Annual Report

Planning for Healthy Babies Program® (P4HB®)

1115 Demonstration in Georgia

YEAR 3

Submitted to the Centers for Medicare and Medicaid Services

By:

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And

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Department of Health Policy and Management (HPM)

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TABLE OF CONTENTS

Executive Summary

The Planning for Healthy Babies Program® (P4HB®), Georgia's section 1115(a) Medicaid Demonstration was designed to expand 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 the state's Medicaid or Children's Health Insurance Program (CHIP). Additionally, the Demonstration was created to provide Interpregnancy Care (IPC) services to women who meet the eligibility criteria mentioned above and delivered a very low birth weight (VLBW) infant (less than 1,500 grams) on or after January 1, 2011. The Demonstration includes a third level of service for women - those ages 18 through 44 with a family income at or below 200 percent of the FPL, who delivered a VLBW infant on or after January 1, 2011, and also qualify under Georgia's Low Income Medicaid (LIM) Class of Assistance or the Aged, Blind and Disabled (ABD) Classes of Assistance. They are eligible for nurse case management/Resource Mother Outreach only services.

Georgia's goals for the Demonstration are to:

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

All services provided under the P4HB program are delivered through the Georgia Families Care Management Organizations (CMOs) and their networks of providers. The three CMOs - Amerigroup, WellCare of Georgia, Inc., and Peach State Health Plan - receive an actuarially sound capitated per member per month (PMPM) payment for each of the Demonstration participants enrolled with them. A PMPM was established for each level of service within the P4HB program and the capitation rates were approved by CMS. The capitated rates have served as the basis for calculating the expenses in the quarterly budget neutrality worksheets submitted to CMS.

During Program Year 3 (PY 3) of the P4HB program, DCH and the CMOs conducted outreach to professional associations, the Georgia Department of Public Health (DPH) and consumers via printed and other media about the P4HB program. Despite these efforts, there has been lower than expected enrollment counts for the program and lower utilization of the program's benefits among those enrolled. Using an estimate from the American Community Survey (ACS) of uninsured women < 200% FPL in Georgia in 2013, approximately 11% of the estimated eligible population was enrolled in the family planning (FP) only component at the end of PY 3. If the number of eligible women is adjusted for the percentage of women 'in need' of family planning services, the percentage enrolled in the family planning only component is estimated at 20% in 2013.

In order to increase enrollment in the program, Georgia implemented an auto-enrollment process in December 2011. By the beginning of PY 3, a large number of women had been auto-enrolled into the family planning only component of the P4HB program; these women accounted for 67% of total enrollees in this component in PY 3. The auto-enrollment of FP only women was discontinued in July 2013, the month when the program's enrollment topped 41,000 women. Some of the data presented here would indicate these auto-enrolled women had less interest or understanding of the P4HB program and hence, used services at a lower rate than those initiating their own enrollment into the program.

The cost of the P4HB program grew as enrollment grew. The PMPM payments to the CMOs totaled $18,373,944.39 by the end of PY 3 resulting in a total of $34,496,977.76 across the three years since implementation of the P4HB program. The PY 3 total includes $17,811,781.29 for FP only services, $386,160 for IPC services, and $176,003.10 for Resource Mother Only services. The total PY 3 expenditures of just over $18 million reflects an overall growth in enrollment during this period from PY 2 and represents approximately a 24% increase in total spending when compared with the expenditures during the second year of the program ($14,776,646.80). As reported in the fourth quarter 2013 P4HB Quarterly Report to CMS, the member months for the FP only component peaked in July of 2013 and then declined through the end of 2013. Conversely, the IPC enrollee and member months were on the decline during 2013 until August of that year when they started increasing significantly through the end of the year. Some of the initial decline may have been the result of a small number (about 9%) of the IPC enrolled women experiencing a new pregnancy in 2013.

As a continuation of the evaluation design, the evaluation team examined early effects of the P4HB program on: 1) use of family planning services among Medicaid enrolled women and among women in the income range targeted by P4HB; 2) trends in the total number of Medicaid paid deliveries/births and birth weight distributions; 3) pregnancies and births among P4HB enrollees and infant birth weight outcomes; 4) comparisons of birth outcomes between P4HB participants and non-participants; 5) time to next pregnancy for Right from the Start Medicaid (RSM) enrollees with an index birth between 2009 and 2013; and 6) evidence of increased management of chronic conditions among IPC enrollees. This PY 3 report uses enrollment data for P4HB enrollees based on their enrollment into a CMO (the revised PY 2 report used the same methodology) since this is the date that determines their eligibility to receive services under the Demonstration. This report presents data that support the following key findings:

Use of Family Planning:

- The percentage of uninsured women in the income range targeted by the P4HB program (>25% but < 200% FPL) using any family planning services at Title X clinics increased slightly from the first quarter of 2009 through the last quarter of 2013;
- Use of contraceptives at Title X clinics shifted toward long-acting, reversible contraceptives (LARCs) based on both descriptive and multivariate analysis;
- Use of family planning services among all Medicaid enrolled women ages 18-44 increased from 35.2% in 2009 to 36.3% in 2013;
- Growth in family planning services paid for by Medicaid or Title X did not increase enough to result in an increasing percentage of *all* women < 200% FPL in the community with a family planning or birth control visit over the 2009-2013 time period; but
- A higher percentage of non-auto-enrolled P4HB family planning only women used family planning services than did all Medicaid enrolled women ages 18-44.

Trends in Births/Costs:

- Medicaid paid births were declining prior to implementation of the P4HB program and continued through CY 2011, rose in CY 2012 and remained fairly stable in CY 2013;
- Average paid amounts for infants at delivery increased from $3,274 to $4,321 over the 2009-2013 years;
- Average paid amount for VLBW infants at delivery in PY 3 equaled $87,496; and
- The percentage of very low birth weight infants remained close to 2.0% each year between 2009 -2013 with a slight increase to 2.2% in 2013 based on Medicaid claims *only*.

Pregnancy/Birth Experiences of P4HB Enrollees:

- Total births to P4HB enrollees were 3,462 in 2013, less than 'expected' given the fertility rates cited in the DCH Planning for Healthy Babies Concept Paper used in the application process[1] but this is a higher percentage (66%) of those expected in PY 3 than seen in PY 2 (10%) data;

[1] http://dch.georgia.gov/sites/dch.georgia.gov/files/imported/vgn/images/portal/cit_1210/33/52/156793595PlanningforHealthyBabiesProgram121709Final.pdf

- An estimated 10.9% of FP only P4HB enrollees experienced a pregnancy within 6 months of continuous enrollment in the P4HB program, and 8.2% had a delivery paid by Medicaid after enrollment;
- The 10.9% of FP only P4HB enrollees experiencing a pregnancy within 6 months of continuous enrollment in the P4HB program is less than the 14.1% of RSM women who did not participate in P4HB and experienced a pregnancy within 6 months of an index delivery;
- Eleven IPC enrollees experienced a delivery in PY 3; ten had a live born delivery and one had a fetal death paid by Medicaid in PY 3;
- Repeat pregnancies among Medicaid-enrolled women with a VLBW birth in PY 3 equaled 4.8% within 6 months for IPC enrollees compared to 6.9 % for RSM women with a VLBW infant not participating in IPC;
- Repeat pregnancies within 12 months were 11.1% for IPC enrollees and 22.1% for RSM women; and
- There were no repeat VLBW births among the IPC enrollees – a tremendous success for the program.

Changes in Other Outcomes:

- The percentage of eligible women in the community who were enrolled in the P4HB program declined slightly from 12% in 2012 to 11.1% in 2013 and dropped from about 22% in 2012 to 20% in 2013 among eligible women estimated to be 'in need' of family planning services;
- The percentage of all Medicaid eligible mothers who delivered a VLBW infant and subsequently enrolled in the IPC/Resource Mother only component of P4HB increased from about 15% to about 19% between 2012 and 2013;
- Infant first year of life costs after delivery hospitalization averaged $2,540 in 2013, $2,355 in 2012, and $1,851 in 2011; and
- Small percentages of IPC participants were using services in 2011 but this increased in 2012 and in 2013 (to 46%), with an average of 6.8 and 3.3 encounters per IPC participant, respectively, for 2012 and 2013. While the majority of the encounters by IPC participants were for acute conditions in 2012, the most frequently utilized services by IPC participants in 2013 were contraceptive management, gynecologic care, and preventive care. Compared to 2011, service utilization by IPC participants for chronic conditions did increase in 2012 (23%) and 2013 (19%), with the most common diagnosis codes corresponding to service use for hypertension, depression, and obesity.

The numbers we present in this third year annual report are based on claims and encounter data from 2009-2013 with linkages to the Georgia vital records maintained by the Department of Public Health (DPH) for CY 2009 through CY 2011. As noted in our Year 2 report, the evaluation team found similar agreement between claims and vital records when using ICD-9 coding rather than DRG coding, to categorize infant birth weight based on claims. However, when using either coding system in comparison to the vital records, claims data consistently showed: 1) a smaller percentage of infants were categorized as LBW; and 2) within those categorized as LBW, a larger percentage was categorized as VLBW than reported in the vital records for the same set of infants. Hence, in this report, Emory University (the P4HB evaluator) continued to use ICD-9 coding and assigned the lowest birth weight observed in claims in order to provide more conservative measures of any effect seen and to be consistent with reporting over time. Ultimately, Emory will use the vital records data as the 'gold standard' for measuring birth weight once they are available and linked for the full pre and post P4HB periods.

The evaluation team also noted that the claims led to an apparent undercount of infants in CY 2011 and an undercount of deliveries in CY 2012. The latter is most important for the measures reported over time since deliveries to women enrolled in the P4HB program in the first full year after the implementation year were likely *understated.* This should be kept in mind as the results for PY 3 are reviewed. We recognize there is a lack of standardization in the definition of 'Medicaid-financed births' across states and hope that our effort in Georgia will contribute toward a common set of definitions and standards for computing these measures using Medicaid claims data, vital records, and once completed, linked claims-vital records.

Based on the analysis of the data through the third year of the Demonstration presented here, Emory makes the following recommendations to DCH:

- Continue to work on providers' and women's understanding of the P4HB program as a significant number of women continue to come into the program apparently already pregnant. This number was smaller in PY 3 compared to PY 2 indicating some efforts have been successful.
- At the time of this writing, Georgia is awaiting approval of its extension request for the P4HB program. Once the extension is approved, we encourage the state to continue working with the state and local public health departments and the new Title X grantee as

active partners in the enrollment of eligible women into the P4HB program and in the provision of family planning services to uninsured and under insured women who, if pregnant, are eligible for Medicaid coverage.

- Continue to use the Title X and Medicaid data to ensure that the total system—Medicaid and Title X combined—increases the use of family planning services among those income and age groups targeted by the Demonstration.
- To the extent there are auto-enrolled women in the P4HB program, ensure these women are made aware of the benefits available to them and work to retain them in the program.
- Continue the success of the IPC component in enrolling women with a VLBW infant. Ensure their awareness and utilization of the range of services available to them and, in particular, the management of chronic conditions in addition to the family planning services intended to help them prevent a repeat pregnancy or birth within a short time period.
- Continue efforts to decrease the time between the eligibility determination and actual CMO enrollment for P4HB women. We understand that DCH will soon implement improvements that will substantially reduce this time period; however, the impact of these improvements will not be documented until the PY 5 annual report is prepared.

I. OVERVIEW OF THE PLANNING FOR HEALTHY BABIES PROGRAM (P4HB)

In 2010, the Georgia Department of Community Health (DCH) designed a Section 1115(a) Demonstration, titled Planning for Healthy Babies® (P4HB®), and was granted authority by CMS to expand access to family planning services under the P4HB program. This program became available in January 2011 for women eligible under the following criteria: U.S. citizens and residents of Georgia who are otherwise uninsured and not eligible for Medicaid; 18 through 44 years of age; not pregnant but able to become pregnant; and with incomes at or below 200% of the Federal Poverty Level (FPL).

