

Annual Report

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

1115 Demonstration in Georgia

January-December 2024

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**

July 01, 2025

TABLE OF CONTENTS

| | | |
|-------------|--|-----------|
| I. | Summary and Background..... | 3 |
| | Demonstration Goals & Objectives | 4 |
| | Key Accomplishments | 5 |
| II. | Operational Updates..... | 6 |
| | Unexpected Trends-COVID-19 | 6 |
| | Unanticipated Trends | 6 |
| | Legislative Updates..... | 6 |
| | Public Forum..... | 7 |
| III. | Performance Metrics | 7 |
| | Impact of the Demonstration | 7 |
| | Objectives and Performance Metrics | 8 |
| IV. | Summary of Member Surveys..... | 32 |
| | Member Surveys | 33 |
| V. | Budget Neutrality and Financial Reporting..... | 37 |
| | 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 | 37 |
| VI. | Disenrollment, Denial of Service & Provider Claim Counts | 37 |
| | Disenrollment, Denials and Provider Claims..... | 38 |
| | Grievances..... | 39 |
| VII. | Evaluation Activities & Interim Findings..... | 40 |
| | Interim Evaluation Report in 2022 | 40 |
| | Objective: Decrease late teen pregnancies by reducing the number of first or repeat teen births among Medicaid eligible women ages 18-19 year | 43 |
| | Outcome and Interim Findings | 43 |
| | REFERENCES..... | 44 |

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.

Note: The content of this report is based on updated data for Table 2 (CMO enrollment growth), Charts 1-3 (CMO Enrollment by program), Table 3 (CMO outreach and activity), Tables 7-9 (RM only tables), Table 12 (Financials), Tables 13-17 (CMO Member Surveys), Table 18 (Disenrollment, denial of Service, provider Claims) and Table 19 (Grievances by CMO). The content of the remaining tables will be updated upon receipt and analysis of updated claims and enrollment data from the Georgia DCH and DPH. This will include Table1 (Enrollment of P4HB eligible population), Tables 4-6 (Use of family planning, contraceptive services and post-partum visits), Charts 4-6 (Cumulative months to pregnancy among P4HB, IPC and RM only enrollees), Table 10 (Number and percent with repeat pregnancy, IPC eligible) and Table11 (Differences in probability of adverse outcomes).

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.
- Based on Medicaid enrollment and claims data, 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 2022 (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 implementation of the Affordable Care Act in 2014 which provided other options for insurance. Specifically, those in Georgia Medicaid in the post- period compared to the pre-P4HB period were older and more likely living in impoverished census tracts. 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.

Based on findings from the Georgia PRAMS analysis key accomplishments are:

- 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 when compared to a similar group in states without a change in their family planning policies. The effect on VLBW births was concentrated among Georgia’s non-Hispanic Black mothers (who disproportionately experience VLBW deliveries).

Key Accomplishments in Reporting Period – This section will be completed upon receipt and analysis of the updated claims and enrollment data from the Georgia DCH and DPH.

II. Operational Updates

Unexpected Trends –COVID-19 Public Health Emergency (PHE). As stated in prior reports, 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. The 2023 data indicated the percent of women eligible in the community enrolling in P4HB increased slightly from the prior year, to 38%. (Enrollment data for 2024 will be updated later this year.) RSM and other women with a delivery on Medicaid retained full Medicaid benefits under the PHE and hence, there was little enrollment of women in Georgia’s RSM with a recent delivery of a very low birth weight infant into the IPC component of Georgia’s P4HB waiver. While women in all Medicaid eligibility categories in Georgia had lengthy postpartum extensions as a result of the PHE, they may not have been aware of their continued coverage.

Unanticipated Trends. Throughout the demonstration the enrollment of eligible women in the community into the FP only component has unexpectedly lagged behind the projections set forth in the original concept of P4HB. This has likely moderated the potential effects of the waiver on the goal of reducing VLBW infants. While based on *claims data*, implementation of P4HB was not associated with overall reductions in LBW and VLBW births in Georgia, recent work using the Pregnancy Risk Assessment Monitoring System (PRAMS) data indicates a reduction in VLBW especially among non-Hispanic Black mothers in Georgia, compared to states without a similar policy change.

Legislative Updates. Governor Kemp had declared a PHE (March 14, 2020) under which all Medicaid enrollees retained their eligibility status until the end of the emergency. As in other states, there were several extensions of Georgia’s PHE. Governor Kemp declared and renewed the Economic State of Emergency continuously through April 2022 via various Executive Orders (January 18, 2022, February 18, 2022, and March 21, 2022) to keep the PHE extended through October 13, 2022. The PHE ended officially on May 11, 2023.

Disenrollment of women retained in each Medicaid eligibility category under the PHE began in Georgia on April 1, 2023. The state created a website, for enrollees seeking news and resources regarding eligibility. Enrollees were encouraged to work through their Gateway accounts to make sure that their information was up to date, including phone number, address, job or income, and number of people in their household. Recipients were also encouraged to select "Email" notifications for the fastest alerts. States were initially required to submit monthly unwinding data to CMS and this has been continued. Based on Kaiser Family Foundation (KFF) reporting through September 2024, of those in Georgia with a completed renewal, over half (55%) were renewed while 45% were terminated. Georgia's Medicaid enrollments declined from March 2023 to November 2024, but enrollment in November 2024 was still up 6% from enrollment in February 2020, just prior to the PHE.

Public Forum. On Wednesday, August 14, 2024, the State afforded the public the opportunity comment on the P4HB demonstration during a virtual Medical Care Advisory Committee (MCAC) meeting on Microsoft Teams. The state posted a public notice of the post-award forum to its website on Thursday, July 11, 2024, with a copy of the most current P4HB Annual Report. There was one comment which was summarized and addressed during the meeting.

On May 10, 2024, the Centers for Medicare & Medicaid Services (CMS) published the 2024 Access Final Rule establishing requirements for states to operate Medicaid Advisory Committee (MAC) and Beneficiary Advisory Council (BAC). These newly required MACs build off the state's existing required MCAC. The next public forum will be held during the new MAC meeting in July 2025.

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 2022 and 2023 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 ≤ 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 ≤ 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 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) and for consistency with the earlier parts of this report, use a denominator⁴ that 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. 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

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

footnote to **Table 1**) enrolled in the FP only component from 68% in 2022 to 69.7% in 2023.

