Semi-Annual Report

Planning for Healthy Babies Program® (P4HB®)

1115 Demonstration in Georgia

January 1-June 30, 2022

Submitted to the Centers for Medicare and Medicaid Services

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I. Summary and Background

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

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

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

The goals of the demonstration and related performance metrics are listed below.

Demonstration Goals:

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

Demonstration Objectives

- Improve access to family planning services by extending eligibility for these services to newly eligible women.
- Provide access to interpregnancy primary care health services for eligible women who deliver a VLBW infant.
- Decrease unintended and high-risk pregnancies among Medicaid eligible women.
- Decrease 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.
- Increase consistent use of contraceptive methods by providing wider access to family planning services and incorporating care coordination and patient-directed counseling into family planning visits.
- Increase family planning utilization among Medicaid eligible women by using an outreach and public awareness program designed with input from family planning patients and providers as well as women needing but not receiving services.
- Decrease Medicaid spending attributable to unintended births and LBW and VLBW babies.

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

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

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

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

Key Accomplishments in Renewal Period:

- The percent of uninsured women eligible in the community enrolled into the FP increased even as the number of uninsured women increased during the pandemic year of 2020.

- The percent of women *eligible* for the IPC and RM only components of P4HB and enrolled also increased during the pandemic year of 2020.

- Repeat pregnancies within 18 months were lower among RSM women eligible for P4HB FP only and participating by using any family planning service.

- Repeat pregnancies within 18 months of an index VLBW infant delivery were lower among women eligible for P4HB IPC and participating by using any family planning services.

- Subsequent deliveries were delayed and outcomes in subsequent deliveries were significantly better for IPC women eligible and enrolling in the program.

II. Operational Updates

Unexpected Trends –COVID-19. The onset of the COVID-19 pandemic in 2020 had an unexpected impact on the Medicaid program in general and possibly, on enrollment of eligible women in the community into the P4HB FP only program component. The pandemic also likely increased the number of women eligible (uninsured and < 211% FPL) for P4HB in Georgia's communities. As reported in our 2021 P4HB Annual Report, even while the number of uninsured increased from 179,161 in 2019 to 194,126 in 2020 the percent of women eligible for P4HB FP only and IPC/RM only who enrolled, increased. The continuation of full Medicaid benefits for RSM women may have led to lower use rates of RM services.

Unusual or Unanticipated Trends. Throughout the demonstration the enrollment of eligible women in the community into the FP only component has unexpectedly lagged behind the projections set forth in the original concept of P4HB. This may have moderated the potential of the waiver to achieve its intended goals. As previously reported, based on claims data, implementation of P4HB has not been associated with overall reductions in LBW and VLBW births in Georgia Medicaid. Recent evaluation work using the Pregnancy Risk Assessment Monitoring System (PRAMS) data and comparison to other states without this policy change, however, indicates a reduction in VLBW especially among non-Hispanic blacks. COVID-19 has also slowed the enrollment of women into the IPC/RM only components of P4HB. This trend may reverse itself once the PHE is ended.

Legislative Updates. There have been several extensions of the State of Georgia's public health emergency (PHE), which was originally set to expire on July 1, 2021, at 12:00 AM. Governor Kemp renewed the Economic State of Emergency continuously through March 27, 2022. The PHE was extended through July 15, 2022.

Public Forum. There were no P4HB Public Forum during this reporting period.

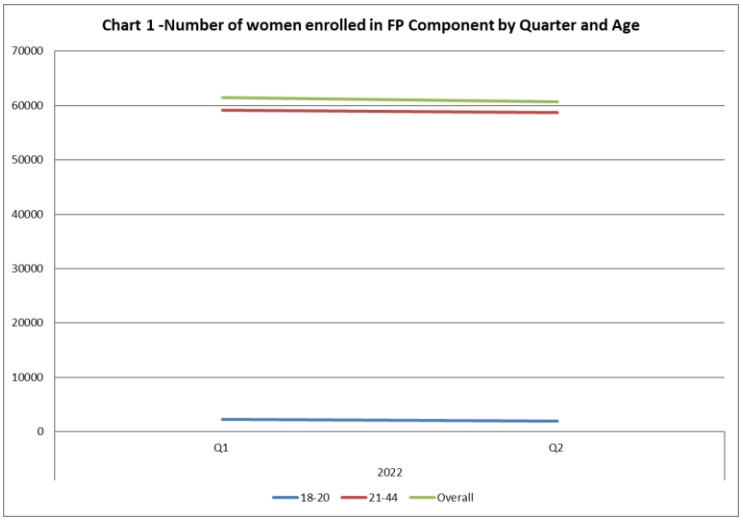
III. Performance Metrics

Impact of the Demonstration. For the P4HB to have an impact on the performance metrics outlined above, the enrollment of those eligible for the FP only and other components of the program is the first step. Since the implementation of the Georgia Gateway System in July 2017, enrollment in Medicaid and hence, the components of P4HB, have been centralized. The Georgia Gateway System is the state's integrated web portal that clients can use to apply for, check and renew their benefits. Through a series of screening questions, the system determines client eligibility across multiple benefits programs. Applicants are screened for various Medicaid eligibility categories through a 'cascading process' and P4HB is provided as an option if the applicant is not eligible for full-scope Medicaid. In this section we report on the reach of P4HB in terms of enrollment in the first two quarters of 2022.