In addition to family planning services, the P4HB program provides Interpregnancy Care (IPC) services to women who meet the family planning eligibility criteria and who deliver a very low birth weight (VLBW) infant on or after January 1, 2011. The IPC component was modeled after a study by researchers at Emory University and published in 2007 in the Journal of Maternal and Child Health. The article, "*Interpregnancy Primary Care and Social Support for African-American Women at Risk for Recurrent Very-low-birthweight Delivery: A Pilot Evaluation,*" published at the conclusion of the study, concluded that primary health care and social support for low-income, African-American women following a VLBW delivery may enhance achievement of a subsequent 18-month interpregnancy interval and reduce adverse pregnancy outcomes. The P4HB program offers nurse case management and Resource Mother outreach services to women receiving IPC services and to women enrolled in the Georgia LIM (Low Income Medicaid) or ABD (Aged, Blind and Disabled) Medicaid programs who delivered a very low birth weight infant on or after January 1, 2011.

DCH identified the following as key outcome goals for the P4HB program:

- **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.

By increasing inter-pregnancy intervals among our 'targeted' group of near-poor women through the use of effective contraception and through the provision of IPC services to women at or below 200% of the FPL who delivered a VLBW infant and are at increased risk of repeating an adverse pregnancy outcome such as a VLBW delivery, the P4HB program is poised to achieve success in lowering the state's rate of VLBW births and achieving its goal to reduce the number of unintended pregnancies/births. The P4HB program may also provide positive influences on birth weight by expanding the use of effective birth control methods among women in this income range, thereby decreasing unintended pregnancies and lengthening inter-pregnancy intervals.

Family planning services are available to eligible women for as long as they remain eligible for the program. These services include all family planning services covered by the Georgia Medicaid program as identified below:

- Comprehensive annual exam;
- Pap smear including follow-up testing with colposcopy as indicated, clinical breast examination;
- Follow-up contraceptive visits;
- Pregnancy testing;
- Provision of FDA-approved contraceptive methods and supplies, evaluation and management of contraceptive-related problems;

- Sterilization;
- Treatment of major complications of delivered services;
- Diagnostic treatment and follow-up of STIs;
- Drugs, supplies, devices related to women's health services (genital tract infections, UTI's, etc);
- Multivitamin with folic acid or folic acid;
- HepB and Td vaccinations for 19 and 20 year-olds;
- Education and counseling (with referral as needed) related to reproductive health, preventive and preconception care, pregnancy timing and spacing, risk reduction for sexually transmitted infections, tobacco and substance abuse, domestic violence, and benefits and risks of contraceptive methods; and
- Counseling and referrals to social services and primary health care providers.

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

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

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

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

Demonstration Objectives

The objectives identified below were established to affect achievement of the Demonstration's goals. During PY 3, progress toward achievement of these objectives was monitored quarterly through reporting from the CMOs and the evaluator. The objectives include:

- Improve access to family planning services by extending eligibility for these services to the newly eligible women during the length of the Demonstration.
- Provide access to inter-pregnancy primary care health services for eligible women who deliver a VLBW infant during the length of the Demonstration.
- Decrease unintended and high-risk pregnancies among Medicaid eligible women.
- Decrease late teen pregnancies by reducing the number of first or repeat teen births among Medicaid eligible women ages 18-19 years.
- Decrease the number of Medicaid-paid deliveries from the number expected to occur in the absence of the Demonstration beginning in the second year.

- Increase child spacing intervals through effective contraceptive use to foster reduced LBW rates and improved health status of women.
- Increase consistent use of contraceptive methods by providing wider access to family planning services and incorporating care coordination and patient-directed counseling into family planning visits.
- Increase family planning utilization among Medicaid eligible women by using an outreach and public awareness program designed with input from family planning patients and providers as well as women needing but not receiving services.
- Decrease Medicaid spending attributable to unintended births, LBW and VLBW babies.

Demonstration Evaluation Objectives

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

- Total family planning visits per poor and near poor woman;
- Use of contraceptive services/supplies per poor and near poor woman;
- Use of inter-pregnancy care services (primary care and outreach) by women with a VLBW delivery;
- Average inter-pregnancy intervals for poor and near poor women;
- Average inter-pregnancy intervals for women with a VLBW delivery;
- Teen and repeat teen births for poor and near poor 18 and 19 year olds;
- Rate of LBW and VLBW deliveries among the Medicaid population with comparisons to the statewide rates for LBW and VLBW deliveries;

- Rate of LBW and VLBW deliveries[2] 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[3] among poor and near poor women and among Medicaid enrolled women compared to other populations within the state.

These evaluation objectives not only test for changes in the performance measures pre and post P4HB but also assess whether there is evidence of a causal pathway through the expanded access that the P4HB program provides. In order for the P4HB program to achieve significant changes in these measures, sufficient numbers of eligible women must enroll such that there is an increase in the overall use of family planning services/supplies among low-income women or an increase in consistent use of more effective contraceptive methods than would otherwise occur.

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. From the perspective of budget neutrality, this Year 3 P4HB report describes whether there was an overall shift in the distribution of infants across birth weight categories. If the Demonstration causes changes such that there are relatively fewer low birth weight and very low birth weight infants born to Medicaid enrolled women in Georgia, total expenditures should be lowered for the state and federal government.

[2] 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.
[3] 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.

II. SUMMARY OF THIRD YEAR ACTIVITIES

Communication and Outreach

During PY 3 of the Demonstration, DCH and each of the participating Care Management Organizations (CMOs) increased awareness of the P4HB program and encouraged participation by both consumers and providers. The communication and outreach efforts are summarized below.

A. DCH Supported Activities

In PY 3, DCH: 1) educated providers about the P4HB program; 2) implemented consumer-based outreach; 3) used existing resources for support and coaching; and 4) completed an annual evaluation. The DCH link for the P4HB program is: http://dch.georgia.gov/planning-healthy-babies.

1. **Educate Providers.** DCH educated the new State Health Benefit Plan administrator about the P4HB program and DCH staff continued to provide training to the Georgia Family Planning Program's (Georgia Title X Grantee) staff about the P4HB program. Additionally, DCH worked with the evaluation team and the CMOs to refine and implement two rounds of provider surveys during PY 3. The provider survey focused on providers' knowledge and understanding of the P4HB program as well as potential barriers with the program. One provider survey was distributed in February 2013 and a second provider survey was distributed in August 2013. The February 2013 provider survey results were reported in the Q3 2013 P4HB report, and the August 2013 provider survey results were reported in the Q1 2014 P4HB report.

- **Outreach to Neonatal Intensive Care Unit (NICU)**: In April 2013, Emory University's Global Collaborating Center on Reproductive Health in Atlanta, Georgia began offering webinars to Georgia hospitals' NICU staff to promote their engagement in assisting women to enroll in the Interpregnancy Care component. E-mail invitations were sent to NICU medical directors, nurse coordinators, and social workers prior to each planned webinar. One webinar was delivered in April, 2013 (attended by staff from three NICU sites) and another in May, 2013 (attended by staff from five NICU sites). The webinars lasted approximately 35 minutes and addressed three learning objectives: (1) To convey the goals and objectives, eligibility criteria, and services covered by the P4HB program (the Family Planning only and the Inter-pregnancy Care components); (2) To promote understanding of the need for improving women's underlying health status as a strategy for improving Georgia's feto-infant mortality and; (3) To convey how NICU providers can assist women to enroll in the P4HB program, with a focus on the Interpregnancy Care component. After the didactic presentation, the webinars ended with practical advice from a NICU social worker who was a champion in enrolling women into the P4HB program followed by an open question and answer session for the webinar participants.

2. **Consumer-Based Outreach**. DCH continued to conduct extensive client outreach during 2013. RSM staff made 1,499 public presentations that included information about the P4HB program to interested individuals throughout the state. The venues used by the RSM staff ranged from health fairs to community events to church meetings and visits to children's hospitals and youth development centers.

- **Developed and implemented an interview/survey for the IPC enrollees:** DCH worked with Emory to develop interview questions for the IPC enrollees that focused on: reproductive health/birth spacing; birth control methods and barriers to getting them; nutrition; chronic conditions; protection from infections; management of stressors and social issues; substance abuse; and dental health. These questions were included in the 2013 member surveys.

3. **Using Existing Resources for Support and Coaching.** Georgia's WIC program and the POWERLINE (a telephone resource sponsored by Georgia's Healthy Mothers, Healthy Babies program) continued to promote prenatal care, healthy lifestyles before and during pregnancy, and smoking cessation. DCH included these resources on the P4HB program's website.

B. CMO Supported Activities

Each of the three CMOs working with the P4HB program has their own client and provider education action plans related to P4HB. This information has been posted on their respective websites (https://www.myamerigroup.com/GA/Pages/planning-for-healthy-babies.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/).

During PY 3, the CMOs engaged in the following client-related outreach efforts: new member welcome calls to all newly enrolled P4HB members; home visits to IPC participants to conduct case management and to educate them on the IPC program; mailing of program materials (including contraceptive benefit information) to all new and existing P4HB members; enhanced call scripting for call center staff to educate P4HB members about the importance of understanding their benefits and services; distribution of a postcard to new members that emphasized the importance of utilizing contraception and reporting such use on the member secure web portal; on hold messaging to include information about types of contraception covered in the plan and; quarterly incentives to members to encourage them to report birth control methods.

The CMOs' provider related outreach efforts included: telephone calls and office visits to providers to educate them on the P4HB program; distribution of provider toolkits to P4HB participating providers; and conducting new provider orientation meetings.

Major Changes in the Year

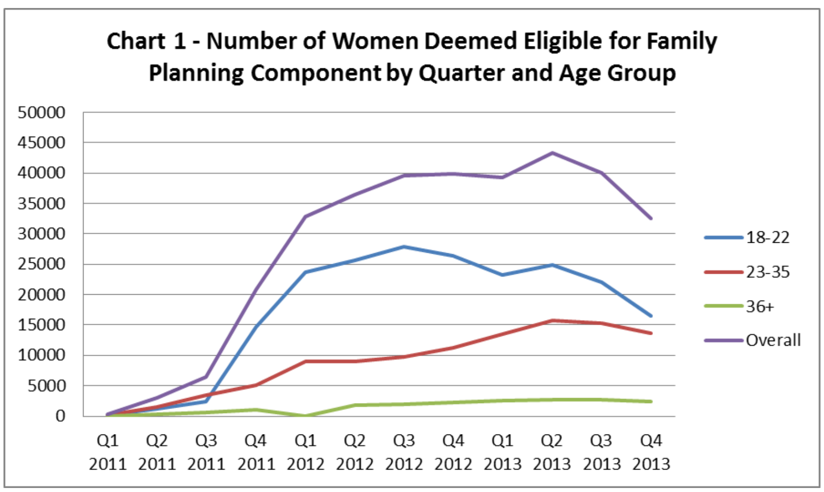
In June 2013, DCH discontinued its process of auto-enrolling women into the P4HB program's family planning component who were losing Medicaid eligibility following delivery of a baby under the RSM eligibility criteria and who were 'aging out' of the Medicaid or the PeachCare for Kids® program – Georgia's stand-alone CHIP program. Following the termination of the auto-enrollment process, Medicaid and PeachCare for Kids® eligible women who were pregnant received a letter during their eight month of pregnancy, informing them about the P4HB program and encouraging them to enroll in the program once their pregnancy-related coverage ended.

While the auto-enrollment process appeared to expand knowledge of the P4HB program and increase enrollment in the program, data presented in our PY 2 annual report cited key differences in the behavior of the auto-enrolled and the non-auto-enrolled women in P4HB. In particular, those auto-enrolled were less likely to use family planning services and more likely to experience a pregnancy while enrolled. DCH continues to auto-enroll eligible women into the IPC component of P4HB.