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 in earlier reports, 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 2024

| ENROLLMENT BY CMO AND AGE GROUP FOR Q1-Q4 2024 | | | | | | | | | | | | |
|--|------------|---------|--------|------------|---------|--------|------------|---------|--------|---------|---------|--------|
| | Amerigroup | | | Caresource | | | Peachstate | | | Overall | | |
| | Q1 2024 | Q4 2024 | Growth | Q1 2024 | Q4 2024 | Growth | Q1 2024 | Q4 2024 | Growth | Q1 2024 | Q4 2024 | Growth |
| Family Planning Only | | | | | | | | | | | | |
| 18-20 | 1245 | 1158 | -7.0% | 1028 | 866 | -15.8% | 1779 | 1379 | -22.5% | 4052 | 3403 | -16.0% |
| 21-44 | 17551 | 17645 | 0.5% | 16091 | 11308 | -29.7% | 24933 | 19171 | -23.1% | 58575 | 48124 | -17.8% |
| Total | 18796 | 18803 | 0.0% | 17119 | 12174 | -28.9% | 26712 | 20550 | -23.1% | 62627 | 51527 | -17.7% |
| % Total | 30.0% | 36.5% | | 27.3% | 23.6% | | 42.7% | 39.9% | | | | |
| Inter-Pregnancy Care | | | | | | | | | | | | |
| 18-20 | 6 | 6 | 0.0% | 3 | 2 | -33.3% | 7 | 7 | 0.0% | 16 | 15 | -6.3% |
| 21-44 | 89 | 102 | 14.6% | 95 | 49 | -48.4% | 175 | 112 | -36.0% | 359 | 263 | -26.7% |
| Total | 95 | 108 | 13.7% | 98 | 51 | -48.0% | 182 | 119 | -34.6% | 375 | 278 | -25.9% |
| % Total | 25.3% | 38.8% | | 26.1% | 18.3% | | 48.5% | 42.8% | | | | |
| Resource Mother Outreach | | | | | | | | | | | | |
| 18-20 | 4 | 5 | 25.0% | 1 | 1 | 0.0% | 3 | 2 | -33.3% | 8 | 8 | 0.0% |
| 21-44 | 41 | 42 | 2.4% | 66 | 44 | -33.3% | 90 | 70 | -22.2% | 197 | 156 | -20.8% |
| Total | 45 | 47 | 4.4% | 67 | 45 | -32.8% | 93 | 72 | -22.6% | 205 | 164 | -20.0% |
| % Total | 22.0% | 28.7% | | 32.7% | 27.4% | | 45.4% | 43.9% | | | | |
| All Programs | | | | | | | | | | | | |
| 18-20 | 1255 | 1169 | -6.9% | 1032 | 869 | -15.8% | 1789 | 1388 | -22.4% | 4076 | 3426 | -15.9% |
| 21-44 | 17681 | 17789 | 0.6% | 16252 | 11401 | -29.8% | 25198 | 19353 | -23.2% | 59131 | 48543 | -17.9% |
| Total | 18936 | 18958 | 0.1% | 17284 | 12270 | -29.0% | 26987 | 20741 | -23.1% | 63207 | 51969 | -17.8% |
| % Total | 30.0% | 36.5% | | 27.3% | 23.6% | | 42.7% | 39.9% | | | | |

While 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 the data in **Table 2** shows marked declines in enrollment in this and all other components of P4HB over Q1 to Q4 2024. Across all components of P4HB there was almost an 18% decline in enrollment over this period. The decline started in Q3 of 2024 as total enrollment declined 5.5% from 63,777 to 60,251 and continued through Q4 to end at 51,969. These declines reflect the disenrollment of women retained in each Medicaid eligibility category under the PHE which began in Georgia on April 1, 2023.

Consistent with the decline in the overall program, the FP only component of P4HB declined almost 18% from 62,627 to 52,527 over Q1 to Q4 2024 while the IPC component declined ~26% from 375 to 278 over this time period. The RM only component also declined. Enrollment in this component of P4HB equaled 205 in Q1 2024 but declined by 20% to 164 by Q4 2024. Total enrollment at the end of 2024 was largest in the Peach State CMO (20,741 and ~40% of

total enrollment) followed by the Amerigroup (18,958 or ~37% of total enrollment) and CareSource CMOs (12,270 or ~24% of total enrollment).

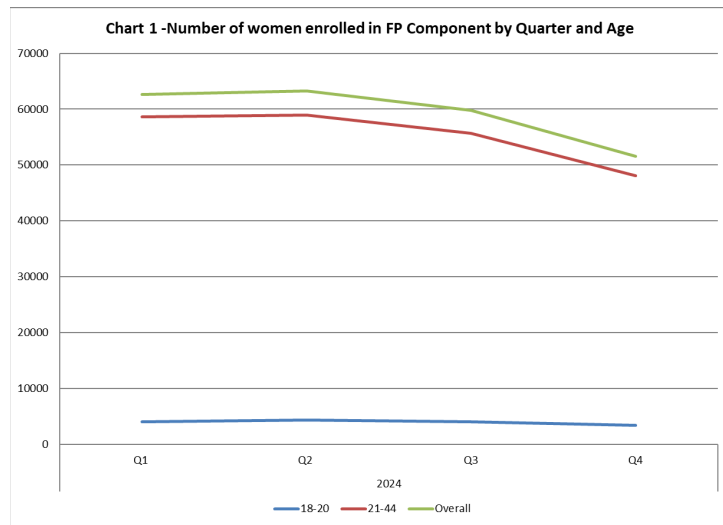
Specific to the FP only component, the decline in enrollment was similar for the two age groups; enrollment of the 18–20-year-olds declined 16% while those ages 21-44 declined almost 18%. The latter is a larger portion of the total FP only enrollment at 48, 124 out of a total 51,527 seen at the end Q4 2024. While there were declines in FP only enrollment in the Peach State (23%) and CareSource (~29%) enrollment was stable in the Amerigroup CMO over this period. In Q1 2024 enrollment in this CMO equaled 18,796 and in Q4, enrollment equaled 18,803; while there was a 7% decline in the 18–20-year age group there was a slight increase in the 21-44 age group within the Amerigroup CMO. Declines in FP only enrollment in the Peach State CMO were similar for the two age groups but within the CareSource CMO, the smallest decline was within the 18–20-year-old group (~16%) compared to the 21-44 age group which declined by ~30%. These declines are in contrast to the growth seen over the four quarters of 2023. The 2023 patterns were affected by the continuation of the PHE through May of 2023 while the 2024 patterns reflect the Medicaid disenrollment with the ending of the PHE.

Although the number of women in the IPC component of P4HB is smaller, enrollment in this component of P4HB had grown markedly over Q1 to Q4 of 2023. While this trend was also reversed in 2024, as with the FP only component, declines in enrollment only occurred within the Peach State and CareSource CMOs. Declines in Peach State's IPC enrollment equaled almost 35% while the decline within the CareSource CMO, equaled 48%. In both of these CMOs, the decline was greatest among their 21–44-year-old enrollees. Within the Amerigroup CMO there was actually an increase in IPC enrollment (~14%) and this growth was within their 21–44-year-old group of enrollees.

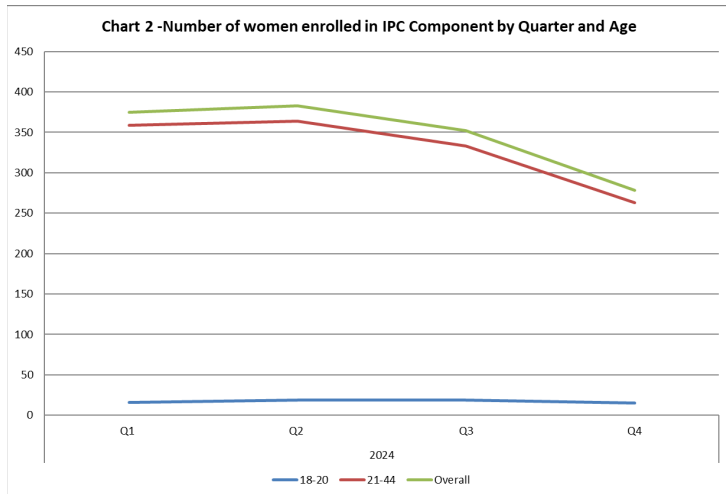
Patterns within the RM only component in 2023 were different than the other two components of P4HB with *declines* in the range of 30 to 32% over Q1 to Q4 of that year for CareSource and Peach State CMOs while there was an increase of 2.9% within Amerigroup. In the four quarters of 2024, there were declines in the RM only component of P4HB of ~23% within Peach State and ~33% within CareSource. Again, in contrast, there was a 4.4% increase in RM only enrollment within the Amerigroup CMO across the four quarters of 2024.

