
- In the case of a twin or multiple gestations, 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.

<sup>2</sup> This count of total deliveries omits those with \$0 Medicaid dollars, private third party liability or Medicare coverage (n = 3,176). If these records were included the number of deliveries would be 81,366 with 72,340 live born deliveries, 1,105 stillbirths and 7,921 fetal deaths.

<sup>3</sup> Family planning only participants were identified using Aid Eligibility Code = 181; all deliveries that occurred to these women were after their first three months of continuous enrollment in the P4HB. Women who came into the program pregnant should not be counted and our methods for omitting them are described in the text.

<sup>4</sup> IPC participants were identified using Aid Eligibility Code = 180. Only the deliveries and births to IPC women **subsequent** to their 3<sup>rd</sup> month of enrollment are reported in these tables.

<sup>5</sup> Participants in the Demonstration with Resource Mother only benefits are LIM and ABD classes of eligibility with a delivery and VLBW birth weight infant in the year. They were identified using Aid Eligibility Codes 182 (LIM) and 183 (ABD). Only the deliveries and births to women with LIM and ABD classes of eligibility **subsequent** to their 3<sup>rd</sup> month of enrollment are reported.

Because the great majority of infants receive their own Medicaid ID at birth, the Medicaid amounts paid shown in Table 2 are largely representative of those expenses incurred for care of the mother at the time of the delivery hospitalization. In addition to the costs for the deliveries with live born infants, Georgia Medicaid incurred costs totaling just over \$11 million for deliveries ending in fetal death or stillborn infants in CY2012. Since overall trends in fertility affect the changes from Year 1 to Year 2, we report later on the trends in counts of births and average amounts paid by Medicaid over the full 2009-2012 time period for which we have data.

In the bottom portion of Table 2, we show the counts and costs of any deliveries observed for women enrolled in the FP, IPC or Resource Mother only components of P4HB. Our first step in defining P4HB enrollees in this table was to identify the subset of women with a P4HB eligibility code who had three months of continuous enrollment in a CMO. The program staff assumed the member would have their family planning appointment within the first month of CMO enrollment and if the woman started on some form of contraception at the beginning of the second month, two months are allowed for the method to become effective before any subsequent pregnancy is considered a failure – hence the required 90 days of continuous CMO enrollment. We also omitted women with an indication of a pregnancy using ICD and/or RSM eligibility codes in these first 3 months of CMO enrollment and those with a delivery  $\leq$  245 days after enrollment in a CMO since they most likely came into the CMO in a pregnant status. The number of pregnancies (1,035) and birth outcomes (215) found in this process can be seen as a failure of women to understand the program and/or failure of the delivery system to get the women in for pregnancy testing/services in a timely fashion.

After making these omissions we have P4HB enrollees who we believe were not pregnant when they came in and for whom the CMO had 3 months to reach/serve. We then count pregnancies [ICD/RSM codes] in the 91st day forward and any delivery outcome [fetal death/live birth/stillbirth] after the 245<sup>th</sup> day among these women as a ‘failure’ of the program. The counts of outcomes for P4HB enrollees shown here and in later tables are to women enrolled starting in January 2011 and running through October 2012; we stopped in October 2012 in order to allow for measurement of the 3 months of continuous enrollment.

We note that any system of classification of pregnancies as occurring before or after P4HB enrollment that is based upon claims data could result in misclassification of the timing of occurrence of these pregnancies. We have attempted to minimize the potential for this misclassification by applying the above rules. Importantly, once the claims/enrollment data are linked to vital records we will have a measure of gestational age of the birth and fetal death events such that we can more accurately define whether the pregnancies were conceived before or after P4HB enrollment. By counting deliveries/births which occur for these women only after the 245 day cut-off, we allow for births with a short gestation (~5 months) after the first 90 days of enrollment but will also include births with a longer gestation that may have begun in the first 3 months of enrollment but for which there were no pregnancy or RSM codes seen in the data we used to make omissions.

Using these methods, there were an estimated 561 live born deliveries in 2012 to women in the FP only component of the P4HB with total costs of over \$3.0 million. There were an additional 90 fetal deaths and 11 stillbirths among the women enrolled in this component of P4HB with Medicaid costs of about \$130,000. These outcomes in the second year of the Demonstration could be seen as ‘failures’

to prevent pregnancies and births among women enrolled since they are eligible for a wide range of family planning services and have been enrolled in a CMO continuously for 3 months. These women either decided to become pregnant or if wishing to avoid pregnancy, did not access and use birth control methods effectively. However, we cannot discern from claims data whether or not pregnancies are intended. We discuss later in this report how the birth rate observed here compares to that 'expected' for women in the income range targeted by the P4HB program and to those observed in other states' family planning programs.

Also shown in the bottom section of Table 2 are births to the IPC and Resource Mother only enrollees. We identified that IPC enrollees only had one live birth and one stillbirth during 2012 after three months of enrollment in the program. It is important to note that the live birth was of normal birth weight but the delivery costs were higher than average at \$6,609.

We note corrections to the counts reported in our Year 1 report are now possible with the additional claims run-out but will also be affected by the correction on data regarding the month of P4HB enrollment and updated eligibility files. We originally reported no live born deliveries or stillbirths observed for the P4HB participants and a total of 6 fetal death deliveries (< 22 weeks' gestation) among women enrolled in the FP only component of P4HB in CY2011. With the new version of extracted claims/enrollment data we found no fetal deaths or live births among family planning enrollees in the program for three or more months.

## Counts of Infants and Costs 2012

In Table 3 below, we show the counts of infants identified with their own Medicaid IDs and categorized as a live birth or stillbirth. Note that the number of live born infants (78,824) is far greater than the number of live born deliveries shown in Table 2 (69,643). This may be due to multiple gestations but also an apparent undercount of total deliveries in the 2012 claims data available at this time. These numbers will be updated in future reports as more claims data are made available.

Given our new methods of classifying infant birth weight (see footnotes to Table 3), all live born infants have been classified. Previously, we had not categorized those with a missing DRG code.

Of the 78,824 live births, a total of 1,522 or 1.9% were categorized as VLBW and 6,060 (1,522 plus 4,538) or 7.7% were categorized as LBW. We have noted that claims data tends to underestimate the percentage of LBW but overestimate the percentage of VLBW within this group. We will not get a reliable measure of the distribution of birth weight until more years of data are linked to vital records. We report later on the birth weight distributions for 2009-2011 where the data have been linked.

The data in Table 3 indicate that the costs of all live births were approximately \$306 million and averaged to \$3,889 per infant (Column 5). These costs are for the delivery hospitalization of the infant. We do see the anticipated pattern of higher costs for those infants born LBW or VLBW relative to those born normal weight. Average costs for infants of normal weight were estimated to be \$1,750 (Column 5) while for those infants born LBW, costs were estimated at \$11,651. Very low birth weight infants born during 2012 had an average delivery hospital cost of \$82,949. The difference in costs for



VLBW or LBW versus normal birth weight infants illustrates the cost savings that could occur by lowering the percentage of infants born VLBW.

In Table 3, we also include data for the delivery costs of the mothers by the birth weight category of their infant for those mothers who could be linked to an infant (Truven Health Analytics). These data indicate that the delivery costs for the mother also follow the pattern of higher costs for LBW and VLBW infants at the delivery hospitalization; the mother’s costs at a delivery of a normal birth weight baby were estimated at \$5,214 while the mother’s costs at delivery of a VLBW delivery were estimated at \$6,558.

**Table 3 Infant Counts and Costs for Mother and Infant at the Delivery Hospitalization Calendar Year 2012 (CY2012)**

MEASURE	Counts	Average \$ Paid Mother <sup>3</sup>	Total \$ Paid Infant Delivery Hospitalization	Average \$ Paid Infant Delivery Hospitalization
All Medicaid Live births <sup>1</sup>	78,824	\$5,282	\$306,520,261	\$3,889
VLBW	1,522	\$6,558	\$126,247,882	\$82,949
LBW	4,538	\$6,024	\$52,870,464	\$11,651
Normal BW	72,714	\$5,214	\$127,261,005	\$1,750
All Medicaid Stillbirths <sup>2</sup>	50	\$5,467	\$140,910	\$2,818

<sup>1</sup>Liveborn infants were identified and further categorized according to infant birth weight as very low birth weight (VLBW) < 1500 grams, low birth weight (LBW) 1500 – 2499 grams, and normal birth weight ≥ 2500 grams). Birth weight categories for live born infants were then defined using ICD-9 codes in the encounter data as follows:

- VLBW (< 1500 grams): ICD-9 = 764.xx or 765.xx or V21.3 that pertain to weight < 1500 grams
  - LBW (1500 – 2499 grams): ICD-9 = 764.xx or 765.xx or V21.3 that pertain to weight 1500 = 2499 grams
- NBW (≥ 2500 grams): ICD-9 = 764.xx or 765.xx or V21.3 that pertain to weight ≥ 2500 grams or not otherwise classified as VLBW, LBW or stillborn.

<sup>2</sup> Stillborn infants were identified using ICD-9 diagnosis codes V35.xx, 768.0, 768.1, or 779.9.

<sup>3</sup> Amounts paid for mothers at the time of delivery were summarized for all deliveries in Table 2 and are summarized here by birth weight of the infant for the subset of mothers (n =57,317 ) who could be linked to an infant based on the SSN of the head of the household.

In Table 4, we provide the estimated costs to the Georgia Medicaid program of infants in their first year of life in the program. These costs are counted beginning with the claims and encounters for the first service date occurring after their delivery hospitalization discharge date in order to isolate the

delivery versus first year of life costs. We can only analyze those 36,776 infants born in the first six months of 2012 due to the lag in claims data. The estimate is extrapolated based on the averages by birth weight category, applied to the infants born in the second half of the year based on their birth weight category and added to the actual total for those born in the first six months. As the costs are based on claims paid through June of 2013, estimates may not be complete even for these infants.