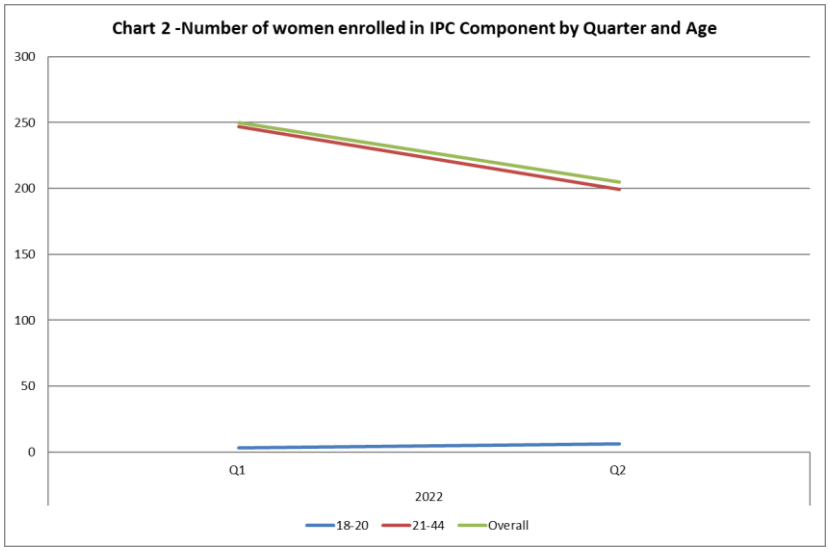
Objective: Improve access to family planning services by extending eligibility for these services to newly eligible women.

Outcome: Enrollment is monitored by quarter in these semi-annual reports. In the charts and tables below, we show the trends in enrollment by age group in each component of P4HB and the distribution of enrollees across the Care Management Organizations (CMOs) in the first two quarters of 2022.

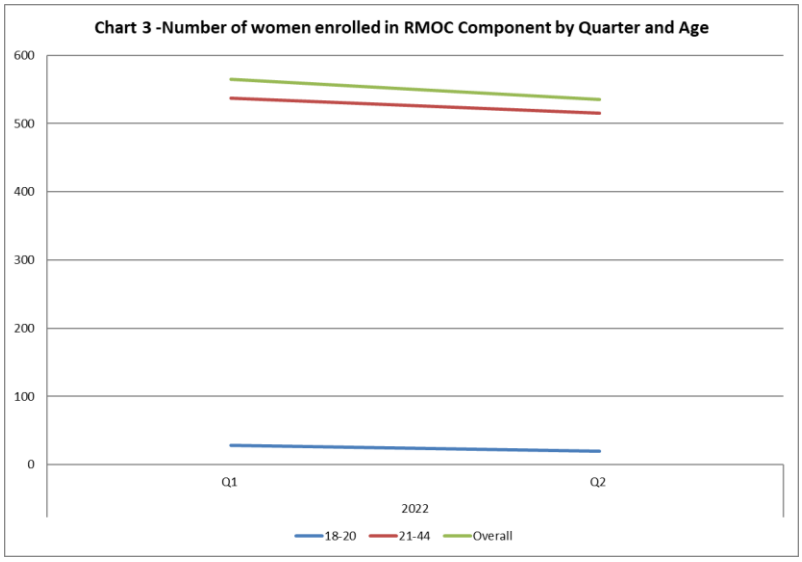
As shown in the following graphs, the trends in the growth of the number of enrollees in the several components of P4HB in Q1 and Q2 of 2022 are similar to those seen over Q3 and Q4 of 2021. Enrollment in the family planning only (FP only) component at the end of Q4 2021 stood at 61,247 and dominated total P4HB program enrollment. While it is still the largest component of P4HB in 2022, enrollment actually declined over the first two quarters of 2022. Enrollment increased slightly to 61,454 in Q1 2022 from Q4 2021 but then declined by ~1% to 60,638 in Q2 2022.



The women enrolled in the FP only component of P4HB continue to be largely in the 21 to 44 age group with this group comprising ~97% of the total FP only enrollment in Q2 2022. The overall decline is again driven by a decline of 358 or 15%, in enrollment of women in the 18-20 age group over these first two quarters of 2022. By the end of Q2 2022 the total of those 18-20 years of age in the FP only component at 1,977 was 36% lower than their total of 3,106 at the end of Q4 2021. This decline among the youngest group likely reflects their retention in the CHIP program under the PHE in Georgia. The decline in this younger age group was accompanied by a slight decline in the enrollment of women in the 21-44 age group; this is in contrast to the upward trend for this older age group seen in the last two quarters of 2021.



As seen in the last quarters of 2021, there was again a decline in the enrollment of women in the IPC only component of P4HB over Q1 and Q2 2022. Total enrollment in IPC declined from 256 at the end of Q4 2021 to only 205 at the end Q2 2022. The decline in IPC enrollment was in the 21-44 age group. While this component of P4HB has been the smallest, it is unique to the demonstration and enrollment should be monitored closely as Georgia comes out of the PHE.



In contrast to the growth pattern seen in the RM only component in 2021, there was a slight decline in enrollment in the RM only component of P4HB in the first two quarters of 2022. While enrollment in this component increased from 521 in Q4 2021 to 565 in the first quarter of 2022 there was a 5% decline from Q1 to Q2 2022; by the end of Q2 total enrollment was 535. Here too, the total number of women enrolled is predominantly women in the older age group (21-44), but the decline held for both age groups.

We note that trends in enrollment in the IPC and RM only components of P4HB reflect, in part, the trends in the rate of VLBW births. Older women are more likely to have developed the health conditions that can result in poor maternal and infant outcomes and hence, deliver a very low birth weight infant (VLBW) which qualifies women for IPC/RM only services. We note that the total of 740 women in the IPC and RM only components of the P4HB program at the end of Q2 2022 is less than half (46%) of the total 1,610 VLBW infants born to Medicaid women by the end of 2019 (based on claims data).

