Annual Report

Planning for Healthy Babies Program® (P4HB®) 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

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Executive Summary

The Planning for Healthy Babies Program® (P4HB®), 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® 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® 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® 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® program. Of this 7,566 total enrolled population, 19 women were enrolled in the IPC component of P4HB®, 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® 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® 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® 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 liveborn 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® 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® 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® (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 an 1115 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 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® (P4HB®) 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® 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® 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® in lowering the state's rate of VLBW births. The FP and IPC components of P4HB® 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® 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® 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® also covers:

- 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.

The IPC services under the P4HB® 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®). 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® 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 chose to stay with their current CMO or choose a new CMO if desired. Women enrolled in the IPC component of P4HB® 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[1] 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[2] 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® 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 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® 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

[1] 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.

[2] 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.

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® 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® program, the DCH developed a multi-pronged communication plan which incorporated 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. 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.

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® 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®. The Provider Outreach Information brochure and Provider Manual addendum provide written descriptions of the P4HB® 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® 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® materials) to the following provider organizations: Georgia Primary Care Association; Georgia Association of Family Physicians (GAFP); 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® 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® outreach materials that had been developed (i.e. postcards, applications, provider FAQs).

DCH directly distributed P4HB® 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® program and disseminated information about the P4HB® program in their professional societies' newsletters. The Georgia Academy of Family Physicians hosted an information session about the P4HB® program during its summer membership meeting in June 2011. The Georgia OB/GYN Society

presented information on P4HB® 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® 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:

- September 2011: RSM workers promoted P4HB® to over 1,000 people at both "Paint the Town Pink" and "Troup Family Day" in LaGrange county;
- October 2011: RSM workers promoted P4HB® 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® applications and educational information targeting IPC members in three regions;
- Case management (CM) education to high risk OB members about P4HB® 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® program and how to apply; 3) to newly enrolled P4HB® members to educate them on benefits and services; 4) to members with VLBW babies admitted to the NICU to provide education on the P4HB® program and how to apply;
- Mass mailed applications to postpartum members who had recently delivered to educate them about P4HB®;
- 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® program. Distributed one P4HB® poster in each Georgia county DFCS office lobby along with an ample supply of P4HB® applications and postcards;
- Trained staff in Georgia's Public Health District 7 (16 counties) on the P4HB® 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® program. DCH also included these resources on the P4HB® 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® 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®; conducting joint webinar trainings for providers and health care managers; and creating a quick reference card for P4HB®.

To date, the Georgia CMOs have posted information about P4HB® 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/). 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®. 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 liveborn, 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® program – Georgia's stand- alone CHIP program. RSM and PeachCare for Kids® 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 their current CMO to receive their P4HB® services. Based on January 2012 statistics, this auto-enrollment process expanded knowledge of the P4HB® 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® 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® eligibility requirements.

III. ENROLLMENT AND PARTICIPATION

Before discussing the patterns of enrollment in the first year, it is important to understand the P4HB®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®, 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® 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

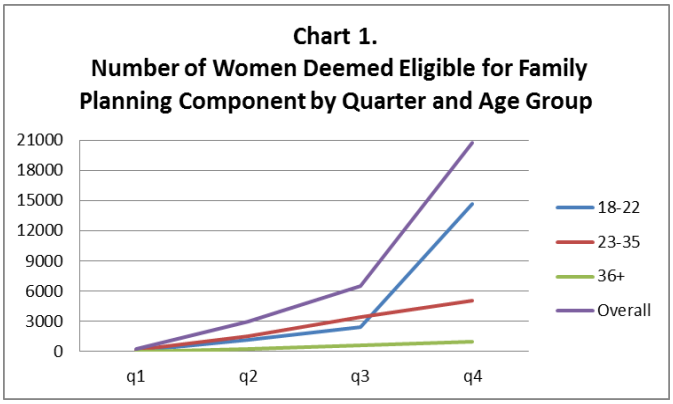
department, county DFCS staff and RSM staff were responsible for verifying this documentation. Once the applications were completed by the prospective Demonstration participants, they were forwarded via mail or electronically to Policy Studies Incorporated (PSI) for processing. PSI would verify that 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® 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® program; send them a new member packet that detailed their benefits under the P4HB® program; and send them a membership card which identified their benefits.