The total amount paid for infants regardless of their birth weight was estimated at \$185.5 million. There was very little change in the average per infant costs when we adjusted for their disenrollment from Medicaid (due to death or other causes). When total costs are estimated based only on the 35,412 of the 36,776 infants born in the first six months who were still alive and continuously enrolled through December 31, 2012, it is \$182 million. There is the expected pattern of higher first year of life costs for infants of lower birth weight; costs for normal birth weight infants was estimated at \$2,199 while costs for LBW infants was estimated at \$3,710 and for VLBW infants, at \$5,759. These cost patterns by birth weight hold for those not disenrolled due to death/other reasons as shown in the last column.

**Table 4 Infant Costs for Medicaid Live Births During First Year of Life (Post-Delivery Hospitalization)**

MEASURE	Infants <sup>1</sup> Born on Medicaid in First 6 Months of CY2012	1 <sup>st</sup> Year of Life Post-Delivery Hospitalization			
		Average \$ Paid per Infants <sup>2</sup> Born in First 6 Months of CY2012 <sup>6</sup>	Total \$ Paid <sup>3</sup> Extrapolated to All Infants <sup>4</sup> from those Born in First 6 Months	Total \$ Paid Extrapolated to Continuously Enrolled Infants <sup>5</sup>	Average \$ Paid per Continuously Enrolled Infants <sup>5</sup>
Medicaid Live births <sup>1</sup> in First 6 Months of 2012	36,776	\$2,355	\$185,511,836	\$182,344,224	\$2,369
VLBW	504	\$5,759	\$8,764,543	\$8,764,322	\$6,492
LBW	1,995	\$3,710	\$16,834,664	\$15,960,050	\$3,626
Normal BW	34,277	\$2,199	\$159,912,629	\$157,619,852	\$2,213

<sup>1</sup> The 36,776 live born infants born in the first six months of CY2012 were categorized as very low birth weight (VLBW) < 1500 grams, low birth weight (LBW) 1500 – 2499 grams, and normal birth weight >= 2500 grams as noted in Table 14.

<sup>2</sup> Costs for all infants born in the first six months of CY2012 are included regardless of their disenrollment or death.

<sup>3</sup> Dollars paid for services for infants in their first year of life were counted beginning with the first service date occurring after their delivery hospitalization discharge date. Paid claims for infants born in CY2012 were complete through June of 2013; expenses paid after this date will not be counted in their first year costs.

<sup>4</sup> Costs for the full first year of the infant's life were only available for those infants born in the first six months of 2012 (and based on claims paid only through June 2013). We used the average costs for this cohort of infants born in the first part of 2012 (n = 36,776) to extrapolate to an annual estimate for CY 2012.

<sup>5</sup> Costs for all infants born in the first six months of CY2012 are included only for those 35,412 alive and continuously enrolled (data on enrollment were only available through December 31, 2012). We used the average costs for this cohort of infants (n = 35,412) to extrapolate to an annual estimate for CY 2012 as shown in the last column.

<sup>6</sup> Omits those with 0 Medicaid dollars, private third party liability or Medicare coverage

## VI. SERVICE USE

### IPC Service Use

A key goal of the IPC component of the demonstration is to help these mothers maintain or improve their health by providing access to the expanded set of services noted earlier. The administrative data can be used to ascertain the types of conditions for which these women are seeking and receiving care under the P4HB program. Among the IPC component's participants, the claims data indicate that 157 of the 235 women enrolled (67%) utilized services. The number of encounters for services by IPC component participants ranged from 1 to 70 with a mean of 6.8 encounters. Additionally, the claims

data indicate that 61 of the 86 women enrolled (71%) in the Resource Mother only component of P4HB utilized services, with the number of encounters ranging from 1 to 62 with a mean of 13.1 encounters. The ICD-9 diagnosis codes that appear in the claims data for these members are summarized below, separately for the IPC and Resource Mother only participants.

According to ICD-9 diagnostic codes within the Medicaid claims data, the use of services by women enrolled in the IPC component reflected the receipt of care for preventive services, acute gynecologic conditions or other gynecologic testing, dental conditions, other acute conditions, contraceptive services, and chronic health conditions. Examples of preventive health care services received were routine well-woman and gynecologic examinations (10), routine medical check-ups and other screenings (3), and vaccinations (3). Among the most common services utilized were those for acute gynecologic conditions or gynecologic testing (65), including for pelvic inflammatory disease (1), cervicitis (1), vaginitis (12), abnormal Pap smear and cervical dysplasia (15), as well as screening for sexually transmitted infections (3). Dental services that were utilized included care for gingivitis or periodontitis (3) or other tooth infections (2). Services for care of acute conditions (132) were the most commonly utilized services. Examples of common acute conditions for which care was sought included respiratory tract infections and disorders (23), dysuria or urinary tract infection (18), abdominal pain (8), headache (6), and fatigue (5). Contraceptive management services were received by 8 of the enrolled women.

Table 5 below summarizes the specific ICD-9 codes reflecting chronic health conditions that were present in the Medicaid claims data for IPC and Resource Mother only participants.

**Table 5 ICD-9 Diagnostic Codes for Chronic Conditions for IPC and Resource Mother Only Participants**

Component of Program	Chronic Health Condition Evidence from Claims Data
Interpregnancy Care (55 of 235 members with evidence of chronic condition)	Hypertension (22) Thyroid disorder (7) Depression/Anxiety (22) Obesity/Overweight (15) Gastroesophageal reflux disease (6) Long-term medication monitoring (5) Migraine headache (5) Diabetes mellitus (4) Atopic dermatitis (1)
Resource Mother Only (18 of 86 members with evidence of chronic condition)	Diabetes mellitus (2) Hypertension (8) Diabetic eye disease (2) Depression (8) Valvular heart disease (2) Embolism with long-term anticoagulation therapy (1) Hyperlipidemia (1) Arterial disease (1) Gastroparesis (1)

**Trends in Births, Averted Births and Budget Neutrality**

We have focused in the earlier sections of the report on deliveries and births in 2012. It is important, as we move forward to further analysis, that we look over the full pre and post period of P4HB for which we now have claims data. It is also helpful to compare the information gained from the claims data regarding birth outcomes to that which we will eventually have from the linked Medicaid and vital records data. To this end, we provide a brief summary of the changes we are seeing in the numbers of deliveries and live born infants in the study years. As shown below (Table 6), the number of Medicaid paid births was declining prior to the Demonstration, declining from 85,370 in 2009 to 81,463 in the two years prior (2009-2010) and to a low of 75,087 in the first year (2011) of the P4HB program. Birth counts increased again in 2012 to 78,824.

**Table 6 Number of Medicaid Paid Births by Year (2009-2012)**

Weight Category	2009		2010		2011		2012	
	N	Percent	N	Percent	N	Percent	N	Percent
<b>VLBW</b>	1,718	2.0	1,650	2.0	1,506	2.0	1,522	1.9
<b>LBW</b>	4,679	5.5	4,547	5.6	4,210	5.6	4,538	5.8
<b>Normal BW</b>	78,890	92.4	75,187	92.3	69,331	92.3	72,714	92.3
<b>Stillbirth</b>	83	0.1	79	0.1	40	0.1	50	0.1
<b>Total</b>	85,370		81,463		75,087		78,824	

While these trends are consistent with the overall trends in the vital records data, the drop in 2011 is larger than seen in overall patterns and indicates perhaps an undercount of infants in the claims. In addition, the ratio of infants to deliveries was 1.05 and 1.06 in 2009 and 2010, respectively, but drops to 1.01 in 2011, a further indication of undercounts of infants. This ratio climbs to 1.10 in 2012, an indication of an under count of deliveries in 2012 as noted throughout the report. These issues will be kept in mind as the evaluation proceeds.

Based on the claims data, the average paid amount for the infants at delivery increased only slightly from \$3,274 in 2009 to \$3,889 in 2012. Important to the evaluation of P4HB, we found that the percentage of these infant records linking to the vital records is similar in 2009 and 2010 at about 89% but decreased to 82% in 2011. This is likely due to the lack of fetal death records at this time and this will be updated once those files are available. As shown in Table 7 below, we found that the birth weight distribution using claims only is very close to that using the linked vital records for the percentage of very low birth weight at about 2% but differs from the vital records on the percentage low birth weight and hence, on the percentage of normal birth weight.

**Table 7 Birth Weight Distribution (2009-2011)**

	2009		2010		2011	
	Birth Certificate Weight Category	Claims Weight Category %	Birth Certificate Weight Category	Claims Weight Category %	Birth Certificate Weight Category	Claims Weight Category %
<b>VLBW</b>	2.0%	2.1%	2.0%	2.0%	1.9%	2.1%
<b>LBW</b>	8.3%	5.4%	8.5%	5.5%	8.2%	5.5%
<b>NORMAL BW</b>	89.7%	92.5%	89.5%	92.5%	89.9%	92.4%

While both sources reflect a very stable percentage of Medicaid eligible VLBW infants, we will treat the vital records as the ‘gold standard’ when measuring birth weight and work primarily with linked records when completing the final evaluation of P4HB.

***Averted Births.*** As opposed to earlier Section 1115 Family Planning waivers in other states, the P4HB program in Georgia has a budget neutrality requirement that is based on a ‘shifting’ of the birth weight distribution such that the total costs to the Medicaid program supported by the federal matching rate is lowered from what it would otherwise be by lowering the percentage of all Medicaid births that are LBW and VLBW. This shifting of the distribution should occur from the increased use of family planning services by those brought into the family planning component of the Demonstration as well as from the management of contraceptive use and health conditions that affect reproductive outcomes among those women in the IPC and Resource Mother only components of the Demonstration which should help lengthen their interpregnancy intervals. Additionally, the treatment of acute and management of chronic conditions of women enrolled in the IPC component should lead to better health of the women, and in turn better birth outcomes, if they become pregnant.