Access through the CMOs. Access to services and their specific modes of service delivery will vary across the three remaining CMOs based on their provider networks. The women in the FP only and IPC/RM components of P4HB are now enrolled in three CMOs serving Medicaid enrollees in Georgia: Amerigroup, CareSource and Peach State as of May 1, 2021. In Table 1 we show the counts of FP only and IPC/RM only enrollees in Q1 and Q2 2022 for each of the CMOs. We also show the percentage change in enrollment over the first two quarters of 2022 by each CMO.

Table 1. Enrollment Growth and Share Served by CMO, January – June 2022

ENROLLMENT BY CMO AND AGE GROUP FOR Q1 AND Q2 2022												
	Amerigroup			Caresource			Peachstate			Overall		
	Q1	Q2	Growth	Q1	Q2	Growth	Q1	Q2	Growth	Q1	Q2	Growth
Family Planning Only												
18-20	724	626	-13.5%	604	530	-12.3%	1007	821	-18.5%	2335	1977	-15.3%
21-44	17515	17431	-0.5%	15419	15575	1.0%	26185	25655	-2.0%	59119	58661	-0.8%
Total	18239	18057	-1.0%	16023	16105	0.5%	27192	26476	-2.6%	61454	60638	-1.3%
% Total	29.7%	29.8%		26.1%	26.6%		44.2%	43.7%				
Inter-Pregnancy Care												
18-20	1	1	0.0%	1	2	100.0%	1	3	200.0%	3	6	100.0%
21-44	70	47	-32.9%	103	88	-14.6%	74	64	-13.5%	247	199	-19.4%
Total	71	48	-32.4%	104	90	-13.5%	75	67	-10.7%	250	205	-18.0%
% Total	28.4%	23.4%		41.6%	43.9%		30.0%	32.7%				
Resource Mother Outreach												
18-20	6	2	-66.7%	6	8	33.3%	16	10	-37.5%	28	20	-28.6%
21-44	98	82	-16.3%	221	236	6.8%	218	197	-9.6%	537	515	-4.1%
Total	104	84	-19.2%	227	244	7.5%	234	207	-11.5%	565	535	-5.3%
% Total	18.4%	15.7%		40.2%	45.6%		41.4%	38.7%				
All Programs												
18-20	731	629	-14.0%	611	540	-11.6%	1024	834	-18.6%	2366	2003	-15.3%
21-44	17683	17560	-0.7%	15743	15899	1.0%	26477	25916	-2.1%	59903	59375	-0.9%
Total	18414	18189	-1.2%	16354	16439	0.5%	27501	26750	-2.7%	62269	61378	-1.4%
% Total	29.6%	29.6%		26.3%	26.8%		44.2%	43.6%				

Source: Georgia Department of Community Health, MMIS (Medicaid management Information System) Reports MGD-3823-M (MCHB Enrollment after EOM processing)

The data by CMO reflect the declines in enrollment in the components of P4HB over this first part of 2022. There was an overall decline in P4HB enrollment among the 18-20 year old group of almost 15% across all CMOs. The total enrollment of the older age group in P4HB was virtually unchanged with a -.9% decline over Q1 and Q2 2022. These trends combined for an overall slight decline of 1.4% in total P4HB enrollment in this first part of 2022.

As shown in Table 1, the share of all women enrolled in P4HB at the end of Q2 2022 ranged from ~26.8% to ~43.6% across the CMOs with Peach State having the largest share of all enrolled women. This is driven by their larger share (43.7%) of the FP only enrollment women which as noted, dominates the P4HB program. The CareSource CMO had a larger share of all IPC and RM only enrollees at the end of Q2 2022 than the other two CMOs. This CMO had 43.9% of all IPC enrollees compared to 23.4% of IPC enrollees in Amerigroup and 32.7% in Peach State and 45.6% of all RM only enrollees compared to 15.7% in Amerigroup and 38.7% in Peach State.

Objective: Provide access to interpregnancy primary care health services for eligible women who delivery at VLBW infant.

Outcome. The patterns in IPC enrollment varied across CMOs with larger percentage declines in enrollment in the Amerigroup CMO. For this CMO, there was a decline of 32% in their IPC enrollment and 19% in their RM only enrollment. This compared to declines of 10.7% and 13.5% in IPC enrollment in the other two CMOs. The Amerigroup also had a greater percentage decline (-19.2%) in RM only enrollment in these two quarters than Peach State CMO (-11.5%) while there was actually a 7.5% increase in RM only enrollment in the CareSource CMO.

To gauge the importance of these patterns across the CMOs, data on the rates of VLBW infants born to their members over this and earlier time periods would be needed, as it is only these women who are eligible for the IPC and RM only components of P4HB.

Access to services and their specific modes of service delivery will vary across the three remaining CMOs based on their provider networks. Given that many enrollees are now in a new CMO after the merger it is important to report on the outreach CMOs have employed and access to services each of them are reporting in this first part of 2022.

As reflected in Table 2 below, service utilization among the CMOs' IPC enrollees also varied during the first half of 2022. Compared to the first half of 2021, utilization of primary care services decreased 90.1% among Amerigroup enrollees (from 111 to 11), decreased 80.0% among CareSource enrollees (from10 to 2), and increased 21.8% among Peach State enrollees (from 78 to 95). Dental care utilization differed among the three CMOs in the first half of 2022, compared to the first half of 2021. Dental care utilization decreased 100% for Amerigroup IPC enrollees (from 17 to 0), increased 100% for CareSource IPC enrollees, (from 1 to 2), and increased 47.6% for Peach State enrollees (from 21 to 31). We note that all three CMOs began reporting separately the utilization of pharmacy, case management, and "other" services. We will track the changes in the utilization of these services in subsequent reports.