During Year 1, data obtained from DCH's P4HB® 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

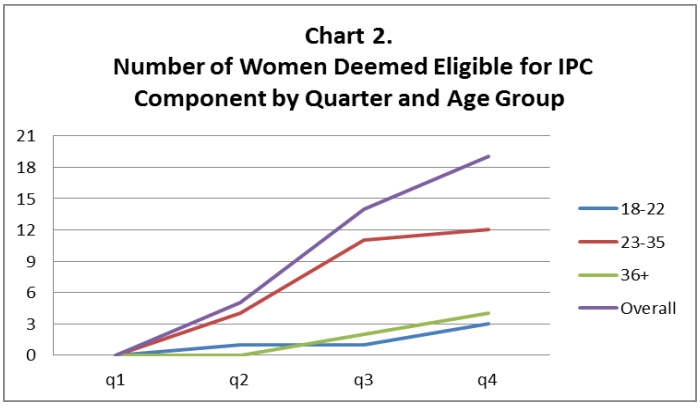
viewed. Despite repeated efforts to educate local public health offices about their ability to accelerate the enrollment process, the average time from application to referral in Year 1 did not decline. The auto-enrollment process was implemented in December 2011 to further expedite enrollment for RSM women who would otherwise be disenrolled from Medicaid 60 days post-partum, and for young women aging out of the PeachCare for Kids® program.

Enrollment Trends

During the first year of the P4HB®, 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.



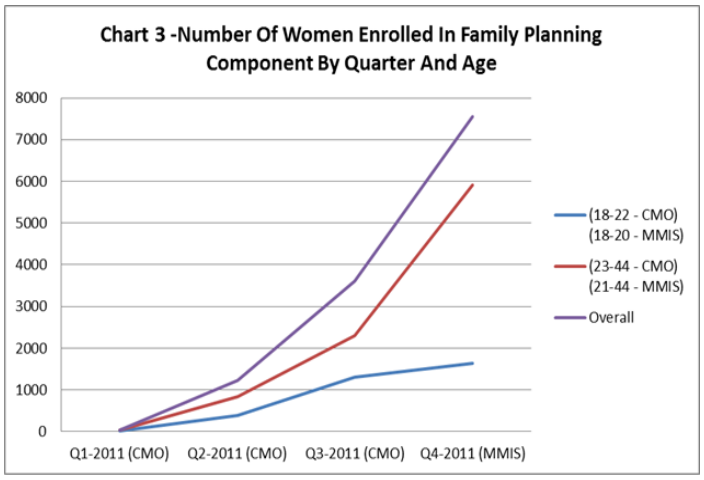
The number of women deemed eligible for the family planning only component of P4HB®grew from less than 3,000 by the end of the second quarter to a total of almost 21,000 by the end of the fourth quarter of Year 1 (See Chart 1). While there was a steady increase in the number of women in the 23-35 year 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® 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®.

The number of women enrolled in the family planning component of P4HB® by the end of the first year fell short of the 20,976 deemed eligibile 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®. We note that the DCH fourth quarter P4HB® 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® may indicate the lack of awareness and knowledge of P4HB® 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® program, we have to consider the total number of women likely eligible for P4HB® 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®. An shown below in Table 1 using the ACS data, 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 (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 4th Quarter 2011	Population Eligible in Community[1,2]	Percent Eligible Enrolled
FP Only[3]	7,543	257,895	2.9%
FP Only[3]	7,543	140,522[4]	5.3%
IPC/Resource Mother Only	23	1,420	1.6 %

[1]*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.*

[2]*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.*

[3]*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.*

[4] *This denominator adjusts for women in need of family planning services based on a report from the Guttmacher Institute. Their estimate is that 54.5% of women in the age group 13-44 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® program, the CMOs, in collaboration with the DCH, monitor member and provider overall knowledge and understanding of P4HB® 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® 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® 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® 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® 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® 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® program as reported by the 169 members responding. It is apparent that a substantial number of members report enrolling in P4HB® to receive primary care services such as a 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®

	Responses N (%)
Enrollment in P4HB® to get…	
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%)
Have used these P4HB® services…	
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%)
Before enrolling in P4HB® , had trouble getting…	
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%)
Types of problems prior to P4HB®:	
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%)
Changes P4HB® made for the participant…	
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® reported by these women (83%) was their ability to obtain preventive and primary care due to the P4HB® 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® program.