While the count of ‘averted’ births is therefore not central to the calculation of budget neutrality on a quarterly or annual basis under P4HB, we present in Table 8 below an estimate of the number of births that would have been expected among participants in the family planning only component of the Demonstration. Based on the DCH Planning for Healthy Babies Concept Paper submitted to CMS in the application process, the fertility rate among women 18-44, < 200% FPL and uninsured in the second year of the Demonstration was estimated at 169 per 1,000. If this expected fertility rate is applied to all women enrolled in the family planning and other program components by the end of PYs 1 and 2 (as reported from Georgia’s MMIS data shown above), expected births would be 5,814 in Year 2.

**Table 8 An Estimate of Averted Births Among P4HB Demonstration Population**

Number of ‘Expected’ Births Among Participants <sup>1</sup>	Number of Deliveries/Live Births in 2012 to Participants <sup>2</sup>	Number of ‘Averted’ Births
5,814	562	5,252

<sup>1</sup>Based on fertility rates from the concept paper developed in application process: [http://dch.georgia.gov/sites/dch.georgia.gov/files/imported/vgn/images/portal/cit\\_1210/33/52/156793595PlanningforHealthyBabiesProgram121709Final.pdf](http://dch.georgia.gov/sites/dch.georgia.gov/files/imported/vgn/images/portal/cit_1210/33/52/156793595PlanningforHealthyBabiesProgram121709Final.pdf)

<sup>2</sup>Reflects the count of all deliveries of a live born in all three components but includes only those counted based on the methods described earlier in the text. If stillbirth and fetal deaths to women in all three components of the program are counted the total in 2012, would be 664.

The number of actual births in Year 2 to participants fell far below that at 562. ‘Averted’ births are then estimated at 5,252 in Year 2 which indicates potential savings to the state from a lower-than-expected birth rate among those enrolled. It is also helpful to compare the P4HB experience to that of other states with family planning waivers. In a study of six study states (Bronstein, Adams and Edwards, 2003)<sup>8</sup>, states reported that births to participants in one to two years post the program

<sup>8</sup> See Bronstein, J, Adams EK and J Edwards. Evaluation of Medicaid Family Planning Demonstrations. Final Report under CMS Contract # 752-2-415921 completed by CNA Analysis and Solutions, Alexandria, VA, November, 2003.



implementation, ranged from a low of 11% (AR, SC) of the ‘expected’ number of births to as high as 80% (NM). The 562 births in 2012 among Demonstration participants in Georgia constitute about 10% of the number ‘expected’ which puts the P4HB program well at the lower end of the other states’ experiences.

**Budget Neutrality.** The budget neutrality requirement for Georgia’s P4HB program, as noted, is based on the potential of the Demonstration to ‘shift’ the birth weight distribution. Specifically, the budget neutrality spreadsheet requires that the total federal costs for all low and very low birth weight babies plus normal birth weight babies born to IPC enrollees in each Demonstration year must be less than the total federal costs for all low and very low birth weight babies in the base year for the P4HB program to be considered budget neutral. These measures will be derived for calendar years 2009-2011 in the same manner as those reported here for 2012 and compared to the 2008 estimates in our budget neutrality worksheet in our upcoming Quarterly Report. We anticipate that these cost data can be better used to gauge whether the Demonstration prevented enough unintended first births and through better management of the health of women with very low birth weight babies, prevented enough repeat births among this group, such that the distribution of all Medicaid births shifted away from the low and very low birth weight categories. However, we cannot attribute such an outcome to the Demonstration until we review the CY2012 data in this way.

### **Family Planning Service Use**

A key goal of the P4HB program is to increase access to family planning services for women in the income range targeted. In Georgia, the targeted income range was largely uninsured women > 25%

FPL but < 200% FPL. In the absence of P4HB, women in this income range could access family planning services free or on a sliding scale basis, at Title X clinics throughout the state. In Georgia, these clinics are largely public health departments and all of them are included in one or more of the Medicaid CMO networks. In order for the P4HB program to increase overall access and use of services, we need to observe that newly funded Medicaid services do not ‘displace’ services otherwise available and used at Title X clinics.

**Title X Analysis.** As part of the evaluation, the team assembled data by quarter, on all visits to the Title X clinics in the state over the pre and post P4HB time periods shown in Table 9 below.

**Table 9 Quarterly Data 2009- 1<sup>st</sup> Quarter 2013 on Percentage of Uninsured Women in the Income Range Targeted by P4HB Using Any Birth Control and Type by WHO Tiers**

Use Rates of Family Planning Services at Title X Clinics from Q1 2009 to Q1 2013																	
Qtr	Data are for Pre P4HB Quarters								Data are for Post P4HB Quarters								
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
BC After Visit - Any (N=464,645)																	
% Any Method	96.2	96.2	96.4	96.0	95.0	95.1	95.0	94.8	94.8	94.6	94.4	93.5	93.9	94.3	97.3	97.3	97.4
BC After Visit - Any - Not Using at Entry (N=50,512)																	
% Any Method	64.8	63.7	64.9	63.0	59.0	60.1	58.9	57.9	59.5	58.0	57.8	51.6	54.3	54.2	72.8	73.7	74.3
% No Method	35.2	36.3	35.1	37.0	41.1	40.0	41.1	42.1	40.5	42.0	42.2	48.4	45.7	45.8	27.2	26.3	25.7
BC After Visit - WHO Tiers - Using at Entry (N=414,133)																	
% Tier 1 (High Effect)	9.7	9.9	8.7	8.1	9.2	9.6	9.2	8.5	9.0	9.7	9.9	9.5	10.1	9.9	10.1	9.4	10.2
% Tier 2 (Med Effect)	78.9	78.5	80.8	81.5	78.3	78.3	78.7	80.1	79.2	78.1	77.3	78.6	77.4	77.8	78.6	80.0	78.2
% Tier 3 (Low Effect)	11.0	11.3	10.1	10.0	12.1	11.8	11.8	11.0	11.4	11.8	12.2	11.5	12.1	12.0	11.0	10.1	11.3
% No Method	0.4	0.3	0.4	0.4	0.4	0.3	0.4	0.4	0.4	0.4	0.5	0.4	0.5	0.4	0.4	0.5	0.4
BC After Visit - LARC - Using at Entry (N=414,133)																	
% LARC	5.2	5.3	4.6	4.7	5.3	5.5	5.5	5.1	5.8	6.5	6.8	6.5	7.2	7.2	7.7	7.4	8.4
% Non-LARC	94.4	94.4	95.0	95.0	94.3	94.2	94.1	94.5	93.8	93.0	92.7	93.1	92.4	92.4	91.9	92.1	91.3
Notes: Income =>25% and <200%, Insurance=Uninsured, Visits Included=ALL																	

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.*

As the descriptive data in Table 9 indicate:

- Across all visits, the percent using any method after their visit is higher in the latter quarters of 2012 and the first quarter of 2013, at 97.4%, than all of the preceding quarters of the pre and post P4HB period shown in the data;
- There was also an increase in those visits where the woman entered as a non-user (those using no method) and left as a user of any method, but here too, the gains appear to be focused in the latter quarters of 2012 and first quarter of 2013 when the percentage of non-users at entry leaving with any method began to exceed 72%; and
- Among those who were using a method of contraception before their visit, there is only slight indication of moving toward more effective methods (i.e., moving from a WHO Tier 3 or 4 to a Tier 1 or 2) but a strong indication of moving toward long-acting reversible contraceptive methods, or LARCs (a subset of Tier 1 methods that are reversible). At the beginning of 2009 only 5.2% of the visits were for women using LARCs upon entry; in the last two quarters of 2012, this percentage exceeded 7% and in the first quarter of 2013, equaled over 8%.

While these patterns indicate increased use, they could also be a reflection of seasonal patterns and/or changes in the composition (age, race/ethnicity) of women seeking services at Title X clinics over this time period. To further test for effects of P4HB, we used regression analysis, as summarized in Table 10, to control for women's characteristics. We tested for significant differences in the changes across the 17 quarters of data in the: 1) the probability more women reported Medicaid coverage; and 2) birth control use by type of method among women in the income range targeted (> 25% FPL and < 200%

FPL) as the program matured. We controlled for Age, Race, Ethnicity, English Proficiency, Family Size, Marital Status, Education Level, and Urban/Rural Status. The results are shown below in Table 10; if the P-value is < .05, this indicates a significant change across the 17 quarters.

**Table 10 Changes in Insurance and Contraceptive Use at Title X Clinics among Women Targeted by P4HB**

		Quarterly Trends		Quarterly Trends	
		>25%, < 200% FPL <sup>1</sup>		>50%, <200% FPL <sup>2</sup>	
Test	Dependent Variable	ME	P-value	ME	P-value
Mprobit	Client Insurance Status				
	<b>Private No FP vs. Uninsured</b>	0.0042	0.047	0.0038	0.088
	<b>Public or Medicaid vs. Uninsured</b>	-0.0009	0.083	-0.0009	0.116
Probit	Birth Control After Visit				
	<b>Any Method vs. No Method</b>	0.0051	<0.001	0.0049	0.001
Probit	Birth Control After Visit Among Those Not Using at Entry				
	<b>Any Method vs. No Method</b>	0.0158	<0.001	0.0153	<0.001
Mprobit	Birth Control Type After Visit -Among Those Using At Entry				
	<b>Tier 1 (High Effect) vs. Tier 3/4 (Low Effect)</b>	-0.0050	<0.001	-0.0043	<0.001
	<b>Tier 2 (Medium Effect vs. Tier 3/4 (Low Effect)</b>	0.0105	<0.001	0.0096	<0.001
Probit	LARC After Visit- Among Those Using at Entry				
	<b>LARC vs. Non LARC</b>	0.0014	<0.001	0.0015	0.001

<sup>1</sup>Includes those between 25% and 200% FPL (N=163,021), <sup>2</sup>Includes those between 50% and 200% FPL (N=124,543)

**Insurance:** Excludes those with Private-FP Coverage, Private-UK FP Coverage and Unknown Insurance

**Controlling For:** Age, Race, Ethnicity, English Proficiency, Family Size, Marital Status, Education Level, Urban/Rural Status

**Sample:** Includes only the last or most recent visit for each woman in the dataset

**Quarters:** Q1-Q17 are being treating as a continuous variable in the model to capture time trends

**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

Data from this analysis show the following statistically significant (p < .05) changes over the quarters:

- There was a small increase in the number of Title X clients covered by private insurance that did not carry family planning coverage vs. being uninsured. In comparison, there was no significant change in the number of women reporting Medicaid vs. uninsured.
- There was a small increase in the probability of using any method vs. no method after the visit among all women at these clinics and a significant increase in the probability (1.53-1.58 percentage points) of using any method among those entering as non-users.
- There was an increase in the use of medium vs. low effect birth control methods with a corresponding decrease in high vs. low effect birth control. Among the high effect methods, there was a small increase in the use of LARCs vs. non-LARC methods.

