

Annual Report

Planning for Healthy Babies Program[®] (P4HB[®])

1115 Demonstration in Georgia

January-December 2023

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 who were enrolled into the FP only component during this program year increased to ~38% from ~37.1% in the prior program 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 during this program year increased to 20.4% from 19.1% in the prior program year.
- Among FP only enrollees, 14.2% had a family planning visit and 7.2% had a visit for contraceptives within the first six months of program enrollment (compared with 14.5% and 7.2%), respectively in the prior program year. Among FM only enrollees using contraceptives, most (78.7%) use Tier 2 methods (injectables, patch, pills, ring), up from 75.1% in the prior program year, with 13.9% using long-acting reversible contraceptives (LARCs), down from 16% in the prior program year.

- Repeat pregnancy within 18 months (short interpregnancy interval) of an RSM-covered delivery was 8 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 (57.7%) of women with a chronic condition enrolled in IPC used some method of contraception by one year postpartum and 14% used LARCs.
- A similar percentage of women with a chronic condition enrolled in RM only used some method of contraception by one year postpartum (59%) and 15.1% used LARCs.
- Repeat pregnancy within 18 months of an index VLBW delivery was 8.8 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 13.2 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 78.6% of women enrolled in P4HB IPC and 83.7% of those enrolled in RM only with evidence of diabetes or hypertension received services to manage these conditions in the 12 months following delivery.
- Compared to those eligible for IPC who did not enroll, women eligible for IPC who enrolled had a 12.52 percentage point lower probability of having a repeat pregnancy and a 9.46 percentage point lower probability of having a repeat delivery within 18 months. Adverse outcomes in subsequent deliveries were 4.14 percentage points lower for women eligible for IPC who enrolled compared with those eligible who did not enroll.
- Fully 39% of P4HB enrollees surveyed noted that they had ‘trouble getting primary care (e.g. routine check-up)’ before enrolling but 80.9% said one of the changes P4HB made for them was that they ‘can get preventive care and family planning counseling’ now.
- Around 60% of those with the Purple Card in P4HB said they could now ‘get care when I need it’ and ‘get medicine when I need it’.
- A remaining problem is that 27.8% of P4HB enrollees said they cannot find a doctor or nurse willing to take P4HB clients.

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 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.

The PHE ended May 11, 2023, ending COVID-19 PHE waivers and other flexibilities provided by CMS during the PHE. Many of the Medicaid waivers and flexibilities, including those that support home and community-based services, are available for states to continue if they choose to do so. Georgia submitted an application to amend P4HB to include permanent provisions permitting legally responsible individuals (including legally responsible family caregivers) to be reimbursed for the provision of medically necessary personal care services (PCS) to medically fragile children under age 21 enrolled in the Georgia Pediatric Program (GAPP). The state is in dialogue with CMS on the evaluation of this amendment.

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 Peach State and all P4HB enrollees were brought into Peach State for service provision. As noted in prior reports, this change meant that the highest share of FP only enrollees (~46%) was now in the Peach State

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 the P4HB was held on August 16, 2023, via Microsoft Teams, during the Medical Care Advisory Committee (MCAC) meeting. There were no post award public comments for the program.

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.

<p>Objective: Improve access to family planning services by extending eligibility for these services to newly eligible women.</p>
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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 2022 and 2023

Demonstration Group	Enrolled in 4 th Quarter	Population Eligible in Community ^{1,2}	Percent Eligible Enrolled
2022 P4HB Enrollment/Participation			
FP Only 2022 ³	60,313	162,759	37.1%
FP Only 2022 ⁴	60,313	88,704	68.0%
IPC/Resource Mother Only	599	3130	19.1%
2023 P4HB Enrollment/Participation			
FP Only 2023 ³	61,828	162,759*	38.0%
FP Only 2023 ⁴	61,828	88,704	69.7%
IPC/Resource Mother Only	594	2915	20.4%

¹Those eligible for family planning only benefits are uninsured female citizens ages 18-44 with income \leq 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. ²Those eligible for IPC include uninsured women 18-44 with income \leq 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 2021 and 2022 (2021 n = 1,568 and 2022 n = 1,562) as the denominator in 2022 and 2022 and 2023 (2022 n = 1,562 and 2023 n = 1,353) as the denominator in 2023. ³We 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. ⁴This 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.

*2023 ACS data not available. 2022 ACS estimation used.

While the number of women enrolled in the FP only program declined from the 2021 level of 61,247 (DY12 Annual Report) to 60, 313 in 2022, this number increased slightly to 61,828 in 2023. The percentage of those eligible in the community increased slightly from 35.3% in 2021 to the 37.1% seen in **Table 1** for 2022 and further, to 38% in 2023. 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 68% in 2022 to 69.7% in 2023.

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 in Medicaid with a VLBW in 2021/2022 and 2022/2023 and use these counts as the denominator for percent eligible enrolled. There has been a decline in the number of VLBW births over the 2021 time period from 1,568 in 2021 to 1,562 in 2022 to 1,533 in 2023 (see note to **Table 1**). The number of women enrolled in the IPC and RM only components in 2022 and 2023 remained fairly stable at 599 in 2022 and 594 in 2023; these total numbers are down from the 777 enrolled in 2021 (DY12 Annual

Report). The percentage of women eligible and enrolled in these components also declined from the 25.3% seen in 2021 to 19.1-20.4% seen in the 2022 and 2023 data. The low percentage of eligible women being enrolled and hence, offered IPC and RM only services, should be addressed as the state moves out of the continued eligibility under the PHE and into the one-year postpartum coverage for all persons delivering on Medicaid.

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 to which they are assigned. As noted above, the number of CMOs serving Georgia Medicaid clientele was reduced from four to three in July 2021 (due to merger). Total enrollment in 2023 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 2023