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

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

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®. The percentage responding correctly to the eligibility criteria for this component of the P4HB® 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® 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 (%)
Services available through the "Pink Card"…	
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%)
Services available through the "Purple Card"…	
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%)
Eligibility for 'Pink Card'	
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%)
Eligibility for 'Purple Card'	
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®

Problems Under P4HB®	Responses N (%)
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	Respones 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® 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® 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® 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® 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® 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® 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® program;
- Eligibility criteria for the specific components of P4HB®; or
- Services covered under their CMO contract for P4HB®.

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®

Eligibility Criteria for P4HB®	Correct Responses by Category of P4HB®	
	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®. 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® 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®.

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

Table 9. Providers' Knowledge of Services Covered Under their P4HB® Contract

Services Covered Under P4HB®	Correct Responses N (%)
Family planning initial and follow-up exams	25 (40%)
Contraceptive services and methods	27 (44%)
Tubal litigation	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-Diptheria 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® 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® 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® 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®.

Table 12. Providers' Preference for Receipt of Information

Preferred Route of Receiving Information	Response N (%)
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® program, a great deal more education was needed for those already involved in the P4HB® 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® 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® 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® 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® 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®.

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 liveborn, stillborn (≥ 22 weeks' gestation) or fetal deaths (<22 weeks' gestation) and to further categorize liveborn 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® 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® 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 liveborn, 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 liveborn 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 liveborn 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 liveborn 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
All Medicaid Deliveries[1]			
Total Deliveries[2]	78,229	$364,806,937	$4,663[(6)]
Liveborn deliveries	69,638	$352,769,025	$5,066[(6)]
Stillborn deliveries (>= 22 weeks)[1]	1,239	$4,493,957	$3,627[(6)]
Fetal deaths < 22 weeks[1]	7,352	$7,543,955	$1,026[(6)]
Deliveries[1] to Demonstration			
Entire Demonstration population			
Total Deliveries	6	$450	$75
Liveborn deliveries	0	0	0
Stillborn deliveries (>= 22 weeks)[1]	0	0	0
Fetal deaths < 22 weeks[1]	6	$450	$75
FP only[3]			
Liveborn deliveries	0	0	0
Stillborn deliveries (>= 22 weeks)[1]	0	0	0
Fetal deaths < 22 weeks[1]	6	$450	$75
IPC and FP[4]			
Liveborn deliveries	0	0	0
Stillborn deliveries (>= 22 weeks)[1]	0	0	0
Fetal deaths < 22 weeks[1]	0	0	0
Resource Mother only[5]			
Liveborn deliveries	0	0	0
Stillborn deliveries (>= 22 weeks)[1]	0	0	0
Fetal deaths < 22 weeks[1]	0	0	0

[1] *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 Livebirths*** *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.*

[2] *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 liveborn deliveries, 1,276 stillbirths and 7,756 fetal deaths.*

[3] *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® 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.*

[4] *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.*

[5] *Participants in the Demonstration with Resource Mother only benefits are LIM and ABD classes of eligibility with a delivery and VLBW birthweight 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.*