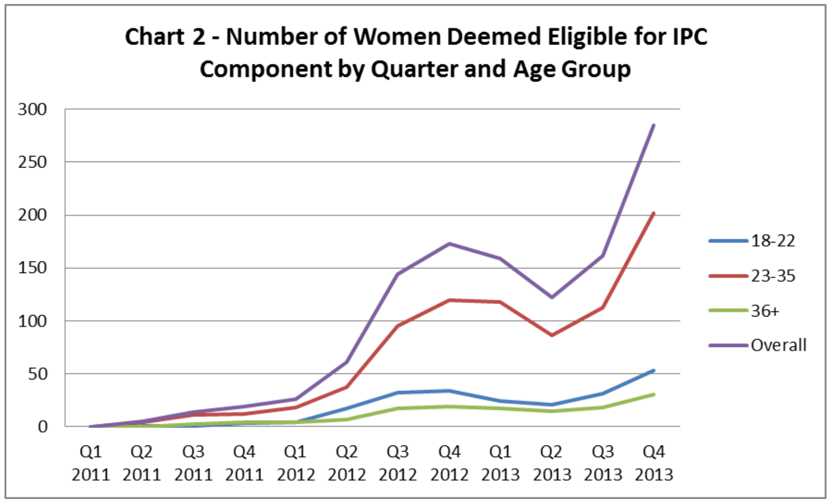
III. ENROLLMENT AND PARTICIPATION

The auto-enrollment of women into the P4HB family planning only services affected the numbers and patterns seen in the data presented in our quarterly reports and in this annual report. We report below on trends in the number of women deemed eligible and in turn, enrolled in the family planning only and IPC components of the Demonstration.

Enrollment Trends



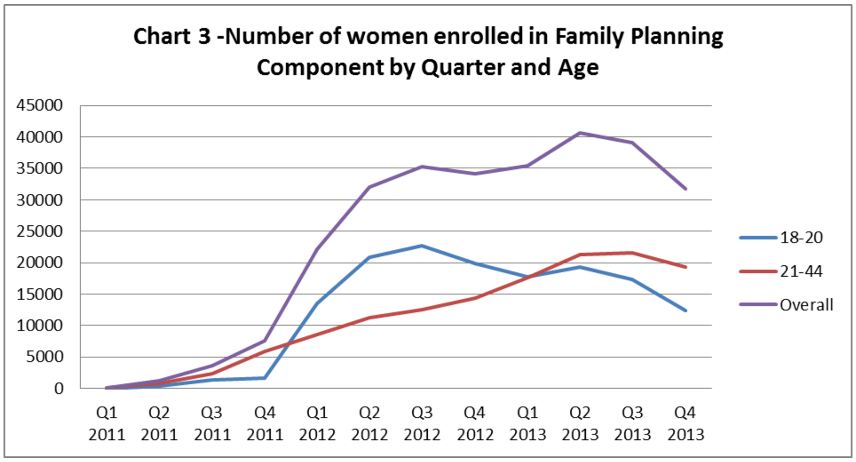
Throughout PY 3, DCH monitored P4HB call center volume and applications as proxies for continued interest in the P4HB program. As shown in Chart 1, the number of women who applied and were deemed eligible for the family planning only component of P4HB grew through the end of the second quarter of 2013 and then declined by almost 25% by the end of 2013 to just below 32,561. The peak for those aged 18-22, the largest age group of all those deemed eligible, occurred during 2012 then declined during 2013. This youngest age category showed the biggest decline from Q2 2013 to the end Q4 2014, going from 24,921 to 16,420 - a decrease of 34%, nearly three times the decrease of the other two age groups. The number of women deemed eligible aged 36 and older decreased from 2,753 in Q2 2013 to 2,466 in Q4 2013 - a decrease of 10.4%.



The number of women deemed eligible for the IPC component, as shown in Chart 2, declined during the first two quarters of PY 3 from the December 2012 total of 173 women. Improvements were seen by December 2013 when 285 women were deemed eligible for IPC services. The great majority of these women were in the 23-35 year old age group and their numbers grew from 118 in March 2013 to 202 in December 2013. In December 2013, 53 women in the 18-22 year old age group and 30 in the oldest age group were deemed eligible for IPC services.

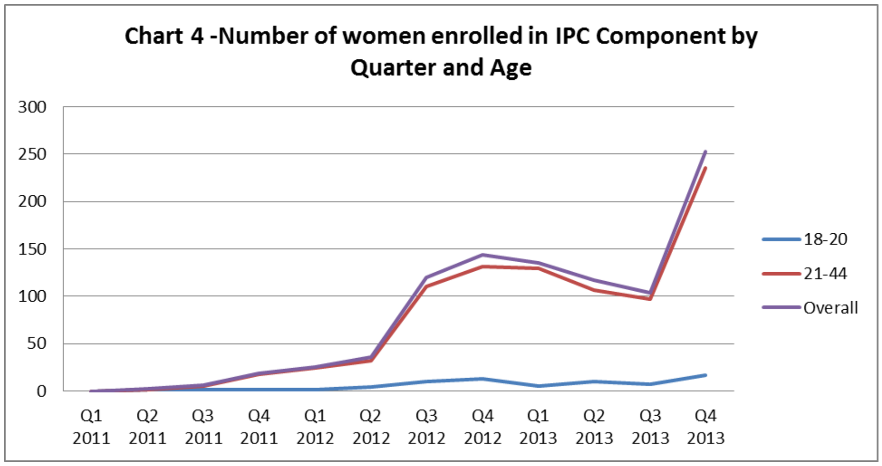
The number of women actually enrolled in the P4HB program has historically been lower than the number deemed eligible but this gap has narrowed. By the end of PY 3, the number of women actually enrolled in one of the CMOs and eligible to receive family planning only services, 31,690, was just under the 32,561 deemed eligibile for this component as depicted in Chart 3 (by age group).

Also shown in Chart 3, the patterns of enrollment indicate a continued increase for the 21-44 year old age group through Q3 2013, with enrollment peaking at 21,619. Enrollment in this group then dropped by 10.8% to 19,287. Enrollment for the 18-20 age group, after an earlier peak in Q3 2012, declined by 35.7% from Q2 2013 to the Q4 2013 level of 12,403.



As noted, the gap between the numbers of women deemed eligible for P4HB services and the numbers enrolled in a CMO to receive family planning services narrowed; by the end of 2013, the gap was 2.7%, compared to 14.3% at the end of 2012. The overall increase in enrollment during the third year of P4HB through Q2 was driven in part by the auto-enrollment policy and the end of auto-enrollment is evident in the declines seen in Chart 3. Using a list of study IDs for women auto-enrolled in the P4HB family planning only component at some point in 2013 indicated that 67% were auto-enrolled into the program. Given this high percentage, if these enrollees exhibit different behaviors regarding the use of family planning services or pregnancy during their time enrolled, the overall patterns among family planning only enrollees in P4HB will be affected. We will provide some separate statistics for these women in parts of this report.

Nearly 89% of the women deemed eligible for the IPC component in December 2013 were actually enrolled in a CMO by the end of 2013 (253 of 285 deemed eligible). Chart 4 shows that over 93% of the enrolled IPC women were in the 21-44 age range and the overall growth in the IPC component enrollment was due to growth in this age group. While the overall enrollment in the IPC component declined during the first 3 quarters of 2013, it increased dramatically by the end of 2013. There were 104 women enrolled in a CMO to receive IPC services at the end of Q3 2013 and 253 enrolled in a CMO to receive IPC services at the end Q4, an increase of 143%. Some of this growth was due to auto-enrollment into the IPC component which was instituted in April 2012.



The number of women enrolled in a CMO to receive Resource Mothers only services totaled 65 by the end of PY 3. Combined with the 253 women enrolled in the IPC component, there were 318 women who had delivered VLBW infants and were enrolled to receive nurse case management and Resource Mother services under the P4HB program, in addition to the primary care and other IPC services available to them, by the end of PY 3.

Participation Rates

We have assessed these enrollment numbers in light of the total number of women likely eligible for the P4HB program in the communities across Georgia. The program targets women ages 18-44 not otherwise insured with a family income at or below 200% FPL. The American Community Survey (ACS) has been used each year to estimate the number of uninsured women in this age and income range. In PY 3, this survey estimated there were 287,220 women meeting the eligibility criteria established for the P4HB program. This number excludes women who were non-citizens and hence, not eligible for the program. In 2011, less than three percent of the estimated total number of women living in the community and meeting the income, age and citizenship criteria (296,949 women per ACS) for the P4HB program was enrolled in the P4HB program. This is demonstrated in Table 1 below. Using data from the 1-year public use micro sample (PUMS) which resulted in the PY 3 estimate of 287,220 uninsured women citizens in Georgia in the age and income group targeted by P4HB in 2013, we estimate that 11% of this eligible population was enrolled in the family planning only component of P4HB in PY 3.

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

Demonstration Group	Enrolled in 4th Quarter	Population Eligible in Community[1,2]	Percent Eligible Enrolled
FP Only 2011	7,543	296,949	2.5%
2012 P4HB Enrollment/Participation			
FP Only 2012[3]	34,184	285,927	12.0%
FP Only 2012	34,184	155,830[4]	21.9%
IPC/Resource Mother Only	221	1,522	14.5%
2013 P4HB Enrollment/Participation			
FP Only 2013[3]	31,690	287,220	11.1%
FP Only 2013	31,690	156,535[4]	20.2%
IPC/Resource Mother Only	318	1,716	18.5%

[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 was estimated using the ACS 1-year PUMS for 2011 – 2013 as shown in column 3.

[2]*Those eligible for IPC include uninsured women 18-44 with income < 200% FPL residing in Georgia with a liveborn 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 in 2013 (n = 1,716 in Table 3 shown later) as the denominator.*

[3]*We use the numbers enrolled as of the 4th quarter of 2013 (and reported in our 4th Quarter 2013 Report) for consistency with the earlier parts of this report.*

[4] *This denominator adjusts for women in need of family planning services based on a report from the Guttmacher Institute. Their estimate is that 54.5% of women in the age group 13-44 were actually in need of family planning services; they count women who are sexually active, able to get pregnant but not currently pregnant or trying to get pregnant. See:* http://www.guttmacher.org/pubs/win/contraceptive-needs-2008.pdf. *We multiplied the "in the community" population by .545 to get the 155, 830 for 2012 and the 156,535 for 2013 as shown in column 3*

When we consider that only an estimated 54.5% of the eligible population may be 'in need' of family planning services (sexually active, able to get pregnant, not currently pregnant or trying to get pregnant) the estimated percentage enrolled was approximately 20.2% in PY 3. Comparing the unadjusted rate in PY 3 to PY 2 indicates a slight drop to 11% of all eligible and to 20% of the adjusted denominator of those in need. While participation rates are not as high as desired they do indicate significant improvement from the first year of the P4HB.

As noted earlier, a large percentage of the P4HB enrollees in PY 2 and PY 3 were auto-enrolled into the family planning component. Many of those women failed to complete the eligibility redetermination process during PY 3 and as such lost their eligibility, thus adding to the decline in the P4HB program's total population during PY 3. We also note that a large number of women in need of family planning continued to be served by the Title X program in Georgia. We report on changes seen in this program pre and post implementation of the P4HB program in terms of Medicaid coverage, rates of use of contraceptives and the types of contraceptives used. We also estimate unduplicated counts of family planning visits in the combined systems of Title X and Medicaid in order to assess whether the P4HB program increased the overall usage of family planning services and contraceptives (shown later in this report).

In contrast to the family planning only component of P4HB, the data in Table 1 shows that the number of women with a VLBW infant and enrolled in the IPC and Resource Mother only components of the program relative to the population eligible in the community (based on the ACS) increased from PY 2 to PY 3. The percent eligible enrolled increased from 14.5% in PY 2 to 18.5% in PY 3. This upward trend is encouraging. Education and outreach to the health care providers who care for or interface with those women experiencing a very low birth weight delivery must continue**.**

IV. DATA ON DELIVERIES AND INFANTS

In this section we report on the total counts of deliveries and infants by birth weight category to help assess changes in these key outcomes over the pre and post P4HB time period. These counts were derived from the administrative claims/encounter data provided by DCH to Emory through its data sharing agreement. Details of the methods are provided in the footnotes of the following tables on the specific billing codes found within the Medicaid claims data that were used to define deliveries (unduplicated using the mother's ID), to categorize them by 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 used ICD-9 diagnosis codes predominantly throughout this process instead of DRGs as this coding was incomplete in the CMOs' encounter data starting in 2011. We note that a growing number of records were found in the 2013 data for women with either an ICD-9 or CPT-4 procedure code (indicating a delivery) and a DRG delivery code but without a V-code to indicate the outcome of the delivery. We have noted in the footnotes to

Table 2 the counts of deliveries so affected. We will consider whether to include these counts in later analysis of the full pre/post P4HB time period.