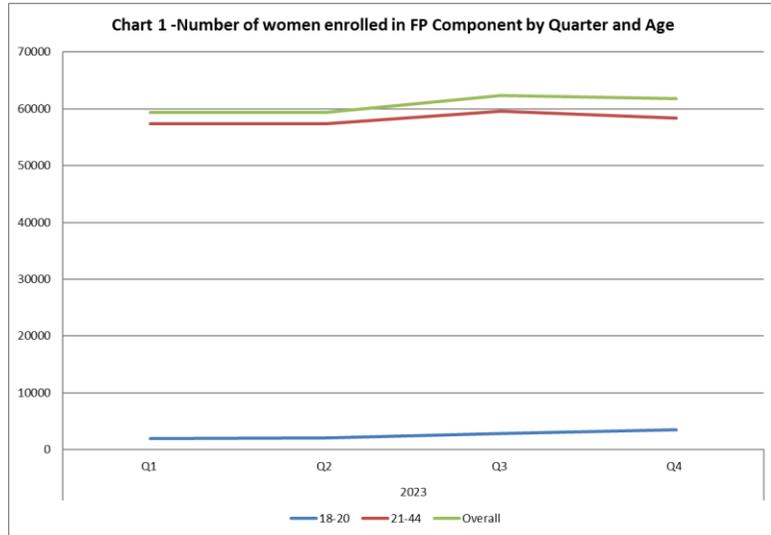
ENROLLMENT BY CMO AND AGE GROUP FOR Q1 AND Q4 2023												
	Amerigroup			Caresource			Peachstate/Wellcare			Overall		
	Q1	Q4	Growth	Q1	Q4	Growth	Q1	Q4	Growth	Q1	Q4	Growth
Family Planning Only												
18-20	647	1047	61.8%	512	893	74.4%	773	1553	100.9%	1932	3493	80.8%
21-44	17495	17469	-0.1%	15839	15972	0.8%	24082	24894	3.4%	57416	58335	1.6%
Total	18142	18516	2.1%	16351	16865	3.1%	24855	26447	6.4%	59348	61828	4.2%
% Total	30.6%	29.9%		27.6%	27.3%		41.9%	42.8%				
Inter-Pregnancy Care												
18-20	0	3	N/A	3	4	33.3%	2	4	100.0%	5	11	120.0%
21-44	26	63	142.3%	49	108	120.4%	57	147	157.9%	132	318	140.9%
Total	26	66	153.8%	52	112	115.4%	59	151	155.9%	137	329	140.1%
% Total	19.0%	20.1%		38.0%	34.0%		43.1%	45.9%				
Resource Mother Outreach												
18-20	0	1	N/A	6	2	-66.7%	4	4	0.0%	10	7	-30.0%
21-44	35	35	0.0%	194	94	-51.5%	148	129	-12.8%	377	258	-31.6%
Total	35	36	2.9%	200	96	-52.0%	152	133	-12.5%	387	265	-31.5%
% Total	9.0%	13.6%		51.7%	36.2%		39.3%	50.2%				
All Programs												
18-20	647	1051	62.4%	521	899	72.6%	779	1561	100.4%	1947	3511	80.3%
21-44	17556	17567	0.1%	16082	16174	0.6%	24287	25170	3.6%	57925	58911	1.7%
Total	18203	18618	2.3%	16603	17073	2.8%	25066	26731	6.6%	59872	62422	4.3%
% Total	30.4%	29.8%		27.7%	27.4%		41.9%	42.8%				

In contrast to the patterns of declining enrollment seen for Q1 to Q4 of 2022, there was a marked increase in the enrollment of women in the Family Planning (FP) only component of P4HB from Q1 to Q4 of 2023. As shown in **Table 2**, enrollment in FP only grew by 4.2% and IPC enrollment by a surprising 140% over these quarters. However, there was a continued decline from 2022 in the number of RM only enrollees from Q1 (387) to Q4 (265) of 2023.

Specific to the FP only component, the number of enrollees at the end of Quarter 1, 2023 was 59,348 increasing to 61,828 by Quarter 4, 2023. The increase was driven by the 18-20 year age group which grew by 80.8% overall, ranging from a 61.8% growth for Amerigroup to 100.9% growth for Peach State/WellCare over this time period. This reverses the previous trend in enrollment toward older women in the FP only component seen in 2022. Although the number of women in the IPC component of P4HB are smaller, the percentage growth seen in this component was even greater at 140.1% overall and ranged from a 115.4% growth in CareSource to a 155.9% growth in the Peach State/WellCare CMO. While the growth in this enrollment was similar for the 18-20 year old (120.0%) and 21-44 year old (140.9%) groups the growth by age group varies somewhat across the CMOs.

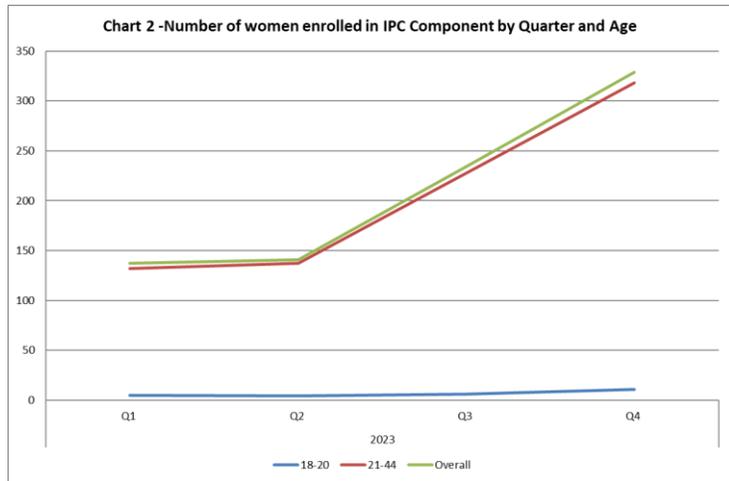
Patterns within the RM only component were starkly different as there was an overall decline (-31.5%) in enrollment and the percentage decline was similar for the two age groups (-30.0 and -31.6%). While both CareSource and Peach State/WellCare saw declines in RM only enrollees, Amerigroup experienced a 2.9% increase. Across all components of P4HB there was a 80% increase in the 18-20 year old group and a 1.7% increase in the 21-44 year old group for an overall increase in enrollment from Q1 of 2023 to Q4 of 2023 of 4.3%.

Taken together, the changes in enrollment in the FP only component of P4HB result in an upward trend seen in **Chart 1**, starting in the third quarter of 2023 as the PHE ended. While the growth rate (**Table 2**) was higher for the 18-20 year olds the number of enrollees in the 21-44 year age group dominate the



overall trend, as shown by the green line 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, teens aging out of PeachCare are made aware of their possible eligibility for P4HB. Previous declines in P4HB enrollment among those 18-20, as noted in DY12 Annual Report, may have reflected a lack of need for P4HB-covered services; 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; or that young members home during the pandemic were placed back on their parent’s insurance for coverage. The reversal of the trend may reflect, in part, the end of the PHE which may have affected the teens’ parents’ insurance coverage or other systemic and policy changes. The 80.8% growth in the 18-20 year olds in the FP only component of P4HB in the latter part of 2023 helped drive the overall increase.

The decline in IPC enrollment during 2022 shown in the prior Annual Report (**Chart 2**) likely reflect their retention in a full Medicaid eligibility category during the PHE. With the end of the PHE there is a stark upward trend as shown here in **Chart 2**, in the last two quarters of 2023.



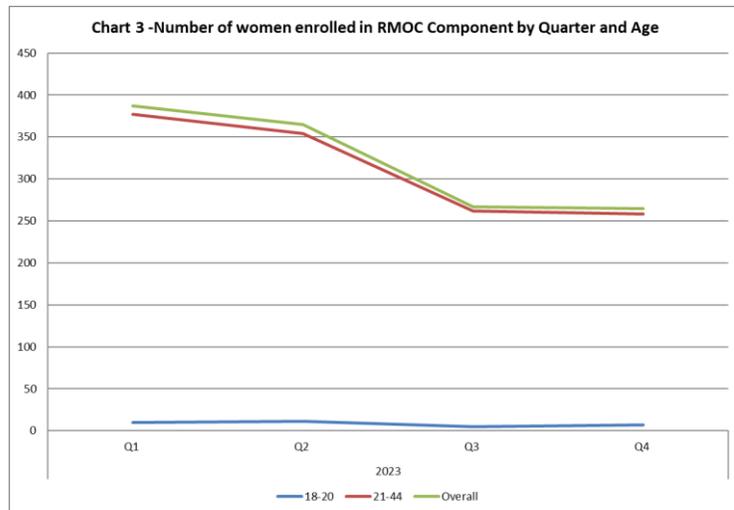
While the rate of growth was similar for the 18-20 and the 21-44 age

groups, the older age group of IPC enrollees constitute 97% of the total IPC enrollment and hence, dominate the upward trend shown in **Chart 2**.