As noted in prior reporting, the Peach State/WellCare merger resulted in the largest percentage of all P4HB enrollees being in this CMO; this continued to hold as noted earlier. While there was a decrease in the percentage enrolled in the Peach State CMO from the first two, to the last two, quarters of 2024. The percentage enrolled in the CareSource CMO also declined from 27% to ~24% in the last two quarters of 2024 but the reverse held for the Amerigroup CMO. Here, there was an increase from 30% to ~37% of all P4HB enrollees in this CMO.

Taken together, and in contrast to the 2023 reporting period, the changes in enrollment in the FP only component of P4HB result in a downward trend as shown in **Chart 1**, starting in the second quarter of 2024. This reflects the continuing disenrollment after the end of the PHE. The overall decline was driven by the decline in the 21–44-



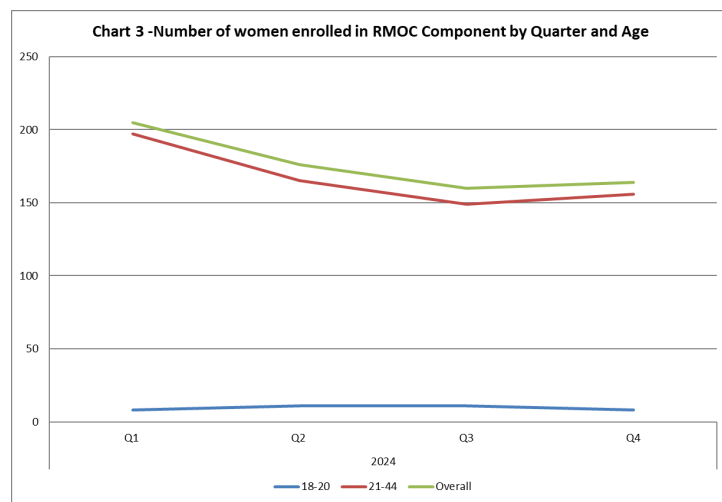
year-old age group (**Table 2**) in this component of P4HB. There may have been changes in teens’ parents’ insurance coverage or other systemic and policy changes affecting the enrollment of the 18–20-year-olds in the FP only component as the PHE ended. Indeed, there was ~81% growth in the 18–20-year-olds in the FP only component in the latter part of 2023 and subsequently, only a very slight decline for this age group seen in Chart 1 over the four quarters of 2024.



With the end of the PHE there was a stark upward trend in IPC enrollment in the last two quarters of 2023. This growth continued slightly through the first quarter of 2024. However, in the last three quarters of 2024 there was a stark decline in IPC enrollment as shown here in **Chart 2**. This decline occurred among the 21–44-year-old age group while the enrollment of the

18–20-year-olds stayed fairly stable (**Chart 2**). Since the 21–44-year-old group dominates the overall group there is an overall decline in IPC enrollment as shown in **Chart 2**.

The decline in the RM only component of P4HB of almost 32% through the end of 2023, continued into the first three quarters of 2024 as shown in **Chart 3**. The steepest decline was in the 2nd quarter of 2024 and among the 21-44 age group, which dominates (95%) total enrollment in this component of P4HB. However, this decline was



reversed in the 4th quarter last quarter of 2024 as shown in **Chart 3**; the change in this trend was again, due to the increases in the dominant 21–44-year-old group.

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

Outcome. In Table 3 we provide information received from each CMO regarding outreach activities to new and prospective FP and IPC/RM enrollees and providers for 2024 (Q1-Q4). These activities ranged from virtual and in-person events, as well as outreach delivered by “other” means, including telephone calls and mailings. While virtual events were favored by all CMOs during and immediately post-COVID-19 pandemic, most outreach activities have returned to being delivered in person and through mailings or telephone calls.

CMOs may provide qualitative, textual information about any barriers to these outreach activities as well as their strategies to overcome these barriers. Many CMOs note that barriers to delivering outreach to current members are largely due to incorrect contact information and in addition, specific lack of interest in outreach, lack of availability or competing priorities for outreach activities, and transportation barriers experienced by program enrollees. CMOs report that they are actively working to strengthen their P4HB outreach by developing more appealing marketing materials and utilizing other platforms and strategies for outreach (e.g., social media, texting outreach information). Also the CMOs strengthen their outreach campaigns and planning by partnering with local, community-based organizations that can enhance promotion of their outreach activities. The CMOs report limited barriers to delivering outreach activities/events to providers. These activities are mainly delivered virtually and through mailings and telephone calls. Some CMOs are trying to address their challenges with providers by providing advanced notice to pre-scheduled meetings, establishing lunch-time meetings to meet the providers’ availability and to improve provider outreach presentations to educate them about the scope and benefits of the P4HB program.

Access to services and their specific modes of service delivery will vary across the CMOs based on their outreach and provider networks.

Table 3: CMO Outreach and Activities, January-December 2024 (Q1-Q4)

| CMO | FP and IPC/RM Enrollees | Provider Outreach |
|-------------------|--|--|
| Amerigroup | <ul style="list-style-type: none"> • Virtual face-to-face conferencing, in-person activities/events, and activities delivered by other means (mail, calls) • Outreach activities include current FP, IPC, and RM Only members as well as prospective members. • IPC and RM-Only Outreach: 191 successful visits*; 32 linked to medical care; 30 linked to social services; 7 linked to mental health/behavior health services. • FP and IPC Outreach: 0 virtual events; 41 in-person activities delivered to 140 participants. 77 activities delivered by other means (mail, calls, etc.) to 77 participants. • Prospective Member Outreach: 2 virtual activities conducted, and 71 in-person activities conducted with a total of 1,306 prospective members. No activities conducted by other means (mail, calls, etc.) | <ul style="list-style-type: none"> • 225 virtual provider outreach activities conducted. • 5 in-person provider outreach activities conducted. • 37 provider outreach activities delivered by other means (mail, calls, etc.) |
| CareSource | <ul style="list-style-type: none"> • Virtual face-to-face conferencing, in-person activities, and activities delivered by other means (mailings) • Outreach activities include current FP, IPC, and RM Only members as well as prospective members. • IPC and RM-Only Outreach: 115 successful visits*; 55 linked to medical care; 19 linked to social services; 23 linked to mental health/behavior health services. • FP Outreach: 4 virtual activities and 0 in-person activities conducted with a total of 14 members. 16 activities delivered by other means (mail, calls) with 34, 350 members. • IPC Outreach: 4 virtual activities and 0 in-person events conducted. 29 activities delivered by other means (mail, calls, etc.) with 549 members. • Prospective Member Outreach: 0 virtual activities conducted, but 28 in-person activities conducted with 328 prospective members. No activities delivered by other means (mail, calls, etc.). | <ul style="list-style-type: none"> • Three virtual provider outreach activities conducted, and 3 in-person provider outreach activities conducted with a total of 78 providers. • Eight provider outreach activities delivered by other means (mail, calls, etc.) with 93 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) • Outreach activities include current FP, IPC, and RM Only members as well as prospective members. • IPC and RM-Only Outreach: 29 successful visits*; 188 linked to medical care; 39 linked to social services; 13 linked to mental • FP Outreach: 0 virtual outreach activities conducted but 21 in-person activities conducted with 42 total members. 4 activities delivered by other means (mail, calls, etc.) with 85 participants. • IPC Outreach: 0 virtual outreach activities but 21 in-person activities delivered to 14 total participants. 5 activities delivered by other means (mail, calls, etc.) to 62 participants. • Prospective Member Outreach: 0 virtual activities delivered, but 21 in-person activities conducted with 1,650 prospective members. Nine activities delivered by other means (mail, calls, etc.) to 13,911 prospective members. | <ul style="list-style-type: none"> • 2,885 virtual provider outreach activities and 4,644 in-person provider outreach activities conducted, with a total of 7,539 providers. • 72, 412 provider activities conducted by other means (via mail) with a total of 145, 988 providers. |

