Annual Report

Planning for Healthy Babies Program® (P4HB®)

1115 Demonstration in Georgia

January-December 2022

Submitted by:

The Georgia Department of Community Health (DCH)

And their Outside Contractor

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

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I. Summary and Background

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

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

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

The goals of the Section 1115 demonstration and related objectives are listed below.

Demonstration Goals:

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

Demonstration Objectives

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

Key Accomplishments

The original evaluation design was based on a quasi-experimental, pre/post analysis of key outcomes; below is a brief summary of key findings from those analyses based on that design:

- P4HB was associated with the following positive outcomes for Georgia's Medicaid population:
    - decreased unintended pregnancies;
    - decreased teen births;
    - decreased very short (< 6 months) interpregnancy intervals; and
    - increased age at first birth.

- Among Medicaid paid births, implementation of P4HB was not associated with reduction in the rates of VLBW or LBW; the percentage of Medicaid births that were VLBW or LBW actually increased from 2009 (pre-P4HB) to 2018 (post-P4HB) period. Notably, however, the composition of Medicaid program enrollees also changed from the pre- to the post-P4HB period as a result of the full implementation of the Affordable Care Act in 2014 (with those in Medicaid in the post- period compared to the pre-P4HB period being older and more likely

living in impoverished census tracts, for example); thus, it is difficult to draw conclusions from this analysis until further adjusted analyses are completed.

- Following a Medicaid paid birth, P4HB enrollees who utilize covered services were less likely to conceive within a short interpregnancy interval and had improved outcomes in subsequent pregnancies relative both to P4HB enrollees *who did not utilize covered services* and to Right from the Start (RSM) women eligible for P4HB following the Medicaid paid birth *who did not enroll.*

- Women enrolled in IPC were less likely to have shorter than clinically recommended interpregnancy intervals (<12 and <18 months) than were RSM women eligible for IPC enrollment *who did not enroll*.

- Women enrolled in IPC were less likely to have an adverse outcome (fetal death, stillbirth, VLBW or LBW infant) in subsequent deliveries than were RSM women eligible for IPC enrollment *who did not enroll*.

- Low-income Medicaid mothers who participated in the Resource Mother (RM) only benefits (for which they were eligible due to delivery of a VLBW infant) were far less likely to have a repeat pregnancy within 12 or 18 months postpartum.

New findings from the Georgia PRAMS analysis are summarized below:

- In comparison to states without a change in their family planning policies, Georgia's implementation of P4HB was associated with a significant reduction in unintended pregnancies and the delivery of a VLBW infant among those uninsured but likely eligible for P4HB; notably, this latter effect was concentrated among Georgia's non-Hispanic Black mothers (who disproportionately experience VLBW deliveries).

Key Accomplishments in Reporting Period:

- The percent of uninsured women eligible in the community enrolled into the FP only component in this program year increased to ~35% from ~32% in the previous year, even as the number of uninsured women increased during the pandemic.

- The percent of women eligible for IPC or RM only services who were enrolled in this program year increased to 25.3% from 24.4% in the prior program year.

- The percentage of long-acting reversible contraceptives (LARCs) users among FP only enrollees using contraceptives increased to 20.3% in this program year.

- Repeat pregnancy within 18 months (short interpregnancy interval) of an RSM-covered delivery was 7.2 percentage points lower among those who enrolled in P4HB FP only and who used any family planning services compared to those eligible who did not enroll.

- More than half (59.5%) of women enrolled in IPC used some method of contraception by one year postpartum and 15.1% used LARCs.

- A similar percentage of women enrolled in RM only used some method of contraception by one year postpartum (61.8%) and 15.3% used LARCs.

- Repeat pregnancy within 18 months of an index VLBW delivery was 7.8 percentage points lower among those who enrolled in P4HB IPC and who used any family planning services compared to those eligible who did not enroll.

- Repeat pregnancy within 18 months of an index VLBW delivery was 12.9 percentage points lower among those who enrolled in P4HB RM only and who used any family planning services compared to those eligible who did not enroll.

- Fully 78% of women enrolled in P4HB IPC or RM only with evidence of diabetes or hypertension received services to manage these conditions in their postpartum period.

- Adverse outcomes in subsequent deliveries were 3.6 percentage points lower for women eligible for IPC who enrolled compared with those eligible who did not enroll.

II. Operational Updates

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

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

Legislative Updates. On April 16, 2021, the Center for Medicare and Medicaid Services (CMS) approved Georgia's Section 1115(a) Postpartum Extension Demonstration, implementation of which began statewide effective July 1, 2021, to continue through October 31, 2022. This waiver extended postpartum Medicaid coverage to women with incomes up to 220 percent of the Federal Poverty Level (FPL), from 60 days to one hundred and eighty (180) days, or six months. While the original P4HB program remained a critically important source of partial coverage for women of reproductive age not otherwise insured, the Public Health Emergency (PHE) (March 14, 2020) for COVID-19 kept all enrollees eligible through the official end of the PHE on May 11, 2023. Similarly, while the Postpartum Extension Demonstration was designed to allow women delivering on Georgia's Right from the Start Medicaid (RSM) to retain Medicaid coverage for six months, the PHE superseded the waiver's extension.

On May 2, 2022, DCH announced its intent to terminate the Georgia Postpartum Extension Section 1115 waiver and convert to a State Plan Amendment (SPA) as permitted via section 9812 of the American Rescue Plan. On August 17, 2022, DCH submitted the SPA to extend postpartum services to a full twelve (12) months and on October 26, 2022, CMS informed the state of their approval. With this, the Section 1115 demonstration authority for the six-month postpartum extension was no longer needed. The effective date for the 12-month extension of Medicaid postpartum benefits was November 1, 2022.

Public Forum. The Annual Public Forum for both the P4HB and Postpartum Extension programs was held on August 17, 2022, via Microsoft Teams, during the Medical Care Advisory Committee (MCAC) meeting. There were no post award public comments for the programs.

III. Performance Metrics

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

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

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

Outcome: The percentage of eligible women in the community successfully enrolled in the FP only component of P4HB lagged behind expectations in earlier program years but increased with the implementation of the Georgia Gateway System in 2017. **Table 1**, shows the numbers and percentage of women eligible for the FP only and IPC/Resource Mother only components, enrolled and hence, made newly eligible for services, in the 2020 and 2021 time period.

Table 1. Enrollment of P4HB Population Eligible in the Community 2020 and 2021

Demonstration Group	Enrolled in 4th Quarter	Population Eligible in Community[1,2]	Percent Eligible Enrolled
2020 P4HB Enrollment/Participation			
FP Only 2020[3]	61,348	194,126	31.6%
FP Only 2020[4]	61,348	105,799	58.0%
IPC/Resource Mother Only	762	3,129	24.4%
2021 P4HB Enrollment/Participation			
FP Only 2021[3]	61,247	173,829	35.3%
FP Only 2021[4]	61,247	94,737	64.6%
IPC/Resource Mother Only	777	3,077	25.3%

[1]Those eligible for family planning only benefits are uninsured female citizens ages 18-44 with income ≤ 211% FPL and residing in Georgia. The number of uninsured women in this age and income range was estimated using the ACS 1-year PUMS for 2020 – 2021 as shown in column 3. [2]Those eligible for IPC include uninsured women 18-44 with income ≤ 211% FPL residing in Georgia with a live born infant under 1500 grams at delivery. We use women with a VLBW infant born on Medicaid in the past two years as the denominator for this calculation in each year. Those eligible for Resource Mother only include LIM and ABD Classes of Eligibility women with a VLBW infant. We combine the enrollment counts for IPC and Resource Mother for the numerator and use all Medicaid paid VLBW births in 2020 and 2021 (2020 n = 1,509 and 2021 n = 1,568) as the denominator in 2021. [3]We use the numbers enrolled as of the 4th quarter of 2021 (and reported in our 4th Quarter 2021 Report) for consistency with the earlier parts of this report. [4] This denominator adjusts for women in need of family planning services based on a report from the Guttmacher Institute. Their estimate is that 54.5% of women in the age group 13-44 needed family planning services; they count women who are sexually active, able to get pregnant but not currently pregnant or trying to get pregnant. See: http://www.guttmacher.org/pubs/win/contraceptive-needs-2008.pdf. *We multiplied the "in the community" population by .545 to get the 155,830 for 2012, 156,535 for 2013, 126,831 for 2014, 113,341 for 2015, 102,101 for 2016, 109,373 for 2017, 107,694 for 2018, 97,910 for 2019, 105,799 and 94,737 for 2021 as shown in column 3.*

The number of women enrolled in the FP only remained steady from 2020 to 2021 (61,348 to 61,247). The percentage of those eligible in the community increased slightly from 31.6% to 35.3% in this reporting period due to the decline in the population eligible in the community. This decline may reflect the improving economy in the state and nation. There was also an increase in the percentage of those eligible and estimated to be in need of, family planning services (see footnote to Table 1) enrolled in the FP only component from 58% in 2020 to 64.6% in 2021.

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

Outcome: We consider those eligible for IPC or RM only as those with a VLBW in 2019/2020 and 2020/2021 paid by Medicaid. There was a slight decline in the number of VLBW births of 1,620 in 2019 to 1,509 in 2020 but an increase to 1,568 in 2021 (see note to **Table 1**). The number of women enrolled in the IPC and RM only components increased slightly from 762 in 2020 to 777 in 2021 and this corresponded to an increase in the percentage of women eligible and enrolled in these components from 24.4% to 25.3%. While the increase in enrollment of those eligible is an accomplishment, the percentage of eligible women being enrolled and hence, offered IPC and RM only services, could be improved from the roughly 25% level shown.