[6] *A total of 46 records with zero amounts paid are included in this average; for fetal deaths there were 5, stillborn 2 and liveborn 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®. 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 liveborn deliveries to Demonstration participants. While there were no liveborn deliveries or stillbirths observed for the P4HB® participants, there were 6 fetal death deliveries (< 22 weeks' gestation) observed among women enrolled in the family planning only component of P4HB®. 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®. 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 livebirth or stillbirth. Note that the number of liveborn infants (72,122) is greater than the number of liveborn deliveries (69,638) due to multiple gestations, whereby deliveries result in more than a single birth. Of the total 72,122 liveborn 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 liveborn 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 birthweight. 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 livebirths 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® program and

since we were not able to categorize all liveborn 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® 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 birthweight, 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%) liveborn 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 birthweight 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[4]	Total $ Paid Infant Delivery Hospitalization	Average $ Paid Infant Delivery Hospitalization
All Medicaid Livebirths [2]	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[3]	133	5,821	370,290	2,784

[1] We note that there were no livebirths or stillbirths for women enrolled in the family planning only component of the Demonstration nor were there livebirths 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.

[2] 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 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*

[3] Stillborn infants were identified using Georgia DRG code 600.

[4] 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.

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

MEASURE	Infants[1] Born on Medicaid in First 6 Months of CY2011	1st Year of Life Post-Delivery Hospitalization			
		Average $ Paid per Infants[2]Born in First 6 Months of CY2011	Total $ Paid[3] Extrapolated to All Infants[4] from those Born in First 6 Months	Total $ Paid Extrapolated to Continuously Enrolled Infants[5]	Average $ Paid per Continuously Enrolled Infants[5]
Medicaid Livebirths[1]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

[1] The 35,756 liveborn 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.

[2]Costs for all infants born in the first six months of CY2011 are included regardless of their disenrollment or death.

[3]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.

[4]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.

[5] 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® 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® 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® 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

Demonstration Participants	Total Annual Costs	Average Annual Costs/Woman
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®.

Averted Births and Budget Neutrality

***Averted Births*.** 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 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®, 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

Year	Number of 'Expected' Births Among Participants[1]	Number of Births to Participants	Number of 'Averted' Births
2011	1312	0	1312

[1] 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

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® 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® 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. 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® 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® into P4HB®. 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® 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® 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® 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® 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® 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®. 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® 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® program. Working with the CMOs, DCH could develop text-based messaging to P4HB® 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® program. The toolkit is available at: 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®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, GAFP, GOGS, public health nurse association) and hospital networks to deliver provider education about the P4HB® program (purpose, eligibility, covered services, means of enrollment). Care should be taken to clarify whether all services covered by P4HB® 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® have their anticipated impact. DCH now has through June of 2013 to enroll women in the several components of the P4HB® 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® in order for the Demonstration to reach its full potential in terms of improving the reproductive health of P4HB® 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® 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.