Table2: IPC Primary Care Service Utilizations (January-June 2022)

CMO	IPC Service Utilization (Q1 +Q2)
Amerigroup	**IPC Service Utilization** Dental care: 0 (Q1; 0; Q2: 0) Primary care/office visits: 11 (Q1: 7; Q2: 4) Pharmacy: 7 (Q1:4; Q2:3) Case Management: 6 (Q1:3; Q2:3) "Other" services: 50 (Q1:27; Q2: 23)
CareSource	**IPC Service Utilization** Primary Care/office visits: 2 (Q1: 0; Q2: 2) Dental: 2 (Q1: 2; Q2:0) Substance Abuse: 5 (Q1: 4; Q2:0) Pharmacy: 40 (Q1: 22; Q2: 18) Case Management: 20 (Q1: 9; Q2: 11) "Other" services: 25 (Q1:11; Q2:15)
Peach State	**IPC Service Utilization** Primary Care/office visits: 95 (Q1: 53; Q2:42) Dental Care: 31 (Q1:17; Q2:14) Substance Abuse: 17 (Q1: 9; Q2: 8) Case Management: 129 (Q1: 72; Q2: 57) Pharmacy: 12 (Q1: 8; Q2: 4) "Other "services: 20 (Q1: 14; Q2:6)

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

Outcome. In Table 3**,** we provide information from each CMO regarding outreach activities to potential and new FP and IPC/RM enrollees for January through June 2022. The CMO data represents a total of all outreach activities conducted by the end of this time-period. These activities targeted new and prospective enrollees across the CMOs and ranged from telephone calls, mailings, and virtual face-to-face visits. Most outreach activities were limited or conducted virtually due to the continuation of the COVID-19 pandemic. Note, that Peach State resumed some in-person, face-to-face outreach activities in Q2 (April-June 2022).

Table 3: CMO Outreach, January-June 2022

CMO	All Outreach Activities	IPC Specific Outreach
Amerigroup	• Virtual face-to-face conferencing in place of in-person visits. • 42 virtual and drive-through baby showers/diaper days with 1,884 participants • New member mailings and welcome calls • Recertification reminders and loss of benefit notifications • Provider visits and education conducted by Provider Solutions	• Reminder letters and phone calls • 162 total successful welcome calls made to IPC and RM participants • 4 virtual face-to-face visits were completed. All physical F2F visits and unannounced visits are on hold until further notice.
CareSource	• Welcome calls and postcards to all P4HB enrollees within 30 days of being eligible. • New member mailings and ID cards were mailed.	• Welcome calls to IPC and RM participants • Reminder letters and phone calls • A total of 2, 506 successful calls were made by CareSource to IPC and RM members, representing a 31.3% increase in successful calls made during the first half of 2021 (783 total successful calls) • Due to the COVID-19 pandemic, no home visits were made.

Table 3: CMO Outreach, January-June 2022		
CMO	**All Outreach Activities**	**IPC Specific Outreach**
Peach State	• New enrollees received a call from PS about the P4HB benefits and services, • Hosted 1 "virtual bingo" event in Q1 with current P4HB FP clients and 5 in person baby showers in Q2 with prospective P4HB clients • PSHP mailed 7,613 letters and packets • PSHP mailed an 8th month letter to clients prior to delivery.	• A total of 831 members who had a VLBW infant received telephone calls • During the first half of 2022, a total of 133 face-to-face visits were made. PSHP reengaged in these types of visits beginning in Q1 2022 with the plan to conduct virtual visits as needed.

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

Outcome. The Care Management Organizations (CMOs) track aspects of case management for women enrolled in P4HB IPC or RM only. In this report, we review the case management files for the first two quarters of 2022 (Q1 and Q2), which included data on 1813 unique women enrolled in either IPC (536) or RM only (1277) across all three CMOs (403 Amerigroup, 699 CareSource, 711 Peach State). Among these 1813 women, 857 (47.3%) accepted case management, 92 (5.1%) declined case management, and for 846 (47.6%) information about acceptance or declination of case management was either missing or pending. For Q1 and Q2, the declination of case management varied according to whether the woman was enrolled in IPC (14 declinations of 536, 2.6%) or RM only (78 declinations of 1277, 6.1%). There was also substantial variation in women's acceptance of case management across the three CMOs, as shown in Table 4.

Table 4. Acceptance of Case Management Services by Medicaid Care Management Organization

Case Management	Medicaid Care Management Organization			TOTAL N = 1813
	Amerigroup N = 403	CareSource N = 699	Peach State N = 711	
Accepted	211 (52.4%)	70 (20%)	576 (81%)	857 (47.3%)
Declined	15 (3.7%)	23 (3.3%)	54 (7.6%)	92 (5.1%)
Missing/Pending	177 (43.9%)	606 (86.7%)	81 (11.3%)	864 (47.7%)

Among the 857 women who accepted case management, 319 (37.2%) had at least one phone or face-to-face contact with the case manager during Q1 and/or Q2, whereas 538 (62.8%) had no documented contact with the case manager, with substantial variation in the proportion of IPC and RM only enrollees having at least one phone or face-to-face contact with the case manager according to CMO assignment (Table 5).