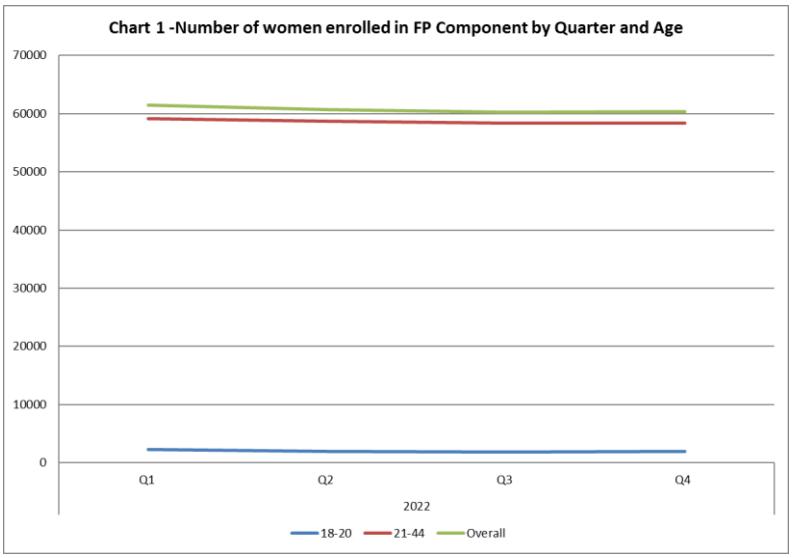
Once enrolled in P4HB, access to services for women in each of the P4HB components is through the CMO provider network that the enrollees choose or are assigned to. As noted above, the number of CMOs serving Georgia Medicaid clientele was reduced from four to three in July 2021. Total enrollment in 2022 in each component of P4HB by the CMO in which they were enrolled, is shown in **Table 2** below.

Table 2. Growth in Enrollment of P4HB Population by CMO and Age Group in 2022

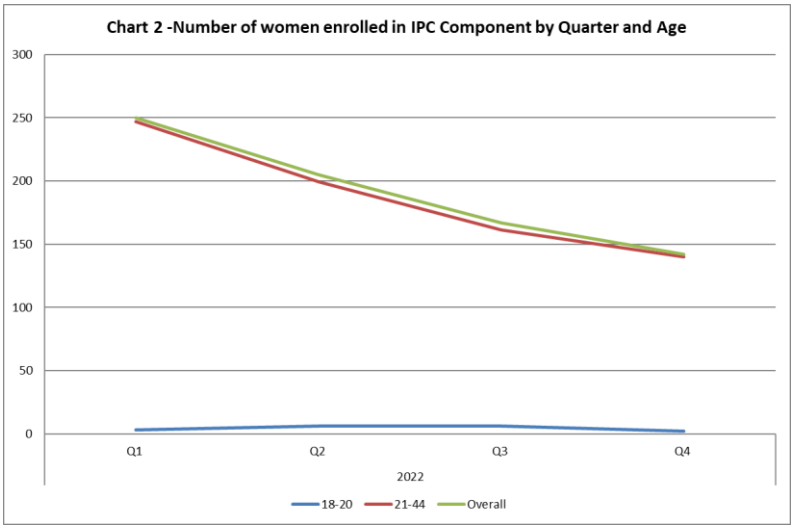
ENROLLMENT BY CMO AND AGE GROUP FOR Q1 AND Q4 2022												
	Amerigroup			Caresource			Peachstate/Wellcare			Overall		
	Q1	Q4	Growth	Q1	Q4	Growth	Q1	Q4	Growth	Q1	Q4	Growth
Family Planning Only												
18-20	724	613	-15.3%	604	515	-14.7%	1007	785	-22.0%	2335	1913	-18.1%
21-44	17515	17624	0.6%	15419	15934	3.3%	26185	24842	-5.1%	59119	58400	-1.2%
Total	18239	18237	0.0%	16023	16449	2.7%	27192	25627	-5.8%	61454	60313	-1.9%
% Total	29.7%	30.2%		26.1%	27.3%		44.2%	42.5%				
Inter-Pregnancy Care												
18-20	1	0	-100.0%	1	2	100.0%	1	0	-100.0%	3	2	-33.3%
21-44	70	21	-70.0%	103	49	-52.4%	74	70	-5.4%	247	140	-43.3%
Total	71	21	-70.4%	104	51	-51.0%	75	70	-6.7%	250	142	-43.2%
% Total	28.4%	14.8%		41.6%	35.9%		30.0%	49.3%				
Resource Mother Outreach												
18-20	6	1	-83.3%	6	6	0.0%	16	8	-50.0%	28	15	-46.4%
21-44	98	47	-52.0%	221	217	-1.8%	218	178	-18.3%	537	442	-17.7%
Total	104	48	-53.8%	227	223	-1.8%	234	186	-20.5%	565	457	-19.1%
% Total	18.4%	10.5%		40.2%	48.8%		41.4%	40.7%				
All Programs												
18-20	731	614	-16.0%	611	523	-14.4%	1024	793	-22.6%	2366	1930	-18.4%
21-44	17683	17692	0.1%	15743	16200	2.9%	26477	25090	-5.2%	59903	58982	-1.5%
Total	18414	18306	-0.6%	16354	16723	2.3%	27501	25883	-5.9%	62269	60912	-2.2%
% Total	29.6%	30.1%		26.3%	27.5%		44.2%	42.5%				

As seen in **Table 2** there was a slight decline in the level of enrollment in the FP only component by the end of Quarter 4 2022 with a total of 60,313 compared to the total of 61,454 in Quarter 1 2022. The age distribution of FP only enrollees continues to shift toward older women although there were declines in all age categories in 2022; the larger decline (-18.1%) in the FP only enrollees 18-20 years of age were far greater than that (-1.2%) in the older age group. The declines in enrollment in IPC (-43.2%) and RM only (-19.1%) P4HB components were larger than declines in the FP only component but also varied by age group. Specifically, the percentage decline in IPC enrollment among those ages 18-20 was 33.3% compared to a 43.3%

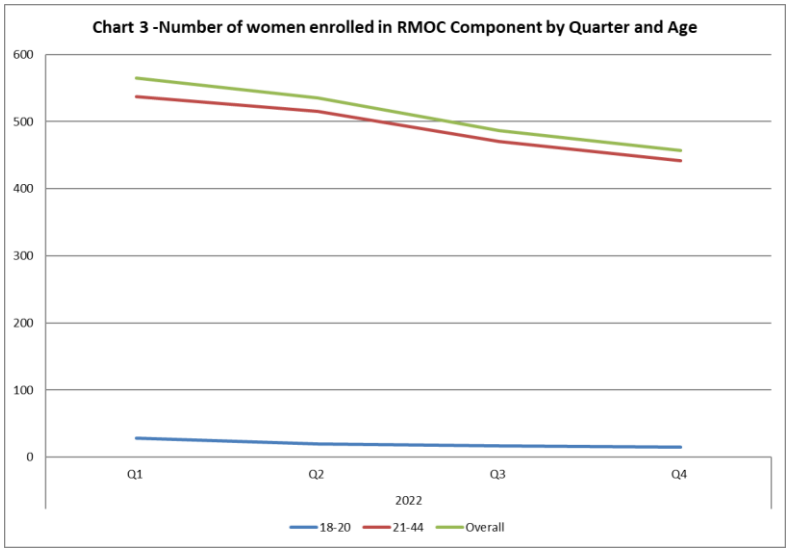
decline among those ages 21-44. Within the RM only component of P4HB the larger decline was among those 18-20 (46.4%) compared to those ages 21-44 (17.7%). Taken together, the changes in enrollment in the FP only component of P4HB result in a fairly flat trend over the 4 quarters of 2022 as shown in **Chart 1.** While the retention of Medicaid eligibility under the PHE was not extended to teens in Georgia's Children's Health Insurance Program (CHIP), called PeachCare in Georgia, but teens aging out of PeachCare are made aware of their possible eligibility for P4HB. Reasons for the decline in enrollment among the young are hard to enumerate but may include: their perception of less need for P4HB-covered services, their access to services through other sources in the community (that may preferentially target younger age groups), greater difficulty in understanding and/or completing the enrollment process (including having and accessing required documents for verification of eligibility). that young members may have moved home during the pandemic and were placed back on their parent's insurance for coverage.



Declines among youth as well as older age groups may include difficulties enrolling through Gateway, and challenges in accessing health care not covered by P4HB, thus being dissatisfied with the program and choosing not to renew or enroll. However, the steep decline in IPC



enrollments during 2022 (see **Chart 2**) likely reflect their retention in a full Medicaid eligibility category during the PHE.



The overall decline of 19% in RM only enrollment is reflected in the downward curve shown in **Chart 3.** While these enrollees also retained Medicaid eligibility during the PHE, the decline indicates that those with a VLBW infant in LIM were not also enrolled in the RM benefits.

Access through CMOs**.** Access to services and their specific modes of service delivery will vary across the CMOs based on their provider networks. As noted in prior reporting, the PeachState/WellCare merger resulted in the largest percentage (~45%) of the FP only enrollees being in the PeachState CMO by the end of the 4th quarter of 2021. While there is a slight decline in this percentage to ~43%, the PeachState CMO still serves the largest percentage of all P4HB enrollees in 2022. This pattern holds for the FP and IPC components of P4HB but CareSource served the largest percentage of RM only (~48.8%) enrollees at the end of 2022. While all CMOs experienced a decline in the FP only component of P4HB over the 2022 period, the CareSource CMO experienced the smallest decline (1.8%) in this component.