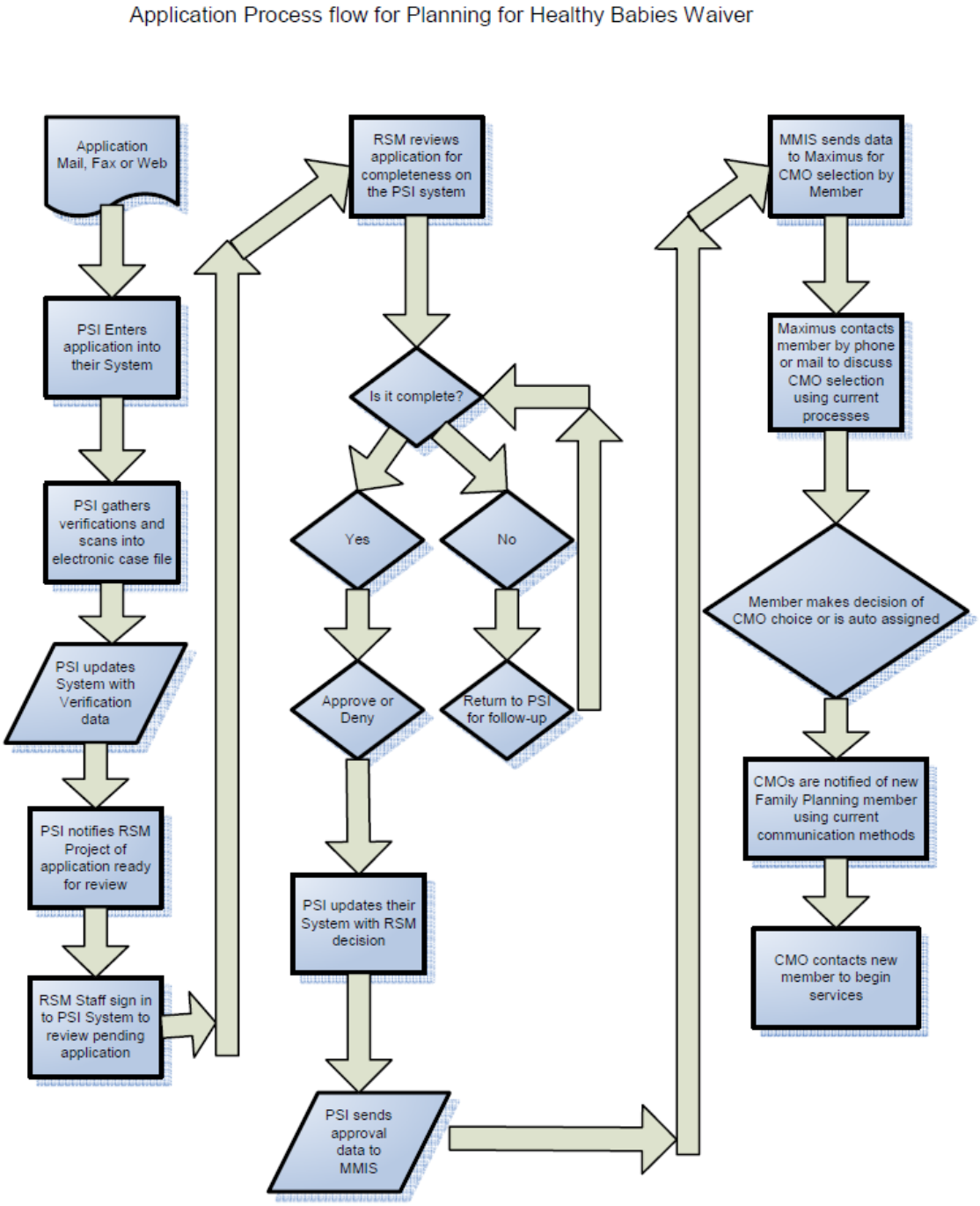
Appendix A: P4HB® Communication Plan

Phase	Activities	Status
Phase 1: Educate Providers and CMOs 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."	1) Introducing a revised P4HB Communication Plan to the Work Group and the CMOs; 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 3) Introduce the P4HB program and program-related materials to the CMOs (including program logo, poster and postcards).	1) through 3). Completed initial education. Re-education is ongoing. Web page developed and updated as needed. CMOs utilizing program-related materials.
Phase 2: Leverage the Strengths & Assets of Partners Purpose is to use local experts to champion LBW prevention by encouraging eligible women in their respective communities to enroll in the P4HB program	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.	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
Phase 3: Implement Consumer-Based Outreach (statewide and Locally) Purpose is to inform consumers and providers about P4HB using media, messaging, and an organized set of communication activities	1) Introduce campaign to 18 public health districts 2) Outline marketing proposal and estimated costs 3) Determine overall budget and process in which marketing materials will be purchased 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	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.