We repeated this type of analysis using just a Pre/Post P4HB time indicator and found that only the movement toward LARC usage remained statistically significant. We also used women with household incomes < 25% FPL as a comparison group for those made newly eligible under P4HB and again, the only significant finding that remained was the increase in the use of LARCs vs. non-LARC methods. We will follow up with more analysis of this type as more quarters of Title X data become available and explore methods for better defining the treatment and control groups.

***Title X and Medicaid Analysis.*** While Title X providers are central to providing access to the women in the income range affected by the Demonstration, we need to examine the effects of the P4HB program on the use of family planning services through Title X, Medicaid and in the two programs together. To do this we combined the visit data from the Medicaid claims with the non-Medicaid paid visits funded by Title X. The data in Table 11 shows the changes over the pre/post P4HB period in the percent of Medicaid enrolled women ages 18-44 receiving any family planning visit and in turn, the percent for which the visit/service (drug claims are included) was for some form of birth control.

As more of the Medicaid enrolled women are in the P4HB program we would anticipate these use rates to increase. The percentage of Medicaid women with any family planning visits increased from about 36% in 2010 to almost 40% in 2011 and remained close to that in 2012. The number of visits per enrolled woman was higher in 2012 than in 2009 but there was not a consistent upward trend in this or in the percentage with a visit/service for birth control. In the next bank of data in Table 11, we see that visits paid by Title X for non-Medicaid enrolled women ages 18-44, as a percentage of all women < 200% FPL in Georgia, followed a downward trend over the pre/post period while visits per woman increased only slightly. When the visits paid through Medicaid are added to those paid through Title X (omitting those Medicaid paid) visits, the percentage of women < 200% FPL in Georgia with a family planning visit in either program declined over this time period. Hence, the growth in family planning visits within Medicaid was not sufficient when accompanied by insufficient growth in Title X family planning visits, to lead to an increasing percentage of use in the overall population of women with household incomes < 200% FPL in Georgia.

**Table 11 Use of Family Planning and Birth Control Visits among Medicaid Enrolled, Title X Non-Medicaid Enrolled and Combined Usage, 2009-2012**

	Use Among Medicaid Women Ages 18-44/All Medicaid Enrolled			Use At Title X Clinics among non-Medicaid Enrolled Women Ages 18-44/All Women < 200%FPL			Total Use (Title X Non Medicaid Plus Medicaid)/All Women < 200% FPL	
	Any Family Planning Visit <sup>1</sup>	Mean Visits Per Woman	Any Visit /Service for Birth Control <sup>1</sup>	Any Family Planning Visit <sup>2</sup>	Mean Visits Per Woman	Any Visit /Service for Birth Control <sup>2</sup>	Any Family Planning Visit <sup>3</sup>	Any Visit /Service for Birth Control <sup>3</sup>
<b>2009</b>	35.2%	2.19	11.6%	14.1%	2.13	12.9%	35.6%	20.0%
<b>2010</b>	35.8%	2.42	10.8%	14.4%	2.10	13.1%	35.5%	19.5%
<b>2011</b>	39.9%	2.66	11.6%	13.6%	2.13	12.4%	34.0%	18.3%
<b>2012</b>	39.0%	2.44	11.4%	12.2%	2.17	11.2%	32.7%	17.2%

<sup>1</sup> Denominator is all women ages 18-44 enrolled in Medicaid during year. <sup>2</sup> Denominator is all women ages 18-44, citizen, and < 200% FPL in Georgia during year. <sup>3</sup> Denominator is all women ages 18-44, citizen, and < 200% FPL in Georgia during year; numerator is sum of use among Medicaid enrolled women and Title X non-Medicaid enrolled women ages 18-44.

Another way the system could affect the rates of unintended pregnancies and births is to move those women using some form of birth control toward the use of more effective methods. In Table 12 below, we show the composition of the birth control methods used with the Medicaid enrolled and the Title X, non-Medicaid enrolled user groups.

**Table 12 Composition of Contraceptive Use among Users in Medicaid and Title X Non-Medicaid Groups, 2009-2012**

	Composition of Medicaid Birth Control Methods Used				Composition of Title X (Non-Medicaid) Birth Control Methods Used			
	Tier 1	Tier 2	Tier 3/4	LARC	Tier 1	Tier 2	Tier 3/4	LARC
<b>2009</b>	54.4%	42.3%	3.3%	38.4%	11.3%	71.8%	16.9%	5.8%
<b>2010</b>	51.9%	45.0%	3.0%	33.4%	11.2%	71.9%	16.9%	6.5%
<b>2011</b>	55.3%	41.6%	3.1%	36.4%	11.8%	70.8%	17.4%	8.0%
<b>2012</b>	55.5%	41.0%	3.5%	38.5%	11.9%	71.2%	16.9%	9.0%

*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.*

These data indicate a stable composition of usage across the four WHO tiers within both the Medicaid and Title X, non-Medicaid enrolled groups. With respect to use of LARC methods, there was a decline among Medicaid enrolled women between 2009-2010 that was reversed after the P4HB program was implemented leaving the percentage of all users in Medicaid at 38.5% in 2012. Use of LARCs at Title X clinics steadily increased from about 6% in 2009 to 9.0% of all users in 2012. The increased use of LARC methods, especially near the end of PY2, may mean that the effects of the P4HB program on reductions in unintended pregnancies and births will be even more evident in the coming years.

Finally, in Table 13 below we show the same patterns of usage among the P4HB enrollees with the required three months of continuous enrollment; here we have combined women in all components (FP only, IPC and RM) of the Demonstration but provided separate data for those auto-enrolled versus not.

**Table 13 Use of Family Planning and Birth Control among P4HB Demonstration (FP only, IPC, and RM) Participants, Auto-enrolled and Not Auto-Enrolled, 2011-2012**

Year		Use Among P4HB Women Ages 18-44			Composition of P4HB Birth Control Methods Used			
		Any Family Planning Visit <sup>1</sup>	Mean Visits Per Woman	Any Visit /Service for Birth Control <sup>1</sup>	Tier 1	Tier 2	Tier 3/4	LARC
2011	Overall	30.1%	0.67	9.0%	43.0%	46.3%	10.7%	37.1%
	Auto-enrolled	*	*	*	*	*	*	*
	Not Auto-Enrolled	30.4%	0.66	9.1%	43.0%	46.3%	10.7%	37.1%
2012	Overall	29.8%	0.75	8.6%	39.3%	49.1%	11.6%	35.1%
	Auto-enrolled	20.2%	0.44	5.4%	27.6%	59.1%	13.2%	26.6%
	Not Auto-Enrolled	44.8%	1.23	13.5%	46.6%	42.9%	10.5%	40.5%

<sup>1</sup>Denominator is all women enrolled in aid category codes 180-183 at least three months of continuous enrollment. \*<5 family planning visits were found in the data for these women in 2011.

Overall, we see the percentage of participants in the P4HB program who had any family planning visit remained stable at 30.1% in 2011 and 29.8% in 2012. The overall percentage with a visit/service for birth control remained low at almost ~9% in 2011 and 2012. There is a marked difference, however, in the utilization patterns for those auto and not auto-enrolled. Whereas 20.2% of those auto-enrolled had any family planning visit in 2012 and 5.4% had a visit/service for birth control, the corresponding percentages for those not auto-enrolled into P4HB were 44.8% with a family planning visit and 13.5% with a visit/service for birth control. Overall, from 35 - 37% of P4HB enrollees using a birth control method were using LARCs in 2011 and 2012. In 2012 this percentage was higher among those not auto-enrolled at 40.5% compared to approximately 27% among those auto-enrolled.



## **VII. Births and Birth Outcomes among Waiver Participants**

In the following table we report on the number of deliveries inclusive of live born infants, still births and fetal deaths, in 2012 observed among Demonstration participants enrolled sometime in 2012; we also present counts of pregnancies for the women enrolled in PY2 through the first six months of 2013 as these claims data were available and are indicative of outcomes for women enrolled during the second year of the Demonstration and likely to be paid by the Georgia Medicaid program. We again present data separately for the auto-enrolled and not auto-enrolled women.

It is important to again note that classification of deliveries/births occurring before or after enrollment in P4HB based upon claims data, from which accurate gestational dating of any pregnancy is not possible, could be subject to misclassification, particularly of those pregnancies that end at an early gestational age. In counting pregnancies among Demonstration participants for presentation in Table 14 below, we again use pregnancy codes as well as an RSM aid eligibility codes as evidence of a new pregnancy among Demonstration participants. We also note that the denominators for the percentage with a pregnancy or delivery in Table 14 include any woman who met our requirements (three plus months of continuous enrollment, no pregnancy during that time, no live birth, stillbirth, or fetal death within 245 days of enrollment) and enrolled in the family planning or IPC components sometime during 2011 and 2012.