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

Counts of Deliveries and Costs 2013

As shown in Table 2 below, there were a total of 75,802 Medicaid paid deliveries occurring in calendar year 2013 based on the claims data. This count omits an additional 3,326 deliveries for which there was an indicator of private third party liability (including Medicare) at the time of delivery or for which the amount paid by Medicaid was zero. We also omitted, as noted, records with indications of a delivery based on our coding algorithm but without a V-code indicating the outcome of the delivery. While these counts were low in previous study years, in 2013 the number of such records equaled 955.

Table 2 Medicaid Deliveries for Calendar Year 2013 (CY2013)

MEASURE	Counts	Total $ Paid Mother	Average $ Paid Mother
<u>All Medicaid Deliveries[1]</u>			
Total Deliveries[2]	75,802	359,641,092	4,744
Liveborn deliveries	67,522	348,429,759	5,160
Stillborn deliveries (>= 22 weeks)[1]	1,084	4,302,437	3,969
Fetal deaths < 22 weeks[1]	7,196	6,908,896	960
<u>Deliveries[1] to Demonstration</u>			
Entire Demonstration population			
Total Deliveries	3,875	18,784,665	4,848
Liveborn deliveries	3,462	18,324,097	5,293
Stillborn deliveries (>= 22 weeks)[1]	49	154,770	3,159
Fetal deaths < 22 weeks[1]	364	305,797	840
FP only[3]			
Liveborn deliveries	3,449	18,241,823	5,289
Stillborn deliveries (>= 22 weeks)[1]	49	154,770	3,159
Fetal deaths < 22 weeks[1]	362	305,406	844
IPC [4]			
Liveborn deliveries	10	65,367	6,537
Stillborn deliveries (>= 22 weeks)[1]	0	0	0
Fetal deaths < 22 weeks[1]	1	274	274
Resource Mother only[5]			
Liveborn deliveries	3	16,907	5,636
Stillborn deliveries (>= 22 weeks)[1]	0	0	0
Fetal deaths < 22 weeks[1]	1	117	117

[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 Live births** were identified in the claims by using: ICD-9 diagnostic codes 640-676 plus V27.x **OR** ICD-9 procedure codes 72, 73, or 74 plus V27.x **OR** CPT-4 codes 59400, 59409, 59410, 59514, 59515,59612,59614,59620, 59622 plus V27.x*
- ***Deliveries of Stillbirths** were identified by using ICD-9 code 656.4x (intrauterine fetal death >= 22 weeks gestation) OR specific V-codes [V27.1 (delivery singleton stillborn, V27.3 (delivery twins, 1 stillborn), V27.4 (delivery twins, 2 stillborn), V27.6 (delivery multiples, some stillborn), V27.7 (delivery multiples, all stillborn)].*
- ***Deliveries associated with Fetal deaths** < 22 weeks were identified by using ICD-9 codes 632 (missed abortion) and 634.xx (spontaneous abortion).*
- *In the case of a twin or multiple gestations, the delivery was counted as a live birth delivery if ANY of the fetuses lived. Costs were accumulated over the pregnancy and attributed to the delivery event if there was a fetal death (632) that preceded a live birth.*

[2] *This count of total deliveries omits those with $0 Medicaid dollars, private third party liability or Medicare coverage (n = 3,326). If these records were included the number of deliveries would be 79,128 with 70,380 liveborn deliveries, 1,131 stillbirths and 7,617 fetal deaths.*
[3] *Family planning only participants were identified using Aid Eligibility Code = 181 and the CMO lock-in code; all deliveries that occurred to these women were after their first three months of continuous enrollment in the P4HB; for births to demonstration enrollees in CY2013 the three months of continuous coverage were in the period April 1, 2012 to March 31, 2013. Women who came into the program pregnant should not be counted and our methods for omitting them are described in the text. The resulting number of family planning only enrollees equaled 47,319.*
[4] *IPC participants were identified using Aid Eligibility Code = 180. Only the deliveries and births to IPC women **subsequent** to their 3rd month of enrollment are reported in these tables. The three months of continuous coverage were in the period April 1, 2012 to March 31, 2013. The resulting number of IPC enrollees equaled 145.*
[5] *Participants in the Demonstration with Resource Mother only benefits are LIM and ABD classes of eligibility with a delivery and VLBW birth weight infant in the year. They were identified using Aid Eligibility Codes 182 (LIM) and 183 (ABD). Only the deliveries and births to women with LIM and ABD classes of eligibility **subsequent** to their 3rd month of enrollment are reported; the three months of continuous coverage were in the period April 1, 2012 to March 31, 2013. The resulting number of Resource Mother only enrollees equaled 92.*

Based on the count of deliveries paid fully by Medicaid, 67,522 of the total 75,802 could be categorized as liveborn deliveries while 7,196 or 9.5 % of the total were coded as fetal deaths of less than 22 weeks gestation and another 1,084 were coded as stillborn deliveries. The Georgia

Medicaid program made payments totaling almost $350 million for the 67,522 liveborn deliveries paying an average of $5,160 for the mother's expenses at the time of these deliveries. Because the great majority of infants receive their own Medicaid ID at birth, the Medicaid amounts paid shown in Table 2 are largely representative of maternal expenses incurred at the time of the delivery hospitalization. In addition to the costs for the deliveries with liveborn infants, Georgia Medicaid incurred costs totaling almost $7 million for deliveries ending in fetal death and another $4 million for stillborn infants in CY2013.

The bottom portion of Table 2 shows the counts and costs of any deliveries observed for women enrolled in the FP, IPC or Resource Mother only components of P4HB. As in our last annual report we defined P4HB enrollees in this table as those with a P4HB eligibility/lock-in code who had three months of continuous enrollment. We again made the assumption that the woman would have her family planning appointment within the first month of CMO enrollment and, if she started on some form of contraception at the beginning of the second month, the method would be effective after two months. Hence, any subsequent pregnancy is considered a 'failure'.

In deriving these counts, we omitted women with an indication of a pregnancy using ICD and/or RSM eligibility codes in these first 3 months of CMO enrollment and those with a delivery ≤ 245 days after enrollment in a CMO since they most likely came into the CMO in a pregnant status. By counting deliveries/births which occurred for these women only after the 245 day cut-off, we allowed for births with a short gestation (~5 months) after the first 90 days of enrollment but will also include births with a longer gestation that may have begun in the first 3 months of enrollment but for which there were no pregnancy or RSM codes seen in the data we used to make omissions. The number of pregnancies (789) and birth outcomes (262) found in this process in 2013 could also be seen as a ‘failure’ of women to understand the program and/or failure of the delivery system to get them in for pregnancy testing/services in a timely fashion. The total number of these outcomes in PY 3 is lower, however, than that reported in PY 2.

After making these omissions we have P4HB enrollees who we believe were not pregnant when they were deemed eligible for the program and for whom the CMO had 3 months to reach/serve them. We then count pregnancies [ICD/RSM codes] in the 91st day forward and any delivery outcome [fetal death/live birth/stillbirth] after the 245th day; the 2013 counts of outcomes for P4HB enrollees are to women enrolled for three consecutive months between April 1, 2012 and March 31, 2013. Using these methods, there were an estimated 3,449 liveborn deliveries in 2013 to women in the FP only component of the P4HB with total Medicaid payments of over $18 million. There were an additional 362 fetal deaths and 49 stillbirths among the women enrolled in this component of P4HB with Medicaid payments totaling about $460,000. While we view these outcomes as ‘failures’ these women may have decided to become pregnant rather than failing to access/use birth control methods effectively. We cannot discern from claims data whether or not these pregnancies were intended. Follow-up qualitative data, via focus groups or interviews with P4HB clients, could be used to gather such information.

As shown in the bottom sections of Table 2, there were also deliveries to the IPC and Resource Mother only enrollees in P4HB in 2013. We identified ten (10) liveborn deliveries in 2013 among the IPC women after three consecutive months of their enrollment in the P4HB program during the time period noted. The cost of these deliveries to the Medicaid program was approximately $65,000. IPC women also experienced one fetal death delivery in 2013. Among Resource Mother only enrollees there were three deliveries of liveborn infants for a cost of approximately $17,000 and one fetal death delivery.

Counts of Infants and Costs 2013

In Table 3 below, we show the counts of infants identified with their own Medicaid IDs and categorized as a live birth or stillbirth. Note that the number of liveborn infants (78,681) is far greater than the number of liveborn deliveries shown in Table 2 (67,522). This is due in part to multiple gestations but may also reflect some undercounting of total deliveries in the 2013 claims data available at this time; we had observed a similar undercounting in the 2012 data. These numbers will be updated in future reports as more claims data are made available.

Table 3 Infant Counts and Costs for Mother and Infant at the Delivery Hospitalization Calendar Year 2013 (CY2013)

MEASURE	Counts	Average $ Paid Mother[3]	Total $ Paid Infant Delivery Hospitalization	Average $ Paid Infant Delivery Hospitalization
All Medicaid Live births [1]	78,681	5,296	339,979,781	4,321
VLBW	1,716	6,682	150,143,391	87,496
LBW	4,737	6,080	55,446,267	11,705
Normal BW	72,186	5,231	133,998,064	1,856
All Medicaid Stillbirths[2]	42	5,092	392,059	9,335

[1]*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 liveborn infants were then defined using ICD-9 codes in the encounter data as follows:*

- *VLBW (< 1500 grams): ICD-9 = 764.xx or 765.xx or V21.3 that pertain to weight < 1500 grams*
- *LBW (1500 – 2499 grams): ICD-9 = 764.xx or 765.xx or V21.3 that pertain to weight 1500 = 2499 grams*

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

[2] *Stillborn infants were identified using ICD-9 diagnosis codes V35.xx, 768.0, 768.1, or 779.9.*

[3] *Amounts paid for mothers at the time of delivery were summarized for all deliveries in Table 2 and are summarized here by birth weight of the infant for the subset of mothers (n = 56,473) who could be linked to an infant based on the SSN of the head of the household and other factors used in an algorithm developed by Truven.*

Of the 78,681 live births, a total of 1,716 or 2.2% were categorized as VLBW and 6,453 (1,716 plus 4,737) or 8.2% were categorized as LBW. We have previously noted that claims data tends to underestimate the percentage of LBW but overestimate the percentage of VLBW within this group and that we will use the distribution of birth weight from the vital records once linkages are complete for several years pre and post the P4HB. We report later on the birth weight distributions for 2009-2011 where the data have been linked; we anticipate the crosswalk to link claims and vital records for 2012 in time to include this analysis in our first quarterly report in 2015.

The data in Table 3 indicate that the costs of all live births were approximately $340 million and averaged $4,321 per infant (Column 5). These costs are only those incurred for the infant at the time of the delivery hospitalization. We again see the anticipated pattern of higher costs for those infants born LBW or VLBW relative to those born normal weight. Average costs for infants of normal weight were estimated to be $1,856 (Column 5) while for those infants born LBW, costs were over six times higher, estimated at $11,705. Very low birth weight infants born during 2013 had markedly higher costs than LBW infants with an average delivery hospitalization costing $87,496. The difference in costs for VLBW or LBW versus normal birth weight infants helps highlight the goal of reducing these adverse outcomes and their related Medicaid costs.

In Table 3, we also include data for the delivery costs of the mothers by the birth weight category of their infant but *only* for those mothers who could be linked to an infant within the claims data. These data again indicate that the delivery costs for the mother follow the pattern of higher costs for LBW and VLBW infants at the delivery hospitalization. The mother’s costs at a delivery of a normal birth weight baby were estimated at just over $5,000 while the mother’s costs at delivery of a VLBW delivery were approaching $7,000.

The additional costs related to adverse outcomes at the time of birth are likely to continue into the first year of life for the infant. In Table 4, we provide these estimated costs to the Georgia Medicaid program. We count these costs beginning with the claims and encounters for the first service date occurring after the infants' delivery hospitalization discharge date in order to isolate the delivery versus first year of life costs.