Table 5. Interaction with Case Manager (Among those Accepting) by Medicaid Care Management Organization

Case Management	Medicaid Care Management Organization			TOTAL N = 857
	Amerigroup N = 211	CareSource N = 70	Peach State N = 576	
Face-to-face or telephone	53 (25.1%)	56 (80%)	210 (36.5%)	319 (37.2%)

Among the 319 enrollees who accepted case management and who had at least one phone or face-to-face contact with the case manager, 111 (34.8%) had a problem list that contained at least one problem; the most common items on the problem list were annual health exam, baby preparations, childcare, employment and job skills, high blood pressure, diabetes, other health conditions, community resources, housing, transportation, food and family and intimate relationships. For this group of enrollees with a least one phone or face-to-face contact, 142 (44.5%) had care plan goals, with the most common goals being around healthy lifestyle education, community resource education, employment/job skills, housing, finances, and education, as well as safety, transportation, and controlling risk factors. In contrast, among the 538 enrollees who did not have at least one phone or face-to-face contact, only 29 (10%) had a problem list that contained at least one problem; the most common items on the problem list were annual health exam, high blood pressure and other contributing health conditions. For this

Objective: Increase child spacing intervals through effective contraceptive use.

group of enrollees, 29 (10%) also had care plan goals, the most common of which focused on healthy lifestyle education and community resource education.

Outcome. One of the goals of the RM in the IPC/RM only components of P4HB is to help enrollees gain access to primary and preventive care with a focus on access to the contraceptive method they desire. However, RMs have varied success in reaching enrollees and in turn, obtaining their acceptance of the case management services. Across the three groups of enrollees (*i.e.,* those who accepted case management services and had at least one face-to-face or phone contact, those who accepted case management services and did not have any face-to-face or phone contact, and those who declined case management services), there were not differences in the percentage who were adjudicated as 'using a more effective method of birth control during the quarter' compared to the method they were using at the start of the quarter (Table 6), with the three groups ranging from 5.2% to 6%. Of note, however, the criteria by which this adjudication of 'using a more effective method of birth control during the quarter' are not explained, so this is difficult to interpret.

Table 6. IPC and RM Only Enrollees' Use of Birth Control According to Case Management Group

Birth Control Outcome	Case Management Group		
	Declined **N = 92**	**Accepted, No face-to-face or phone contact** **N = 538**	**Accepted, Face-to-face or phone contact** **N = 319**
Participant selected more effective form of birth control	5 (5.4%)	28 (5.2%)	19 (6%)
Birth control method used at end of the period:			
Sterilization	0 (0%)	28 (5.2%)	6 (2%)
LARC	1 (1.1%)	14 (2.6%)	28 (5.6%)
Injectable	9 (9.8%)	15 (2.8%)	19 (6%)
Oral contraceptive pills	7 (7.6%)	26 (4.8%)	24 (7.5%)
Condoms	1 (1.1%)	8 (1.5%)	6 (1.9%)
Other	0 (0%)	0 (0%)	0 (0%)
None	2 (2.2%)	11 (2%)	34 (10.7%)
Unknown/Missing	72 (78.3%)	436 (81%)	212 (66.5%)

The birth control method being used by the client at the end of the period is also documented in Table 7 according to the case management group. Of note, it is difficult to draw conclusions

about this data across all case management groups as the percentage of clients for which this data is unknown or missing is more than two-thirds of the data. DCH is in the process of revising the reporting templates to limit the number of unknown or missing methods of birth control.

Table 7 below reflects the contraception and family planning utilization as reported by each CMO for their FP, IPC, and RM only enrollees.

Table 7: CMO Contraception and Family Planning Utilization of Services (January-June 2022)

CMO	Contraception Utilization Among Family Planning Users (Q1 +Q2)	Family Planning Utilization (Q1 +Q2)
Amerigroup	**Use of Known Contraception** FP: 1,089 (Q1: 598; Q2: 491) IPC: 10 (Q1:6; Q2: 4) RM: 18 (Q1:10; Q2:8) Total: 1,117 (Q1: 614; Q2: 503) **Most Common Form of Contraception among Users of Known Contraception** FP: Oral contraception (47.0%); injectable (38.8%) IPC: Oral contraception (70.0%); injectable (30.0%) RM: Oral contraception (61.1%); injectables (27.8%) **Number of Women with Unknown Form of Contraception** FP: 6,926 (Q1: 3,593; Q2: 3,333) IPC: 41 (Q1: 22; Q2: 19) RM: 126 (Q1: 62; Q2: 64) Total: 7,093	**Number of Participants who Utilized One or More Covered FP Services** FP: 8, 015(Q1: 4191; Q2: 3,824) IPC: 51 (Q1: 28; Q2: 23) RM: 144 (Q1: 72; Q2: 72) Total: 8,210
CareSource	**Use of Known Contraception** FP: 1,056 (Q1:528; Q2: 528) IPC: 2 (Q1: 1; Q2: 1) RM: 2 (Q1: 1; Q2:1) Total: 1,060 (Q1: 530; Q2: 530) **Most Common Form of Contraception among Users of Known Contraception** FP: Oral contraception (86.5%); injectables (5.0%); injectables (4.1%) IPC: Oral contraception (100%) RM: Oral contraception (100%) **Number of Women with Unknown Form of Contraception** FP: 5,733 (Q1:4,029; Q2: 1,704) IPC: 65 (Q1: 41: Q2: 24) RM: 62 (Q1:29; Q2: 33) Total: 5,860 (Q1: 4099; Q2: 1,761)	**Number of Participants who Utilized One or More Covered FP Services** FP: 6, 789 (Q1: 4,557; 2,232) IPC: 67 (Q1: 42; Q2:25) RM: 64 (Q1:30; Q2: 34) Total: 6, 920