As shown in **Chart 3**, the overall decline of 19% in RM only enrollment in 2022 not only continued but was a decline of almost 32% over the quarters of 2023 as illustrated in **Chart 3**.

The steepest decline was in the 3rd quarter of 2023 among the 21-44 age group which also dominates (97%) total enrollment in

this component of P4HB. The LIM enrollees retained Medicaid eligibility during the PHE but it appears that those with a VLBW infant in LIM were not also enrolled in the RM benefits. While there was a decline in the actual number of VLBW infants in 2022 and 2023, as noted in **Table 1**, there was also



a decline in the percentage of those eligible for IPC/RM only benefits who were enrolled.

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 Peach State/WellCare merger resulted in the largest percentage (~45%) of the FP only enrollees being in the Peach State CMO by the end of the 4th quarter of 2021. While there is a slight decline in this percentage to ~43% in Q4 2023, the Peach State CMO still serves the largest percentage of all P4HB enrollees. This pattern holds for the FP and IPC components of P4HB (~43% to 46%) and in 2023, the RM only component (50%); at the end of 2022, CareSource was serving the largest percentage of RM only (~48.8%) enrollees.

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 2023. These activities were designed to reach new and prospective enrollees across the CMOs and ranged from telephone calls, mailings, community events, and virtual and in-person activities. Additionally, activities were delivered to providers both in-person and virtually throughout the year.

Amerigroup’s outreach activities included virtual and in-person activities, including community events and “diaper days.” New member mailings and welcome calls were provided to members, as well as reminders about recertification and loss of benefits. Outreach to prospective members was also conducted virtually and in-person and via mailings. Provider education and outreach occurred both in person and virtually and through mailings. No provider outreach was conducted in Q1 2023.

CareSource outreach activities included welcome calls and mailings of postcards to enrollees within 30 days of eligibility. Welcome packets and ID cards were also mailed to new members. Outreach to prospective members was also conducted virtually and in-person and via mailings. Provider education and outreach was conducted during virtual and in-person activities; however, no provider outreach was conducted in Q2 2023.

Peach State outreach activities included virtual and in-person activities and mailings/calls to new and existing members about P4HB benefits and services. This outreach also emphasized the importance of utilizing contraception. Outreach to prospective members was also conducted through virtual and in-person community events such as baby showers. Provider education and outreach included virtual and in-person activities along with provider mailings.

CMO	FP and IPC/RM Enrollees	Provider Outreach
Amerigroup	<ul style="list-style-type: none"> • Outreach included virtual face-to-face conferencing, in-person activities/events, and activities delivered by other means (mail, calls) • Outreach activities include current and prospective members. • With both FP and IPC members, there were 5 virtual activities, 55 in-person activities, and a total of 39 activities were delivered by other means (mail, calls, etc.) • For prospective members, there were 46 in-person activities, 2 virtual activities, and 37 activities delivered by other means (mail, calls, etc.) 	<ul style="list-style-type: none"> • No provider outreach activities reported in Q1 2023 as there was no specific need identified. • During Q2-4 2023, 338 total provider activities were conducted in person, 152 activities were conducted virtually, and 37 activities were delivered by other means (mail, calls, etc.)
CareSource	<ul style="list-style-type: none"> • Outreach included virtual face-to-face conferencing, in-person activities, and activities delivered by other means (mail, calls) • Mailings were sent to 10, 351 FP members and to 224 IPC members during 2023. • There were 10 additional outreach activities with FP members and 4 additional outreach activities with IPC/RM members. • There were 4 virtual and 2 in-person activities with prospective members during 2023. 	<ul style="list-style-type: none"> • In Q1 2023, there were 278 provider activities delivered virtually and 75 activities delivered in person • In Q2 2023, there were no virtual or in-person provider outreach activities. However, CareSource reports that their Health Partner Network Managers conducted 1,426 partner meetings with providers to discuss issues related to contracts, incentives and claims. • During Q3-4, 2023, there were 2 in person activities, 1 virtual activity, and 2 activities delivered by other means (mail, calls) with providers.

CMO	FP and IPC/RM Enrollees	Provider Outreach
Peach State	<ul style="list-style-type: none"> • Virtual face-to-face conferencing, in-person activities and activities delivered by other means (mailings) • In 2023, there were 22 in-person activities for FP members, 24 in-person activities for IPC/RM members, and 2 virtual activities for IPC/RM members. There were no virtual activities for FP members. • For prospective members during 2023, there were 28 in-person activities and 12 “other” activities. 	<ul style="list-style-type: none"> • Provider outreach included virtual and in-person activities, along with mailings, deemed “other” activities. • In 2023, there were 3,008 virtual and 2,746 in-person provider activities. There was a total of 134, 240 “other” provider activities.

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 ~14% had any family planning visit in their first 6 months of enrollment in 2022 or 2023 and yet, this is a slight increase from the 11.4% in 2021.

Table 4. Use of Family Planning Services within Six Months of Enrollment among P4HB Family Planning only Enrollees, 2022-2023

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
2022	8,647	14.5%	1.85	7.2%
2023	14,538	14.2%	1.78	7.2%

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

In both 2022/2023, the number of family planning visits averaged roughly two per enrollee and the percentage of FP only enrollees having a visit/service for a contraceptive method in those first 6 months was steady at 7.2%. The 7.2% with a visit/service for a contraceptive method is a slight increase from the 6% reported in 2021 which may have reflected a lower utilization rate during the PHE.