**Table 14 Pregnancies and Deliveries to Unique P4HB Participants after their Enrollment in 2011 or 2012 by Auto-Enrollment Status**

<b>Demonstration Participants<sup>1</sup></b>	<b>Number, % with Pregnancy after Enrollment in the Demonstration<sup>1</sup></b>	<b>Number, % with Delivery in 2012 after Enrollment in the Demonstration<sup>1</sup></b>
Family Planning Only Enrollees N = 43,428	2,860 (6.6%)	662 (1.5%)
IPC Enrollees N = 123	9 (7.3%)	2 (1.6%)
<b>Auto-Enrolled Demonstration Participants</b>		
Family Planning Only Enrollees N =26,277	1,605 (6.1%)	178 (0.7%)
IPC Enrollees N = 78	6 (7.7%)	0
<b>Not Auto-Enrolled</b>		
Family Planning Only Enrollees N =17,151	1,255 (7.3%)	484 (2.8%)
IPC Enrollees N = 45	3 (6.7%)	2 (4.4%)

<sup>1</sup> FP Only and IPC enrollment must start with at least 3 consecutive months to be included in this denominator. See earlier notes on methods used to count deliveries/births.

As the data in Table 14 indicate, the percentage of FP only enrollees with at least three months of consecutive enrollment that had evidence of a pregnancy after enrollment was 6.6% with the not auto-enrolled slightly higher (7.3%) than the auto-enrolled (6.1%). There is also a higher percentage of the not auto-enrolled group with a delivery in 2012. The number of deliveries to these women equaled 484 or 2.8% of those not auto-enrolled while the 178 deliveries to the auto-enrolled equaled only 0.7%.

While the number of total IPC enrollees is small, the data indicate 7.3% experienced a repeat pregnancy after enrollment and this was higher among the auto-enrolled versus not auto-enrolled. As noted earlier, two IPC participants experienced a repeat delivery. Both of these deliveries were among those women not auto-enrolled in the IPC component of P4HB.

### **Participants vs. Non-Participants**

While we do observe births to FP only participants, their fertility rate is lower than the ‘expected’ number from calculations in our Planning for Healthy Babies Concept Paper and indeed, may have

been planned pregnancies and births with good outcomes. Since the P4HB participants who become pregnant are already enrolled in a Medicaid program they may detect their pregnancy earlier and gain access to timely and adequate prenatal care whereas RSM women likely come into Medicaid from an uninsured status. One way to examine this possibility is to compare the birth outcomes of the Demonstration participants to other women with Medicaid paid births (RSM) during the same time period.

In Table 15 below, we compare outcomes for Demonstration participants to RSM women with Medicaid paid live births during the same period and who were not enrolled in the P4HB program at any time. All classifications of outcomes (live birth, birth weight) are derived as in Table 3 and based on those delivery records that can be matched to an infant. We note that only 528 of the total 561 deliveries with live births to FP only participants matched to infants in the claims data.

**Table 15 Infant Counts and Costs for Mother and Infant at the Delivery Hospitalization in 2011/2012, Waiver Demonstration Participants and Non-Participants**

<b>MEASURE</b>	<b>Counts and Percentage</b>	<b>Average \$ Paid Mother</b>	<b>Total \$ Paid Infant Delivery Hospitalization</b>	<b>Average \$ Paid Infant Delivery Hospitalization</b>
<b>Family Planning Only Participants</b>	528	\$5,381	\$1,828,328	\$3,462
VLBW	11 (2.1%)	\$5,438	\$811,817	\$73,802
LBW	24(4.5%)	\$5,921	\$177,898	\$7,412
Normal BW	493(93.4%)	\$5,354	\$838,613	\$1,701
<b>Non- Participants in Family Planning Only</b>	50,841	\$5,235	\$168,285,387	\$3,310
VLBW	726(1.4%)	\$6,357	\$53,442,904	\$73,613
LBW	2,794(5.5%)	\$5,804	\$31,147,547	\$11,148
Normal BW	47,321(93.1%)	\$5,188	\$83,694,935	\$1,769

The distribution of birth weight for the FP only participants is different from that of non-participants but in an unexpected direction. Whereas non-participants exhibit a rate of VLBW of 1.4% that is lower

than the state's average of ~2.0%, those participating in the FP only component of P4HB exhibit a higher percentage of infants with VLBW at 2.1%. The percentage of LBW infants among women in the Family Planning Only P4HB program, however, is lower at 4.5% compared to non-participants at 5.5%. The higher percentage of VLBW infants among P4HB participants may reflect a selection of women into P4HB who were at higher risk of poor birth outcomes. Under this assumption we would expect their expenses to be higher and on average they are for infants (\$3,462 compared to \$3,310). On the other hand both mother and infant costs at delivery are generally lower for women in the FP only component of the Demonstration than other RSM women and infants within the LBW category.

Since there are differences in the characteristics of mothers in these two groups that affect birth outcomes, we estimated the probability of LBW and VLBW outcomes among these two groups, controlling for age, race/ethnicity, poverty level of county of residence and months enrolled in Medicaid since January 2011. We also controlled for auto-enrollment. In preliminary results age, race and county poverty levels were all significant explanatory variables; more work will be done to explain these patterns as participants can be observed over longer periods and more control variables (e.g. smoking) can be brought into the analysis from vital records; vital records will also provide the most accurate measure of birth weight category.

We can also make a comparison of the IPC P4HB participants to other women in Medicaid giving birth to a VLBW infant during the same time period. In Table 16 below we present data on the number and percentage with a repeat pregnancy within 6 or 12 months and in turn, a repeat delivery within 12 months. We also report on the outcomes of the deliveries resulting in a live birth.

**Table 16 Number and Percent of Women with VLBW Infant with Repeat Pregnancy and Deliveries within Six or Twelve Months, IPC Waiver Demonstration Participants and Non-Participants**

	N	Pregnant within 6 months	Pregnant within 12 months	Delivery within 12 months	Delivery Outcome	Birth Weight
<b>RSM random sample<sup>1</sup></b>	220	16 (7.3%)	30 (13.6%)	2 (0.9%)	Live Birth	1 VLBW, 1 NBW
<b>IPC Group<sup>2,3</sup></b>	123	7 (5.7%)	9 (7.3%)	1 (0.8%)	Live Birth	NBW

<sup>1</sup>Within 6 months or 12 months after Delivery in RSM plus 60 days.

<sup>2</sup>Within 6 months or 12 Months after Enrollment Start Date in IPC Component of Waiver using methods to identify deliveries/births as described for Table 2.

<sup>3</sup>The stillbirth to the IPC participant shown in Table 2 occurred after 12 months of enrollment

These data indicate that IPC women had lower repeat pregnancies within six months (5.7% vs. 7.3%) of enrollment in IPC than the women in a random sample of RSM mothers within six months of losing their Medicaid coverage. When a 12 month window is used IPC women again had lower rates of repeat pregnancies (7.3% vs. 13.6%) than the RSM (non-IPC) comparison group. Important to the goals of the P4HB program, the live birth to the IPC participant was normal birth weight; however, for the repeat births to the RSM (non-IPC) comparison group, one was normal birth weight and one was very low birth weight.

### ***Pre/Post Analysis of RSM Women***

With two years of data post the implementation of the Demonstration, we can now look at some measures for two years pre and two years post, the program’s implementation. One outcome that could be affected by the P4HB program is the number of repeat pregnancies and deliveries among women with an ‘index’ delivery/birth paid by Medicaid (RSM) as more of these women are enrolled in P4HB after a birth on Medicaid. In Table 17, we provide data on the percentage of RSM women who have a pregnancy/birth within six months and twelve months of the index birth that was paid by

Medicaid. Births will be understated due to the lack of full run out of claims in 2013 and as noted earlier, we know that deliveries in 2012 are understated due apparently, to incomplete claims in the currently available extract of claims.

**Table 17 Percent of RSM Women with a Repeat Pregnancy/Birth Paid by Medicaid within Six/Twelve Months Pre and Post the Demonstration**

	<b>Number and Percent of RSM Delivering Mothers with Pregnancy within 6 Months</b>	<b>Number and Percent of RSM Delivering Mothers with Pregnancy within 12 Months</b>	<b>Number and Percent of RSM Delivering Mothers with Delivery within 12 Months</b>
<b>Pre P4HB</b>			
2009	2,812 3.7%	8,830 11.6%	2,889 3.8%
2010	2,351 3.2%	7,772 10.6%	2,316 3.2%
<b>Post P4HB</b>			
2011	2,635 3.7%	8,131 11.5 %	2,663 3.8%
2012	2,332 3.4%	Not enough claims run-out	Not enough claims run-out

As the data in Table 17 indicate, the percentage of RSM women with a repeat pregnancy within six months ranges from 3.2% to 3.7% during both the pre and post periods although slightly lower in 2012 (at 3.4%) than 2009. Longer run out of claims data will help us assess whether the percentages with repeat pregnancies and/or deliveries within the next 12 months changes in 2012 and multivariate analysis will help us assess whether these patterns are indicative of an effect of the P4HB program itself. We will also complete sensitivity analysis by treating the first six months of 2011 as being in the ‘pre’ period due to the slow roll out and take-up of P4HB benefits.

## **VIII. CONCLUSIONS AND RECOMMENDATIONS**

The innovative P4HB program was implemented in the state of Georgia on January 1, 2011 with extensive efforts at both the DCH and local levels to market the benefits of this Demonstration. While the DCH used all available resources to make women and providers aware of the program across both

the urban and rural areas of the state, the numbers expected to enroll in either the first or second year did not meet the expectation that half of those eligible would enroll. As shown in the data presented in this report, the percent enrolling in the FP component by the end of the second year of the Demonstration was 12%, far lower than expectations and most other states' experiences. However, we do find that the use of family planning services among Medicaid enrolled women has increased over the 2009-2012 pre/post period and that those using some form of contraceptives from visits to Title X clinics and/or other Medicaid paid providers have shifted toward the use of highly effective, LARC contraceptive methods. This is important for the success of the program.