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

Outcome: Table 3 reflects details from each CMO regarding their outreach activities and public awareness programs from January-December 2022. These activities targeted prospective, new, and current enrollees for the FP and IPC programs. Additionally, the CMOs continued provider education activities throughout the year.

Amerigroup's activities included virtual face-to-face conferencing and in-person activities such as virtual and drive-through baby showers. New member mailings and welcome calls were provided to members, as well as reminders about recertification and loss of benefits. Provider education was conducted through visits from Provider Solutions. Notably, Amerigroup did not have any provider outreach activities in the last quarter of 2022.

CareSource outreach activities included welcome calls and the mailing of postcards to all enrollees within 30 days of eligibility. Additionally, CareSource mailed welcome packets and ID cards to all new members. CareSource also conducted telephone calls and sent reminder letters to IPC enrollees. Provider outreach activities also continued throughout 2022.

Peach State outreach activities included welcome packets and telephone calls to new members to inform them about P4HB benefits and services, including the importance of utilizing contraception. Peach State also held face-to-face virtual orientation sessions with new members. For prospective members, Peach State held in-person baby showers. For current members, Peach State hosted an online bingo event in the first quarter of 2022. It also mailed an 8th month letter to pregnant clients prior to delivery to inform them of the P4HB program. Additionally, Peach State conducted provider outreach activities throughout 2022.

Table 3: CMO Outreach, January-December 2022		
CMO	**All Outreach Activities**	**IPC Specific Outreach**
Amerigroup	• Virtual face-to-face conferencing and in-person activities/events. • 42 virtual and drive-through baby showers/diaper days with 1,884 participants in the first half of 2022 and 49 virtual and in-person activities and events with 1,605 participants in the second half of 2022. • New member mailings and welcome calls • Recertification reminders and loss of benefit notifications • Provider visits and education conducted by Provider Solutions • There were no provider outreach activities reported in Q4 2022.	• Reminder letters and phone calls • 162 total successful welcome calls made to IPC and RM participants in the first half of 2022 and 229 total successful welcome calls in the second half of 2022. • 4 virtual face-to-face visits were completed in the first half of 2022 and 0 successfully completed visits in the second half of 2022 (though 2 were attempted)
CareSource	• Welcome calls and postcards to all P4HB enrollees within 30 days of being eligible. • New member mailings and ID cards were mailed. • A total of 77 provider outreach activities were completed, reaching 247 providers in Q4 2022.	• 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 in Q1 and 2 of 2022 and 1,445 calls were made in Q3 of 2022. In Q4 2022, there were 1,259 virtual activities, 36 in-person activities, and 135 “other” activities conducted for a total of 1,430 IPC/RM enrollees

Table 3: CMO Outreach, January-December 2022		
CMO	**All Outreach Activities**	**IPC Specific Outreach**
Peach State	• New enrollees received a call from PS about the P4HB benefits and services. • New enrollee orientations/virtual sessions were held to provide face-to-face interactions with P4HB enrollees • New member mailings and program materials, including info on importance of utilizing contraception. • Hosted 1 "virtual bingo" event in Q1 with current P4HB FP clients and a total of 8 in person baby showers with prospective P4HB clients by end of 2022. • PSHP mailed a total of 11,878 letters and packets. • PSHP mailed an 8th month letter to clients prior to delivery. • A total of 7 provider outreach activities were completed, reaching 49 providers in Q4 2022.	• A total of 1,205 members who had a VLBW infant received telephone calls • A total of 198 face-to-face visits were made.

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

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

We note that the access measures used in this and the following sections, reflect the Andersen framework.[1] This framework posits that *access* can be measured as 'potential' (having a usual source of care) or 'realized' (actual use of services) access. The framework used by this author also links the use of services to desired health outcomes as a reflection of *quality*. In this and

following sections, we use the linked enrollment and claims data for women in the several components of P4HB to measure their utilization of covered services and in turn, outcomes reflective of the quality of services received.

Women in the FP only component of P4HB gain access to a family planning initial exam and annual exam; family planning and related services including contraceptives and supplies; sterilization; follow-up family planning visits; pregnancy tests and pap smears; testing for Sexually Transmitted Infections (STIs); treatment and follow-up for all STI(s) except HIV/AIDS and hepatitis. Services also include counseling and referrals to social services and primary health care providers; family planning pharmacy visits; vitamins/folic acid; select immunizations for participants ages 18 through 20.[2]

Table 4 shows the percentage of women in the FP only component who had 1) a family planning visit, 2) number of visits, and 3) a visit for a contraceptive method in their first 6 months of enrollment in P4HB. As these data show, only 17.4% had any family planning visit in their first 6 months of enrollment in 2020 and this dropped to 11.4% in 2021.

Table 4. Use of Family Planning Services within Six Months of Enrollment among P4HB Family Planning only Enrollees, 2020-2021

Demonstration Year	Use Among P4HB Women FP Only			
	N	Any Family Planning Visit in First 6 Months	Mean Visits Per User in First 6 Months	Any Visit /Service for Contraceptive Method in First 6 Months
2020	24,536	17.4%	2.06	10.9%
2021	10,433	11.4%	1.89	6.3%

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

In both years, the number of family planning visits averaged roughly two per enrollee. There was also a decline in the percentage of FP only enrollees having a visit/service for a contraceptive method in those first 6 months. This percentage declined from almost 11% in 2020 to around 6% in 2021. Some of these declines could be related to the COVID-19 pandemic and the overall lower utilization of health care services during this time-period.

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

Table 5. Distribution of Contraceptive Methods among Users within Six Months of Enrollment, P4HB Family Planning only Enrollees, 2020-2021

Demonstration Year	% of Contraceptive Methods Paid by Medicaid According to Tier of Effectiveness: P4HB – FP Only					
	N	Tier 1	Tier 2	Tier 3/4	Tier Not Spec	LARC
2020	2678	20.2%	70.4%	0.7%	8.7%	18.8%
2021	661	21.0%	68.8%	1.2%	8.9%	20.3%

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

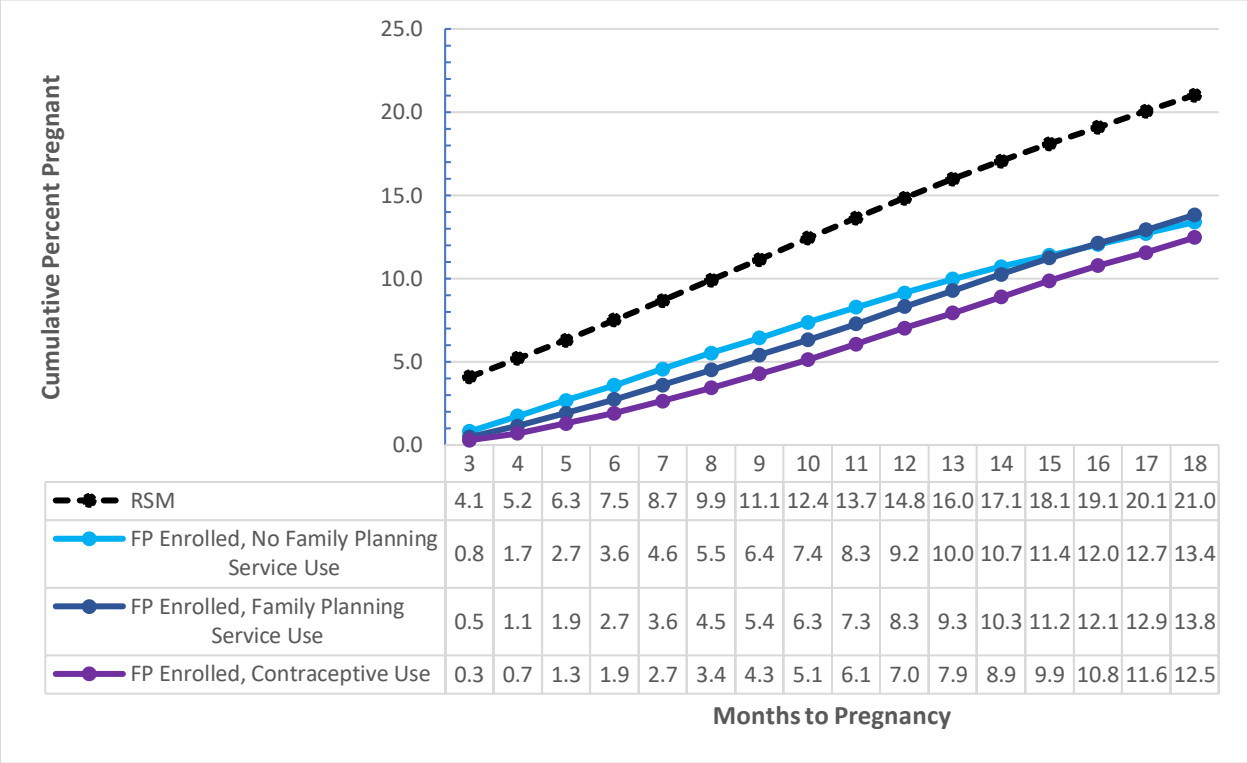
During both 2020 and 2021, the most commonly used contraceptive methods were those in Tier 2 (injectable methods, patch, pills, and vaginal ring). There was a slight increase from 2020 (20.2%) to 2021 (21.0%) in the percentage of contraceptive methods among FP enrollee users being highly effective (Tier 1) with nearly all of these being long-acting reversible

Objective: Increase child spacing intervals through effective contraceptive use.

contraceptives (LARCs). The percentage using LARCs rose from 18.8% to 20.3%.