Table 7: CMO Contraception and Family Planning Utilization of Services (January-June 2022)		
CMO	**Contraception Utilization Among Family Planning Users (Q1 +Q2)**	**Family Planning Utilization (Q1 +Q2)**
Peach State	**Use of Known Contraception** FP: 13, 667 (Q1: 7,113; Q2: 6,554) IPC: 151 (Q1:75; Q2:76) RM: 593(Q1: 338; Q2:255) Total: 14,411 (Q1: 7,526; Q2: 6,885) **Most Common Form of Contraception among Users of Known Contraception** FP: Oral contraception (83.2%); injectables (6.8%); Barrier method (4.9%) IPC: Oral contraception (92.7%); injectables (3.3%) RM: Oral contraception (92.4%); injectables (4.2%). **Number of Women with Unknown Form of Contraception** FP: 1,4 (Q1: 250; Q2: 1,170) IPC: 68 (Q1: 16; Q2: 52) RM: 187 (Q1:9; Q2: 178) Total: 1,675	**Number of Participants who Utilized One or More Covered FP Services** FP: 5,916 (Q1: 2,937; Q2: 2,979 IPC: 27 (Q1: 13; Q2: 14) RM: 140 (Q1: 71; Q2: 69) Total: 6,083

Utilization patterns varied across the three CMOs. Compared to the first half of 2021, the use of known contraception decreased in the first half of 2022 among Amerigroup and CareSource enrollees but increased substantially among Peach State enrollees (due largely to the merger with WellCare in May 2021 and thus the increase in clients). For Amerigroup enrollees, contraception utilization decreased 45.6% (from 2,054 to 1,117). For CareSource enrollees, known contraception utilization decreased 46.9% (from 1,996 to 1,060). For Peach State enrollees, known contraception utilization increased 212.3% (from 4,614 to 14, 411).

In the first half of 2022, oral contraception was the most preferred form of contraception reported for FP enrollees for all three CMOs (47.0% for Amerigroup, 86.5% for CareSource, and 83.2% for Peach State). For IPC enrollees, oral contraception was the preferred form of contraception for all three CMOs as well (70.0% for Amerigroup, 100% for CareSource, and 92.7% for Peach State).

Changes in the total number of P4HB women who utilized one or more covered family planning services varied by enrollees in each of the three CMOs. Overall utilization of family planning services decreased 21.3% for Amerigroup enrollees (from 10,676 to 8,210) and 10.9% for Peach State enrollees (from 6,829 to 6,083). Utilization of family planning services increased slightly for CareSource enrollees by 0.9% (from 6,858 to 6,920). Broken down by type of enrollee within each CMO, trends were fairly similar. For Amerigroup enrollees, utilization of family planning services decreased 23.4% for FP enrollees, decreased 41.4% for IPC enrollees, and increased 14.3% for RM enrollees. For CareSource, utilization of family planning services increased .8% for FP enrollees, decreased 43.7% for IPC enrollees, and increased 966.7% for RM enrollees. For Peach State enrollees, utilization of one or more family planning services decreased 8.2% for FP enrollees, decreased 76.2% for IPC enrollees, and decreased by 48.5% for RM enrollees.

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

Outcome. The women in the IPC and RM only components have recently delivered a VLBW infant who has high medical needs. The women who are likely to have medical conditions with a repeat pregnancy, would be considered high-risk. In prior reports we have used claims data to show a lower rate of repeat pregnancies on Medicaid to IPC and RM only participants. These data are not available for this quarterly report but will be contained in the next reporting period.

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

Outcome: If the components of P4HB can increased the use of effective contraceptives and reduce unintended pregnancies delivered on Medicaid, the capitated payments made to CMOs within Georgia Medicaid can be reduced. Table 8 shows the total capitated payments made to the CMOs for the FP only, IPC and RM only components by the last month of Q1 and Q2 2022. As reported in Table 1, there was virtually no growth in total P4HB enrollment over the first half of 2022. Consistent with this, there was virtually no change in total capitated payments to the CMOs form the last half (~$10 million) of 2021 to the first half of 2022 (~$10 million).

Table 8. P4HB Capitation Payments for January, June & Year-to-date for 2022

Program	*January*		*June*		*Total $ Q1&Q2*	
FP Only	$839,061	83.6%	$1,718,998	92.5%	$9,481,374	91.3%
IPC	$71,435	7.1%	$44,920	2.4%	$333,623	3.2%
RMOC	$92,799	9.2%	$93,554	5.0%	$570,534	5.5%
Total	$1,003,295	100.0%	$1,857,472	100.0%	$10,385,531	100.0%

As seen in earlier reporting periods, the FP only component is the most costly for Medicaid in terms of total capitated payments, accounting for 91% of the total in the first two quarters of 2022. Payments to CMOs for women in this component almost doubled from $839,061 in the first quarter of 2022 to $1,718,998 by the end of the second quarter of 2022. This increase accounts for the overall increase of $854,177 in expenditures from Q1 to Q2 of 2022.

While expenditures on capitated payments for FP only enrollees increased, they declined by ~37% for IPC enrollees and were virtually unchanged for the RM only enrollees. The changes seen in expenditures by the subcomponents of P4HB are not consistent with the changes in enrollment; enrollment in the FP only component was virtually unchanged over the two quarters and yet expenditures increased markedly. This pattern reflects an increase in the PMPM rate for FP only implemented in the Fall of 2021.

Member Surveys. No member surveys were conducted in the first two quarters of 2022.

Disenrollment, Service Denials, and Provider Claims. CMS requires that each semi-annual report show comparisons for *disenrollment; denials of service; provider claims; and complaints, grievances and appeals* for the current reporting period and comparison of these measures for the same period for the previous 2 years**.** These data were included in our prior semi-annual report; here we report comparisons for two years prior (January – June and July-December 2020 & 2021) and for the current reporting period (January-June 2022).

We first show data on the first three measures—disenrollment, service denials and provider claims—and discuss the following comparisons:

- January-June 2022 compared to January-June 2021 and January-June 2020; and
- July-December 2021 compared to July-December 2020 and July-December 2019 (back reporting).