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

MEASURE	Infants[1] Born on Medicaid in First 9 Months of CY2013	1st Year of Life Post-Delivery Hospitalization			
		Average $ Paid per Infants[2] Born in First 9 Months of CY2013[6]	Total $ Paid[3] Extrapolated to All Infants[4] from those Born in First 9 Months	Total $ Paid Extrapolated to Continuously Enrolled Infants[5]	Average $ Paid per Continuously Enrolled Infants[5]
Medicaid Live births[1] in First 9 Months of 2013	57,177	2,540	203,358,990	202,503,751	2,504
VLBW	926	9,519	16,335,273	18,430,063	10,740
LBW	3,279	4,241	20,087,817	20,473,503	4,322
Normal BW	52,972	2,313	166,935,900	163,600,185	2,266

[1] The *57,177 liveborn infants born in the first nine months of CY2013 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 nine months of CY2013 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 CY2013 were complete through September of 2013; 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 nine months of 2013 (and based on claims paid only through September 2014). We used the average costs for this cohort of infants born in the first part of 2013 (n = 57,177) to extrapolate to an annual estimate for CY 2013.*
[5] *Costs for all infants born in the first nine months of CY2013 are included only for those 55,731 alive and continuously enrolled (data on enrollment were only available through December 31, 2013). We used the average costs for this cohort of infants (n = 55,731) to extrapolate to an annual estimate for CY 2013 as shown in the last column.*
[6] *Omits those with 0 Medicaid dollars, private third party liability or Medicare coverage*

For this PY3 annual report we had a longer run-out of claims (through September 2014) and therefore based our estimate of first year of life costs on those 57,177 infants born in the first *nine* months of 2013. The estimate is extrapolated based on the averages by birth weight category, applied to the infants born in the last quarter of 2013 based on their birth weight category and added to the actual total for those born in the first nine months. As the costs are based on claims paid through September of 2014, estimates may still be incomplete. The total amount paid for first year of life costs for infants regardless of their birth weight was estimated at $203.3 million. When total costs are estimated based only on the 57,177 infants born in the first nine months still alive and continuously enrolled through December 31, 2013, the estimated costs are $202.4 million. There is again the expected pattern of higher first year of life costs (omitting delivery costs) for infants of lower birth weight; costs for normal birth weight infants was estimated at $2,313 while costs for LBW infants was estimated at $4,241 and for VLBW infants, at $9,519. These cost patterns by birth weight hold for those not disenrolled due to death/other reasons as shown in the last column of Table 4.

V. SERVICE USE

IPC Service Use

A key goal of the IPC component of the demonstration is to help these mothers maintain or improve their health by providing access to the expanded set of services noted earlier. The administrative data can be used to ascertain the types of conditions for which these women are seeking and receiving care under the P4HB program. Among the IPC participants, the claims data indicate that 118 of the 253 women enrolled (46.6%) utilized services of any type. The number of encounters for services by IPC participants ranged from one (1) to sixteen (16) encounters with a mean of 3.3 encounters per IPC participant. Additionally, the claims data indicate that 84 of the 296 women (28%) enrolled at least one month during PY 3 in the Resource Mother only component of P4HB utilized services, with the number of encounters ranging from 1 to 22 encounters with a mean of 4.3 encounters per Resource Mother only participant. The ICD-9 diagnosis codes that appear in the claims data for these members are summarized below, separately for the IPC and Resource Mother only participants.

According to ICD-9 diagnostic codes within the Medicaid claims data, the use of services by women enrolled in the IPC component reflected the receipt of care for preventive services, acute gynecologic conditions or other gynecologic testing, contraceptive services, non-gynecologic acute conditions, dental conditions, mental health services and substance abuse, and chronic health conditions. Contraceptive management services were the most commonly utilized services, with 94 of the women enrolled in the IPC component receiving these. The next most commonly utilized services were those for gynecologic conditions, including for vaginitis (46) and genital symptoms (10), abnormal Pap smear and cervical dysplasia (10), irregular menstruation or dysfunctional uterine bleeding (7), pelvic inflammatory disease or cervicitis (5) and other sexually transmitted infections (3), as well as screenings for sexually transmitted infections (32) and for pregnancy (13). Preventive care was also commonly utilized by IPC participants. Examples of preventive health care services received were routine well-woman and gynecologic examinations with Pap smear (65), routine medical check-ups and other health screenings (11), and vaccinations (2). Services for care of non-gynecologic acute conditions were also utilized. Examples of common acute conditions for which care was sought included respiratory tract infection (28), abdominal pain (11), chest pain (11), urinary tract infection (11) or dysuria (5), nausea and vomiting (8), back pain (8), and non-migraine headache (7). Mental health services were utilized for depression (10) and anxiety (19) and for other psychiatric conditions (5) as well as for tobacco (9), opioid (17), and alcohol (2) dependence. IPC enrollees received services for dental infections (3).

According to ICD-9 diagnostic codes within the Medicaid claims data, the use of services by women enrolled in the Resource Mother only component reflected the receipt of care for preventive services, acute gynecologic conditions or other gynecologic testing, contraceptive services, non-gynecologic acute conditions, dental conditions, mental health services and substance abuse, and chronic health conditions. Services for care of non-gynecologic acute conditions were the most commonly utilized services; examples of common acute conditions for which care was sought included abdominal pain (43), respiratory tract infection (31), non-migraine headache (27), gastroenteritis (19), urinary tract infection (18), back pain (17), nausea and vomiting (17), and chest pain (12). Also commonly used services by Resource Mother only participants were those for acute gynecologic conditions including for vaginitis (43), irregular menstruation or dysfunctional uterine bleeding (18), abnormal Pap smear and cervical dysplasia (5), pelvic inflammatory disease or cervicitis (4), as well as screenings for sexually transmitted infections (16) and for pregnancy (4). Contraceptive management services were received by 33 of the women enrolled in the Resource Mother only component. Examples of preventive health care services received were routine well-woman and gynecologic examinations with Pap smear (22), routine medical check-ups and other health screenings (11), and vaccinations (2). Mental health services were utilized for depression (21) and anxiety (7) and for other psychiatric conditions (13) as well as for tobacco dependence (7) and opioid and other drug dependence (9). Resource Mother only component enrollees also received services for dental infections (9) and for a broken tooth (1).

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

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

Component of Program	Chronic Health Condition Evidence from Claims Data
Interpregnancy Care[1] (49 of 253 members with evidence of chronic condition) [2]	Hypertension (16) Depression/Anxiety (16) Obesity/Overweight (11) Migraine headache (9) Long-term medication monitoring (8) Thyroid disorder (7) Malaise/Fatigue (7) Tobacco Disorder (5) Asthma (5) Allergies (5) Hyperlipidemia (3) Anemia (3) Diabetes mellitus (2) Gastroesophageal reflux disease (2) Congestive heart failure (1)
Resource Mother Only[1] (41 of 296 members with evidence of chronic condition) [2]	Hypertension (14) Depression/Anxiety (13) Obesity/Overweight (3) Migraine headache (13) Long-term medication monitoring (3) Thyroid disorder (2) Malaise/Fatigue (2) Tobacco Disorder (9) Asthma (3) Allergies (4) Hyperlipidemia (2) Anemia 4) Diabetes mellitus (2) Gastroesophageal reflux disease (2) Congestive heart failure (2)

[1] *111 of the 253 IPC women and 80 of the 296 Resource Mother Only had at least one Medicaid claim for services*

[2] Enrolled at least one month in 2013

Trends in Births, Averted Births and Budget Neutrality

We focused in the earlier sections of this PY 3 report on deliveries and births in CY 2013 as part of the annual reporting process. It is important, as we move forward in completing the evaluation design, that we look over the full pre and post period of P4HB for which we now have more complete claims data. We also compare the information gained from the claims data regarding birth outcomes to that which we will eventually have from the linked Medicaid claims and vital records data. To this end, we provide a brief summary of the changes we are seeing in the numbers of deliveries and liveborn infants in the study years. As shown in Table 6 below, the number of Medicaid paid births was declining prior to the Demonstration, declining from 85,370 in 2009 to 81,463 in the two years prior (2009-2010) and to a low of 75,087 in the first year (2011) of the P4HB program. We note that declines were also seen in national data possibly due to the financial conditions imposed on families during the recession. Birth counts increased from the 2011 level in 2012 to 79,589 and to 78,681 in CY 2013. The counts of births shown in Table 6 for 2012 are higher than those reported in our Year 2 annual report due to the more complete claims data processed by Truven and received by the evaluation team. It is likely that the CY2013 birth count will increase as well as we receive more complete data.

Table 6 Number of Medicaid Paid Births by Birth Weight Based on Claims Data (2009-2013)

	2009		2010		2011		2012		2013	
Weight Category	**N**	**Percent**	**N**	**Percent**	**N**	**Percent**	**N**	**Percent**	**N**	**Percent**
VLBW	1,718	2.0	1,650	2.0	1,506	2.0	1,612	2.0	1,716	2.2
LBW	4,679	5.5	4,547	5.6	4,210	5.6	4,672	5.9	4,737	6.0
Normal BW	78,890	92.4	75,187	92.3	69,331	92.3	73,255	92.0	72,186	91.7
Stillbirth	83	0.1	79	0.1	40	0.1	50	0.1	42	0.1
Total	85,370		81,463		75,087		79,589		78,681	

These trends in Medicaid paid births are generally consistent with the overall trends in the Georgia vital records data but the drop in 2011 is larger than seen in overall state patterns indicating perhaps, an undercount of infants when using the claims data. As noted in the PY 2 report, the ratio of infants to deliveries was 1.05 and 1.06 in 2009 and 2010, respectively, but dropped to 1.01 in 2011, a further indication of an undercount. On the other hand, this ratio climbed to 1.10 in 2012, an indication of an under count of deliveries in 2012 as noted in our PY

2 report. We hope that a longer run-out of claims will help address some of these issues and we will keep these in mind as the evaluation proceeds.

As the data in Table 6 indicates, the percentage of all Medicaid births that are VLBW has been remarkably stable at about 2.0% over the pre/post P4HB time period with a slight increase to 2.2% in CY 2013. Important to the evaluation of the P4HB program, we have previously reported that the birth weight distribution using claims only is very close to that using the linked vital records for the percentage of very low birth weight births, at about 2%, but differs from the vital records on the percentage of low birth weight births and hence, on the percentage of normal birth weight infants. Table 7 below shows, for those infants whose Medicaid records link to vital records, this pattern holds in each of the years for which we have linked claims and vital records data.

Table 7 Birth Weight Distribution from Claims versus Vital Records (2009-2012)

	2009		2010		2011		2012	
	Birth Certificate Weight Category	Claims Weight Category %	Birth Certificate Weight Category	Claims Weight Category %	Birth Certificate Weight Category	Claims Weight Category %	Birth Certificate Weight Category	Claims Weight Category %
VLBW	2.0%	2.1%	2.0%	2.0%	1.9%	2.1%	na	na
LBW	8.3%	5.4%	8.5%	5.5%	8.2%	5.5%	na	na
NORMAL BW	89.7%	92.5%	89.5%	92.5%	89.9%	92.4%	na	na
Link Rate	89.0%		89.1%		82.2%		na	

Distribution of birth weight categories *only* for babies linked to birth certificate.

While both sources reflect a very stable percentage of Medicaid eligible infants being born VLBW, we will ultimately treat the vital records as the 'gold standard' when measuring birth weight and work primarily with the linked records when completing the final evaluation of P4HB. We do note that the linkage rate, while close to 90% in 2009/2010, fell to approximately

82% in 2011. We have not received the crosswalk that links these two files for 2012 but hope that the linkage rate returns to the 90% range for this and future years.

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 that are LBW and VLBW. This shifting of the distribution should occur from the increased use of family planning services by those brought into the family planning component of the Demonstration as well as from the management of contraceptive use and health conditions that affect reproductive outcomes among those women in the IPC and Resource Mother only components of the Demonstration which should help lengthen their interpregnancy intervals. Additionally, the treatment of acute and management of chronic conditions of women enrolled in the IPC component should lead to better health of the women, and in turn better birth outcomes should they become pregnant.

While the count of 'averted' births is not central to the calculation of budget neutrality on a quarterly or annual basis under P4HB, we present in Table 8 below an estimate of the number of births that the state would have 'expected' to see among participants in the family planning only component of the Demonstration. Based on the DCH Planning for Healthy Babies Concept Paper submitted to CMS in the application process (see footnote to Table 8), the fertility rate among women ages 18-44, $\leq$ 200% FPL and uninsured in the third year of the Demonstration was estimated at 164 per 1,000. If this expected fertility rate is applied to all women enrolled in the family planning only and other program components by the end of PY 3 (32,008 from Table 1), the number of expected births would be 5,249 in PY 3 as shown below.