**A successful RM outreach is a face-to-face visit with the RM and the mother lasting 30 minutes or more OR a virtual/phone visit lasting 10 minutes or more*

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 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% |

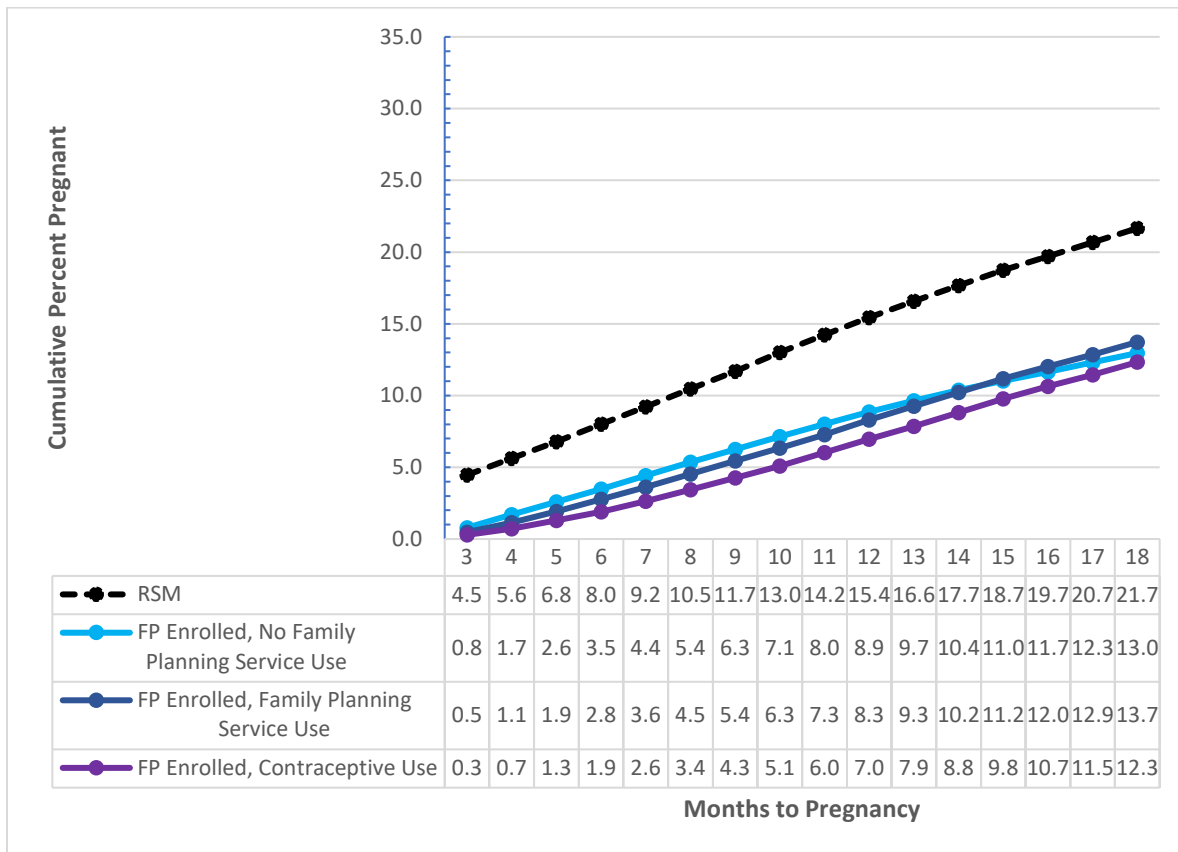
Notes: WHO Tiers of contraceptive effectiveness: Tier 1(High effectiveness): implants, intrauterine devices, sterilization; Tier 2 (Medium effectiveness): injectable methods, patch, pills, and vaginal ring; Tier 3 and 4 (Low effectiveness): condoms, diaphragms, fertility awareness methods, spermicides; 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 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) indicates 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