Table 9 - Disenrollment, Denial of Service & Provider Claims 2019-2022			
Reporting Period	**Disenrollment**	**Denials of Service**	**Provider Claims**
Jan-June 2020	463	143,659	32,799
Jan-June 2021	84	104,833	32,096
Jan-June 2022	308	87,498	33,710
July-Dec 2019	528	158,693	36,339
July-Dec 2020	406	156,708	34,539
July-Dec 2021	421	87,242	32,606

As the data in the top rows of Table 9 show, disenrollment of P4HB members declined from a total of 463 in the Jan-June 2020 time period to only 84 in this same period in 2021. In the current Jan-June 2022 time period, however, disenrollment increased to 308. These patterns likely reflect the PHE retention of enrollees in Medicaid due to the Covid-19 extension of eligibility. CMOs reported that disenrollment increased in 2022 because members either did not meet program criteria, had other health insurance; became pregnant, were older than 44 years of age, had been sterilized, did not have a history of a VLBW newborn, had a fetal demise, or were unable to contact.

In contrast, denials of service for the Jan-June 2021 period (104,833) were 27% lower than the 143,859 reported for the same period in 2020. These declined further to 87, 498 or by ~17%, in the Jan-June 2022 time period. Counts of provider claims shown in column three of Table 8 were fairly stable over the time periods reported. The counts of providers claims stood at 32, 799 in Jan-June 2020, decreased slightly in Jan-June 2021 to 32,096 and then increased slightly to 33,710 in the Jan-June 2022 time period.

The pattern in disenrollment of clients in the last six months of each of the 2019-2021 years is one of declining disenrollment although there was a slight increase (5) from July-Dec 2020 to the same period in 2021. Denials of service which stood at 87,242 in the July-Dec 2021 period reflects a significant decrease from the denials (156,708) reported in the July-Dec 2020 period and the 158,693 reported for this period in 2019. Finally, the provider claims for the last six months of each year show a decline from 2019 to 2021. In the July-Dec 2019 period the state reported 36,339 provider claims and in the subsequent 2020 time period the claims stood at 34,539. There was a further decline in provider claims to 32,606 in the last six months of 2021.

Grievances. We discuss the data in Table 10 on counts of grievances overall and by CMOs for the similar time periods:

- January-June 2022 compared to January-June 2021 and January-June 2019; and
- July-December 2021 compared to July-December 2020 and July-December 2019 (back reporting).

Table 10 - Grievances by County By CMO 2019-2022

P4HB Grievance Count by CMO					
Reporting Period	**Amerigroup**	**CareSource**	**Peach State**	**WellCare**	**Total**
Jan-June 2020	1	0	0	0	1
Jan-June 2021	21	2	0	15	38
Jan-June 2022	19	8	7	-	34
Average 1st Half of Each Year	11.8	2.0	1.6	6.0	20.2
July-Dec 2019	6	0	0	0	6
July-Dec 2020	0	0	0	0	0
July-Dec 2021	13	13	9	-	35
Average 2nd Half of Each Year	8.0	3.5	2.3	2.7	15.8
Total (P4HB)	91	24	17	32	164

Given that there are data for 2019 and 2020 all four CMOs are included in this table; we discuss the data with the merger of CMOs in May 2021 in mind. In the Jan-June 2022 reporting period there were a total of 34 grievances across all 4 CMOs with most (19) of those from the Amerigroup CMO. The total of 34 is a bit lower than the total of 38 reported in Jan-June 2021. In this period there were more grievances from Amerigroup (21) while WellCare reported 15; the enrollees from WellCare were moved to the other CMOs in May 2021. The total of 34-38 grievances in the 2022 and 2021 time periods is markedly higher than the 1 grievance reported in Jan-June 2020. As noted in the table, the average number of grievances in the Jan-June periods of these years was 20.2

IV. Budget Neutrality and Financial Reporting

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

Outcome: Expenditures for the P4HB demonstration for January 1 through June 30, 2022 appears in the Budget Neutrality Report as submitted by DCH.

V. Evaluation Activities & Interim Findings

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

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

Research Question 1. Regarding the first question above, we have continued to report on the use of family planning and contraceptive services by women enrolled in the FP only, IPC and RM only components of P4HB. Several tables in the prior Annual Report show the data for 2019 and 2020 but these data have been compiled over the full demonstration period. The 2022 Interim Report will update these data through 2021.

BRFSS Data**.** To assess a broader view of access to primary and preventive services, we used BRFSS data from 2008-2013 to assess use and changes in use of three preventive health services – primary care visit within the last year, receipt of flu shot within the last year, and lifetime receipt of HIV test – among uninsured women of reproductive age (18-44 years) under 211% FPL in Georgia and women in comparison states. Comparison states were identified as states that: 1) did not significantly change their Medicaid family planning programs over the study period, and 2) met the formal test of equality in trends of outcome measures in Georgia and other control states. Eight comparison states met these criteria, including: Arizona, Kansas, Massachusetts, North Dakota, South Dakota, Tennessee, Utah, and West Virginia.

To address this research question, we conducted quasi-experimental difference-in-difference analyses using multivariable logistic regression analyses controlling for survey participant age, race/ethnicity, education level, work status, marital status, household size, health status, rural/urban county categorization, and state and year fixed effects. We hypothesized that uninsured women in Georgia < 211% FPL will be more likely to have access to primary care and receive guideline concordant screening services than similar women in comparison states. Although analyses are ongoing, results suggest that P4HB did not have a statistically significant effect on utilization of the three preventive health services of interest among uninsured women of reproductive age with incomes <211% FPL. (See Table 11 Below.)