Table 8 An Estimate of Averted Births among the P4HB Demonstration Population

Number of 'Expected' Births Among Participants[1]	Number of Deliveries/Live Births in 2013 to Participants[2]	Number of 'Averted' Births
5,249	3,462	1,787

[1]*Based on fertility rates from the concept paper developed in application process: http://dch.georgia.gov/sites/dch.georgia.gov/files/imported/vgn/images/portal/cit_1210/33/52/156793595PlanningforHealthyBabiesProgram121709Final.pdf*

[2]*Reflects the count of all deliveries of a live born in all three components but includes only those counted based on the methods described earlier in the text. If stillbirth and fetal deaths to women in all three components of the program are counted the total in 2013, would be 3,875.*

The number of actual births in PY 3 to P4HB participants fell below that estimation at 3,462 and hence, 'averted' births are estimated at 1,787 as shown in Table 8. This number of averted births indicates potential savings to the state from a lower-than-expected birth rate among those enrolled in the P4HB program if these women had otherwise enrolled in Medicaid for their delivery. We noted in our PY 2 report that the P4HB experience in Georgia compared well to that of other states with family planning waivers (Bronstein, Adams and Edwards, 2003)[4]. In this report, states reported that births to participants one to two years into their programs, ranged from a low of 11% (AR, SC) of the 'expected' number of births to as high as 80% (NM). The 3,462 births in CY 2013 among P4HB program participants enrolled as of the end of 2013 constitute about 66% of the number 'expected'. This is markedly higher than the percentage calculated using PY 2 estimates (10%) and puts the P4HB program at the upper end of the other states' experiences regarding the percentage of expected births seen among enrollees.

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

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* (2008) for the P4HB program to be considered budget neutral. We anticipate that as the program matures and there is a longer follow-up period for those enrolled in the Demonstration, we can better gauge whether the Demonstration prevented enough unintended first births and through better management of the health of women with very low birth weight babies, prevented enough repeat births among this group, such that the distribution of all Medicaid births shifted away from the low and very low birth weight categories.

In this PY 3 report we provide data on the second year of the Demonstration, using the claims for CY 2013 to give us a full estimate of the first year of life costs for infants born in 2012 (see Appendix B). We note that the birth weight distribution used in these calculations is based on claims data only and will be updated in the Q1 2015 report using linked claims and vital records data. Based on the claims data *only* and as shown in the data in the budget neutrality sheet, there were 1,612 VLBW infants and 4,672 LBW infants born under Medicaid coverage in CY 2012. The average costs for the delivery and first year of life for infants in these two categories of birth weight were $65, 010 and $11, 021 respectively.

When the total federal costs for the per member per month payments for the family planning only components of the Demonstration and the base year VLBW and LBW infants are totaled, the sum is approximately $214 million. To calculate the effects of the Demonstration we subtract from this total, the costs of the IPC per member per month payments, the 2012 costs for VLBW and LBW infants and the costs of any births to IPC enrollees that are of normal birth weight; these costs total approximately $156 million. The difference in these two sums, approximately $58 million as shown in the bottom of the spreadsheet, constitutes the estimated savings to the federal government from the implementation of the P4HB Demonstration.

Family Planning Service Use

One of the goals for the P4HB program is to increase access to family planning services for women in the income range targeted. Georgia's targeted income range is largely uninsured women > 25% FPL but < 200% FPL. In the absence of the P4HB program, women in this income range may access family planning services free or on a sliding scale basis at Title X clinics throughout the state. In 2013, the Title X clinics were primarily located in local county public health departments and all of them are included in one or more of the Medicaid CMOs' networks. In order for the P4HB program to increase overall access and use of services, we need to observe that newly funded Medicaid services do not 'displace' services otherwise available and used at Title X clinics.

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

As the descriptive data in Table 9 indicate:

- Across all visits to Title X clinics, the percentage of women using any contraceptive method after their visit is higher in the latter quarters of 2012 and all quarters of 2013, ending at 97.2%, than all of the preceding quarters of the pre and post P4HB period shown in the data;

- There was also an increase in those visits where the woman entered as a non-user (those using no method) and left as a user of a method, but here too, the gains appear to be focused in the latter quarters of 2012 and continuing through the third quarter of 2013 when the percentage leaving with any method equaled 77%; and

- Among those who were using a method of contraception before their visit, there was only slight indication of moving toward more effective methods (i.e., moving from a WHO Tier 3 or 4 to a Tier 1 or 2) but a strong indication of moving toward long-acting reversible contraceptive methods, or LARCs (a subset of Tier 1 methods that are reversible). At the beginning of 2009 only 5.3% of the visits were for women using LARCs upon entry; beginning in the first quarter of 2013, this percentage exceeded 8% and in the final quarter of 2013, equaled 8.1%.

While these patterns do indicate increased use among women at Title X clinics, they could also be a reflection of seasonal patterns and/or changes in the composition (age, race/ethnicity) of women seeking services at these clinics over the study period.

Table 9 Quarterly Data 2009- 2013 on Percentage of Uninsured Women in the Income Range Targeted by P4HB Using Any Birth Control and Type by WHO Tiers

Use Rates of Family Planning Services at Title X Clinics from Q1 2009 to 2013																				
	Data are for Pre P4HB Quarters								Data are for Post P4HB Quarters											
	2009				2010				2011				2012				2013			
Quarter	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
BC After Visit - Any (N=515,014)																				
% Any Method	96.1	96.2	94.4	95.9	95.0	95.0	94.9	94.7	94.7	94.4	94.2	93.3	93.8	94.2	97.3	97.2	97.4	97.7	97.7	97.2
BC After Visit - Any - Not Using at Entry (N=54,464)																				
% Any Method	63.8	63.4	64.6	62.2	58.4	59.3	58.4	57.2	58.8	57.1	57.4	50.7	53.2	53.7	72.3	72.0	74.2	76.9	77.1	74.3
% No Method	36.2	36.6	35.4	37.8	41.6	40.7	41.6	42.8	41.2	42.9	42.6	49.3	46.8	46.3	27.7	28.0	25.8	23.1	22.9	25.7
BC After Visit - WHO Tiers - Using at Entry (N=460,550)																				
% Tier 1 (High Effect)	9.8	10.0	8.9	8.2	9.3	9.7	9.3	8.6	9.2	9.9	10.1	9.6	10.3	10.2	10.2	9.8	10.4	9.7	10.1	9.6
% Tier 2 (Med Effect)	78.7	78.3	80.6	81.4	78.2	78.2	78.4	79.8	78.8	77.7	77.0	78.4	77.0	77.3	78.3	79.4	78.0	78.8	79.0	79.7
% Tier 3 (Low Effect)	11.1	11.4	10.1	10.1	12.1	11.8	11.9	11.1	11.6	11.9	12.3	11.5	12.2	12.2	11.1	10.3	11.2	11.1	10.5	10.1
% No Method	0.4	0.3	0.4	0.4	0.4	0.3	0.4	0.4	0.4	0.5	0.5	0.4	0.5	0.4	0.4	0.5	0.3	0.4	0.4	0.6
BC After Visit - LARC - Using at Entry (N=460,550)																				
% LARC	5.3	5.4	4.6	4.7	5.3	5.5	5.6	5.2	5.9	6.7	7.0	6.6	7.3	7.4	7.8	7.7	8.5	8.4	8.6	8.1
% Non-LARC	94.3	94.3	94.9	94.9	94.3	94.2	94.0	94.4	93.7	92.9	92.5	93.0	92.2	92.3	91.9	91.8	91.2	91.2	91.0	91.3
Notes: Income =>25% and <200%, Insurance=Uninsured, Visits Included=ALL																				

***N**otes: WHO Tiers of contraceptive effectiveness:*

Tier 1 (High effectiveness): implants, intrauterine devices, sterilization

Tier 2 (Medium effectiveness): injectable methods, patch, pills, and vaginal ring

Tier 3 and 4 (Low effectiveness): condoms, diaphragms, fertility awareness methods, spermicides

Long-acting reversible contraceptive methods (LARC) are a subset of Tier 1 methods that are reversible and include implants and intrauterine devices.

To further test for changes in the use of contraceptives at Title X clinics pre and post P4HB, we controlled for Title X user characteristics using regression analysis. We tested for significant differences in the: 1) probability more women reported Medicaid coverage; and 2) birth control use by type of method among women in the income range targeted (> 25% FPL and < 200% FPL) as P4HB matured through the 20th quarter (last quarter of 2013) of data. In the regressions, we controlled for the following characteristics: Age, Race, Ethnicity, English Proficiency, Family Size, Marital Status, Education Level, and Urban/Rural Status. Results are shown below and significance levels are shown in parentheses in Table 10.

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

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

[1]*Includes those between 25% and 200% FPL (N=163,021),* [2]*Includes those between 50% and 200% FPL (N=124,543)*
Insurance: *Excludes those with Private-FP Coverage, Private-UK FP Coverage and Unknown Insurance*
Controlling For: *Age, Race, Ethnicity, English Proficiency, Family Size, Marital Status, Education Level, Urban/Rural Status*

Sample: *Includes only the last or most recent visit for each woman in the dataset*
Quarters: *Q1-Q20 are being treating as a continuous variable in the model to capture time trends*
WHO Tiers of contraceptive effectiveness: *Tier 1 (High effectiveness): implants, intrauterine devices, sterilization; Tier 2 (Medium effectiveness): injectable methods, patch, pills, and vaginal ring ; Tier 3 and 4 (Low effectiveness): condoms, diaphragms, fertility awareness methods, spermicides; Long-acting reversible contraceptive methods (LARC) are a subset of Tier 1 methods that are reversible and include implants and intrauterine devices*

After controlling for these characteristics of women using services at Title X clinics, the regressions indicate the following statistically significant changes:

- There was a small increase in the number of Title X clients covered by private insurance that did not carry family planning coverage versus being uninsured among those between 25% and 200% FPL;
- There was a small increase in the probability of using any method versus no method after the visit among all Title X users and a significant increase in the probability of using any method among those entering as non-users.
- There was an increase in the use of medium versus low effect birth control methods with a corresponding decrease in high versus low effect birth control. Among the high effect methods, there was a small increase in the use of LARCs versus non-LARC methods.

We repeated this type of analysis using just a Pre/Post P4HB time indicator and found that only the movement toward LARC usage remained statistically significant. We also used women with household incomes < 25% FPL as a comparison group for those made newly eligible under P4HB. In these regression runs we found a significant increase in the use of LARCs vs. non-LARC methods Pre/Post P4HB. This type of analysis will continue as we complete more of the evaluation design.

Title X and Medicaid Analysis. While Title X providers are central to providing access to the women in the income range affected by the Demonstration, we need to examine the effects of the P4HB program on the use of family planning services across both the Title X and Medicaid programs. We combined the visit data from the Medicaid claims with the non-Medicaid paid visits funded by Title X in order to get a full picture of total utilization. The data in Table 11 shows the usage over the pre/post P4HB period. The data in this table reflects the percent of Medicaid enrolled women ages 18-44 receiving any family planning visit and in turn, the percent for which the visit/service (drug claims are included) was for some form of birth control. We also report on the intensity of usage by including the number of family planning visits per user.

As more of the Medicaid enrolled women are in the P4HB program, we would anticipate the overall usage to increase. The percentage of Medicaid women with any family planning visits increased from about 35% in 2010 to almost 40% in 2011 but fell back to 36% by 2013. There was also no consistent upward trend in the percentage of Medicaid enrolled women with a visit/service for birth control. This percentage remained close to 11% throughout the 2009-2013 period. The data do indicate that women who use some family planning may be using these services more intensely as the mean number of visits per user increased from 2.19 to 2.42 over the study period.

In the next bank of data in Table 11, we see that visits paid by Title X for non-Medicaid enrolled women ages 18-44, as a percentage of all women < 200% FPL in Georgia, followed a downward trend over the full pre/post period while here too, visits per user woman increased. When the visits paid through Medicaid are added to those paid through Title X (omitting those Medicaid paid) visits, the percentage of women < 200% FPL in Georgia with a family planning visit in either program declined from 19% to 15% over the 2009-2013 time period. These data indicate that the two systems—Medicaid and Title X—are experiencing declines in rate of usage of family planning services among their eligible populations and when combined, are not serving a larger percentage of the overall population of women with household incomes < 200% FPL in Georgia.