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

Chart 2. Cumulative Months to Subsequent Pregnancy for Women Who Recently Delivered on RSM According to P4HB Enrollment and Service Use for 2011 through 2020



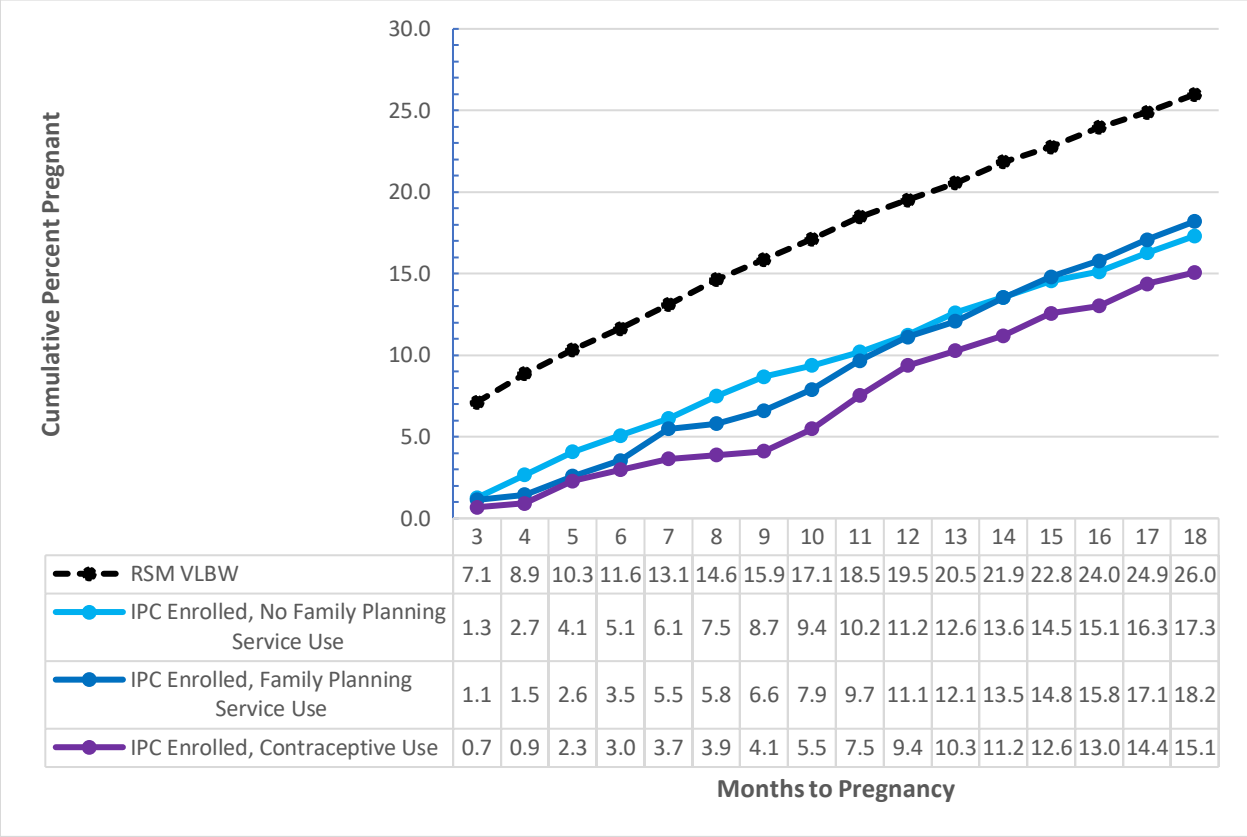
	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
RSM	4.1	5.2	6.3	7.5	8.7	9.9	11.1	12.4	13.7	14.8	16.0	17.1	18.1	19.1	20.1	21.0
FP Enrolled, No Family Planning Service Use	0.8	1.7	2.7	3.6	4.6	5.5	6.4	7.4	8.3	9.2	10.0	10.7	11.4	12.0	12.7	13.4
FP Enrolled, Family Planning Service Use	0.5	1.1	1.9	2.7	3.6	4.5	5.4	6.3	7.3	8.3	9.3	10.3	11.2	12.1	12.9	13.8
FP Enrolled, Contraceptive Use	0.3	0.7	1.3	1.9	2.7	3.4	4.3	5.1	6.1	7.0	7.9	8.9	9.9	10.8	11.6	12.5

Approximately 7% of the RSM women who choose not to enroll have a very short interpregnancy interval of 6 months or less; in comparison, less than 3% of those enrolling in P4HB with family planning service use and only 1.9% of those enrolling and using contraceptives have this very short interval. The percentage with a repeat pregnancy within one year is halved (from 14.8% to 7.0%) for women enrolling and using contraceptive services within the FP only component of P4HB. By 18 months 21% of the RSM not enrolling in P4HB are again pregnant and back in the Medicaid program. Among those enrolling, this is lower at almost 14% while among those enrolling and using contraceptives, it is lower still at 12.5%.

Access to and use of effective contraceptives to prevent and/or delay another pregnancy is particularly important for the IPC and RM only women who have recently had a VLBW infant and may have higher clinical needs of their own. In the following charts we show the percentage of IPC enrollees (**Chart 3**) and RM only enrollees (**Chart 4**) who have a repeat pregnancy within the 18 months following their delivery of a VLBW infant and as above, we distinguish

this outcome for women eligible and enrolled versus not-enrolled and among enrollees, those using family planning or contraceptive services made available through P4HB.

Chart 3. Cumulative Months to Subsequent Pregnancy for Women Who Recently Delivered a VLBW Infant on RSM According to IPC Enrollment and Service Use for 2011 through 2020

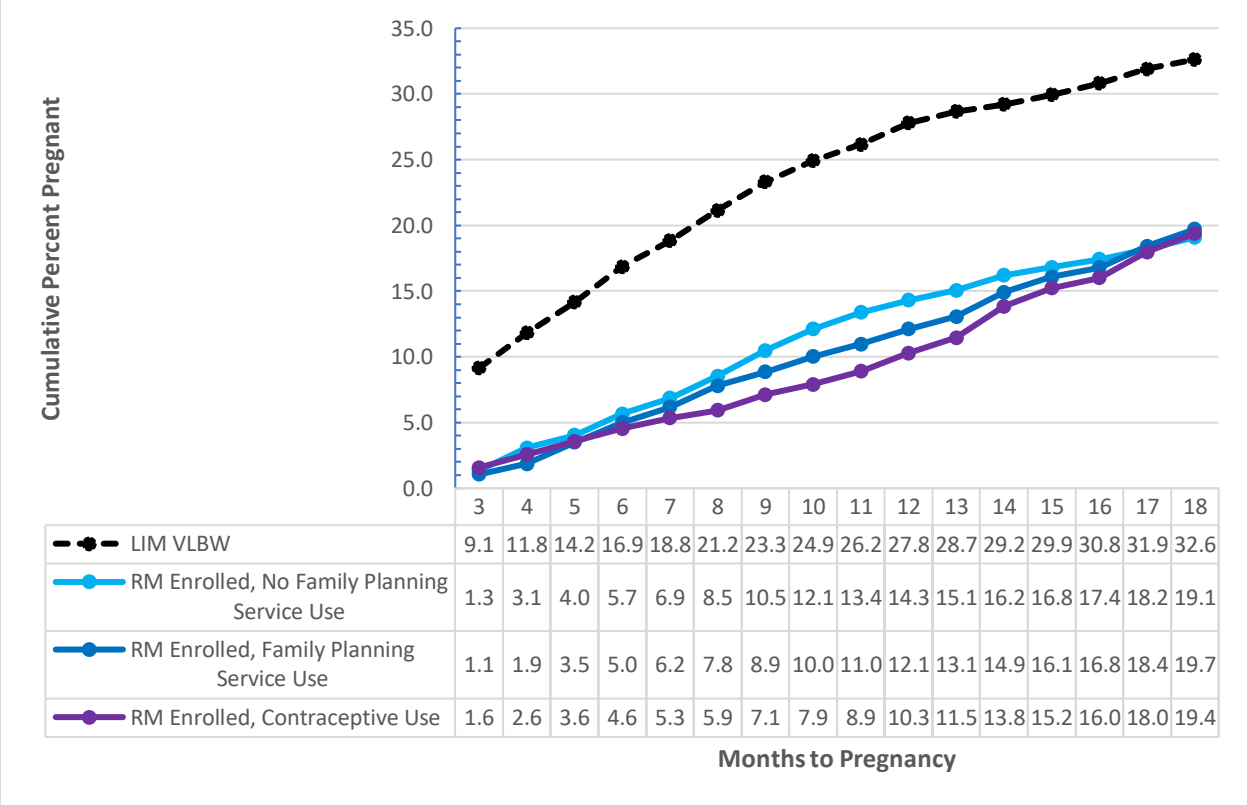


	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
RSM VLBW	7.1	8.9	10.3	11.6	13.1	14.6	15.9	17.1	18.5	19.5	20.5	21.9	22.8	24.0	24.9	26.0
IPC Enrolled, No Family Planning Service Use	1.3	2.7	4.1	5.1	6.1	7.5	8.7	9.4	10.2	11.2	12.6	13.6	14.5	15.1	16.3	17.3
IPC Enrolled, Family Planning Service Use	1.1	1.5	2.6	3.5	5.5	5.8	6.6	7.9	9.7	11.1	12.1	13.5	14.8	15.8	17.1	18.2
IPC Enrolled, Contraceptive Use	0.7	0.9	2.3	3.0	3.7	3.9	4.1	5.5	7.5	9.4	10.3	11.2	12.6	13.0	14.4	15.1

Among those eligible for IPC but not enrolling, the percentage with a very short interpregnancy interval of 6 months or shorter was high at almost 12% (**Chart 3**). This compares to less than 4% of those enrolling and using any family planning service and 3% of those using any contraceptive method. Within 12 months of the index VLBW delivery, those not enrolling were more likely to have a repeat pregnancy at almost 20% and was almost half at 11% among users and reduced to ~9% among those enrollling and using contraceptives. Within 18 months of the index VLBW delivery, fully 26% of non-enrollees had a repeat pregnancy while only 15.1% of those enrolling and using contracpetives did.