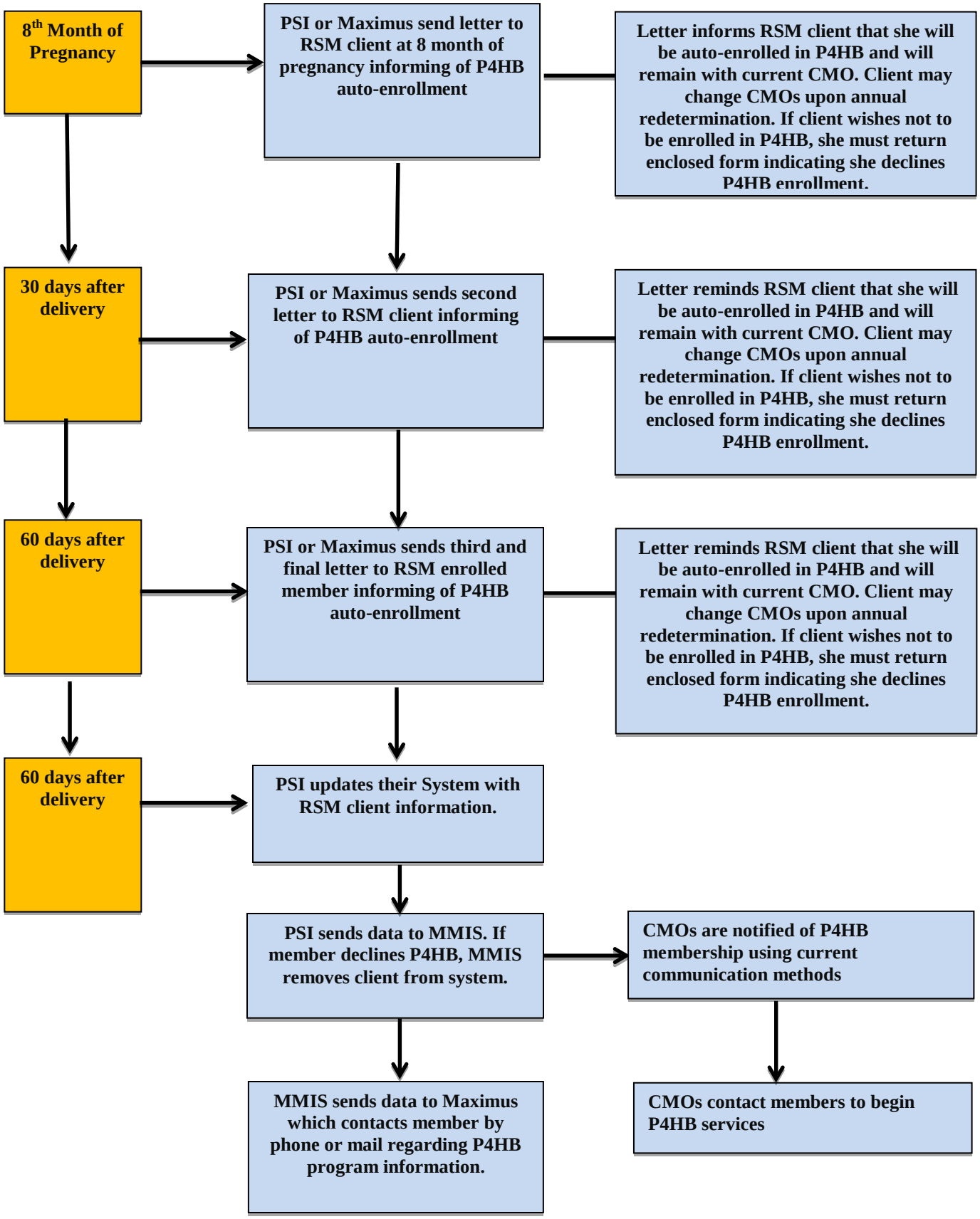
	targeted first for billboard ads. 5) Finalize copy for poster/postcard design 6) Replace postcard with brochure in summer 2011. 7) Obtain approval of printing cost for brochures, posters/postcards; obtain shipping addresses 8) Provide RSM, PH departments, and DFCS officials with notice that postcards/posters and brochures will be distributed and guidance about how to use them. 9) Draft/distribute press release announcing launch of P4HB program. 10) Pitch background sessions to identified reporters from the Atlanta Journal & Constitution. 11) Begin brainstorming a newsworthy event for Summer 2011 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.	

Phase 4: Use Existing Resources for Support and Coaching Goal is to use current available resources in Georgia to promote prenatal care, healthy lifestyles before and during pregnancy, and smoking cessation.	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.
Phase 5: Annual Campaign Evaluation 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	1) Assess the strengths and weaknesses of campaign materials and strategies 2) Measure effort and the direct outputs of campaign 3) Examine the campaign's implementation and how the activities involved are working 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.) 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. 6) Make recommendations for Year 2 of the campaign based on data gained from the annual evaluation; implement necessary changes in Year 2	Ongoing. Emory University is assisting with the evaluation.