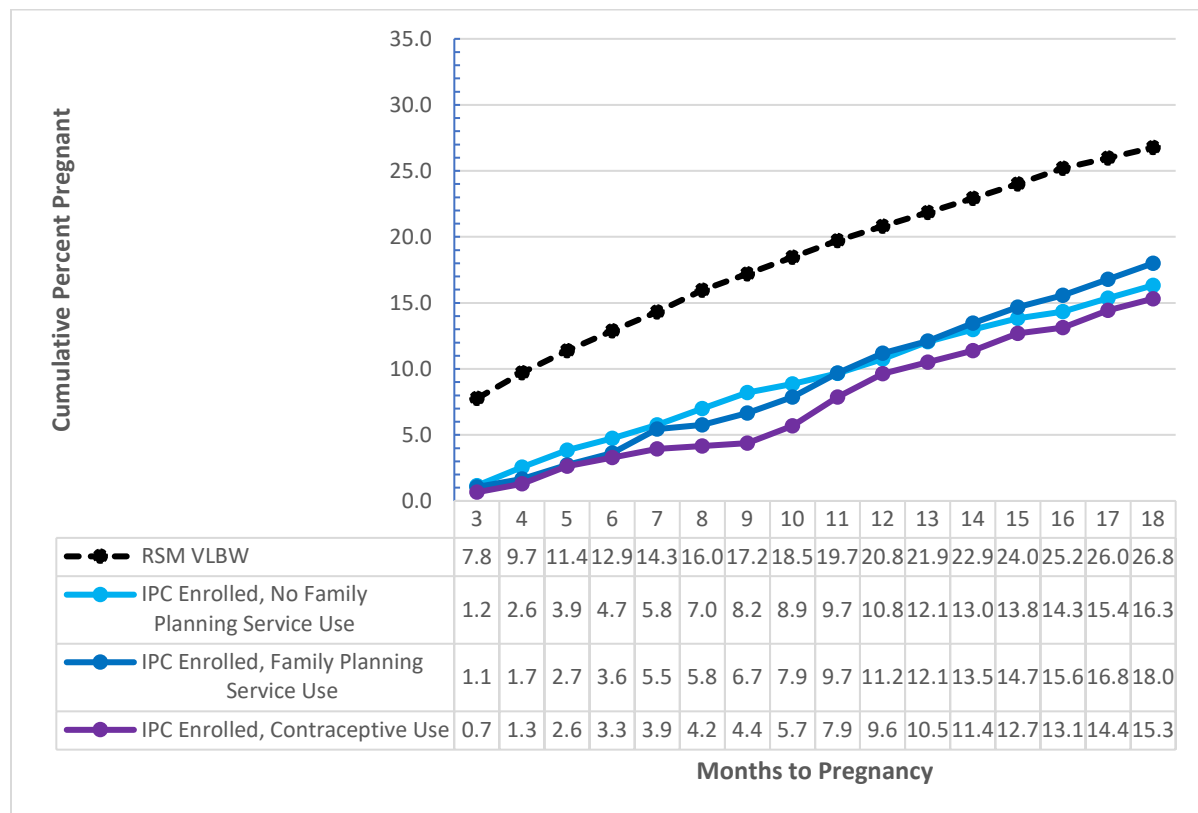


A full 8% of the RSM women who choose not to enroll have a very short interpregnancy interval of 6 months or less; in comparison, < 3.0% of those enrolling in P4HB with family planning service use and only 1.9% of those enrolling and using contraceptives have this very short interval. The percentage 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 enrolled 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.

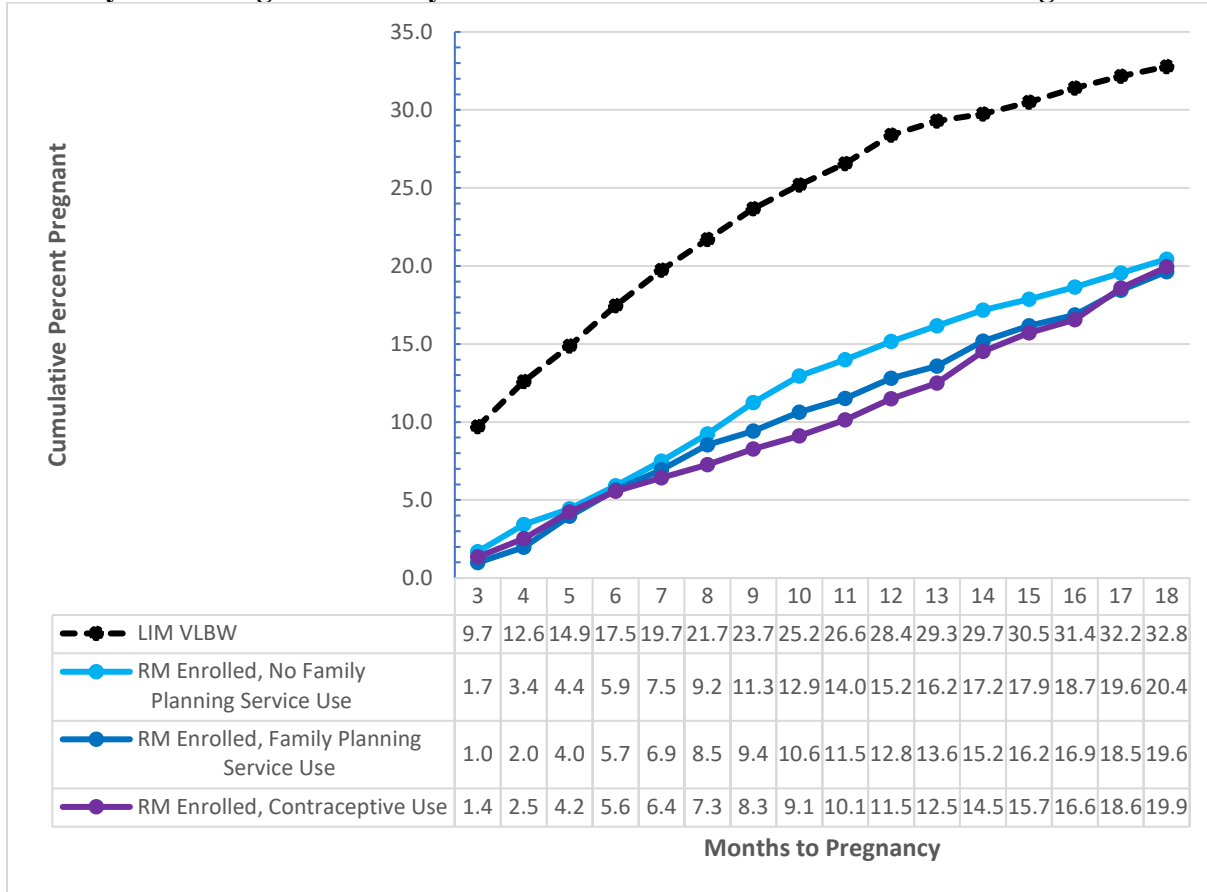
Chart 5. Cumulative Months to Subsequent Pregnancy for Women Who Recently Delivered a VLBW Infant on RSM According to IPC Enrollment and Service Use for 2011 through 2022



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"³.

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 a 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.⁴

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%).

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. Care Management Organizations (CMOs) track aspects of case management for individuals enrolled in P4HB IPC or RM only. In this report, we review the case management files for the 2024 (Q1-Q4), which included data on 2,851 unique individuals enrolled in either IPC (1,824) or RM only (1027) across all three CMOs (748 Amerigroup, 794 CareSource, 1,309 Peach State).

Table 7 shows the proportion of IPC or RM only enrollees who were assigned to a Resource Mother. Among the 2,851 unique individuals enrolled in either IPC or RM only for the Q1 through Q4 2024, across all CMOs a total of 2,021 (70.9%) were assigned to a Resource Mother, while 830 (29.1%) were not assigned. There was substantial variation in assignment of a Resource Mother across the three CMOs, with the lowest assignment rate for CareSource (20.4%) and the highest for Peach State (100%). There was, however, minimal variability in assignment of a Resource Mother according to whether the woman was enrolled in IPC (1304/1824, 71.5%) or RM only (717/1027, 69.8%); this data is not shown in the table.

Table 7. Assignment of Resource Mother (Q1-Q2 2024) by Medicaid Care Management Organization CMO

| Assignment of Resource Mother | Medicaid Care Management Organization | | | TOTAL |
|-------------------------------|---------------------------------------|-------------|-------------|--------------|
| | Amerigroup | CareSource | Peach State | |
| | N=748 | N=794 | N=1309 | N=2851 |
| Yes | 550 (73.5%) | 162 (20.4%) | 1309 (100%) | 2021 (70.9%) |
| No | 198 (26.5%) | 632 (79.6%) | 0 (0%) | 830 (29.1%) |

In addition to reporting on whether IPC or RM only enrollees who were assigned to a Resource Mother, the CMOs also reported on the number of successful encounters (a composite of in-person or telephone) that an enrolled individual had in a given quarter.