In **Chart 4** we show these patterns for the Low-Income Medicaid (LIM) women eligible for RM only services due to having a VLBW delivery. Among those eligible for RM only services but not enrolling, the percentage with a very short interpregnancy interval of 6 months or shorter was even higher than for IPC women at almost 17%. This compares to 5.7% for those enrolling and not using family planning services, 5.0% for those enrolling and using family planning services, and 4.6% among those enrolling and using contraceptives. Within 12 months of the index VLBW delivery, those not enrolling were substantially more likely to have a repeat pregnancy in Medicaid (at nearly 28%) compared to those enrolling and using family planning services (12.1%) and in particular, those enrolling and using contraceptives (10.3%). Within 18 months of the index VLBW delivery, almost 33% of non-enrollees had a repeat pregnancy in Medicaid, compared to ~19% of those enrolling, whether using or not using services.

Chart 4. Cumulative Months to Subsequent Pregnancy for LIM Women with VLBW Delivery According to RM Only Enrollment and Service Use for 2011 through 2020



	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
LIM VLBW	9.1	11.8	14.2	16.9	18.8	21.2	23.3	24.9	26.2	27.8	28.7	29.2	29.9	30.8	31.9	32.6
RM Enrolled, No Family Planning Service Use	1.3	3.1	4.0	5.7	6.9	8.5	10.5	12.1	13.4	14.3	15.1	16.2	16.8	17.4	18.2	19.1
RM Enrolled, Family Planning Service Use	1.1	1.9	3.5	5.0	6.2	7.8	8.9	10.0	11.0	12.1	13.1	14.9	16.1	16.8	18.4	19.7
RM Enrolled, Contraceptive Use	1.6	2.6	3.6	4.6	5.3	5.9	7.1	7.9	8.9	10.3	11.5	13.8	15.2	16.0	18.0	19.4

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

Outcome: The outcome of *unintended pregnancy* was examined using the Pregnancy Risk Assessment Monitoring System (PRAMS) data. Based on the difference-in-differences analysis we found a significant decrease in the probability that a pregnancy in Georgia was unintended in the immediate post-P4HB period relative to the pre-period, with a 13.3 percentage point (pp) decrease ($p<0.01$) based on the second measure. The effect in the immediate post-P4HB period held only for non-Hispanic White individuals, for whom there was a 16.4 ($p<0.05$) to 20.4 pp ($p<0.01$) reduction in the probability that a pregnancy was unintended in the immediate post-period.

Among all respondents, no significant association was observed between P4HB implementation and the probability of a LBW birth in either post-P4HB period. However, among non-Hispanic Black respondents, P4HB implementation was associated with an 8.4 pp decrease ($p<0.05$) in the probability of a LBW birth in the immediate post-period and a 9.0 pp decrease ($p<0.05$) in the later post-period. Among all respondents, P4HB implementation was associated with a 1.1 pp decrease ($p<0.01$) in the probability of a VLBW birth in the immediate post-period. This overall effect was driven by non-Hispanic Black respondents, among whom there was a 3.9 pp decrease ($p<0.05$) in the probability of a VLBW birth in the immediate post-period. We note that the full set of results from these analyses are published in a peer-reviewed journal (available online) from *Women's Health Issues* in an article entitled "Effects of Georgia's Medicaid Family Planning Waiver on Pregnancy Characteristics and Birth Outcomes" (4).

There is concern about repeat *high-risk* pregnancy among those in the IPC and RM only components of P4HB as they have recently delivered a VLBW infant with high medical needs, and the women themselves likely have high medical needs indicating a repeat pregnancy is a high-risk one. A comprehensive postpartum visit is recommended for all following delivery, and it is recognized that those delivering a VLBW infant (because of their high medical needs) may also require care related to the management of chronic health conditions, such as diabetes mellitus and/or chronic hypertension, as well as screening for and management of cardiovascular risk factors following the occurrence of cardiometabolic complications of pregnancy, such as

gestational diabetes and gestational hypertension, which place a woman at risk for the future development of these conditions.[3]

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

Approximately half (49-51%) of IPC and RM only women with chronic or gestational hypertension or diabetes receive a postpartum visit even among those continuously enrolled through one year. Their receipt of cervical cancer screening (23% to 28.5%) and dental care (~10% to ~17%) is even lower but we do not know if the enrollees are due for these cancer screens or have needs for the dental care in this time period. Their very low receipt of family planning counseling at ~14% to ~15% during their postpartum period, puts them at risk of an unintended pregnancy or an intrapartum interval that is too short. However, as discussed below, the use of contraceptives is markedly higher.

Receipt of services for the management of and/or screening for chronic conditions are also high. Among women with chronic or gestational hypertension or diabetes, approximately 78% to 82% received diabetes or hypertension related services during their full 360 days post-delivery. Among the IPC women with these chronic or gestational conditions, the receipt of any mental health or substance abuse related service was 25% and among RM only women, this rate was almost 36%. Again, we do not have good information on their need for these types of services but the utilization among the IPC and in particular, the RM only women increased over the 90 to 360-day period as they perhaps found access to a Medicaid participating provider over this longer period.

The receipt of any contraceptive method and again, the distribution of users by the WHO Tiers of effectiveness, matters for reducing high-risk pregnancies. Overall, the rates of use of any contraceptive method among these high-risk women is high at ~49% to almost 54% in the first 90 days. We see again, an increase in the use of any contraceptive method the longer these women are enrolled. For the IPC women, this increase was from 48.5% to 59.5% and for the RM only women the increase was from 53.5% to almost 62%. By 360 days post-delivery the RM only enrollees were more likely to be using Tier 1 contraceptives (33.6%) than were the IPC enrollees (27.9%). Within Tier 1, the IPC and RM only women were similar in their use of LARCs at ~15% while RM only enrollees with evidence of chronic or gestational hypertension or diabetes had higher rates of sterilization (~18%) than the IPC enrolled women (~13%).

For both IPC and RM only enrollees, the potential of the P4HB program to connect them to needed services goes beyond medical services to needed social support services within their communities through their Recourse Mothers. The CMOs track aspects of this case management using a standardized reporting template. Of note, the standardized template for CMO tracking of case management changed in Q4 2022, such that different templates (reflecting either different reporting items or different response categories) were used by the CMOs for the quarters covered by this annual report (the original template for Q1-Q3 2022 and the new template for Q4 2022). Thus, for this 2022 Annual Report we report on all four quarters, but in some instances report on Q1-Q3 distinct from Q4 due to the change in template.

Table 7 shows the proportion of IPC or RM only enrollees who accepted or declined case management (which was reported for Q1-Q3 2022 under the original template) or who were assigned a Resource Mother (which was reported for Q4 2022 under the new template) overall and by CMO. Among the 2732 individuals enrolled in either IPC or RM only across all CMOs for Q1-Q3 2022, 1303 (47.7%) accepted case management, 1291 (47.3%) had a pending or missing (blank) case management status, and 138 (5.1%) declined case management. The percentage declining case management varied according to whether the individual was enrolled in IPC (22/801 = 2.7%) or RM only (116/1931=6%). There was also substantial variation in acceptance of case management across the three CMOs, with the lowest acceptance rate for CareSource (11.9%), mid-range value for Amerigroup (47.6%), and the highest for Peach State

(85.0%), noting that CareSource also had the highest percentage of enrollees for whom the case management acceptance status was pending or missing (84.6%) while Peach State had the lowest pending or missing status (7.8%). Among the 755 unique women enrolled in either IPC or RM only across all CMOs for Q4 2022, 185 (24.5%) were assigned to a Resource Mother, while 555 (73.5%) were not assigned, and for 15 (2%) this field was missing or blank. There was some variability in assignment of a Resource Mother according to whether the woman was enrolled in IPC (32/157 = 20.4%) or RM only (153/598 = 25.5%). There was substantial variation in assignment of a Resource Mother across the three CMOs, with the lowest assignment rate for CareSource (10.1%) and the highest for Peach State (39.8%). Notably, this Q4 2022 estimate of 24.5% (overall) being assigned a Resource Mother was far lower than the Q1-Q3 2022 estimate of 47.7% (overall) accepting case management.