Table 11 Use of Family Planning and Birth Control Visits among Medicaid Enrolled, Title X Non-Medicaid Enrolled and Combined Usage, 2009-2013

	Use Among Medicaid Women Ages 18-44/All Medicaid Enrolled			**Use At Title X Clinics among non-Medicaid Enrolled Women Ages 18-44/All Women < 200%FPL**			**Total Use (Title X Non Medicaid Plus Medicaid)/All Women < 200% FPL**	
	Any Family Planning Visit[1]	Mean Visits Per User	Any Visit /Service for Birth Control[1]	Any Family Planning Visit[2]	Mean Visits Per User	Any Visit /Service for Birth Control[2]	Any Family Planning Visit[3]	Any Visit /Service for Birth Control[3]
2009	35.2%	2.19	11.6%	13.3%	2.12	12.2%	33.7%	19.0%
2010	35.8%	2.27	10.8%	13.5%	2.09	12.3%	33.4%	18.3%
2011	41.1%	2.21	11.7%	12.8%	2.13	11.7%	32.6%	17.3%
2012	37.8%	2.46	11.6%	12.0%	2.17	11.0%	31.8%	17.1%
2013	36.3%	2.42	10.6%	10.4%	2.18	9.7%	29.8%	15.3%

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

Another way the introduction of P4HB into the combined Medicaid and Title X systems could affect usage is to move women using some form of birth control toward one of the more effective methods. In Table 12 below, we show the composition of the birth control methods used within the Medicaid system and in turn, the use of non-Medicaid enrolled users within the Title X system.

Table 12 Composition of Contraceptive Use among Users in Medicaid and Title X Non-Medicaid Groups, 2009-2013

	Composition of Medicaid Birth Control Methods Used: Enrolled Women Ages 18-44				**Composition of Title X Birth Control Methods Used: All non-Medicaid Insured Users**			
	Tier 1	Tier 2	Tier 3/4	LARC	Tier 1	Tier 2	Tier 3/4	LARC
2009	54.4%	42.3%	3.3%	38.4%	11.3%	71.8%	16.9%	5.8%
2010	51.9%	45.1%	3.0%	33.4%	11.2%	71.9%	16.9%	6.5%
2011	54.7%	42.2%	3.1%	36.0%	11.8%	70.8%	17.4%	8.0%
2012	53.2%	43.6%	3.3%	36.5%	11.9%	71.2%	16.9%	9.0%
2013	52.3%	43.5%	4.2%	35.2%	11.8%	72.3%	15.9%	10.1%

***N**otes: WHO Tiers of contraceptive effectiveness: Tier 1(High effectiveness): implants, intrauterine devices, sterilization; Tier 2 (Medium effectiveness): injectable methods, patch, pills, and vaginal ring; Tier 3 and 4 (Low effectiveness): condoms, diaphragms, fertility awareness methods, spermicides; Long-acting reversible contraceptive methods (LARC) are a subset of Tier 1 methods that are reversible and include implants and intrauterine devices.*

These data indicate an increase in the use of LARCs within the Medicaid program but only from 2010 forward. Beginning in 2011, 36% of Medicaid enrolled women ages 18-44 used LARC methods, which was up from 33% in 2010. By the end of 2013, LARC usage had declined to 35% in this population. Use of LARCs at Title X clinics steadily increased from about 6% in 2009 to just over 10% of all users in 2013.

Finally, in Table 13 below we show the patterns of family planning and birth control usage among the P4HB enrollees (with required months of continuous enrollment). Here we have combined women in all components (FP only, IPC and RM) of the Demonstration but provided separate data for those who were auto-enrolled into P4HB versus those enrolling on their own in 2012 and 2013.

Table 13 Use of Family Planning and Birth Control among P4HB Demonstration (FP only, IPC, and RM) Participants, Auto-enrolled and Not Auto-Enrolled, 2011-2013

Year		**Use Among P4HB Women Ages 18-44**			**Composition of P4HB Birth Control Methods Used**			
		Any Family Planning Visit[1]	Mean Visits Per Woman	Any Visit /Service for Birth Control[1]	Tier 1	Tier 2	Tier 3/4	LARC
2011	Overall	36.1%	1.79	11.0%	41.6%	48.0%	10.4%	35.3%
	Auto-enrolled	*	*	*	*	*	*	*
	Not Auto-Enrolled	36.1%	1.79	11.0%	41.6%	48.0%	10.4%	35.3%
2012	Overall	30.1%	1.98	8.8%	36.8%	53.0%	10.2%	31.9%
	Auto-enrolled	22.7%	1.86	6.2%	29.1%	59.4%	11.5%	27.9%
	Not Auto-Enrolled	43.9%	2.09	13.7%	43.2%	47.6%	9.1%	35.3%
2013	Overall	29.8%	2.0	8.5%	38.5%	48.8%	12.7%	33.6%
	Auto-enrolled	24.1%	1.95	6.7%	36.9%	51.5%	11.6%	32.9%
	Not Auto-Enrolled	43.6%	2.11	12.8%	40.6%	45.4%	14.1%	34.6%

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

Overall, we see the percentage of participants in the P4HB program who had any family planning visit remained stable at roughly 30% in PY 2 and PY 3. The overall percentage with a visit/service for birth control remained below 9% in both of these two program years. There is a marked difference, however, in the utilization patterns for those women who were auto versus not auto-enrolled. Whereas 22.7% of those auto-enrolled had any family planning visit in PY 2 and 24.1% had any family planning visit in PY 3 and 6-7% had a visit/service for birth control in each of those two years, the corresponding percentages for those not auto-enrolled into P4HB were approximately 44% in both years with a family planning visit and approximately 13 - 14% with a visit/service for birth control. Overall, roughly 32 to 34% of P4HB enrollees using a birth control method were using LARCs in PY 2 and PY 3. There were fewer differences in these percentages for the auto versus non-auto-enrolled P4HB enrollees. For those auto-enrolled, this percentage equaled 33% in PY 3 and for those not auto-enrolled, the percentage using LARCs in 2013 was close to 35%.

VI. Births and Birth Outcomes among P4HB Participants

As the evaluation proceeds and more claims data are available we continue to examine the outcomes of pregnancy or delivery among P4HB women after they enroll in the program. In Table 14a we report the number of deliveries inclusive of liveborn infants, still births and fetal deaths observed among Demonstration participants enrolled meeting our requirements. We also present counts of pregnancies for the women enrolled in PY 3 using claims data through the first nine months of 2014 as these claims were available and are indicative of outcomes, if unintended, the P4HB program is designed to prevent.

For the data presented in Table 14a we again note that classification of deliveries/births based upon claims data, from which accurate gestational dating of any pregnancy is not possible to discern, is subject to misclassification, particularly those pregnancies of short gestation. Methods used to count pregnancies among Demonstration participants and requirements for enrollment in the P4HB program (three plus months of continuous enrollment between April 1, 2012 and March 31, 2013, no pregnancy during the first 90 days enrolled and no live birth, stillbirth, or fetal death within 245 days of enrollment) also remain the same. As noted in the footnote to Table 2, the number of family planning only enrollees meeting these requirements equals 47,319 and the number of IPC women meeting the requirements equaled 145.

Table 14a Pregnancies and Deliveries in 2013 to Unique P4HB Participants after their Enrollment in 2012 or 2013 by Auto-Enrollment Status

Demonstration Participants[1]	Number, % with Pregnancy in 2013 after Enrollment in the Demonstration[1]	Number, % with Delivery in 2013 after Enrollment in the Demonstration[1]
Family Planning Only Enrollees N = 47,319	5,180 (10.9%)	3,860 (8.2%)
IPC Enrollees N = 145	13 (9.0%)	11 (7.6%)
Auto-Enrolled Demonstration Participants		
Family Planning Only Enrollees N =31,063	3,599 (11.6%)	2,767 (8.9%)
IPC Enrollees N = 22	2 (9.1%)	3 (13.6%)
Not Auto-Enrolled		
Family Planning Only Enrollees N =16,256	1,581 (9.7%)	1,093 (6.7%)
IPC Enrollees N = 123	11 (8.9%)	8 (6.5%)

Table 14b Pregnancies and Deliveries to those with RSM index delivery from April 1, 2012 to January 31, 2013 and Not Participating in P4HB *

RSM non-Participants	Number, % with Pregnancy in 2013 after RSM index delivery	Number, % with Delivery in 2013 after RSM index delivery
RSM N = 31,461	4,438 (14.1%)	2,232 (7.1%)

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

The data in Table 14a indicate that the percentage of the family planning only P4HB enrollees with a pregnancy after their enrollment (not already pregnant at enrollment) into the program was lower for those non-auto-enrolled women, at 9.7%, compared to those auto-enrolled, at 11.6%. The overall percentage for the family planning only women was 10.9% for PY 3. Overall, the percentage of family planning only enrollees with a delivery (see Table 2) in 2013 equaled 8.2%.

Participants versus Non-Participants.

To put these percentages into perspective, we use a sample of RSM women with an index delivery between April 1, 2012 and January 31, 2013 and with *no* Medicaid enrollment for at least 3 consecutive months from loss of Medicaid eligibility for this index delivery to another outcome of pregnancy or delivery. These data are shown in Table 14b. Both the percentage with a repeat pregnancy (14.1%) and repeat delivery (7.1%) are higher for these RSM women who did not participate in P4HB compared to the respective percentages for non-auto-enrolled family planning only P4HB participants, 9.7% and 6.7% respectively.

While the number of total IPC enrollees is still small in PY 3, the data indicate that 9.0% experienced a repeat pregnancy after enrollment and this percentage was similar for the auto-enrolled versus not auto-enrolled. As noted earlier, eleven IPC participants experienced a repeat delivery in 2013. Eight of these deliveries were among those women not auto-enrolled in the IPC component of P4HB.

We can also make a comparison of the IPC P4HB participants to other women in Medicaid giving birth to a VLBW infant during the same time period. In Table 15 below we present data on the number and percentage with a repeat pregnancy within 6 or 12 months of their index VLBW delivery and in turn, a repeat delivery within 12 months. We also report on the outcomes of the deliveries resulting in a live birth for each of these groups.

Table 15 Number and Percent of Women with VLBW Infant with Repeat Pregnancy and Deliveries within Six or Twelve Months, IPC Waiver Demonstration Participants and Non-Participants

	N	**Pregnant within 6 months**	**Pregnant within 12 months**	**Delivery within 12 months**	**Delivery Outcome**	**Birth Weight**
RSM random sample[1]	145	10 (6.9%)	32 (22.1%)	8 (5.5%)	5 Live Birth, 3 Fetal Death	3 NBW*
IPC Group[2,3]	145	7 (4.8%)	16 (11.0%)	3 (2.1%)	3 Live Birth	2 NBW, 1 LBW

[1]*Within 6 months or 12 months after index delivery of VLBW under RSM program between April 1, 2012 and January 31, 2013.*
[2]*Within 6 months or 12 Months after enrollment in IPC where the P4HB start date was between April 1, 2012 and January 31, 2013 with 3 consecutive months in demonstration.*
[3]*The fetal death and additional seven live births reported for the IPC participants in Table 2 occurred after 12 months of enrollment.*
[4] *Only three of the five live birth deliveries were able to be linked to the newborn.*

These data indicate that IPC women had lower repeat pregnancies within six months (4.8% vs. 6.9%) of enrollment in IPC than the women in a random sample of RSM mothers with a VLBW delivery, within six months of losing their Medicaid coverage. When a 12 month follow-up window is used for both groups, the IPC women again had lower rates of repeat pregnancies (11.0% vs. 22.1%) than the RSM (non-IPC) comparison group; in turn, they experienced fewer deliveries within the 12 month period, 2.1% versus 5.5% of the RSM comparison sample. Important to the goals of the P4HB program, there were no repeat VLBW births to the IPC enrolled women in the 12 months over which we compared outcomes for these two groups. Among the three births to IPC women, two were normal birth weight and one was low birth weight; there were no fetal deaths or stillbirths observed for these women. In comparison, the RSM women experienced 5 live births and 3 fetal deaths over the 12 month follow-up period. Among the live births to the RSM women, there were no VLBW outcomes.