Table 8 shows the proportion of IPC or RM only enrollees who had any documented encounter with a Resource Mother. Among the 2,851 unique individuals enrolled in either IPC or RM only for the combined quarters of 2024, across all CMOs a total of 397 (13.9%) had any documented encounter (with the number of encounters ranging from 1 to 7). There was little variability in having a documented encounter with a Resource Mother according to whether the woman was enrolled in IPC (237/1824, 13.0%) or RM only (160/1027, 15.6%); this data is not shown in the table. There was also some variation in having a documented encounter with a Resource Mother across the three CMOs, with the lowest rates for Peach State (12.1%) and somewhat higher rates for CareSource (14.5%) and Amerigroup (16.4%). CMOs also reported on whether IPC or RM only enrollees with a documented Resource Mother encounter had a problem list that contained at least one problem and/or a corresponding care plan. Table 8 also shows the proportion of IPC or RM only enrollees with a Resource Mother encounter who had any problem identified and a care plan for an identified problem. Across all CMOs, 77.1% of those with a Resource Mother encounter had a documented problem and corresponding care plan, with some variability across the CMOs, with Amerigroup and Peach State having comparatively lower rate (65% and 69.8%, respectively) compared to CareSource (100%). The problems and care plan goals that were documented are also given in Table 8 in rank order for each CMO.

Table 8. Any Encounter with Resource Mother among Interpregnancy Care or Resource Mother Only Enrollees for Q1-Q4 2024, by Medicaid Care Management Organization

| Case Management | Medicaid Care Management Organization | | | TOTAL |
|---|---|---|---|------------------|
| | Amerigroup | CareSource | Peach State | |
| Any Resource Mother Encounter | 123/748 (16.4%) | 115/794 (14.5%) | 159/1309 (12.1%) | 397/2851 (13.9%) |
| Among those with a Resource Mother Encounter | | | | |
| Any Problem Identified | 80/123 (65%) | 115/115/ (100%) | 111/159 (69.8%) | 306/397 (77.1%) |
| Problems Identified | Service coordination (19) Overall health (17) Contraception (7) Mental health care (7) Primary health care (7) Coaching/peer support (7) High blood pressure (6) Parenting support (5) Child health care (4) Asthma management (1) | Primary health care (42) Service coordination (19) Menta health care (17) Coaching/peer support (9) Dental care (7) High blood pressure (4) Diabetes (4) Behavioral health care (3) Child health care (2) Asthma management (2) Contraception (2) | Primary health care (72) Dental care (20) Mental health care (6) Service coordination (3) Child health care (3) Coaching/peer support (3) Parenting support (2) | |

| | | | | |
|--------------------------|---|---|---|-----------------|
| Any Care Plan Documented | 80/123 (65%) | 115/115 (100%) | 111/159 (69.8%) | 306/397 (77.1%) |
| Care Plan Goals | Healthy lifestyle (14) CMO services (10) Community services (10) Scheduling appts (9) Contraceptive options (8) | Scheduling appointment (62) CMO services (9) Community services (7) Keep appointments (5) Diabetes adherence (3) Substance use treatment (3) | Scheduling appointment (91) Keep appointments (10) Community services (3) Navigating health care (2) | |

Objective: Increase child spacing intervals through effective contraceptive use.

Outcome. One of the goals of the RM in the IPC/RM only components of P4HB is to help enrollees gain access to primary and preventive care with a focus on access to the contraceptive method they desire. As such, the CMOs report on whether participants selected a more effective method of contraception during the reporting period and the specific method of contraception that IPC and RM only enrollees are using at the end of the reporting period. Table 9 shows the proportion of IPC or RM only enrollees who had any documented encounter with a Resource Mother for whom there was documentation of selection of a more effective method of contraceptive and the specific contraceptive method that the participant reported using. The extent of missingness of data (response missing or report of ‘unknown’) regarding whether the participant had selected a more effective form of contraception was substantial across all three CMOs (64% overall). Similarly, there was substantial missingness (blank or no response) regarding the contraceptive method that the participant reported using. However, across all three CMOs a substantial percentage reported the use of long-acting reversible contraceptive methods (including IUD or implant) with an overall rate of 11.1% with some variability across the CMOs (Amerigroup 8.1%, CareSource 9.6%, and Peach State 14.5%).

Table 9. IPC and RM Only Enrollees’ Use of Contraceptive Methods for Q1-Q4 2024 by Medicaid Care Management Organization

| Contraceptive Method Outcome | Medicaid Care Management Organization | | | TOTAL |
|---------------------------------|---------------------------------------|------------|-------------|-------------|
| | Amerigroup | CareSource | Peach State | |
| | N=123 | N=115 | N=159 | |
| Selected more effective form | | | | |
| Yes | 12 (9.8%) | 4 (3.5%) | 12 (7.5%) | 28 (7.1%) |
| No | 46 (37.4%) | 22 (19.1%) | 47 (29.6%) | 115 (29.0%) |
| Missing/Unknown | 65 (52.8%) | 89 (77.4%) | 100 (62.9%) | 254 (64.0%) |
| Contraceptive method being used | | | | |
| Blank/No response | 16 (49.0%) | 45 (39.2%) | 89 (56%) | 150 (37.8%) |
| None | 26 (21.1%) | 33 (28.7%) | 29 (18.2%) | 88 (22.2%) |
| Abstinence | 6 (4.9%) | 0 | 0 | 6 (1.5%) |
| Condom | 3 (2.4%) | 2 (1.7%) | 2 (1.3%) | 7 (1.8%) |

| | | | | |
|---|-----------|------------|------------|------------|
| Oral contraceptive | 9 (7.3%) | 12 (10.4%) | 7 (4.4%) | 28 (7.1%) |
| Transdermal | 0 | 0 | 0 | 0 |
| Injectable | 10 (8.1%) | 4 (3.5%) | 9 (5.7%) | 23 (5.8%) |
| Implant | 3 (2.4%) | 1 (0.9%) | 9 (5.7%) | 13(3.3%) |
| IUD | 7 (5.7%) | 10 (8.7%) | 14 (8.8%) | 31 (7.9%) |
| Long-acting reversible (Implant or IUD) | 10 (8.1%) | 11 (9.6%) | 23 (14.5%) | 44 (11.1%) |
| Sterilization | 2 (1.6%) | 5 (4.3%) | 0 | 7 (1.8%) |

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 10** below we first test whether these differences are statistically significant. They are all significant ($p<.01$).

In **Table 10** we 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 for the 2021-2022 time period. 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 in 2011-2022 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 (\geq 2500 g) | 119 (49.4%) | 497 (45.1%) |
| Unknown Weight | | |

| | | |
|----------------------------|------------|---------------------------|
| Fetal Deaths | 58 (24.1%) | 333 (30.2%) |
| Still Births | 29 (12.0%) | 167 (15.2%) |
| Adverse Delivery Outcome** | 12 (5.0%) | 40 (3.6%) |
| | 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 11** below.

Table 11. Estimated Differences in Probability of Outcomes (Marginal Effects) for IPC Compared to RSM Women with VLBW Infants in 2011-2022 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 12 shows the total capitated payments made to the CMOs for the FP only, IPC and RM only components in 2024. In contrast to the growth in the FP and IPC components of P4HB in 2023, we report declines in the enrollment of all components of P4HB in 2024. As noted earlier, there was an 18% decline in FP only enrollees, the group that dominates (99%) overall enrollment. This is consistent with the decline in overall capitation payments for P4HB from just over \$22 million by the end of 2023 to just over \$21 million by the end of 2024, as shown in Table 12.