Table 7. **Acceptance of Case Management (Q1-Q3 2022) or Assignment of Resource Mother (Q4 2022) by Medicaid Care Management Organization**

Acceptance of Case Management or Assignment of Resource Mother	Medicaid Care Management Organization			TOTAL
	Amerigroup	CareSource	Peach State	
Acceptance of Case Management (Q1-Q3 2022)	N=613	N=1081	N=1038	N=2732
Yes (Accepted)	292 (47.6%)	129 (11.9%)	882 (85.0%)	1303 (47.7%)
No (Declined)	26 (4.2%)	37 (3.4%)	75 (7.2%)	138 (5.1%)
Pending OR Missing*	295 (48.1%)	915 (84.6%)	81 (7.8%)	1291 (47.3%)
Assignment of Resource Mother (Q4 2022)	N=74	N=347	N=334	N=755
Yes (Assigned)	17 (23.0%)	35 (10.1%)	133 (39.8%)	185 (24.5%)
No (Not assigned)	42 (56.8%)	312 (89.9%)	201 (60.2%)	555 (73.5%)
Missing*	15 (20.2%)	0 (0%)	0 (0%)	15 (2%)

** Q1-Q3 data include those for whom the response was missing (blank) or 'pending'; Q4 data did not allow for a 'pending' response so only includes those for whom the response was missing (blank)*

In addition to reporting on whether IPC or RM only enrollees accepted case management or were assigned a Resource Mother, the CMOs also reported on the number of successful encounters (in person or telephone) that an enrolled woman had in a given quarter. *Of note, this variable was reported only for enrollees for whom acceptance of case management or assignment of Resource Mother was other than 'yes' (including for whom these variables were coded as 'no' or*

'missing') thus, we reported on the full set of enrollees in the quarter rather than limiting to those who had accepted case management or been assigned a Resource Mother.

Table 8 shows the proportion of IPC or RM only enrollees who had any documented encounter (face-to-face or telephone) with a Resource Mother overall and by CMO. Among the 2732 individuals enrolled in either IPC or RM only across all CMOs for Q1-Q3 2022, a total of 1432 (52.4%) had any documented encounter. There was substantial variation in having any documented encounter with a Resource Mother across the three CMOs, with the lowest rate for Amerigroup (23.5%) and comparatively higher rates for Peach State (41.7%) and especially CareSource (79.1%). For Q1-Q3 2022, there was some variability in having a documented encounter with a Resource Mother according to whether the woman was enrolled in IPC (344/801 = 42.9%) or RM only (1088/1931 = 56.3%). Among the 755 unique women enrolled in either IPC or RM only for Q4 2022, only 52 (6.9%) had any documented encounter. There was variation in having a documented encounter with a Resource Mother across the three CMOs, with the lowest rates for Peach State (2%), then CareSource (8%), and the highest for Amerigroup (21.6%). For Q4 2022, there were quite similarly low rates of any documented encounter for both IPC (12/157 = 7.6%) and RM only (55/598 = 9.2%). The low rates may reflect the change over in the reporting template, with the CMOs being unfamiliar with the new template during the quarter of first use.

Table 8. **Any Face-to-face or Telephone Visit with Resource Mother Among Interpregnancy Care or Resource Mother Only Enrollees for Q1-Q3 2022 and for Q4 2022, by Medicaid Care Management Organization**

Case Management	Medicaid Care Management Organization			TOTAL
	Amerigroup	CareSource	Peach State	
Any face-to-face or telephone (Q1-Q3 2022)	144/613 (23.5%)	855/1081 (79.1%)	433/1038 (41.7%)	1432/2732 (52.4%)
Any face-to-face or telephone (Q4 2022)	16/74 (21.6%	30/374 (8.0%)	6/334 (2%)	52/755 (6.9%)

Table 9 shows the proportion of IPC or RM only enrollees who had at least one documented problem on their problem list and at least on documented care plan goal. Among the 2732 individuals enrolled in either IPC or RM only for Q1-Q3 2022, a total of 851 (31.1%) had at least one documented problem and 852 (31.2%) had at least one care plan goal with variability across

the CMOs, with Amerigroup having a comparatively low rate (14.5% and 17.5%, respectively) compared to Peach State (46.1% and 46.1%, respectively) and CareSource (21.4% and 50.2%, respectively). During Q1-Q3 2022, the primary care plan goals (in rank order) were: healthy lifestyle, housing, safety, help controlling risk factors, employment/job skills, transportation, drugs and alcohol, connecting with community resources, and family and intimate relationships parenting support and childcare. Among the 755 unique women enrolled in either IPC or RM only for Q4 2022, 546 (72.3%) had at least one documented problem and 546 (72.3%) had at least one care plan goal with variability across the CMOs, with Amerigroup having a comparatively low rate (24.3%) compared to CareSource (51.9%) and Peach State (100%). During Q4 2022, the primary care plan goals (in rank order) were: obtain information and contact other community resources, schedule follow-up medical or mental health appointments, adopt healthy lifestyle behaviors, exercise to reduce blood pressure, improve nutrition to reduce blood pressure, keep follow-up appointments, learn about disease processes, schedule dental appointments, schedule initial medical appointments.

Table 9. **Documentation of Problem List and Care Plan for Q1-Q3 2022 and for Q4 2022, by Medicaid Care Management Organization**

Acceptance of Case Management or Assignment of Resource Mother	Medicaid Care Management Organization			TOTAL
	Amerigroup	CareSource	Peach State	
Q1-Q3 2022				
Any problem documented	89/613 (14.5%)	231/1081 (21.4%)	202/438 (46.1%)	851/2732 (31.2%)
Care plan goal documented	107/613 (17.5%)	543/1081 (50.2%)	202 (46.1%)	852/2732 (31.2%)
Q4 2022				
Any problem documented	18/74 (24.3%)	194/374 (51.9%)	334/334 (100%)	546/755 (72.3%)
Care plan goal documented	18/74 (24.3%)	194/374 (51.9%)	334/334 (100%)	546/755 (72.3%)

Pregnancy & Delivery Outcomes among High-Risk Women. A pregnancy conceived within 18 months of the index VLBW delivery, regardless of outcome, is indicative of a short interpregnancy interval and is an adverse outcome that the P4HB IPC and RM only components were designed in part, to prevent. Earlier (**Chart 3**) we showed descriptive differences in the percentage of women in the 2011-2020 IPC enrollee cohort versus the RSM comparison cohort with repeat pregnancies in 18 months or less. In Table 12 we first test whether these differences are statistically significant. They are all significant ($p<.01$).

In **Table 10** we also show the percentage of women in the IPC and RSM cohort with a delivery within 18 months of their index VLBW delivery according to the outcomes of those deliveries. The percentage of IPC women experiencing a delivery within 18 months was significantly lower than for the RSM/VLBW comparison cohort (17.6% vs 26.5%). Moreover, the percentage experiencing an adverse pregnancy or birth outcome (fetal death, stillbirth, VLBW or LBW delivery) was significantly lower for the IPC enrollees than for the RSM women with an index VLBW infant who did not enroll (4.2% vs 7.8%, $p<0.01$).

Table 10. Number and Percent of Women with VLBW Infant with Repeat Pregnancy within Six, Twelve or 18 Months and Repeat Delivery within 18 Months, Among those Enrolled in the IPC Waiver Demonstration and Eligible but Not Enrolled

Timing of Repeat Pregnancy or Delivery	**IPC 2011-2020 N =2,508**	**RSM – VLBW 2011-2020 N =5,386**
Pregnant within 6 months	119 (4.7%)	602 (11.2%) ^^^
Pregnant within 12 months	284 (11.3%)	1,066 (19.8%) ^^^
Pregnant within 18 months	442 (17.6%)	1,427 (26.5%)^^^
	N = 2,406*	**N = 5,088***
Delivery within 18 months	225 (9.4%)	884 (17.4%)^^^
Fetal Deaths	27 (12.0%)	129 (14.6%)
Still Births	12 (5.3%)	35 (4.0%)
Very Low Birth Weight (<1500 g)	22 (9.8%)	73 (8.3%)
Low Birth Weight (1500-2499 g)	39 (17.3%)	161 (18.2%)

Normal Birth Weight (≥2500 g)	112 (49.8%)	418 (47.3%)
Unknown Weight	52 (23.1%)	232 (26.2%)
Adverse Delivery Outcome**	100 (4.2%)	398 (7.8%)^^^

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

Since the characteristics of the participants and non-participants differ, we used regression analysis to assess the adjusted difference in the following outcomes: 1) probability of a repeat pregnancy within 18 months; 2) probability of a delivery within 18 months and 3) probability of an adverse delivery outcome with 18 months. We control for age, race, month of index birth, months enrolled in the 18 months over which we follow them and an indicator for urban/rural residence. The regression results are shown in **Table 11** below**.**

Table 11. Estimated Differences in Probability of Outcomes (Marginal Effects) for IPC Compared to RSM Women with VLBW Infants not Enrolling in IPC, Ages 18-44

Outcome	Marginal Effect
Repeat Pregnancy within 18 Months after Index Delivery	-12.21^^^
Repeat Delivery within 18 Months after Index Delivery	-9.79^^^
Adverse Delivery Outcome within 18 months after Index Delivery	-4.54^^^

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

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

After controlling for these factors there are significantly lower adverse outcomes among IPC participants. Specifically, the probability of a repeat pregnancy after the index delivery (VLBW)

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

is 12 percentage points lower for IPC enrollees and the probability of a repeat delivery almost 10 percentage points lower. Important to the quality of the IPC component the probability of an adverse outcome in a subsequent delivery is 4.5 percentage points lower for those eligible for IPC and participating.