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, 2022-2023

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
2022	626	16.6%	75.1%	0.3%	8.0%	16.0%
2023	1043	14.9%	78.7%	0.5%	5.9%	13.9%

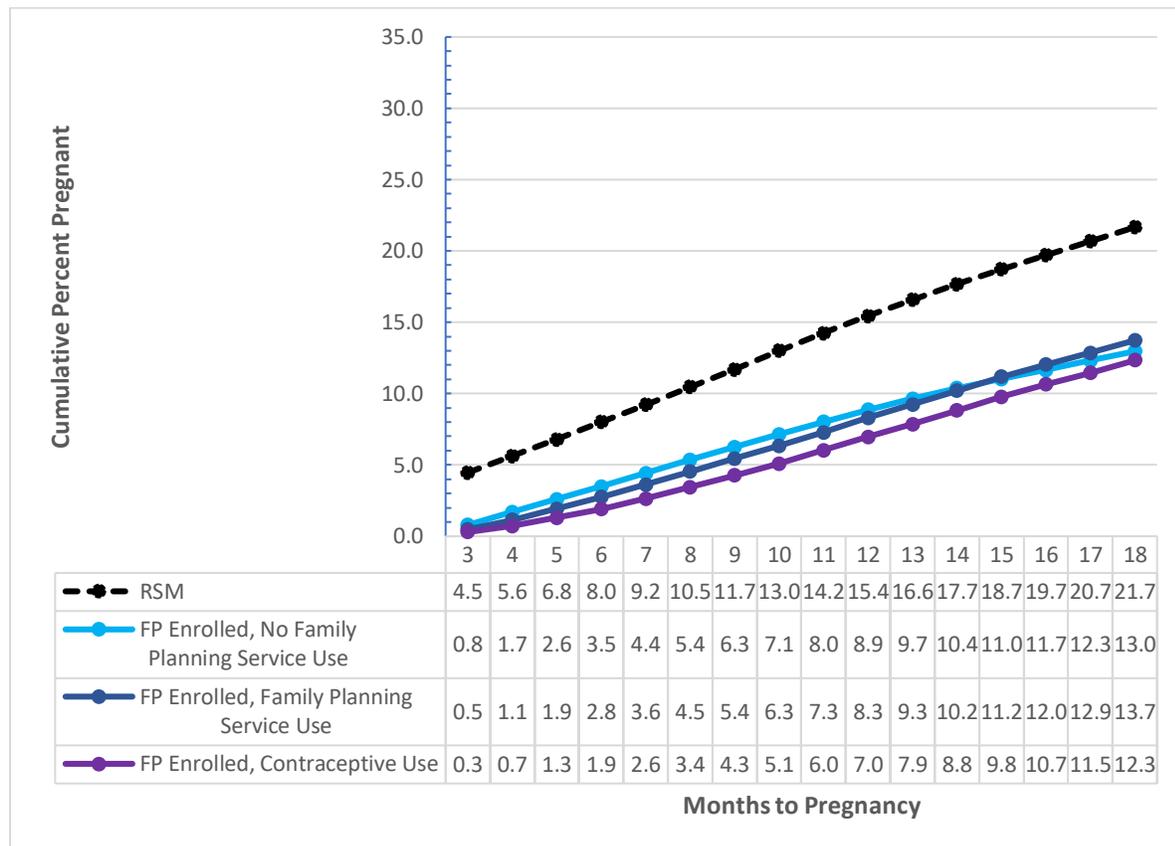
Notes: WHO Tiers of contraceptive effectiveness: Tier 1(High effectiveness): implants, intrauterine devices, sterilization; Tier 2 (Medium effectiveness): injectable methods, patch, pills, and vaginal ring; Tier 3 and 4 (Low effectiveness): condoms, diaphragms, fertility awareness methods, spermicides; 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 prior reporting periods as well as 2022 and 2023, the most commonly used contraceptive methods were those in Tier 2 (injectable methods, patch, pills, and vaginal ring) at 75% and increasing in 2023 to almost 79%. The 16% using highly effective (Tier 1) methods, largely long-acting reversible contraceptives (LARCs) seen in 2022 is a decline from the 21% reported for 2021 and this percentage declined further to ~14% in 2023. (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 contraceptives (LARCs). The percentage using LARCs rose from 18.8% to 20.3%.

Objective: Increase child spacing intervals through effective contraceptive use.

Outcome: The data in **Chart 4** (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 4. Cumulative Months to Subsequent Pregnancy for Women Who Recently Delivered on RSM According to P4HB Enrollment and Service Use for 2011 through 2022

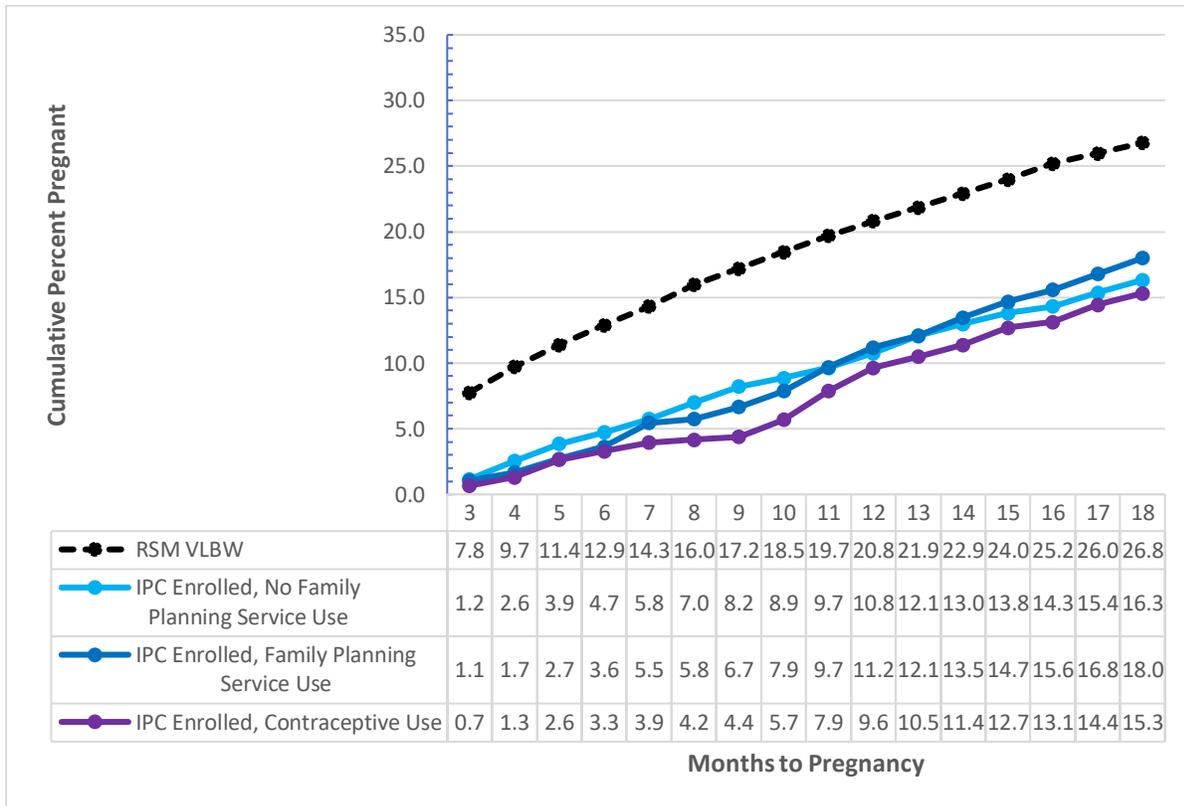


A full 8% of the RSM women who choose not to enroll have a very short interpregnancy interval of 6 months or less; in comparison, < 3.0% of those enrolling in P4HB with family planning service use and only 1.9% of those enrolling and using contraceptives have this very short interval. The percentage with a repeat pregnancy within one year is more than halved (from 15.4% to 7.0%) for women enrolling and using contraceptive services within the FP only component of P4HB. By 18 months 21.7% of the RSM not enrolling in P4HB are again pregnant and back in the Medicaid program. Among those enrolling, this is lower at 13% while among those enrolling and using contraceptives, it is lower still at 12.3%.