Table 12. P4HB Capitation Payments for First and Second Half and Total, 2024

| Program | 1st half of 2024 (1/1/24-6/30/24) | | 2nd half of 2024 (7/1/24-12/31/24) | | Total \$ in 2024 | |
|--------------|--------------------------------------|---------------|---------------------------------------|---------------|---------------------|---------------|
| | \$ | % | \$ | % | \$ | % |
| FP Only | \$10,536,585 | 93.9% | \$9,693,572 | 94.3% | \$20,230,157 | 94.0% |
| IPC | \$470,721 | 4.2% | \$414,070 | 4.0% | \$884,791 | 4.1% |
| RMOC | \$219,087 | 2.0% | \$177,227 | 1.7% | \$396,315 | 1.8% |
| Total | \$11,226,393 | 100.0% | \$10,284,869 | 100.0% | \$21,511,262 | 100.0% |

Source Georgia Department of Community Health, MMIS (Medicaid management Information System) Reports MGD-3610-W (MCHB Payment Activity Report), Covers January- December 2024, includes monthly expenditures and Year to Date totals for each program and overall.

There was growth in payments for the IPC enrollees from ~505 thousand at the end of 2023 to ~884 thousand at the end of 2024 even while IPC enrollment declined in 2024; there was however, a decline in total payments for IPC enrollees from the first to the second half of 2024. Total capitated payments for the RM only enrollees declined from ~705 thousand in 2023 to ~396 thousand by the end of 2024 (Table 12). As noted earlier, enrollments in this component also declined over the 2024 time period. While enrollments drive the total dollars paid there may be changes in the PMPM payments made to the CMOs which also affect total payments made.

As in earlier years, the FP only component of P4HB is the most costly for Medicaid in terms of total capitated payments, accounting for ~94% of the total. The IPC component of P4HB accounted for only 4.1% of total payments while the RM only component was only ~2% of the total costs of the program.

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 represented 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 for which member understanding about the P4HB program is poor. 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 twenty waves. The most recent wave of the member survey was conducted from October through November of 2024. 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, 233 (2.6%) responded to the survey. The section below provides a summary of the responses from the two most recent waves of the CMOs' member survey (19th and 20th).

CMO Member Survey Results

In this most recent 20th 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 2.6% for wave twenty. For the 20th wave, the member response rates were: 2.9% (88/3,000) for Peach State, 2.3% (68/3,000) for Amerigroup, and 2.6% (77/3,000) for CareSource.

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 (39% and ~43% in waves 19 and 20, 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 ~19% in waves 19 and 20, respectively). Less commonly reported problems were in accessing testing or treatment for sexually transmitted infections (~20% and ~19% in waves 19 and 20, respectively) and pregnancy testing (~11% and ~12%, 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 (~48% and ~50% in waves 19 and 20, respectively), did not have to use their own money for family planning (~42% and ~37% in waves 19 and 20, respectively), and started using a method of birth control (~32% and ~33% in waves 19 and 20, respectively). In addition, a substantial percentage reported that they began going to a different doctor or nurse for family planning services (~24% and 19% in waves 19 and 20, respectively) or to a different doctor or nurse for primary care (~34% and ~29% in waves 19 and 20). 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[®] | | |
|--|--|---|
| | 19th Wave N=413 Responses n (%) | 20th Wave N=233 Responses n (%) |
| Before enrolling in P4HB[®], had trouble getting... | | |
| Birth control or family planning services | 86 (20.8%) | 44 (18.9%) |
| Pregnancy testing | 47 (11.4%) | 29 (12.4%) |
| Testing or treatment for sexually- transmitted infections | 82 (19.9%) | 43 (18.5%) |
| Primary care (such as routine check-up, care for an illness) (Purple Card) | 161 (39.0%) | 100 (42.9%) |
| Other (Affordability/Cost, Regular Health Visits/Checkups, Finding a provider/dentist) | 53 (12.8%) | 30 (12.9%) |
| Changes P4HB[®] made for the participant... | | |
| I am going to a different doctor or nurse for family planning services or birth | 99 (24.0%) | 44 (18.9%) |
| I am going to a different doctor or nurse for primary care | 141 (34.1%) | 67 (28.8%) |
| I have started using a birth control | 131 (31.7%) | 76 (32.6%) |
| I have changed the birth control method I use | 69 (16.7%) | 40 (17.2%) |
| I have more choices of birth control methods | 199 (48.2%) | 117 (50.2%) |
| I do not have to use my own money for family planning services or birth control | 172 (41.6%) | 87 (37.3%) |
| I can get preventive care (such as Pap smears) and family planning counseling | 334 (80.9%) | 187 (80.3%) |
| I am able to get care when I need it (Purple Card) | 251 (60.8%) | 149 (63.9%) |
| I am able to get the medicine I need (Purple Card) | 248 (60.0%) | 143 (61.4%) |
| Other (Limited Services/Coverage, Unable to get medications) | 28 (6.8%) | 15 (6.4%) |

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 (~28% and ~31% in waves 19 and 20, respectively).

Nearly one-fifth to one-quarter of respondents reported having problems with getting a referral or follow-up-care that they needed, getting the family planning services they wanted in the two most recent waves of the survey, or with having to wait too long to get services. Fewer than 20% reported any of the other problems surveyed in the two most recent waves of the survey.

| Table 14. Problems Encountered by Members Enrolled in P4HB® | | |
|---|--|--|
| Problems Under P4HB® | 19th Wave N=413 Responses n (%) | 20th Wave N=233 Responses n (%) |
| I cannot get the family planning services I want | 87 (21.1%) | 62 (26.6%) |
| I cannot get referrals or follow-up for care I need | 89 (21.5%) | 52 (22.3%) |
| I cannot find a doctor or nurse willing to take P4HB clients | 115 (27.8%) | 73 (31.3%) |
| I do not want to leave my current doctor or nurse | 68 (16.5%) | 48 (20.6%) |
| I must wait too long to get services | 84 (20.3%) | 45 (19.3%) |
| I do not have transportation | 40 (9.7%) | 38 (16.3%) |
| I cannot get to the doctor or nurse when they are open | 45 (10.9%) | 33 (14.2%) |
| My P4HB doctor or nurse will not prescribe the birth control method I want to use | 33 (8.0%) | 26 (11.2%) |
| Other (Limited Services/Coverage, Finding a P4HB Provider/Specialist) | 50 (12.1%) | 27 (11.6%) |

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 (62% and 70% in survey waves 19 and 20, respectively), whether they use male or female condoms to prevent STIs (~66% and ~73% in survey waves 19 and 20), their sexual practices (~53% and ~55% in survey waves 19 and 20, respectively), and if they had been asked about their plans for having or not having children in the future (54% and ~56% in survey waves 19 and 20, respectively). However, fewer than half (~36% and ~44% in surveys waves 19 and 20, respectively) 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.

| Reproductive Health Topic | 19th Wave N=413 | 20th Wave N=233 |
|--|----------------------------|----------------------------|
| 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 | 223 (54.0%) | 131 (56.2%) |
| Your thoughts or plans about timing or spacing pregnancies | 147 (35.6%) | 102 (43.8%) |
| Your sexual practices | 219 (53.0%) | 128 (54.9%) |
| The use of birth control to prevent or space pregnancies | 257 (62.2%) | 163 (70.0%) |
| The use of male or female condoms to prevent sexually transmitted infections | 274 (66.3%) | 169 (72.5%) |