Outcome: Table 12 shows the total capitated payments made to the CMOs for the FP only, IPC and RM only components. Even with the slower growth and declines in some components of P4HB noted earlier, total capitated payments to the CMOs were fairly stable from the first half of 2022 (~$10.3 million) to the last half (~$11.0 million) of 2022. The total for all three components was just over $21 million by the end of 2022.

Table 12. P4HB Capitation Payments First and Second Half and Total, 2022

	1st Half (1/1-6/30, 2022)		2nd Half (7/1-12/31, 2022)		Total Year (1/1-12/31, 2022)	
Program	**$**	**%**	**$**	**%**	**$**	**%**
FP Only	$9,481,374	91.3%	$10,305,918	93.5%	$19,787,292	92.4%
IPC	$333,623	3.2%	$205,677	1.9%	$539,300	2.5%
RMOC	$570,534	5.5%	$516,376	4.7%	$1,086,910	5.1%
Total	$10,385,531	100.0%	$11,027,971	100.0%	$21,413,502	100.0%

Source Georgia Department of Community Health, MMIS (Medicaid management Information System) Reports MGD-3610-W (MCHB Payment Activity Report), Covers January- December 2022, includes monthly expenditures and Year to Date totals for each program and overall.

As in earlier years, the FP only component of P4HB is the most costly for Medicaid in terms of total capitated payments, accounting for ~92% of the total. Payments to CMOs for women in this component grew only slightly from the first to the second half of 2022 by about $1 million; the total for the FP only component at the end of 2022 was almost $20 million.

Capitated dollar payments for IPC and RM only components of P4HB declined slightly over the first to second half of 2022. The IPC capitated payments equaled $539, 300 by the end of the year accounting for only 2.5% of the total. Capitated payments for women in the RM only component of P4HB were just over $1 million by the end of 2022 program year, accounting for 5.1% of the total $21.4 million paid to CMOs.

IV. Summary of Member Surveys

Overview

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

Survey Methods

To date, the member survey has been administered in eighteen waves. The most recent wave of the member survey was conducted from October through November of 2022. Members identified by the CMOs were contacted by internet, mail, and phone for the survey (11,000 participants). Of the 11,000 program participants contacted, 308 (2.8%) responded to the survey. The section below provides a summary of the responses from the two most recent waves of the CMOs' member survey (17^{th} and 18^{th}).

CMO Member Survey Results

In this most recent 18th wave, each CMO selected a random sample of 3,000-4,0000 members for a total of 11,000 members that met the selection criteria for inclusion in the survey. The rate of participation in the member survey across the three CMOs was 2.8% for wave eighteen. For 18^{th} wave, the member response rates were: 2.8% (113/4,000) for Peach State, 2.6%

(102/4,000) for Amerigroup, and 3.1% (93/3000) for CareSource. As before, we note these response rates are far below the desired level of participation.

Table 13 summarizes the members' responses regarding the services they had trouble accessing prior to enrollment in P4HB and the changes the members experienced since enrolling in P4HB.

The most commonly reported service that respondents indicated that they had trouble accessing prior to enrolling in P4HB was primary care (~25% and ~43% in waves 17 and 18, respectively). A substantial percentage also reported having problems with accessing birth control or family planning services prior to enrolling in P4HB in both of the two most recent waves (~21% and ~28% in waves 17 and 18, respectively). Less commonly reported problems were in accessing testing or treatment for sexually transmitted infections (~19% and ~26% in waves 17 and 18, respectively) and pregnancy testing (~9% and ~19%, respectively).

A substantial number of respondents reported that the enrollment in P4HB resulted in particular changes for them. The most frequently reported changes following enrollment in P4HB among respondents in both of the two most recent waves of the survey was that they had more choice of birth control methods (~45% and ~54% in waves 17 and 18, respectively), did not have to use their own money for family planning (~36% and ~39% in waves 17 and 18, respectively), and started using a method of birth control (~32% and ~36% in waves 17 and 18, respectively). In addition, a substantial percentage reported that they began going to a different doctor or nurse for family planning services (~ 22% and 23% in waves 17 and 18, respectively) or to a different doctor or nurse for primary care (~27% and ~30% in waves 17 and 18). Approximately 18% in both of the two most recent waves of the survey indicated that they changed their birth control method under P4HB.

Table 13. Enrollment and Utilization of Services in P4HB®		
	17th Wave N=261 Responses n (%)	**18th Wave N=308 Responses n (%)**
Before enrolling in P4HB®, had trouble getting…		
Birth control or family planning services	54 (20.7%)	87 (28.2%)
Pregnancy testing	23 (8.8%)	58 (18.8%)
Testing or treatment for sexually- transmitted infections	49 (18.8%)	79 (25.6%)
Primary care (such as routine check-up, care for an illness) (Purple Card)	66 (25.3%)	131 (42.5)
Other (Basic Care/Ob Gyn Preg Related	30 (11.5%)	33 (10.7%)

Changes P4HB® made for the participant…		
I am going to a different doctor or nurse for family planning services or birth	57 (21.8%)	72 (23.43%)
I am going to a different doctor or nurse for primary care	70 (26.8%)	92 (29.9%)
I have started using a birth control	83 (31.8%)	110 (35.7%)
I have changed the birth control method I use	45 (17.2%)	57 (18.5%)
I have more choices of birth control methods	117 (44.8%)	166 (53.9%)
I do not have to use my own money for family planning services or birth control	94 (36.0%)	120 (39.0%)
I can get preventive care (such as Pap smears) and family planning counseling	181(69.3%)	221 (71.8%)
I am able to get care when I need it (Purple Card)	161 (61.7%)	196 (63.6%)
I am able to get the medicine I need (Purple Card)	155 (59.4%)	193 (62.7%)
Other (Meds/Vitamins not covered, Can't get usable services)	9 (3.4%)	17 (5.5%)

Table 14 summarizes the members' responses to the problems they have encountered with the P4HB program since enrollment. The most frequent problem reported in both of the two most recent waves of the survey was not being able to find a doctor or nurse willing to take P4HB clients (~23% and ~22% in waves 17 and 18, respectively). Fewer than 20% reported any of the surveyed problems related to not being able to get services or referrals or to find a provider or clinic in both of the two most recent waves of the survey.

Table 14. Problems Encountered by Members Enrolled in P4HB®

Problems Under P4HB®	17th Wave N=261 Responses	17th Wave N=308 Responses
I cannot get the family planning services I want	50 (19.2%)	55 (17.9%)
I cannot get referrals or follow-up for care I need	49 (18.8%)	50 (16.2%)
I cannot find a doctor or nurse willing to take P4HB clients	59 (22.6%)	67 (21.8%)
I do not want to leave my current doctor or nurse	46 (17.6%)	57 (18.5%)
I must wait too long to get services	37 (14.2%)	48 (15.6%)
I do not have transportation	23 (8.8%)	30 (9.7%)
I cannot get to the doctor or nurse when they are open	21 (8.0%)	29 (9.4%)

My P4HB doctor or nurse will not prescribe the birth control method I want to use	25 (9.6%)	27 (8.8%)
Other (Doesn't Offer Total Health Coverage)	28 (10.7%)	24 (7.8%)

The member survey probed the following areas to assess whether key reproductive health assessments occurred during the encounter: whether the member was asked about key reproductive health topics during her last health care appointment (**Table 15).** At least half of respondents in the two most recent waves of the survey reported that a doctor or nurse asked them about whether they use birth control to prevent or space pregnancies during their last encounter, whether they use male or female condoms to prevent STIs, their sexual practices and if they had been asked about their plans for having or not having children in the future. However, only about 36-37% report that their doctor or nurse asked them about their thoughts or plans about timing or spacing of pregnancies.

Table 15. Provider Inquiry about Reproductive Health Topics during Encounters		
Reproductive Health Topic	**17th Wave N=261**	**18th Wave N=308**
Has a Doctor or Nurse Ever Talked With You About Any Of The Following…? n (%)		
Your thoughts or plans about having or not having children in the future	140 (53.6%)	173 (56.2%)
Your thoughts or plans about timing or spacing pregnancies	93 (35.6%)	113 (36.7%)
Your sexual practices	122 (46.7%)	170 (55.2%)
The use of birth control to prevent or space pregnancies	168 (64.4%)	215 (69.8%)
The use of male or female condoms to prevent sexually transmitted infections	161 (61.7%)	204 (66.2%)

During the 18th wave of the survey, participants were asked how they heard of the P4HB program with responses shown in Table **16**. The most frequent source of information about the P4HB program was the health department (59%), followed by the P4HB letter from the health plan (37%), the providers office (26%) and others (23%), and through a flyer or advertisement (16%).

Table 16. How Did You Hear of the P4HB Program		
	17th Wave	**18th Wave**
Health Department	158 (60.5%)	181 (58.8%)
Providers Office	73 (28.0%)	80 (26.0%)
P4HB Letter from your health plan	103 (39.5%)	114 (37.0%)

Flyer / Advertisement	34 (13.0%)	48 (15.6%)
Other (When applied for insurance, DFCS, Word of Mouth/Family/Friend, Online/Website)	58 (22.2%)	70 (22.7%)

Near the end of the survey, members were asked to rate their satisfaction level with the P4HB program on a 0-10 scale with zero being not at all satisfied and a ten being completely satisfied. The data in **Table 17** indicates that 67% of respondents were highly satisfied with P4HB, whereas 21% had moderate satisfaction, and 11% had low satisfaction.