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 5**) and RM only enrollees (**Chart 6**) 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.

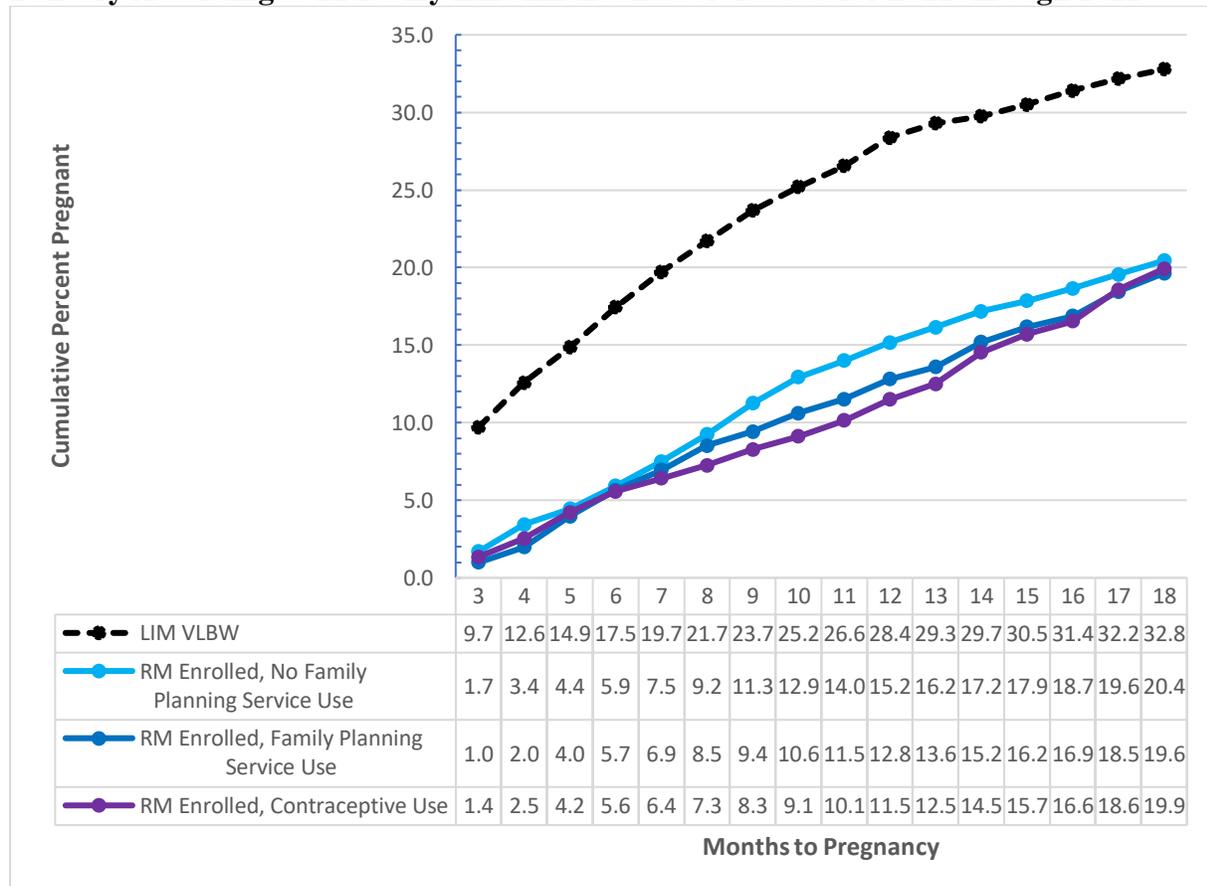
Chart 5. Cumulative Months to Subsequent Pregnancy for Women Who Recently Delivered a VLBW Infant on RSM According to IPC Enrollment and Service Use for 2011 through 2022



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 13% (**Chart 5**). This compares to less than 4% of those enrolling and using any family planning service and 3.3% 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 20.8% and was almost half at 11.2% among users of any family planning service. Among those enrolling and using contraceptives the percentage returning within 12 months was <10%. Within 18 months of the index VLBW delivery, almost 27% of non-enrollees had a repeat pregnancy on Medicaid while only 15.3% of those enrolling and using contraceptives did so.

In **Chart 6** 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 the IPC women at 17.5%. This compares to 5.9% for those enrolling and not using family planning services, 5.7% for those enrolling and using family planning services, and 5.4% 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 28.4%) compared to those enrolling and using family planning services (12.8%) and in particular, those enrolling and using contraceptives (11.5%). Within 18 months of the index VLBW delivery, almost 33% of non-enrollees had a repeat pregnancy in Medicaid, compared to ~20% of those enrolling, whether using or not using services.

Chart 6. Cumulative Months to Subsequent Pregnancy for LIM Women with VLBW Delivery According to RM Only Enrollment and Service Use for 2011 through 2022



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 from *Women's Health Issues* in an article entitled "Effects of Georgia's Medicaid Family Planning Waiver on Pregnancy Characteristics and Birth Outcomes" (4).

IPC Enrollees. 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 earlier² 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).

In **Table 6**, we show the receipt of services and contraceptive use by IPC and RM only women with evidence of chronic conditions in their first 90, 180 and 360 days postpartum.

Approximately half (48% to ~54%) of IPC and RM only women with chronic or gestational hypertension or diabetes delivering in 2022 and continuously enrolled through one year, receive a postpartum visit. Their receipt of cervical cancer screening (23% to ~28%) and dental care (~10% to ~17%) is 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 ~17% 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.

Table 6. Receipt of Post-Partum Visit and Interpregnancy Care Services among IPC and RM only Women with VLBW Delivery Enrolling through 2022 and Evidence of Chronic Hypertension or Diabetes Mellitus or Gestational Hypertension or Diabetes

	IPC			RM Only		
	Delivery to 90-Days Post (RSM)	Delivery to 180-Days Post (IPC)	Delivery to 360-Days Post (IPC)	Delivery to 90-Days Post (RSM)	Delivery to 180-Days Post (RM)	Delivery to 360-Days Post (RM)
N Continuously Enrolled in Medicaid	691	524	435	862	803	754
Postpartum Service						
Postpartum care	48.0%	48.5%	49.7%	52.6%	53.2%	54.1%
Receipt of cervical cancer screening	12.0%	13.2%	23.2%	13.1%	16.7%	27.7%
Family planning	7.1%	9.7%	14.0%	8.8%	12.0%	16.6%
Dental care**	5.8%	7.3%	9.7%	5.3%	8.6%	16.6%
Any diabetes or hypertension related service	78.1%	75.8%	78.6%	79.2%	80.7%	83.7%
Any mental health or substance abuse related service	19.7%	22.9%	26.4%	24.1%	29.3%	38.2%
Telehealth Visit	0.6%	1.0%	1.1%	2.2%	4.4%	7.3%
Contraceptive Method						
Tier 1	23.0%	24.6%	26.2%	26.6%	29.5%	31.3%
Tier 2	23.0%	26.1%	29.1%	21.8%	22.5%	25.2%
Tier 3/4	0.1%	0.2%	0.2%	0	0.1%	0.3%
Tier Unspecified	0.9%	1.1%	2.1%	1.5%	1.9%	2.4%
Any Method	47.0%	52.1%	57.7%	49.9%	54.0%	59.0%
Subsets of Tier 1						
LARC	11.7%	12.2%	14.0%	11.7%	13.3%	15.1%
Sterilization	11.3%	12.4%	12.2%	14.8%	16.2%	16.2%

**Denominator is IPC, RM only women with delivery of VLBW infant and enrolling in demonstration years 2011 through June 2020.