Pre/Post Analysis of RSM Women

With three years of data post the implementation of P4HB, we can examine measures over the 2009-2013 time periods. One outcome that could be affected by the P4HB program is the number of repeat pregnancies and deliveries among all RSM women as more of them are enrolled in P4HB after a delivery paid by Medicaid. In Table 16, we provide data on the percentage of RSM women who have a pregnancy/birth within six months and twelve months of an index birth in each of the 2009-2013 study years. Births in 2013 will be understated due to the lack of full run out of claims and as noted earlier, we know that deliveries in 2012 are understated due apparently, to incomplete claims in the currently available extract of claims.

Table 16 Percent of RSM Women with a Repeat Pregnancy/Birth Paid by Medicaid within Six/Twelve Months Pre and Post the Demonstration

	Number and Percent of RSM Delivering Mothers with Pregnancy within 6 Months	Number and Percent of RSM Delivering Mothers with Pregnancy within 12 Months	Number and Percent of RSM Delivering Mothers with Delivery within 12 Months
Pre P4HB			
2009	2,570 (3.4%)	8,091 (10.8%)	2,435 (3.2%)
2010	2,286 (3.2%)	7,618 (10.5%)	2,237 (3.1%)
Post P4HB			
2011	2,428 (3.5%)	7,489 (10.7%)	2,325 (3.3%)
2012	2,366 (3.5%)	7,398 (10.8%)	2,232 (3.3%)
2013	2,264 (3.4%)	Not enough claims run-out	Not enough claims run-out

As the data in Table 16 indicate, the percentage of RSM women with a repeat pregnancy within six months ranges from 3.2% to 3.5% during both the pre and post periods and there is no indication of a decline in the post versus pre- P4HB period. The percentages with a repeat pregnancy within 12 months and in turn, repeat deliveries within 12 months are also remarkably stable for the full cohort of RSM women in each of the 2009-2013 study years. As the evaluation proceeds, these data will be used to examine these outcomes adjusting for the characteristics of RSM women and testing specifically for changes in intra-partum intervals.

VII. CONCLUSIONS AND RECOMMENDATIONS

Conclusions

The P4HB program, with its unique IPC component, was implemented in the state of Georgia on January 1, 2011 and per this annual report, is in its third year of operation. While the DCH used all available resources to make women and providers aware of the program across all areas of the state, the number of women expected to enroll by this time since implementation of the P4HB program has not been met. The DCH implemented auto-enrollment in late 2011 and continued it through June of 2013 with the hope of increasing awareness and enrollment in the program by easing the administrative steps women had to take to enroll after they lost Medicaid eligibility under the PeachCare for Kids® or RSM eligibility criteria. The effect of this effort was reflected in the sharp increase in enrollment that continued through the third quarter of PY 2012. However, when it was time for recertification, these women did not follow through with this process and it appeared these women were not as aware of or not perhaps as interested in the benefits of the P4HB program as reflected in lower use rates in PY 2. The enrollment numbers for the family planning only component continue to decline from their peak in third quarter 2012, but when measured against the number of women eligible in the community, the percentage enrolled in the family planning only component at the end of PY 3 was just slightly lower (11.1%) than that seen at the end of PY 2 (12%). Still, this percentage is far lower than expectations and most other states' waiver experiences. On the other hand, enrollment in the IPC as well as the Resource Mother only components of the program has increased and early indications are that this component is helping to prevent repeat pregnancies and in particular, repeat VLBW deliveries. Given the large numbers of auto-enrolled women still enrolled in the P4HB program at the end of PY 3 and that the IPC component continues to auto-enroll women, it is important to ensure that they fully understand the benefits to which they are entitled and that these services will still be available to them if they recertify their eligibility and remain enrolled.

One of the goals of the P4HB program is to increase the use of family planning services and in turn, the use of effective contraceptives among those women not wanting to get pregnant. In PY 3, there was continued indication of increased use of LARCs, one of the most effective contraceptive methods. The increase however, appeared to be occurring more in the Title X portion of the total Title X/Medicaid financed family planning service system in Georgia. The use of family planning services among Medicaid enrolled women decreased from the high in 2011 but the overall percentage of enrollees with a family planning visit can be seen as rather stable over the full 2009-2013 pre/post period and those who use some services are receiving more visits per user in both the Medicaid and Title X system over time. There is also evidence that those women enrolling in the P4HB family planning only component of the Demonstration are more likely to use some family planning services during the year than all Medicaid enrolled women ages 18-44.

Recommendations

During the preparation of this PY 3 report, Georgia submitted a request for a three-year extension of the P4HB program. This extension would allow the state to continue to provide needed services to the large number of women $\leq$ 200% FPL remaining uninsured. The P4HB program remains an important safety net for access to family planning and IPC related services for low-income women in the state. It is important for the state to continue to work closely with providers who will inform women about the program and encourage them to enroll and retain eligibility in the program. The state is encouraged to continue their collaborative work with the CMOs to increase use of the benefits available to the women enrolled in the P4HB program. Given the evidence that the Title X system is increasing the use of LARCs and the recent change in the Title X grantee in the state, it is also important for DCH to continue collaborative work with the new Title X grantee and the state and local public health departments to maintain access to Medicaid paid services at these clinics. These efforts will enable women to plan their first pregnancies and deliveries and potentially reduce the rate of first VLBW births in the state. The increased enrollment of women with a VLBW delivery paid by Medicaid into the IPC and Resource Mother only components is encouraged as this part of the P4HB program appears to be making strides in reducing repeat pregnancies and deliveries among this group of high-risk women. Specific recommendations are as follows:

1. The patterns seen near the end of the third year indicate the program is experiencing significant declines in enrollments in the family planning only component and in the use of family planning services by Medicaid women ages 18-44. It is important for the state to reverse these trends in this component of the program while continuing to increase enrollments and success seen in the other components of P4HB.
2. Continue the collaborative working relationship recently established by the state with the new Title X grantee and work as an active partner with them in the enrollment of eligible women into the P4HB program and in turn, their use of effective family planning services. At the same time, continue the collaborative relationship with the state and local public health departments and their efforts to assist women with the P4HB enrollment process. A benefit of this partnership is that public health clinics can 'leverage' Medicaid

funds to increase revenues and allow for use of other public funds, including Title X funding, to further expand outreach, access and provision of more effective family planning services.

3. As evaluators, we will continue monitoring the Title X quarterly data that is critical to DCH's ability to assess overall trends in service use and in particular, the use of LARCs. DCH can assist the evaluation team in making contacts and arranging to obtain the same data elements used in this and prior reports to CMS on a quarterly basis.
4. Work with the CMOs to retain present P4HB participants and enhance their service utilization. Previous efforts have included increased mailings, CMO outreach and dissemination of information regarding the ease of re-enrollment and the wide array of preventive and family planning services available to enrollees at no cost. An evaluation of the effectiveness of these outreach efforts would help inform the state.
5. Encourage the CMOs to continue their case management efforts with the IPC enrollees to assure their use of all available services and in particular the management of chronic conditions. Given the growing enrollment of Resource Mother only mothers, ensure the CMOs are reaching out to them in the same manner as they are with the women in the IPC component regarding the use of effective family planning services as well as the use of the preventive and other services these women have access to within the traditional Medicaid program.
6. Consider a new <u>consumer and provider</u> marketing campaign for P4HB that includes information about the renewal (if awarded) and access to Federally Qualified Health Centers (FQHCs) as well as public health department clinics for P4HB enrollment and services. Assess and use the most effective targets: media outlets (TV, radio), social

media (texts, Face Book, Twitter), and community partners and organizations (churches, beauty salons, health departments, etc.).

7. Consider including a detailed list of the covered services for each component of the program on the P4HB cards given to women as they are enrolled.
8. Monitor the engagement of the CMOs with public health district leaders across the state to determine whether enrollment of the VLBW infants' mothers in the IPC component of the P4HB program is higher in areas with high numbers of VLBW births (and associated coalitions and targeted P4HB enrollment efforts) compared with other areas of the state without such coalitions and enrollment efforts.
9. Continue toward implementation of processes to decrease the time between the eligibility determination and actual CMO enrollment for P4HB benefits. Currently, most women who eventually come into a CMO for P4HB services do so within two months from the date of the eligibility determination. This is a time period when women do not have access to P4HB services so unintended pregnancies may occur. The need for this is seen in the significant number of women coming into the program already pregnant but not knowing it during PY 3. The finding that this count is lower than in PY 2 suggests efforts to increase understanding of the program have improved this issue.
10. Given the effectiveness of LARCs in the prevention of unintended pregnancies and increased intra-partum intervals, work closely with the P4HB providers to ensure their understanding of the change in the Medicaid program's reimbursement of these contraceptive methods during an inpatient stay.

Appendix A. Budget Neutrality Worksheet: Federal Costs in CY 2012 & 1st Yr Infant Costs

Georgia's P4HB Budget Neutrality Worksheet for: FEDERAL COST 2012						
		Quarter 1	Quarter 2	Quarter 3	Quarter 4	TOTAL
WITHOUT DEMONSTRATION - All P4HB Participants (FP and IPC) - FP and associated services (Effective FP?)						
FP and FP-Related Services for All P4HB Pop - 90:10 and reg	FP Enrollee Member Months	52,572	86,082	103,073	109,638	351,365
FMAP rates (multivits, immunizations, admin., etc)	IPC Enrollee Member Months	65	91	290	434	880
	PMPM for FP Members FP related Services	$36.00	$36.00	$36.00	$35.97	$35.99
	PMPM for IPC Members FP related Services	$28.95	$28.95	$28.95	$28.95	$28.95
	Total	$ 1,894,427	$ 3,101,510	$ 3,718,932	$ 3,956,055	$ 12,671,596
First Year Infant Costs for VLBW Babies < 1,500 grams (all Medicaid paid births)	Estimated Persons					2,117
	Cost per Person	$ 59,503	$ 61,268	$ 66,786	$ 72,484	$ 65,010.09
	Total	$ -	$ -	$ -	$ -	$ 137,626,361
First Year Infant Costs for LBW Babies 1,500 to 2,499 grams (all Medicaid paid births)	Estimated Persons					$ 5,768
	Cost per Person	$ 12,701	$ 11,493	$ 9,617	$ 10,273	$ 11,020.87
	Total	$ -	$ -	$ -	$ -	$ 63,568,378
TOTAL WITHOUT- DEMONSTRATION COSTS		**$ 1,894,427**	**$ 3,101,510**	**$ 3,718,932**	**$ 3,956,055**	**$ 213,866,334**
WITH DEMONSTRATION - IPC SERVICES excl. Resource Mothers Only Participants Only						
Interpregnancy Care Services at	Member Months	65	91	290	434	880
the FMAP rate	PMPM	$ 138	$ 138	$ 138	$ 136	$ 137.19
	Total	$ 8,938	$ 12,513	$ 39,876	$ 59,135	$ 120,461
First Year Infant Costs VLBW	Persons	414	377	411	410	1,612
Infants < 1,500 grams (all Medicaid paid births adjusted for effect of IPC services)	Cost per Person	$ 59,503	$ 61,268	$ 66,786	$ 72,484	
	Total	$ 24,634,242	$ 23,098,036	$ 27,449,046	$ 29,718,440	$ 104,899,764
First Year Infant Costs for LBW	Persons	1,094	1,163	1,213	1,202	4,672
Babies 1,500 to 2,499 grams (all Medicaid paid births adjusted for effect of IPC Services)	Cost per Person	$ 12,701	$ 11,493	$ 9,617	$ 10,273	
	Total	$ 13,894,894	$ 13,366,359	$ 11,665,421	$ 12,348,146	$ 51,274,820
First Year Infant Costs for	Persons	0	0	1	0	1
Normal Weight > 2,500 grams	Cost per Person			$ 2,687		
only for women who participated in the IPC	Total	$ -	$ -	$ 2,687	$ -	$ 2,687
TOTAL WITH DEMONSTRATION COSTS		**$ 13,954,397**	**$ 13,427,627**	**$ 11,734,894**	**$ 12,420,630**	**$ 156,297,732**
DIFFERENCE						**$ 57,568,603**