Appendix B: Schematic of Enrollment Process



Process of Auto Enrollment in Planning for Heatlhy 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**
a. Enrolled in these parts of P4HB:			
Family Planning (Pink Card)	□	□	□
Interpregnancy Care or IPC (Purple Card)	□	□	□
Resource Mother Only (Yellow Card)	□	□	□
b. Did you enroll in P4HB to get:			
Family planning services?	□	□	□
Pregnancy testing?	□	□	□
Testing or treatment for sexually transmitted infections?	□	□	□
Primary care (such as check-ups or physicals, care for an illness)?	□	□	□
Other *(please fill in):* _____	□	□	□
c. Have you used any of these P4HB services:			
Family planning ?	□	□	□
Pregnancy testing?	□	□	□
Testing or treatment for sexually transmitted infections?	□	□	□
Primary care (such as routine check-ups, care for an illness)?	□	□	□
Other (*please fill in*):_____			
d. Before you enrolled in P4HB, did you have problems getting:			
Family planning services?	□	□	□
Pregnancy testing?	□	□	□
Testing or treatment for sexually transmitted infections?	□	□	□
Primary care (such as routine check-up, care for an illness)?	□	□	□
Other *(please fill in):* _____	□	□	□

If "Yes" to ANY part of 1d:

What types of problems did you have? *(check all that apply)*

- ❑ I did not have a way to get to appointments
- ❑ I could not pay for services
- ❑ I could not pay for birth control methods
- ❑ I could not find a doctor or nurse
- ❑ I could not get time off from work for appointments
- ❑ I had no one to take care of my children
- ❑ I was too sick to get to the doctor or clinic
- ❑ 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	□	□	□
b. I am going to a different doctor or nurse for primary care	□	□	□
c. I have started using a birth control method	□	□	□
d. I have changed the birth control method I use	□	□	□
e. I have more choices of birth control methods	□	□	□
f. I do not have to use my own money to get birth control methods or services	□	□	□
g. I am able to get preventive care (such as Pap smears) and family planning counseling	□	□	□
h. With the Purple Card (IPC), I am able to get care for illnesses	□	□	□
i. With the Purple Card (IPC), I am able to get medicines for illnesses when I need them	□	□	□
j. Other *(please fill in):* _____	□	□	□

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	□	□	□
b. Pap smear and pelvic exam	□	□	□
c. Tubal Ligation (tubes tied)	□	□	□
d. Pregnancy testing	□	□	□
e. Screening for sexually transmitted infections	□	□	□
f. Follow-up of an abnormal Pap smear	□	□	□
g. Treatment for sexually transmitted infections	□	□	□
h. Treatment for major problems related to family planning services	□	□	□
i. Vitamins with folic acid	□	□	□
j. Some vaccinations	□	□	□

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)	□	□	□
b. Treatment of medical problems (such as high blood pressure or diabetes)	□	□	□
c. Medicines for medical problems (such as high blood pressure or diabetes)	□	□	□
d. Care for drug and alcohol abuse (such as rehab programs)	□	□	□
e. Some dental services	□	□	□
f. Non-emergency transportation	□	□	□
g. Nurse case management/Resource Mother	□	□	□

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	□	□	□
b. Be a resident of Georgia	□	□	□
c. Be a U.S. Citizen	□	□	□
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)	□	□	□
e. Not be eligible for Medicaid or the Children's Health Insurance Program (PeachCare)	□	□	□
f. Other *(Please fill in)* _____	□	□	□

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	□	□	□
b. Be a resident of Georgia	□	□	□
c. Be a U.S. Citizen	□	□	□
d. Have a household income at or below 200% of the federal poverty level	□	□	□
e. Not otherwise eligible for Medicaid or the Children's Health Insurance Program (CHIP)	□	□	□
f. Have delivered a very low birth weight infant since January 1, 2011	□	□	□
g. Other *(Please fill in)* _____	□	□	□