Contraceptive Tiers have been identified in other tables in this report. Tier 1, 2, 3/4, and Unspecified are mutually exclusive. If claims for more than one type during post-partum period, categorized into most effective method. ** Dental care includes those services covered for IPC and RM only women.

Receipt of services for the management of and/or screening for chronic conditions is also high. Among women with chronic or gestational hypertension or diabetes, approximately 79% to 84% 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 26% and among RM only women, was 38%.

Again, we do not have information on the need for these types of services among these women but the utilization among the IPC and in particular, the RM only women did increase 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 ~47% to almost 50% in the first 90 days. We see again, an increase in the use of any contraceptive method the longer these women are enrolled in Medicaid postpartum. For the IPC women, this increase was from 47% to ~58% and for the RM only women the increase was from ~50% to almost 59%. By 360 days post-delivery the RM only enrollees were more likely to be using Tier 1 contraceptives (~31%) than were the IPC enrollees (~26%). Within Tier 1, the IPC and RM only women were similar in their use of LARCs at ~14-15% while RM only enrollees with evidence of chronic or gestational hypertension or diabetes had higher rates of sterilization (~16%) than the IPC enrolled women (~12%).

Case Management for IPC/RM Enrollees. 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. For this 2023 Annual Report we report on all four quarters of 2023, which all use the updated reporting template (that went into effect Q4 2022).

Table 7 shows the percentage of IPC or RM only enrollees who were assigned a Resource Mother overall and by CMO. Among the 2743 individuals enrolled in either IPC or RM only across all CMOs for Q1-Q4 2023, 1207 (44%) were assigned to a Resource Mother, while 1536 (56%) were not assigned. There was substantial variability in assignment of a Resource Mother across the three CMO, with a far higher percentage (84%) for Peach State compared to the other two CMOs (30% for Amerigroup, 16% for CareSource). There was also some variability in assignment of a Resource Mother according to whether the woman was enrolled in IPC (510/1081 = 47%) or RM only (697/1662 = 42%).

Table 7. Assignment of Resource Mother (Q1-Q4 2023) by Medicaid Care Management Organization

Assignment of Resource Mother	Medicaid Care Management Organization			TOTAL
	Amerigroup	CareSource	Peach State	
	N=482	N=1205	N=1056	
Yes	145 (30%)	196 (16%)	866 (82%)	1207 (44%)
No	337 (70%)	1009 (84%)	190 (18%)	1536 (56%)
Missing/Blank	0	0	0	0

In addition to reporting on whether IPC or RM only enrollees 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 and whether a problem list or care plan was documented at that encounter. *Of note, this variable was reported only for enrollees who were assigned a Resource Mother.* As shown in **Table 8**, among the 1207 individuals enrolled in either IPC or RM only and who were assigned a Resource Mother across all CMOs, a total of 282 (23%) had at least one documented encounter. There was substantial variation in having any documented encounter with a Resource Mother across the three CMOs, with the highest rate for CareSource (83%), and comparatively lower rates for Amerigroup (31%) and Peach State (8%). For Q1-Q4 2023, there was some variability in having a documented encounter with a Resource Mother among those assigned a Resource Mother according to whether the woman was enrolled in IPC (83/510 = 16%) or RM only (199/697 = 29%).

Among the 282 IPC or RM only enrollees who were assigned a Resource Mother and for whom a Resource Mother encounter was documented all 282 (100%) had a documented primary problem and a corresponding care plan (also shown in **Table 8**). 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 8. Documentation of Resource Mother Encounter, Problem and Care among Interpregnancy Care or Resource Mother Only Enrollees Assigned a Resource Mother by Medicaid Care Management Organization

Resource Mother Documentation	Medicaid Care Management Organization			TOTAL
	Amerigroup	CareSource	Peach State	
	N=145	N=196	N=866	
In-person or phone encounter	46 (32%)	163 (83%)	73 (8%)	282 (23%)
Among those with an in-person or phone encounter				
Problem List – problem type	46 (100%) Service coordination – 11 Child health care – 8 Blood pressure self-mgmt – 4 Contraception – 4 Overall health – 4 Mental health care – 3 Primary health care – 3 Behavioral health care – 3 Dental care – 2 Diabetes self-mgmt – 2 Unknown - 1	163 (100%) Primary health care – 78 Mental health care – 19 Dental care – 18 Peer support – 13 Service Coordination – 9 Blood pressure self-mgmt – 7 Education – 5 Contraception – 3 Overall health – 2 Parenting support – 1 Behavior health care – 1 Child health care – 1 Unknown - 6	73 (100%) Primary health care - 35 Service coordination – 10 Mental health care - 6 Child health care – 5 Dental care – 4 Blood pressure self mgmt – 3 Coaching/Peer support – 2 Contraception – 2 Unknown – 6	282 (23%)
Care Plan Goal – goal type	46 (100%) Community resources – 10 Development milestones – 4 Medication adherence – 4 Keep appts – 4 Keep appts for children – 3 Learn about hypertension – 3 Healthy behaviors – 3 Choose contraception – 2 Using contraception - 2 Scheduling medical appt – 2 Seek substance treatment – 3 Exercise plan – 1 Transportation – 1 Scheduling mental health – 1 Scheduling dental appt – 1 Scheduling child appt – 1 Unknown - 1	163 (100%) Scheduling medical appt – 58 Keep appts – 29 Scheduling dental appt – 18 Service coordination – 8 Community resources – 7 Learn about hypertension – 5 Scheduling mental health – 5 Healthy behaviors - 3 Workforce training – 3 Using contraception - 3 Self-assess symptoms – 2 Choose contraception – 1 Smoking cessation – 2 Medication adherence – 2 Learn breastfeeding – 1 Coaching support – 1 Apply for nutrition assist – 1 Transportation – 1 Scheduling child appt – 1 Parenting resources – 1 Unknown – 6	73 (100%) Schedule medical appt – 24 Other/Unknown – 16 Keep medical appt – 7 Schedule dental health - 5 Schedule dental appt – 4 Community resources - 4 Apply for nutrition assist – 3 Arrange transportation – 2 Choose contraceptive – 2 Self-assess symptoms – 1 Develop exercise plan – 1 Discuss milestones – 1 Learn about HTN – 1 Healthcare navigation – 1 Coaching support – 1 Unknown – 0	282 (23%)

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 5**) we showed descriptive differences in the percentage of women in the 2011-2022 IPC enrollee cohort versus the RSM/VLBW comparison

cohort with repeat pregnancies in 18 months or less. In **Table 9** below we first test whether these differences are statistically significant. They are all significant ($p < .01$).