Table 11. Preliminary Results from BRFSS Data Analysis

Outcome	Years Available	Comparison States	*Parallel Trend Assumption Met?*	DID Estimator Parameter Estimate	p-value
PCVISIT	2008-2013	AZ, KS, MA, ND, SD, TN, UT, WV	Yes	0.0005 (-0.0671, 0.0681)	0.988
FLU1YR	2008-2013		Yes	0.0226 (-0.0062, 0.0514)	0.124
EVERHIV	2008-2013		Yes	0.0344 (-0.0589, 0.1264)	0.476

In this initial analysis, we tested for effect of P4HB pre (2008-2010) and post (2011-2013) initial implementation. Since the implementation of the Affordable Care Act (ACA) allowed many lower income women otherwise served by Medicaid and P4HB to obtain subsidized insurance through the Marketplace and expanded funding for safety net providers that serve the uninsured, we will subsequently test for changes in the receipt of preventive health services among this group of women from 2014 onward. We will also test models omitting the implementation year of 2011 as enrollment did not pick up until the 3rd quarter of that first DY.

RM and Claims Data. An on-going addition to the work on research question 1 is the use of the individual files on contacts and case management of IPC and RM enrollees. The current quarterly files have been summarized in prior reports to CMS. The next step of linking these files to the individual enrollment and claims files for women in the IPC and RM only components of P4HB is proceeding. Once linked for 2017-2021, we will analyze the association between case management and the use of health care services to manage chronic conditions and subsequent outcomes, analyses which have been missing from earlier evaluation of the RM component of P4HB.

Research Question 2. Regarding the second question above, we have merged data on numerous sociodemographic measures to the enrollment and claims data in order to analyze the role of county level factors related to access to health care (such as numbers of Ob/GYNs per women of reproductive age, FQHCs in county, Medically Underserved Areas) and that represent underlying social and economic conditions (such as residential segregation, percent uninsured females, employment, poverty). This merger of data will allow us to test the role of these external measures along with maternal characteristics (age, race/ethnicity) on the probability of disenrollment from the FP only and other components of P4HB within a 12-month period.

We have not begun these analyses due to the continued PHE which means women have not been disenrolled from Georgia Medicaid eligibility since its beginning. We will start this analysis with the 2017-2019 data (when the Georgia Gateway system began, and the PHE was not in place) and follow it through the PHE to the end of 2021. The earlier data will provide insight on the length of time P4HB enrollees maintain coverage and the factors affecting this; the analysis of the 2020-2021 data will shed light on how these patterns may have changed during the PHE. We note that earlier analysis indicated ~80% of postpartum women remained on Medicaid during the PHE so there has been some voluntary disenrollment even during the PHE period.

Research Questions 3 and 4. Regarding the third and fourth questions listed above, we have continued with the analysis of the linked claims/vital records data for a period pre and post the implementation of P4HB. As we update these analyses, we are estimating the models 1) using only the RSM women as those affected by P4HB; and 2) separately for non-Hispanic whites, non-Hispanic Blacks and Hispanics.

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

Outcome/Interim Findings. We used Medicaid enrollment/claims data linked to vital records to analyze effects of the implementation of P4HB on the intended goals of the program. We found:

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

In doing this analysis we have used privately insured mothers with high school or less education as a comparison group for the RSM women. We have linked enrollment/claims and vital records data for both of these groups which allows us to compare outcomes pre and post P4HB. Since we have found significant effects on lowering teen pregnancy and increasing age at first birth, we will adjust this analysis to test whether there are effects on VLBW or LBW for those with first births. We will also limit the study population to singleton births since multiple gestation is associated with the VLBW outcome.

PRAMS Data. In order to analyze the specific outcome of unintended pregnancy, we are using the Pregnancy Risk Assessment Monitoring System (PRAMS) survey. With this survey we can measure pre-conception use of family planning, intendedness of pregnancy, postpartum contraception and birthweight outcomes among women uninsured pre-pregnancy but insured by Medicaid at delivery. We have updated the data to include not only the immediate post (2012-2013) P4HB study period but a more current period (2017-2019) to test for possible longer-term effects. We are also using a different and larger number of comparison states that did not expand family planning services through a waiver or SPA. We also control for Medicaid expansions in this larger group of control states in the 2017-2019 post period but do sensitivity analysis of effects using three comparison states that did not expand family planning or Medicaid over the full study period. We are also analyzing these outcomes by race/ethnicity.

Findings are:

- Among all mothers, P4HB implementation was associated with a 27.9 percentage-point increase ($p<0.001$) in the probability that a mother used pregnancy prevention pre-conception in the 2012-2013 post P4HB period.

- Similar results were observed among non-Hispanic white mothers (24 percentage-point increase, $p<0.05$) while the effect was larger for non-Hispanic black mothers (31 percentage-point increase, $p<0.01$) in this early post P4HB period.

- Georgia's P4HB implementation was associated with a 11.7 ($p<0.05$) to 16.6 percentage-point decrease ($p< .01$) in the probability that a mother's recent birth was unintended in the immediate (2012-2013) post P4HB period.

- Based on the one measure on unintended pregnancy, there was a 14.3 to 16.1 percentage-point decrease ($p<0.001$) among all women in the later (2017-2019) post P4HB period.

- Among all mothers, P4HB implementation was associated with a 1 percentage-point decrease ($p<0.05$) in the probability that a mother had a very low birthweight infant in the 2012-2013 period.

- The effect on VLBW was driven by non-Hispanic black mothers for whom there was a 3.8 percentage-point decrease ($p<0.05$), in the probability of a VLBW infant in the 2012-2013 post period.

- Moreover, there was 7.9 percentage-point decrease ($p<0.05$) in the probability that a non-Hispanic black mother had a low birthweight infant in this early post implementation period.

Results from the PRAMS analysis will be sent to the CDC PRAMS working group and participating states for review before being submitted to a journal for review.