DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850

State Demonstrations Group

June 6, 2024

Tom Wallace
Deputy Secretary for Medicaid
Florida Agency for Health Care Administration
2721 Mahan Drive, Mail Stop 8
Tallahassee, FL 3230

Dear Tom Wallace,

The Centers for Medicare & Medicaid Services (CMS) completed its review of the Interim Evaluation Report, which is required by the Special Terms and Conditions (STCs), specifically STC #52 "Interim Evaluation Report" of the section 1115 demonstration, "Florida Medicaid Family Planning Waiver" (Project No: 11-W- 00135/4). The demonstration extension was approved on March 8, 2019 and is effective through June 30, 2024. This Interim Evaluation Report covers the period from March 2019 through June 2020. CMS determined that the Evaluation Report, submitted on June 7, 2022 and revised on September 27, 2023, is in alignment with the CMS-approved Evaluation Design and the requirements set forth in the STCs, and therefore, approves the state's Interim Evaluation Report.

In accordance with STC #56 "Public Access", the approved Evaluation Report may now be posted to the state's Medicaid website within 30 days. CMS will also post the Interim Evaluation Report on Medicaid.gov.

The Interim Evaluation Report addresses research questions aligned with the demonstration's goals and presents descriptive trends to evaluate the demonstration. Despite the limitations of a short time period during which to measure outcomes, there are a number of positive findings noted in this report. The report identifies modest increases in utilization of services, increased maintenance of coverage, and higher average inter-birth interval among FPW enrollees when compared to non-enrollees. We look forward to collaborating with the state on the Summative Evaluation Report, which we expect will allow for further assessment of whether the demonstration has been achieving its goal.

We look forward to our continued partnership on the Florida Medicaid Family Planning Waiver section 1115 demonstration. If you have any questions, please contact your CMS demonstration team.

Sincerely,

Danielle Daly -S

Digitally signed by Danielle Daly -S
Date: 2024.06.06 10:20:14 -04'00'

Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

cc: Kia Carter-Anderson, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

Florida Medicaid Family Planning Waiver Program

Draft Interim Evaluation Report DY20, 21 and 22 (SFY2017-2018, 2018-2019 and 2019-2020)

MED206: Deliverable 22

June 7, 2022

Prepared by the Department of Behavioral Sciences and Social Medicine at the Florida State University College of Medicine with assistance from the Department of Health Outcomes and Policy at the University of Florida under contract with the Florida Agency for Health Care Administration.

Table of Contents

Florida Medicaid Family Planning Waiver (FPW) Program

Final Draft Interim Evaluation Report

Demonstration Years (DY) 20 (SFY 2017-2018), 21 (SFY 2018-2019), and 22 (SFY2019-2020)

Executive Summary

Florida's Family Planning Waiver was initially approved on August 23, 1998. Since the program's inception, the Department of Health (DOH) has been the operational agency tasked with determining eligibility and maintaining participant enrollment for Family Planning Waiver services. The Bureau of Family Health Services within DOH works with the local county health departments to provide a vast array of both Medicaid and non-Medicaid community health and family planning services, including preconception counseling, pregnancy tests, screening and treatment of sexually transmitted infections, cancer screening, and contraception supplies.

The purpose of the program is to expand eligibility for family planning services for up to two years to individuals who otherwise are not financially eligible for full Medicaid. Eligibility is limited to women of childbearing age, 14 years of age up through and including women who are 55 years of age; who have a family income at or below 191 percent of the Federal Poverty Level (FPL) (post Modified Adjusted Gross Income (MAGI) conversion); who are not covered by a health insurance program that provides family planning services; and who have lost Medicaid coverage within the last two years, including women who lost Medicaid pregnancy coverage after 60 days postpartum.