By the third quarter of 2011, DCH recognized the need to undertake efforts to increase enrollment and during the fourth quarter of CY2011 initiated auto-enrollment of all RSM women whose Medicaid coverage was ending post-delivery as well as young women aging out of PeachCare for Kids<sup>®</sup> into the P4HB program. The effect of this effort was reflected in the sharp increase in enrollment at the beginning of CY 2012 and these increases did continue into CY 2012. As noted, declines were seen toward the end of CY 2012 and it may be that when it was time for recertification, these women did not follow through with this process. As noted in this report, we found lower usage rates among those women auto-enrolled versus not auto-enrolled. Given the large numbers of auto-enrolled women, it is still important for the CMOs to ensure that the women who are auto-enrolled fully understand the benefits to which they are entitled and that these services will still be available to them if they recertify their eligibility and remain enrolled.

## Recommendations

Given the growing number of uninsured women < 200% FPL in Georgia over our study period as seen in the data presented here, it is important for the state to consider an extension of the P4HB program beyond the scheduled end date of December 2013, in order to provide women in this income range a safety net for access to preventive and family planning services. Given the evidence that enrollment and service use in P4HB has increased; the Title X and Medicaid provider systems appear to be moving more women toward use of LARC methods; births to participants are lower than expected and savings are evident; and the program succeeded in preventing repeat VLBW births among the IPC enrollees, it appears the P4HB program is on track to move further toward its stated goals and objectives. Specific recommendations in this regard are:

- The patterns seen near the end of this second year indicate the program may be reaching maturity in terms of sustainable levels of enrollment, use of effective family planning methods and management of women with VLBW infants. It is important for the state to strengthen these trends.
- Continue to work with Title X as an active partner in the enrollment of eligible women into the P4HB program and as a provider of family planning services to uninsured and under insured women who, if pregnant, are eligible for Medicaid coverage. A continued monitoring of the Title X quarterly data will inform DCH about the trends seen in the most recent quarters that indicate increased use of birth control methods and in turn, more use of LARCs. An added benefit of such a partnership is that these efforts can help Title X clinics ‘leverage’ Medicaid funds to increase revenues and allow for



use of Title X funding to further expand outreach, access and provision of more effective methods of birth control.

- Evaluate the continued role of auto-enrollment as a means of increasing participation in the P4HB program.
- Work diligently to retain and enhance service utilization for those women who were auto-enrolled in the P4HB program through increased mailings, CMO outreach and dissemination of information regarding the ease of re-enrollment and the wide array of preventive and family planning services available to enrollees at no cost. In this process, continue to outreach and train providers to assess and help women develop and achieve a reproductive health plan while they are enrolled.
- Continue working with the IPC enrollees to assure their use of all available services and in particular the management of chronic conditions in addition to the family planning services intended to help them prevent a repeat pregnancy or birth within a short time period.
- Renew the marketing campaign for P4HB to target: media outlets (TV, radio) as well as social media (texts, Face Book, Twitter) and; eligible FP only enrollees as well as eligible IPC enrollees. Increase the placement of advertising materials on radio stations and printed materials in human service and public transportation venues. Materials could include pamphlets and brochures to reach eligible but not yet enrolled women.
- To help enrolled women understand the benefits of the program, as well as to educate women not yet enrolled about the preventive nature of the program, DCH might consider including a list of the covered services for each component of the program.

Podcasts and videos on the DCH website are also options. In addition, listing the specific services on the back of the “Pink” and “Purple” cards which are sent to women once they are enrolled may help both enrolled women and their providers better understand the services they are eligible to receive. Education programs could also be completed with videos in the clinic setting. The large number of women coming into P4HB already pregnant indicates the preventive nature of the program is not well understood.

- A provider component of this renewed marketing campaign might target a broad range of provider types (OBGYN, family physicians, nurse practitioners, Title X women’s health coordinators, neonatal ICU providers and social workers). This renewed marketing campaign should include clear information about eligibility, enrollment, and program benefits.
- Explore opportunities to decrease the time between the eligibility determination and actual CMO enrollment for P4HB. While most women who eventually come into a CMO for P4HB services do so within two months from the date of the eligibility determination, this is a time period when women do not have access to P4HB services so unintended pregnancies may occur. There were 1,043 pregnancies observed among women enrolled less than the three months required for inclusion in the full analysis. These can perhaps be seen as failures of women to understand the program and/or failure of the delivery system to get the women in for family planning counseling and services in a timely fashion.

## Appendix A: P4HB Communication Plan

### Communication Plan (Revised for Year 2)

Phase	Activities	Status
<p><b>Phase 1: Educate Providers and CMOs</b> Focuses on educating health care providers and CMOs about P4HB. These are the major stakeholders identified through the Communication Plan as having “the most potential to positively influence and impact the behaviors of patients through preventative care measures.”</p>	<p>9) Introducing a revised P4HB Communication Plan to the Work Group and the CMOs; 10) Develop a page on the DCH website for the P4HB program that provides specific information about the program, benefits, provider network, client eligibility and enrollment and program application; and 11) Introduce the P4HB program and program-related materials to the CMOs (including program logo, poster and postcards). 12) Added CMOs’ handbooks to the DCH P4HB website. 13) Update DCH P4HB website to include additional program information.</p>	<p>1) through 3). Completed initial education. Re-education is ongoing. Web page developed and updated as needed. CMOs utilizing program-related materials. Handbooks (#4) added to P4HB website in June 2012. P4HB website updated in June 2012 (#5).</p>
<p><b>Phase 2: Leverage the Strengths &amp; Assets of Partners</b> Purpose is to use local experts to champion LBW prevention by encouraging eligible women in their respective communities to enroll in the P4HB program</p>	<p>The Improving Birth Outcomes Work Group will identify local experts at the district level. Additional organizations and providers also identified as potential collaborators, including MCH staff, WIC staff, family practice providers, pediatricians, faith community leaders, nursing and medical schools, nurse midwives, health care professionals, OBGYNs, policymakers, media representatives, civic and cultural leaders, and tobacco program coordinators.</p>	<p>Ongoing meetings with the Improving Birth Outcomes Work Group now held bi-monthly. Communication is ongoing with providers, MCH staff, pediatricians and public health staff. Outreach occurring via the RSM Outreach Project staff</p>
<p><b>Phase 3: Implement Consumer-Based Outreach (Statewide and Locally)</b> Purpose is to inform consumers and providers about P4HB using media, messaging, and an organized set of communication activities</p>	<p>25) Introduce campaign to 18 public health districts 26) Outline marketing proposal and estimated costs 27) Determine overall budget and process in which marketing materials will be purchased 28) Buy billboards, radio and print ads. Advertisement will occur in 2 phases over the course of the program, and counties with highest LBW rates will be targeted first for billboard ads. 29) Finalize copy for poster/postcard design</p>	<p>1) through 12). Completed. The RSM Outreach Project staff from the Department of Family and Children Services has been instrumental in our “grassroots” outreach efforts within the 18 public health districts.</p>

Phase	Activities	Status
	<p>30) Replace postcard with brochure in summer 2011.</p> <p>31) Obtain approval of printing cost for brochures, posters/postcards; obtain shipping addresses</p> <p>32) Provide RSM, PH departments, and DFCS officials with notice that postcards/posters and brochures will be distributed and guidance about how to use them.</p> <p>33) Draft/distribute press release announcing launch of P4HB program.</p> <p>34) Pitch background sessions to identified reporters from the Atlanta Journal &amp; Constitution.</p> <p>35) Begin brainstorming a newsworthy event for Summer 2011</p> <p>36) Other activities: theater ads, health fairs, participating in cause-related charitable events, articles in provider organization newsletters; news releases, media advisories, op-eds, podcast messages placed on PH4B website, Face Book and Twitter pages. In addition, the Plan calls for media advisories, op-eds and conducting “background sessions” with area reporters to discuss the state’s efforts to reduce its LBW rate.</p>	
<p><b>Phase 4: Use Existing Resources for Support and Coaching</b></p> <p>Goal is to use current available resources in Georgia to promote prenatal care, healthy lifestyles before and during pregnancy, and smoking cessation.</p>	<p>Reach out to WIC staff and Georgia Quit Line team and inform them of P4HB and that P4HB will reference them on the P4HB website and possible future marketing materials.</p>	<p>Completed.</p>
<p><b>Phase 5: Annual Campaign Evaluation</b></p> <p>To analyze on an annual basis the strengths and weakness of the P4HB program. Four types of evaluation are suggested: 1) formative; 2) process; 3) outcome; and 4) Impact</p>	<p>13) Assess the strengths and weaknesses of campaign materials and strategies</p> <p>14) Measure effort and the direct outputs of campaign</p> <p>15) Examine the campaign’s implementation and how the activities involved are working</p>	<p>Ongoing. Emory University is assisting with the evaluation.</p>

Phase	Activities	Status
	<p>16) Measure effect and changes that result from the campaign. (Assess outcomes in the target populations or communities that come about as a result of the campaign's strategies and activities; measure policy changes.)</p> <p>17) Measure community-level changes that are achieved as a result of the campaign's aggregate effects on individuals' behavior and the behavior's sustainability. Attempts to determine whether the campaign caused the effects.</p> <p>18) Make recommendations for Year 2 of the campaign based on data gained from the annual evaluation; implement necessary changes in Year 2</p>	