In **Table 9** 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 9. 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 2011-2022 N = 2,817	RSM – VLBW 2011-2022 N = 6,658
Pregnant within 6 months	126 (4.5%)	796 (12.0%) ^^^
Pregnant within 12 months	306 (10.9%)	1,381 (20.7%) ^^^
Pregnant within 18 months	471 (16.7%)	1,816 (27.3%) ^^^
	N = 2,735*	N = 6,335*
Delivery within 18 months	241 (8.8%)	1,102 (17.4%) ^^^
Very Low Birth Weight (<1500 g)	22 (9.1%)	83 (7.5%)
Low Birth Weight (1500-2499 g)	42 (17.4%)	189 (17.2%)
Normal Birth Weight (≥ 2500 g)	119 (49.4%)	497 (45.1%)
Unknown Weight	58 (24.1%)	333 (30.2%)
Fetal Deaths	29 (12.0%)	167 (15.2%)
Still Births	12 (5.0%)	40 (3.6%)
Adverse Delivery Outcome**	105 (3.8%)	479 (7.6%) ^^^

*IPC and RSM-VLBW index deliveries through 06/30/2022 **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 codes O03 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 10** below.

Table 10. 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	-12.52 ^{^^^}
Repeat Delivery within 18 Months after Index Delivery	-9.46 ^{^^^}
Adverse Delivery Outcome within 18 months after Index Delivery	-4.14 ^{^^^}

[^] 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) 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.

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

Outcome: **Table 11** shows the total capitated payments made to the CMOs for the FP only, IPC and RM only components in 2023. In contrast to the slower growth and declines in some components of P4HB during 2022, the growth in the FP and IPC components of P4HB in 2023 could lead to a growth in total capitated payments to the CMOs. While there is some growth the totals, they were fairly stable from the last half (~\$11.0 million) of 2022. As shown in **table 12**,

total payments to CMOs for all three components was just over \$22 million by the end of 2023 compared to the total of \$21.4 million at the end of 2022.

Table 11. P4HB Capitation Payments First and Second Half and Total, 2023

Program	1st Half Year (1/1/23-6/30/23)		2nd Half Year (7/1/23-12/31/23)		Total \$ in 2023	
	\$	%	\$	%	\$	%
FP Only	\$10,238,496	94.5%	\$10,702,880	94.5%	\$20,941,375	94.5%
IPC	\$183,398	1.7%	\$322,597	2.8%	\$505,995	2.3%
RMOC	\$408,721	3.8%	\$296,388	2.6%	\$705,109	3.2%
Total	\$10,830,615	100.0%	\$11,321,865	100.0%	\$22,152,479	100.0%

Source Georgia Department of Community Health, MMIS (Medicaid management Information System) Reports MGD-3610-W (MCHB Payment Activity Report), Covers January- December 2023, 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 ~95% 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 half a million; the total for the FP only component at the end of 2022 was almost \$21 million.

In contrast to 2022, capitated dollar payments for the IPC only component of P4HB grew over the first to second half of 2023 by 75% from ~\$184 thousand to ~\$323 thousand, consistent with the growth in enrollment in this component. The IPC capitated payments equaled \$505,995 by the end of the year accounting for only 2.3% of the total. While capitated payments for women in the RM only component of P4HB were just over \$1 million by the end of 2022 program year they stood at \$705,109 at the end of 2023 and accounted for 3.2% of the total \$22 million paid to CMOs in 2023.

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 nineteen waves. The most recent wave of the member survey was conducted from September through November of 2023. Members identified by the CMOs were contacted by internet, mail, and phone for the survey (9,000 participants). Of the 9,000 program participants contacted, 413 (4.6%) responded to the survey. The section below provides a summary of the responses from the two most recent waves of the CMOs' member survey (18th and 19th).

CMO Member Survey Results

In this most recent 19th wave, each CMO selected a random sample of 3,000 members for a total of 9,000 members that met the selection criteria for inclusion in the survey. The rate of participation in the member survey across the three CMOs was 4.6% for wave nineteen. For the 19th wave, the member response rates were: 5.5% (165/3,000) for Peach State, 4.2% (127/3,000) for Amerigroup, and 4.0% (121/3000) for CareSource. As before, we note these response rates are far below the desired level of participation.

Table 12 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 (~43% and ~39% in waves 18 and 19, 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 (~28% and ~21% in waves 18 and 19, respectively). Less commonly reported problems were in accessing testing or treatment for sexually transmitted infections (~26% and ~20% in waves 18 and 19, respectively) and pregnancy testing (~19% and ~11%, 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 (~54% and ~48% in waves 18 and 19, respectively), did not have to use their own money for family planning (~39% and ~42% in waves 18 and 19, respectively), and started using a method of birth control (~36% and ~32% in waves 18 and 19, respectively). In addition, a substantial percentage reported that they began going to a different doctor or nurse for family planning services (~23% and 24% in waves 18 and 19, respectively) or to a different doctor or nurse for primary care (~30% and ~34% 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 12. Enrollment and Utilization of Services in P4HB[®]		
	18th Wave N=308 Responses n (%)	19th Wave N=413 Responses n (%)
Before enrolling in P4HB[®], had trouble getting...		
Birth control or family planning services	87 (28.2%)	86 (20.8%)
Pregnancy testing	58 (18.8%)	47 (11.4%)
Testing or treatment for sexually- transmitted infections	79 (25.6%)	82 (19.9%)
Primary care (such as routine check-up, care for an illness) (Purple Card)	131 (42.5%)	161 (39.0%)
Other (Getting Basic Care, Specialized/Other Medical services, OB-GYN/Pregnancy Related Services, Affordability/Cost)	33 (10.7%)	53 (12.8%)
Changes P4HB[®] made for the participant...		
I am going to a different doctor or nurse for family planning services or birth	72 (23.43%)	99 (24.0%)
I am going to a different doctor or nurse for primary care	92 (29.9%)	141 (34.1%)
I have started using a birth control	110 (35.7%)	131 (31.7%)
I have changed the birth control method I use	57 (18.5%)	69 (16.7%)
I have more choices of birth control methods	166 (53.9%)	199 (48.2%)
I do not have to use my own money for family planning services or birth control	120 (39.0%)	172 (41.6%)
I can get preventive care (such as Pap smears) and family planning counseling	221 (71.8%)	334 (80.9%)
I am able to get care when I need it (Purple Card)	196 (63.6%)	251 (60.8%)
I am able to get the medicine I need (Purple Card)	193 (62.7%)	248 (60.0%)
Other (Cannot get usable services, Medications / Vitamins Not Covered)	17 (5.5%)	28 (6.8%)