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	□	□	□	□
b. I cannot get referrals or follow-up for care I need	□	□	□	□
c. I cannot find a doctor or nurse willing to take P4HB clients	□	□	□	□
d. I don't want to leave my current doctor or nurse	□	□	□	□
e. I have to wait too long to get services	□	□	□	□
f. I do not have transportation	□	□	□	□
g. I cannot get to the doctor or nurse when they are open	□	□	□	□
h. My P4HB doctor or nurse will not prescribe my birth control methods	□	□	□	□
i. Other *(Please fill in)* _____	□	□	□	□

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	□	□	□
c. Which services are available to me with the Purple Card	□	□	□
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	□	□	□
b. Understand whether I can get P4HB	□	□	□
c. Complete the paper work to sign up for P4HB	□	□	□
d. Complete the web form to sign up for P4HB	□	□	□
e. Get the required documents to sign up for P4HB	□	□	□
f. Pick a Care Management Organization (CMO)	□	□	□
g. Pick a provider	□	□	□
h. Understand what I can get from P4HB	□	□	□
i. Other *(please fill in)* _____	□	□	□

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?	□	□	□
b. Providing family planning or primary care services to women of reproductive age?	□	□	□
c. Aware of Georgia's Planning for Healthy Babies (P4HB) Program?	□	□	□

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?	□	□	□

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	□	□	□
b. Contraceptive services and methods	□	□	□
c. Tubal ligation	□	□	□
d. Pregnancy testing	□	□	□
e. Screening for sexually transmitted infections	□	□	□
f. Follow-up of an abnormal Pap smear, including Colposcopy	□	□	□
g. Treatment for sexually transmitted infections	□	□	□
h. Treatment for major complications related to family planning services	□	□	□
i. Multivitamins with folic acid	□	□	□
j. Hepatitis B and Tetanus-Diphtheria vaccines	□	□	□

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)	□	□	□
b. Management and follow-up of chronic diseases	□	□	□
c. Prescription medications for chronic diseases	□	□	□
d. Detoxification and outpatient rehabilitation for substance abuse	□	□	□
e. Limited dental services	□	□	□
f. Nurse case management and Resource mother outreach for health and social service coordination and support of health behaviors	□	□	□
f. Non-emergency transportation	□	□	□
g. Multivitamins with folic acid	□	□	□
h. Hepatitis B and Tetanus-Diphtheria vaccines	□	□	□

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	□	□	□
b. Resident of Georgia	□	□	□
c. U.S. Citizen	□	□	□
d. Household income at or below 200% of the federal poverty level	□	□	□
e. Not otherwise eligible for Medicaid or the Children's Health Insurance Program (CHIP-PeachCare)	□	□	□
f. Other *(Please fill in)* _____			

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	□	□	□
b. Resident of Georgia	□	□	□
c. U.S. Citizen	□	□	□
d. Household income at or below 200% of the federal poverty level	□	□	□
e. Not otherwise eligible for Medicaid or the Children's Health Insurance Program (CHIP-PeachCare)	□	□	□
f. Delivered a very low birth weight infant since January 1, 2011	□	□	□
g. Other *(Please fill in)* _____			

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	□	□	□	□
b.Waiver does not cover referrals or follow-up	□	□	□	□
c.Waiver does not cover complications of family planning services	□	□	□	□
d.Payments to providers are not adequate	□	□	□	□
e.Problems or delays in receiving payments	□	□	□	□

f. Your practice is full	□	□	□	□
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	□	□	□
b. Determination of eligibility	□	□	□
c. Enrollment process	□	□	□
d. Covered services for those enrolled in the Family Planning Component	□	□	□
e. Covered services for those enrolled in the Interpregnancy Care Component	□	□	□
f. Reimbursement rates	□	□	□

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
P4HB Education	
Member Education	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. CMOs and DCH: Include more information about covered services on their respective websites.
Provider Education	DCH: Engage with professional associations (G-AAP, GAFP, 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
Outreach	
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.
Education Regarding Benefits from Family Planning	
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.