## Appendix B: Member and Provider Survey Results

### CMO Member Survey Results

#### Enrollment and Utilization of Services in P4HB

	First Wave N = 169 Responses n (%)	Second Wave N = 396 Responses n (%)	Third Wave N = 1151 Responses n (%)
<b>Enrollment in P4HB to get...</b>			
Birth control or family planning services	122 (72%)	224 (57%)	542 (47%)
Pregnancy testing	46 (28%)	100 (25%)	289 (25%)
Testing or treatment for sexually-transmitted infections	56 (33%)	118 (30%)	297 (26%)
Primary care (such as routine check-up, care for an illness)	135 (80%)	270 (68%)	616 (54%)
Other	18 (11%)	36 (9%)	91 (8%)
<b>Have used these P4HB services...</b>			
Birth control or family planning services	83 (49%)	154 (39%)	471 (41%)
Pregnancy testing	34 (20%)	62 (16%)	205 (18%)
Testing or treatment for sexually-transmitted infections	56 (33%)	90 (23%)	218 (19%)
Primary care (such as routine check-up, care for an illness)	92 (54%)	154 (39%)	421 (37%)
Other	25 (15%)	11 (3%)	32 (3%)
<b>Before enrolling in P4HB, had trouble getting...</b>			
Birth control or family planning services	85 (50%)	146 (39%)	262 (23%)
Pregnancy testing	57 (34%)	78 (20%)	126 (11%)
Testing or treatment for sexually-transmitted infections	59 (35%)	97 (24%)	133 (12%)
Primary care (such as routine check-up, care for an illness)	107 (63%)	138 (35%)	343 (30%)
Other	19 (11%)	34 (9%)	102 (9%)
<b>Types of problems prior to P4HB:</b>			
I did not have a way to get to appointments	12 (5%)	29 (6%)	Questions not covered on survey
I could not pay for services	74 (34%)	232 (46%)	
I could not pay for birth control method	86 (40%)	135 (27%)	
I could not find a doctor or nurse that would treat me	18 (8%)	37 (7%)	
I could not get time off from work for appointments	2 (1%)	12 (2%)	
I had no one to take care of my children	11 (5%)	16 (3%)	
I was too sick to get to the doctor, nurse or clinic	3 (1.4%)	6 (1%)	
Other	10 (4%)	33 (7%)	
<b>Changes P4HB made for the participant...</b>			
I am going to a different doctor or nurse for family planning services or birth control	60 (36%)	116 (29%)	291 (25%)
I am going to a different doctor or nurse for primary care	46 (27%)	85 (21%)	232 (20%)
I have started using a birth control method	82 (49%)	142 (36%)	429 (37%)
I have changed the birth control method I use	43 (25%)	77 (19%)	221 (19%)
I have more choice of birth control methods	83 (49%)	145 (37%)	498 (43%)
I do not have to use my own money for family planning services or birth control	91 (54%)	185 (47%)	473 (41%)
I am able to get preventive care (such as Pap smears) and family planning counseling	140 (83%)	243 (61%)	605 (53%)
With the Purple Card (IPC), I am able to get care for illnesses	5 (3%)	15 (4%)	33 (3%)
With the Purple Card (IPC), I am able to get medicines for illnesses when I need them	34 (20%)	8 (2%)	29 (3%)
Other	1 (0.6%)	6 (2%)	77 (7%)

### Knowledge of Members about P4HB

Knowledge of...	First Wave N = 169 Responses n (%)	Second Wave N = 396 Responses n (%)	Third Wave N = 1151 Responses n (%)
<b>Services available through the “Pink Card”...</b>			
Birth control services and methods	118 (70%)	202 (51%)	446 (39%)
Pap smear and pelvic exam	116 (69%)	219 (55%)	450 (39%)
Tubal Ligation (tubes tied)	11 (7%)	64 (16%)	90 (8%)
Pregnancy testing	37 (22%)	163 (41%)	391 (34%)
Screening for sexually transmitted infections	88 (52%)	152 (38%)	336 (29%)
Follow-up of an abnormal Pap smear	59 (35%)	144 (36%)	359 (31%)
Treatment for sexually transmitted infections	77 (46%)	109 (28%)	271 (24%)
Treatment for major problems related to family planning services	44 (26%)	98 (25%)	217 (19%)
Vitamins with folic acid	44 (26%)	84 (21%)	168 (15%)
Some vaccinations	36 (21%)	73 (18%)	164 (14%)
Non-emergency transportation	4 (8%) of 44*	27 (7%)	93 (8%)
<b>Services available through the “Purple Card”...</b>			
Primary care services (up to 5 visits per year)	9 (5%)	5 (1%)	14 (1%)
Treatment for medical problems like high blood pressure and diabetes	7 (4%)	3 (1%)	7 (1%)
Medicines for medical problems like high blood pressure and diabetes	6 (4%)	3 (1%)	6 (1%)
Care for drug and alcohol abuse (such as rehab programs)	2 (1%)	2 (1%)	5 (0%)
Some dental services	10 (6%)	5 (1%)	6 (1%)
Non-emergency transportation	7 (4%)	2 (1%)	8 (1%)
Nurse case management/Resource Mother	6 (4%)	1 (0%)	10 (1%)
<b>Eligibility for ‘Pink Card’</b>			
Be between 18-44 years of age	155 (92%)	295 (74%)	443 (38%)
Be a resident of Georgia	147 (87%)	278 (70%)	451 (39%)
Be a U.S. Citizen	144 (85%)	275 (69%)	456 (40%)
Have a household income that is at or below 200% of the federal poverty level	126 (75%)	224 (57%)	347 (30%)
Not be eligible for Medicaid or the Children’s Health Insurance Program (PeachCare for Kids®)	103 (61%)	174 (44%)	290 (25%)
Not otherwise insurer for Family FP Services	27 (55%) out of 49*	139 (49%) out of 281*	270 (23%)
Other	1 (0.6%)	25 (6%)	40 (3%)
<b>Eligibility for ‘Purple Card’</b>			
Be between 18-44 years of age	44 (26%)	27 (7%)	27 (2%)
Be a resident of Georgia	42 (25%)	27 (7%)	25 (2%)
Be a U.S. Citizen	40 (24%)	26 (7%)	25 (2%)
Have a household income that is at or below 200% of the federal poverty level	35 (21%)	22 (6%)	22 (2%)
Not be eligible for Medicaid or the Children’s Health Insurance Program (CHIP)	27 (16%)	15 (4%)	18 (2%)
Not otherwise insured for health care services	0 (0%) of 49*	4 (1%)	17 (1%)
Delivered a baby weighing < 3 pounds 5 ounces since January 1, 2011	17 (10%)	5 (1%)	9 (1%)
Other	5 (3%)	2 (1%)	1 (0%)

## Problems Encountered by Members Enrolled in P4HB

Problems Under P4HB	First Wave N = 169 Responses n (%)	Second Wave N = 396 Responses n (%)	Third Wave N = 1151 Responses n (%)
I cannot get the family planning services I want	38 (22%)	85 (21%)	167 (15%)
I cannot get referrals or follow-up for care I need	31 (18%)	76 (19%)	148 (13%)
I cannot find a doctor or nurse willing to take P4HB clients	30 (18%)	82 (21%)	150 (13%)
I don't want to leave my current doctor or nurse	23 (14%)	59 (15%)	112 (10%)
I have to wait too long to get services	18 (11%)	50 (13%)	115 (10%)
I do not have transportation	19 (11%)	48 (12%)	97 (8%)
I cannot get to the doctor or nurse when they are open	10 (6%)	40 (10%)	83 (7%)
My P4HB doctor or nurse will not prescribe the birth control method I want to use	9 (5%)	29 (7%)	64 (6%)
Other	6 (4%)	12 (3%)	583 (51%)

## Ways in Which Members Learned About P4HB

Source of Information	First Wave N = 169 Responses n (%)	Second Wave N = 396 Responses n (%)	Third Wave N = 1151 Responses n (%)
Mailings	45 (22%)	87 (22%)	Question not covered on survey
E-mail	1 (0.5%)	7 (2%)	
CMO websites	2 (1%)	6 (2%)	
CMO telephone calls	4 (2%)	10 (3%)	
Georgia Department of Community Health websites	17 (8%)	23 (6%)	
Georgia Department of Community Health meetings	9 (4%)	8 (2%)	
Doctors, nurses, or other staff at health department or WIC office	57 (28%)	95 (24%)	
Doctors, nurses, or other staff at the hospital	9 (4%)	23 (6%)	
Doctors, nurses, or other staff at my doctor's office	13 (6%)	28 (7%)	
Friends or family members	28 (14%)	69 (17%)	
Postings on billboards and public transportation	5 (2%)	15 (4%)	
Other	13 (6%)	27 (7%)	

## Information Needs About P4HB

Type of Information	First Wave N = 169 Responses	Second Wave N = 396 Responses	Third Wave N = 1151 Responses
	Needs More Information n (%)	Needs More Information n (%)	Needs More Information n (%)
Where to go for service	77 (46%)	109 (28%)	244 (21%)
Services available with the Pink Card	108 (64%)	221 (56%)	331 (29%)
Services available with the Purple Card	82 (49%)	127 (32%)	184 (16%)



Cost of services	85 (50%)	190 (48%)	297 (26%)
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#### Areas of P4HB that Were Hard to Understand

Area	First Wave N = 169 Responses	Second Wave N = 396 Responses	Third Wave N = 1151 Responses
	Hard to Understand n (%)	Hard to Understand n (%)	Hard to Understand n (%)
Who can get P4HB	29 (17%)	75 (19%)	92 (8%)
Whether I can get P4HB	37 (22%)	87 (22%)	76 (7%)
Complete the paper work to sign up for P4HB	20 (12%)	58 (15%)	53 (5%)
Complete the web form to sign up for P4HB	18 (11%)	47 (12%)	35 (3%)
Get the required documents to sign up for P4HB	27 (16%)	71 (18%)	63 (5%)
Pick a Care Management Organization (CMO)	41 (24%)	83 (21%)	82 (7%)
Pick a provider	45 (27%)	85 (21%)	95 (8%)
Understand what I can get from P4HB	77 (46%)	156 (39%)	212 (18%)
Other	6 (4%)	16 (4%)	616 (54%)