Table 13 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 (~22% and ~28% in waves 18 and 19, 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 13. Problems Encountered by Members Enrolled in P4HB®		
Problems Under P4HB®	18th Wave N=308 Responses n (%)	19th Wave N=413 Responses n (%)
I cannot get the family planning services I want	55 (17.9%)	87 (21.1%)
I cannot get referrals or follow-up for care I need	50 (16.2%)	89 (21.5%)
I cannot find a doctor or nurse willing to take P4HB clients	67 (21.8%)	115 (27.8%)
I do not want to leave my current doctor or nurse	57 (18.5%)	68 (16.5%)
I must wait too long to get services	48 (15.6%)	84 (20.3%)
I do not have transportation	30 (9.7%)	40 (9.7%)
I cannot get to the doctor or nurse when they are open	29 (9.4%)	45 (10.9%)
My P4HB doctor or nurse will not prescribe the birth control method I want to use	27 (8.8%)	33 (8.0%)
Other (OB-GYN/Related Services Not Covered, Does Not Cover Other Medical Services)	24 (7.8%)	50 (12.1%)

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 14**). 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 (~70% and ~62% in survey waves 18 and 19, respectively), whether they use male or female condoms to prevent STIs (~66% in survey waves 18 and 19), their sexual practices (~55% and ~53% in survey waves 18 and 19, respectively) and if they had been asked about their plans for having or not having children in the future (~56% and ~54% in survey waves 18 and 19, respectively). However, only about 36-37% report that their doctor or nurse asked them about their thoughts or plans about timing or spacing of pregnancies in the two most recent waves of the survey.

Table 14. Provider Inquiry about Reproductive Health Topics during Encounters		
Reproductive Health Topic	18th Wave N=308	19th Wave N=413
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	173 (56.2%)	223 (54.0%)
Your thoughts or plans about timing or spacing pregnancies	113 (36.7%)	147 (35.6%)
Your sexual practices	170 (55.2%)	219 (53.0%)
The use of birth control to prevent or space pregnancies	215 (69.8%)	257 (62.2%)
The use of male or female condoms to prevent sexually transmitted infections	204 (66.2%)	274 (66.3%)

Participants were asked how they heard of the P4HB program with responses shown in **Table 15**. The most frequent source of information about the P4HB program was the health department (~59% and ~62% in survey waves 18 and 19, respectively), followed by the P4HB letter from the health plan (~37% and ~46% in survey waves 18 and 19, respectively), the providers office (~26% and ~32% in survey waves 18 and 19, respectively) and others (~23%), and through a flyer or advertisement (~16%).

Table 15. How Did You Hear of the P4HB Program		
	18th Wave N=308	19th Wave N=413
Health Department	181 (58.8%)	255 (61.7%)
Providers Office	80 (26.0%)	134 (32.4%)
P4HB Letter from your health plan	114 (37.0%)	189 (45.8%)
Flyer / Advertisement	48 (15.6%)	65 (15.7%)
Other (Online, Gateway, Family Members, Auto Enrolled, DFCS)	70 (22.7%)	94 (22.8%)

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 16** indicates that ~67% of respondents were highly satisfied with P4HB, whereas 21% had moderate satisfaction, and 11% had low satisfaction during the two most recent waves of the survey.

Table 16. How Satisfied Are You With The P4HB Program?		
	18th Wave N=308	19th Wave N=413
Missing	4 (1.3%)	8 (1.9%)
Low Satisfaction (0-3)	33 (10.7%)	44 (10.7%)
Medium Satisfaction (4-7)	64 (20.8%)	88 (21.3%)
High Satisfaction (8-10)	207 (67.2%)	273 (66.1%)

The final question asked on survey wave nineteen was how the P4HB program could be improved. The most common responses were (communication issues, availability of providers, benefits issues/access to care improvement).

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 the prior semi-annual report; comparisons for two years prior (January – June and July-December 2021 & 2022) and for the current reporting period (January-June and July- December 2023) are reported.

Table 17 - Disenrollment, Denial of Service & Provider Claim Counts, 2021-2023			
Reporting Period	Disenrollment	Denials of Service	Provider Claims
Jan-June 2021	84	104,833	32,096
Jan-June 2022	308	87,498	33,710
Jan-June 2023	551	92,318	37,212
July-Dec 2021	421	87,242	32,606
July-Dec 2022	574	85,967	35,046
July-Dec 2023	498	99,277	39,069

The data in the top rows of **Table 17** include the reporting period, January-June 2023. The pattern in disenrollment of clients in the first six months of each of the years is mixed. The low level of 84 total disenrollments in January-June of 2021 may reflect the Covid-19 extension of eligibility for Medicaid enrollees but the increase in disenrollment to 308 Jan-June of 2022 is not consistent with the continued extension of eligibility. The disenrollments increased again the Jan-June of 2023 to 551. In the latter part (July-December) of 2022 and 2023 there were large and increasing numbers of disenrollment with a total of 421 disenrollments in the last six months of 2021 and an even higher total of 574 in the July-December 2022 period. In the most recent period, July -Dec 2023, the number of women disenrolled declined to 498 from the 551 in the first part of 2023.

Denials of service stood at 104,833 in the Jan-June 2021 period but this declined markedly to 87,242 in the July-December months of 2021. The denials in the Jan-June periods of 2022 and 2023 were also lower than the 104,833 Jan-June 2021 total, ending at 92,318. For both 2021 and 2022 the denials in the second part of the year were lower than in the Jan-June period. However, denials in the July-Dec period of 2023 were higher at 99, 277 than the total in the Jan-June period of 2023. 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 do show an increased from 32,606 in 2021 to 39,069 in 2023.

Table 18 - Grievances Count By CMO 2021-2023

P4HB Grievance Count by CMO				
Reporting Period	Amerigroup	CareSource	Peach State/WellCare	Total
Jan-June 2021	21	2	15	38
Jan-June 2022	19	8	7	34
Jan-June 2023	31	10	5	46
Average 1st Half of Each Year	23.7	6.7	9.0	39.3
July-Dec 2021	13	13	9	35
July-Dec 2022	24	9	15	48
July-Dec 2023	41	13	15	69
Average 2nd Half of Each Year	26.0	11.7	13.0	50.7
Total (P4HB)	149	55	66	270

We discuss the data in **Table 18** on counts of grievances overall and by CMOs and discuss the following comparisons:

- July-December 2022 compared to July-December 2021; and
- January-June 2022 compared to January-June 2021.

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 26.0 with the numbers increasing from 13 in July-Dec 2021 to 41 in July-Dec 2023. In the Jan-June periods of these years the average of 23.7 grievances reflects an increase from 21 in Jan-June of 2021 to 31 in the Jan-June 2023 period. The bulk of the total 270 grievances were reported for Amerigroup (149) compared to lower counts for CareSource (55) and Peach State/WellCare (66) in 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 than 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.

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