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 (~62% and ~55% in survey waves 19 and 20, respectively), followed by the P4HB letter from the health plan (~46% and ~42% in survey waves 19 and 20, respectively), the providers office (~32% and ~24% in survey waves 19 and 20, respectively) and others (~23% and 30% in survey waves 19 and 20, respectively), and through a flyer or advertisement (~16% and ~11% in survey waves 19 and 20, respectively).

| | 19th Wave N=413 | 20th Wave N=233 |
|---|----------------------------|----------------------------|
| Health Department | 255 (61.7%) | 127 (54.5%) |
| Providers Office | 134 (32.4%) | 55 (23.6%) |
| P4HB Letter from your health plan | 189 (45.8%) | 98 (42.1%) |
| Flyer / Advertisement | 65 (15.7%) | 26 (11.2%) |
| Other (DFCS, Medicaid, Family/Friend, Online/P4HB Website, CMO) | 94 (22.8%) | 70 (30.0%) |

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 across the two most recent waves of the survey, ~66% of respondents were highly satisfied with P4HB, ~21% to 24% had moderate satisfaction, and ~9% to ~11%.

| Table 17. How Satisfied Are You with The P4HB Program? | | |
|---|------------------------|-----------------------------------|
| | 19th Wave N=413 | 20th Wave N=233 |
| Missing | 8 (1.9%) | 1 (0.4%) |
| Low Satisfaction (0-3) | 44 (10.7%) | 21 (9.0%) |
| Medium Satisfaction (4-7) | 88 (21.3%) | 56 (24.0%) |
| High Satisfaction (8-10) | 273 (66.1%) | 155 (66.5%) |

The final question asked on survey wave twenty was how the P4HB program could be improved. The most common responses to this final question were as follows: increase number of providers that take P4HB (32), expand coverage or services (27), better communication (11), coverage of more medications and birth control (10), education for members and providers (8), and help with out-of-pocket fees (7).

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 shows 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 2022 & 2023) and for the current reporting period (January-June and July- December 2024) are reported.

| Table 18 - Disenrollment, Denial of Service & Provider Claim Counts, 2022-2024 | | | |
|---|----------------------|---------------------------|------------------------|
| Reporting Period | Disenrollment | Denials of Service | Provider Claims |
| Jan-June 2022 | 308 | 87,498 | 33,710 |
| Jan-June 2023 | 551 | 92,318 | 37,212 |
| Jan-June 2024 | 617 | 79,243 | 29,988 |
| July-Dec 2022 | 574 | 85,967 | 35,046 |
| July-Dec 2023 | 498 | 99,277 | 39,069 |
| July-Dec 2024 | 776 | 70,112 | 21,084 |

The data in the top rows of **Table 18** include the reporting period, January-June 2022 and 2023. The pattern in CMO disenrollment of clients in the first and last six months of each of the years is shown. Disenrollment increased to 308 Jan-June of 2022 from its level in 2021 even while the PHE was still in place. Disenrollment increased further to 551 in Jan-June of 2023 when disenrollment in all Georgia Medicaid eligibility categories officially began due to the end of the PHE. This did not hold in the second part of 2023 as disenrollment by CMOs declined, albeit slightly, from 551 to 498. CMO disenrollment increased again to 617 in Jan-June of 2024 and was greater in the July-Dec months of 2024 at 776 than in the first six-months of the year (617).

The denials in the Jan-June periods of 2022 (87,498) and 2023 (92,318) were lower than the 104,833 Jan-June 2021 total and declined further to 79,243 in the Jan-June 2024 period. For 2022, the denials in the second part of the year (85,967) were slightly lower than in the Jan-June period of that year (87,498) but denials were higher in the second part of 2023 (99,277) than in the first part of that year (92,318). Denials in both Jan-June and July-Dec of 2024 were lower than in any period of the prior years. 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 a slight increase from 2022 (33,710) to 2023 (37,212) but a significant decline in the Jan-June months (29,988) of 2024. There was a slight increase in the provider claim counts from the Jan-June to the July-Dec months of 2022 (35,046) and 2023 (39,069). In the latter part (July-December) of 2024 there is a decline in the provider claim counts from 29,988 in the Jan-June period to only 21,084 in the last part of 2024. To better understand this decline, DCH reached out to the CMOs.

Amerigroup stated that there was a slight decrease in claims submissions for the second half of 2024 but did not identify any apparent aberrations that would have been indicative of a purposeful reduction in claims for this group. Amerigroup noted that many groups obtain needed care in the first half of the year and reduce appointments once summer is winding down and the school year begins.

CareSource stated that upon review of the enrollment and disenrollment data for P4HB enrollees in 2024, they saw an increased volume of disenrollments in Q3, followed by Q4 primarily due to enrollees identified as having third party liability (TPL) coverage. The decline in enrollments and increase in disenrollments would account for the decline in provider claim submission along with claim ‘run-out’.

Peach State stated that there was a drop in P4HB membership in October 2024 following their implementation of a new TPL verification process. That led to the termination of members who were identified as having other insurance. Peach State accounted this as a driver for the drop in provider claims for October of last year and stated they were not able to identify other drivers that may explain the decline.

Table 19 - Grievances Count By CMO 2021-2023

| P4HB Grievance Count by CMO | | | | |
|-------------------------------|------------|------------|----------------------|-------|
| Reporting Period | Amerigroup | CareSource | Peach State/WellCare | Total |
| Jan-June 2022 | 19 | 8 | 7 | 34 |
| Jan-June 2023 | 31 | 10 | 5 | 46 |
| Jan-June 2024 | 58 | 8 | 14 | 80 |
| Average 1st Half of Each Year | 36.0 | 8.7 | 8.7 | 53.3 |
| July-Dec 2022 | 24 | 9 | 15 | 48 |
| July-Dec 2023 | 41 | 13 | 15 | 69 |
| July-Dec 2024 | 42 | 12 | 10 | 64 |
| Average 2nd Half of Each Year | 35.7 | 11.3 | 13.3 | 60.3 |
| Total (P4HB) | 215 | 60 | 66 | 341 |

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

- July-December 2023 compared to July-December 2022; and
- January-June 2023 compared to January-June 2022.

In the July-December 2023 reporting period there were 69 grievances reported across the CMOs compared to the 48 reported for the July-December 2022 time-period. As noted in the table, the average number of grievances in the July-December periods of the three years was 60.3 up from the average of 50.7 observed over the July-Dec 2021 to July-Dec 2023 time-period. The average of 53.3 grievances in the Jan-June periods of these years reflects increases from 34 in Jan-June of 2022 to 46 observed in the Jan-June 2023 period and a marked increase to 80 in the Jan-June 2024 time-period. The bulk of the total 341 grievances were reported for Amerigroup (215) compared to lower counts for CareSource (60) 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. As reported here, disenrollment increased and provider claims decreased, over the 2022-2024 time-period. These patterns would likely result in grievances related to access to care and/or denials for services.

VII. Evaluation Activities & Interim Findings

The updated evaluation and interim findings will be completed upon receipt and analysis of the updated claims and enrollment data from the Georgia DCH and DPH. Results will be reported in the 2025 Interim Evaluation Report.

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.

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. GP Guy, EK Adams, SK Redd and AL Dunlop. “Effects of Georgia’s Medicaid Family Planning Waiver on Pregnancy Characteristics and Birth Outcomes” *Women’s Health Issues*, 34-2 (2024) 125-134 Available at: <https://doi.org/10.1016/j.whi.2023.11.004>.
4. 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.