## CMO Provider Survey Results

### Provider Understanding of Eligibility Criteria for P4HB

Eligibility Criteria for P4HB	First Wave		Second Wave		Third Wave	
	Correct Responses by Category of P4HB N = 62		Correct Responses by Category of P4HB N = 104		Correct Responses by Category of P4HB N = 31	
	FP only n (%)	IPC n (%)	FP only n (%)	IPC n (%)	FP only n (%)	IPC n (%)
Between 18-44 years of age	25 (40%)	17 (27%)	41 (39%)	28 (27%)	14 (45%)	13 (42%)
Resident of Georgia	26 (42%)	20 (32%)	43 (41%)	33 (32%)	15 (48%)	14 (45%)
U.S. Citizen	24 (39%)	18 (29%)	40 (38%)	31 (30%)	13 (42%)	12 (39%)
Household income at or below 200% FPL	19 (31%)	16 (26%)	30 (29%)	25 (24%)	9 (29%)	8 (26%)
Not otherwise eligible for Medicaid or the Children's Health Insurance Program (CHIP- PeachCare for Kids <sup>®</sup> )	19 (31%)	16 (26%)	31 (30%)	24 (23%)	10 (32%)	10 (32%)
Not otherwise insured for family planning services	16 (26%)	15 (24%)	27 (26%)	22 (21%)	10 (32%)	10 (32%)
Delivered a very low birth weight infant since January 1, 2011	----	15 (24%)	----	22 (21%)	----	8 (26%)
Other	2 (3%)	2 (3%)	2 (2%)	2 (2%)	----	----

### Providers' Knowledge of Services Covered Under their P4HB Contract

Services Covered Under P4HB	First Wave N = 62	Second Wave N = 104	Third Wave N = 31
	Correct Responses n (%)	Correct Responses n (%)	Correct Responses n (%)
Family planning initial and follow-up exams	25 (40%)	45 (43%)	17 (55%)
Contraceptive services and methods	27 (44%)	46 (44%)	18 (58%)
Tubal ligation	17 (27%)	31 (30%)	14 (45%)
Pregnancy Testing	21 (34%)	41 (39%)	15 (48%)
Screening for sexually transmitted infections	19 (31%)	33 (32%)	14 (45%)
Follow-up of an abnormal Pap smear, including Colposcopy	14 (23%)	26 (25%)	5 (16%)
Treatment for sexually transmitted infections	18 (29%)	31 (30%)	13 (42%)
Treatment for major complications related to family planning services	10 (16%)	17 (16%)	11 (35%)
Multivitamins with folic acid	16 (26%)	25 (24%)	13 (42%)
Hepatitis B and Tetanus-Diphtheria vaccines	13 (21%)	18 (17%)	8 (26%)
Primary care services (up to 5 outpatient visits per year)	12 (19%)	17 (16%)	7 (23%)

Management and follow-up of chronic diseases	6 (9%)	11 (11%)	2 (6%)
Prescription medications for chronic diseases	5 (8%)	9 (9%)	3 (10%)
Detoxification and outpatient rehabilitation for substance abuse	3 (5%)	5 (5%)	1 (3%)
Limited dental services	4 (6%)	7 (7%)	2 (6%)
Nurse case management and Resource Mother outreach for health and social service coordination and support of health behaviors	10 (16%)	15 (14%)	6 (19%)
Non-emergency transportation	5 (8%)	6 (6%)	5 (16%)

### Providers' Perception of Barriers for P4HB Participation

Factor	First Wave N = 62	Second Wave N = 104	Third Wave N = 31
	Perceived as Barrier n (%)	Perceived as Barrier n (%)	Perceived as Barrier n (%)
Waiver does not cover the full range of family planning services	16 (26%)	27 (26%)	11 (35%)
Waiver does not cover referrals or follow-up care	17 (27%)	28 (27%)	12 (39%)
Waiver does not cover complications of family planning service	16 (26%)	27 (26%)	8 (26%)
Your practice is full	4 (6%)	8 (8%)	3 (10%)
Other	1 (2%)	2 (2%)	-----

### Providers' Information Needs

Type of Information	First Wave N = 62	Second Wave N = 104	Third Wave N = 31
	Need More Information n (%)	Need More Information n (%)	Need More Information n (%)
Enrollment eligibility criteria	21 (34%)	40 (38%)	20 (65%)
Covered services for those enrolled in the Family Planning component	22 (35%)	44 (42%)	24 (77%)
Covered services for those enrolled in the Inter-pregnancy Care component	23 (37%)	47 (45%)	25 (81%)

### Providers' Preference for Receipt of Information

Route of Receiving Information	First Wave N = 62	Second Wave N = 104	Third Wave N = 31
	Preferred Route n (%)	Preferred Route n (%)	Preferred Route n (%)
Direct mailings	20 (32%)	29 (28%)	Question not covered on survey
E-mails to your practice	21 (34%)	38 (37%)	
Websites of the CMOs	62 (100%)	9 (9%)	
Telephone calls to your practice	2 (3%)	6 (6%)	
Website of the Georgia Department of Community Health	11 (18%)	17 (16%)	
Meetings hosted by the Georgia Department of	9 (15%)	15 (14%)	

Community Health or CMOs			
Professional conferences or practice staff meetings	6 (10%)	9 (9%)	
Colleagues	2 (3%)	2 (2%)	
Posting on billboards and public transportation	0 (0%)	0 (0%)	

## **Appendix F**

### **Revised Budget Neutrality Worksheet For Year 1**

## Revised Year 1 Budget Neutrality Worksheet

Georgia's P4HB Budget Neutrality Worksheet for: FEDERAL COST 2011		Quarter 1	Quarter 2	Quarter 3	Quarter 4	TOTAL
<b>WITHOUT DEMONSTRATION - All P4HB Participants (FP and IPC) - FP and associated services (Effective FP?)</b>						
<i>FP and FP-Related Services for All P4HB Pop - 90:10 and reg</i>	FP Enrollee Member Months	41	2,005	10,639	19,455	32,140
<i>FMAP rates (multivits, immunizations, admin., etc)</i>	IPC Enrollee Member Months	-	3	19	51	73
	PMPM for FP Members FP related Services	\$36.32	\$36.22	\$35.96	\$35.96	\$36.11
	PMPM for IPC Members FP related Services	\$28.95	\$28.95	\$28.95	\$28.95	\$28.95
	<b>Total</b>	<b>\$ 1,489</b>	<b>\$ 72,707</b>	<b>\$ 383,091</b>	<b>\$ 701,009</b>	<b>\$ 1,162,758</b>
<b>First Year Infant Costs for VLBW Babies &lt; 1,500 grams (all Medicaid paid births)</b>						
	Estimated Persons					2,117
	Cost per Person	\$ -	\$ -	\$ -	\$ -	\$ 94,106.00
	<b>Total</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 199,222,402</b>
<b>First Year Infant Costs for LBW Babies 1,500 to 2,499 grams (all Medicaid paid births)</b>						
	Estimated Persons					\$ 5,768
	Cost per Person	\$ -	\$ -	\$ -	\$ -	\$ 12,306.00
	<b>Total</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 70,981,008</b>
<b>TOTAL WITHOUT- DEMONSTRATION COSTS</b>		<b>\$ 1,489</b>	<b>\$ 72,707</b>	<b>\$ 383,091</b>	<b>\$ 701,009</b>	<b>\$ 271,366,168</b>
<b>WITH DEMONSTRATION - IPC SERVICES incl. Resource Mothers - Participants Only (Effective IPC?)</b>						
<i>Interpregnancy Care Services at the FMAP rate</i>	Member Months	-	3	19	51	73
	PMPM	\$ 150	\$ 146	\$ 136	\$ 136	\$ 141.94
	<b>Total</b>	<b>\$ -</b>	<b>\$ 439</b>	<b>\$ 2,580</b>	<b>\$ 6,925</b>	<b>\$ 9,944</b>
<b>First Year Infant Costs VLBW Infants &lt; 1,500 grams (all Medicaid paid births adjusted for effect of IPC services)</b>						
	Persons	286	360	380	368	1,394
	Cost per Person	\$ 97,875	\$ 103,669	\$ 92,507	\$ 83,473	
	<b>Total</b>	<b>\$ 27,992,250</b>	<b>\$ 37,320,840</b>	<b>\$ 35,152,660</b>	<b>\$ 30,718,064</b>	<b>\$ 105,775,144</b>
<b>First Year Infant Costs for LBW Babies 1,500 to 2,499 grams (all Medicaid paid births adjusted for effect of IPC Services)</b>						
	Persons	1,405	1,404	1,506	1,521	5,836
	Cost per Person	\$ 12,176	\$ 12,136	\$ 12,420	\$ 12,468	
	<b>Total</b>	<b>\$ 17,107,280</b>	<b>\$ 17,038,944</b>	<b>\$ 18,704,520</b>	<b>\$ 18,963,828</b>	<b>\$ 61,591,530</b>
<b>First Year Infant Costs for Normal Weight &gt; 2,500 grams only for women who participated in the IPC</b>						
	Persons	0	0	0	0	0
	Cost per Person					
	<b>Total</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>
<b>TOTAL WITH DEMONSTRATION COSTS</b>		<b>\$ 17,205,155</b>	<b>\$ 17,142,613</b>	<b>\$ 18,797,027</b>	<b>\$ 19,047,301</b>	<b>\$ 167,376,618</b>
<b>DIFFERENCE</b>						<b>\$ 103,989,550</b>

## **Appendix G – Public Input Announcement**

# **Public Input Announcement**

### **Georgia Medicaid Demonstration Proposal**

Section 1115(a) of the Social Security Act and 42 USC §1315(a); set forth specifications for demonstration proposals that States must implement to ensure the delivery of quality health care by all Managed Care Organizations.

The purpose of this demonstration proposal is to assist the State of Georgia in reducing its low birth weight rates by providing preconception and inter-conception care that promotes birth spacing and appropriately timed pregnancies; with the goal of this project being the reduction of Georgia's low birth weight rate from 9.5% to 8.6% within three (3) years of implementation of the proposal.

A copy of the Planning for Healthy Babies Proposed Extension Demonstration Waiver Document may be made available by written request to the Georgia Department of Community Health, 2 Peachtree Street, N.W., 36<sup>th</sup> Floor Managed Care, Atlanta, Georgia 30303. The Georgia Demonstration Proposal is also available on the department's website at the following link: \_\_\_\_\_

Citizens wishing to comment on the Planning for Healthy Babies Waiver in writing should do so on or before July \_\_, 2014, to the \_\_\_\_\_. Comments can also be made online at P4HB@dch.ga.gov.