Table 17. How Satisfied Are You With The P4HB Program?		
	17th Wave N=261	**18th Wave N=308**
Low Satisfaction (0-3)	19 (7.3%)	33 (10.7%)
Medium Satisfaction (4-7)	50 (19.2%)	64 (20.8%)
High Satisfaction (8-10)	180 (69.0%)	207 (67.2%)

The final question asked on survey wave eighteen was how the P4HB program could be improved. The most common responses were to cover more services and medications and to have more providers available that accept the coverage.

V. Budget Neutrality and Financial Reporting

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

Outcome: Demonstration of P4HB expenditures for January 1 through December 31, 2022, appears in the Budget Neutrality Report as submitted by DCH.

VI. Disenrollment, Service Denials, Provider Claims & Grievances

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

Table 18 - Disenrollment, Denial of Service & Provider Claim Counts, 2020-2022			
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*	84,498	33,710
July-Dec 2020	406	156,708	34,539
July-Dec 2021	421	87,242	32,606
July-Dec 2022	574	85,967	35,046

The data in the top rows of **Table 18** include the reporting period, January-June 2022. The pattern in disenrollment of clients in the first six months of each of the years is mixed. The decline to only 84 total disenrollments in January-June of 2021 may reflect the Covid-19 extension of eligibility for Medicaid enrollees but there was an increase in disenrollment to 308 I Jan-June of 2022. In the latter part (July-December) of each year there were large and increasing numbers of disenrollment. There were 406 total disenrollments in the first six months of 2020 and an even higher total disenrollment of 421 in the July-December 2021 period. In the most

Denials of service stood at 143,659 in the Jan-June 2020 period and this rose to 156,708 in the July-December months of 2020. The denials in the Jan-June periods of 2021 and 2022 were lower, ending at 84, 498. While denials in the July-December 2020 period were higher (156,708) than in the first part of that year, the denials in the July-December time period of 2021 and 2022 were again lower, ending at 85, 967 in the last six months of 2022. Reasons for the denials noted by the CMOs related to several issues, including denials of services not covered, such as emergency department visits, lab draws, and outpatient visits for evaluation or management for low or moderate concerns.

Finally, the provider claim counts for the first six months of each year clearly show little change but a slight increase from 32,096 in Jan-June 2021 to 33,710 in the first six months of 2022. In the latter part (July-December) of each year claim totals were fairly stable but show a slight increase from 34,539 in 2020 to 35,046 in 2022.

Table 19 - Grievances Count By CMO 2020-2022

P4HB Grievance Count by CMO				
Reporting Period	**Amerigroup**	**CareSource**	**PeachState**	**Total**
Jan-June 2020	1	0	0	1
Jan-June 2021	21	2	15	38
Jan-June 2022	19	8	7	34
Average 1st Half of Each Year	13.7	3.3	7.3	24.3
July-Dec 2020	0	0	0	0
July-Dec 2021	13	13	9	35
July-Dec 2022	24	9	15	48
Average 2nd Half of Each Year	12.3	7.3	8.0	27.7
Total (P4HB)	78	32	46	156

We discuss the data in **Table 19** on counts of grievances overall and by CMOs and discuss the following comparisons:

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

In the July-December 2020 reporting period there were no grievances reported across the CMOs but in July-December 2021 there were 13 grievances reported. As noted in the table, the average number of grievances in the July-December periods of the three years was 12.3 with the numbers increasing from 13 in July-Dec 2021 to 24 in July-Dec 2022. The average of 12.3 in the latter parts of 2020-2022 is comparable, albeit lower, than the 13.7 in the Jan-June periods of these years. The bulk of the total 156 grievances were reported for Amerigroup (78). The totals for CareSource (32) and PeachState (46) were much lower over these years. Most grievances were described by the CMOs as having to do with administrative issues, access to care or denials for services, or related to provider issues.

VII. Evaluation Activities & Interim Findings

A key milestone in the P4HB Evaluation Design was the 2022 Interim Evaluation Report submitted to CMS on March 31, 2024. We provide brief summaries of the results here for research questions (RQ) 1, 2, 4 (a & b) as stated in the P4HB Evaluation Design.

RQ1.How did beneficiaries utilize covered health services?

RQ2. Did P4HB enrollees maintain coverage for 12 months or longer? How did sociodemographic, county, and economic factors affect the probability of disenrollment?

RQ4a.Was P4HB associated with a reduction in the share of unintended pregnancies among Medicaid live births?

RQ4b.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?

We reported results on RQ4a regarding unintended pregnancies in our earlier text and report on the remaining research questions here. Key findings related to RQs 1, 2 are summarized below.

Regarding RQ2, we merged data on numerous sociodemographic measures to the enrollment and claims data in order to analyze the role of county level factors related to access to health care (such as numbers of Ob/GYNs per women of reproductive age, FQHCs per capita) and that represent underlying social and economic conditions (percent uninsured, employment).

Retention in both the FP only and IPC/RM only components of P4HB is not optimal:

- For FP only enrollees, between 36% to 43% were enrolled fewer than 12 months in 2018 and between 33% to 41% were enrolled fewer than 12 months in 2019, with significant variation in the percentage enrolled fewer than 12 months across the CMOs;

- For IPC/RM only enrollees, between 44% to 66% were enrolled fewer than 12 months in 2018 and between 35% to 59% were enrolled fewer than 12 months in 2019, with significant variation in the percentage enrolled fewer than 12 months across the CMOs.

- Perhaps related to shorter periods of enrollment, FP only and IPC/RM only enrollee utilization of family planning visits and receipt of contraceptive methods and covered screenings and preventive services was lower than desired. And utilization of many covered services by both FP only and IPC/RM only enrollees varied across the CMOs.

- Among FP only enrollees, the odds of disenrollment before 12 months was significantly lower among those who had a family visit and among those who were unmarried with significant variation across the CMOs.

- Of IPC/RM only enrollees, between 44% to 66% were enrolled fewer than 12 months in 2018 and between 35% to 59% were enrolled fewer than 12 months in 2019, with significant variation in the percentage enrolled fewer than 12 months across the CMOs.

- Of IPC/RM only enrollees entering and staying in the program 3 months after a delivery, a higher percentage of those in the RM only group compared to the IPC group remained continuously enrolled for 360 days (~90% vs. ~72%).

- Receipt of contraceptive methods (including receipt of LARC methods) as well as screening, preventive, and disease management services increased over the 360-day period of IPC/RM only program enrollment, underscoring the importance of retention in the program for health service utilization.

- Of the 32% of IPC enrollees and 26% of RM only enrollees with hypertension (gestational or pre-gestational) or diabetes mellitus (gestational or pre-gestational there was a high percentage (77% of IPC; 72% of RM only) who received hypertension and/or diabetes related services. Among enrollees with these chronic conditions, the percentage receiving mental health and/or substance use services was 25% (IPC) and 33% (RM only), respectively. This underscores that both groups of enrollees with VLBW deliveries have both cardiometabolic and behavioral health conditions that require management.

Regarding RQ4b we used the results on unintended pregnancy as summarized earlier in combination with data on the costs of delivery for mother and baby as well as the costs of the infant in their first year of life to estimate the cost savings. Based on the mean effect of -8.33% on unintended pregnancies among those likely to be eligible for Medicaid at delivery, we estimate a savings of ~$147.2 million or about $73 million in 2012 and 2013. In the longer period of 2017-2019, the estimated savings based on the same definition of unintended pregnancy and the mean effect of -13.19% could result in a total of $367.7 million or about $123

million in savings each year. There is variation around these estimates, as noted in the Interim Evaluation Report. Using the variation in these estimated effects, for example, the first estimate of $147. 2 million in savings could be as low as zero but as high as $311 million in savings.

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

Outcome/Interim Findings:

- Age at first birth increased with the implementation of P4HB and this increase was greater 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 claims analyses to date.

In doing this analysis we have used privately insured mothers with high school or less education as a comparison group for the RSM women. We have linked enrollment/claims and vital records data for both of these groups which allows us to compare outcomes pre and post P4HB. We have reported on these analyses earlier but plan to return to the claims analysis to: 1) reduce the sample to just singleton, first-births; 2) include sociodemographic and clinical risk factors for those delivering on Medicaid versus private insured; and 3) use the most current data. Notably, the composition of Medicaid program enrollees also changed from the pre- to the post-P4HB period as a result of the full implementation of the Affordable Care Act in 2014 (with those in Medicaid in the post- period compared to the pre-P4HB period being older and more likely living in impoverished census tracts, for example); thus, it is difficult to draw conclusions from this analysis until further adjusted analyses are completed.

As noted and reported earlier in this report, we used the Pregnancy Risk Assessment Monitoring System (PRAMS) survey to analyze unintended pregnancies as this survey includes measures of 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.

References

1. Andersen RM. Revisiting the behavioral model and access to medical care: does it matter? Journal of Health and Social Behavior. 1995 Mar;36(1):1–10. doi: 10.2307/2137284. Available from: http://dx.doi.org/10.2307/2137284.
2. Fact Sheet, Planning for Healthy Babies, P4Hb Overview. Georgia Department of Community Health. Planning4HealthyBabiesFY12_2.pdf (georgia.gov)
3. McKinney J, Keyser L, Clinton S, Pagliano C. ACOG Committee Opinion No. 736: optimizing postpartum care. Obstetrics & Gynecology. 2018 Sep 1;132(3):784-5.
4. Guy Jr GP, Adams EK, Redd SK, Dunlop AL. Effects of Georgia's Medicaid Family Planning Waiver on Pregnancy Characteristics and Birth Outcomes. Women's Health Issues. 2023 Dec 15. https://doi.org/10.1016/j.whi.2023.11.004