On March 8, 2019, the Centers for Medicare and Medicaid Services (CMS) approved the State's request to extend Florida's 1115 Family Planning Waiver through June 30, 2023. As part of the extension review and approval process, it was determined that compliance with section 1943 of the Act and implementing regulations was required. To achieve this, the eligibility determination process for the Family Planning Waiver will need to be integrated into the Medicaid State Plan eligibility system, operated by the Department of Children and Families. The Department of Children and Families (DCF) is the Florida agency responsible for determining all Medicaid eligibility, with the exception of the Family Planning Waiver. The DCF has ownership of the Access Florida System where Medicaid applications are submitted and eligibility determinations are made. This system works in conjunction with the Florida Medicaid Management Information System to track individuals' Medicaid eligibility.

The expectation for the State to build the Family Planning Waiver eligibility process into the Medicaid State Plan process was codified in the Special Terms and Conditions (STCs) approved by CMS with the waiver extension request. The STCs outline mitigations the State will use prior to full compliance, and require the State to submit a three-year timeline with milestones to demonstrate the State's plan for aligning the Family Planning Waiver eligibility and the Medicaid State Plan eligibility processes. The State is required to fully implement this change within three years of CMS approval of the waiver extension, which is March 8, 2022.

In order to come into compliance with the approved STCs, the Agency for Health Care Administration (Agency), in coordination with DOH and DCF, has developed an implementation plan to seamlessly and efficiently transition the Family Planning Waiver eligibility determination process from DOH to DCF. The transition is primarily operational and focuses on systematic changes. Beginning in March 2022, the process for eligibility determinations under the waiver will transition from the Department of Health to the Department of Children and Families.

Florida State University (FSU) in collaboration with the University of Florida (UF) was contracted to evaluate the program during the most recent four-year extension of the FPW (March 8, 2019, through June 30, 2023). The evaluation team and the Agency identified key issues of importance to policy makers and FPW stakeholders. The evaluation team, in concert with the Agency, developed ten research questions (RQs) to guide this evaluation, which uses quantitative and qualitative analytical methods to support findings. The RQs addressed in this interim report are:

- Research Question 1: What differences in recipient demographic characteristics exist between FPW enrollees and eligible women who do not enroll in FPW per Demonstration Year?
- Research Question 2: What are the interbirth intervals for FPW enrollees compared to eligible women who do not enroll in the FPW program who gave birth during the study period?
- Research Question 3: What is the rate of unintended pregnancies for FPW enrollees and eligible women who do not enroll in the FPW program per Demonstration Year?
- Research Question 4: What is the rate of low birth weight and preterm births for FPW enrollees compared to women who are eligible but do not enroll in the FPW program?
- Research Question 5: Is the FPW achieving cost savings by slowing the birth rate?

- Research Question 6: What are the reasons that women eligible for the FPW program choose to enroll or not enroll in the FPW program and the reasons women enrolled in the FPW program do not participate?
- Research Question 7: How do FPW enrollees utilize covered health services?
- Research Question 8: What gaps in coverage are experienced by FPW enrollees over time?
- Research Question 9: Are FPW enrollees satisfied with services?
- Research Question 10: What strategies are being used by the Department of Health to increase FPW participation rates?

According to the Centers for Medicare and Medicaid Services (CMS) approved Evaluation Design for the FPW approved extension period, the five objectives of the FPW program are:

(1) to increase access to family planning services;

(2) to increase child spacing intervals through effective contraceptive use;

(3) to reduce the number of unintended pregnancies in Florida;

(4) to reduce Florida's Medicaid costs by slowing the birth rate among females who would otherwise be eligible for Medicaid pregnancy-related services; and,

(5) to improve or maintain health outcomes for the target population as a result of access to family planning services and/or family planning-related services.

The primary data sources used to evaluate the effectiveness of the FPW program during the extension period include Medicaid eligibility, enrollment, and claims files, State of Florida Hospital Discharge data, Florida birth certificates, Healthy Start Prenatal Risk Screen data from the Department of Health (DOH), and qualitative survey data.

Findings

Demographics (RQ1):

The number of FPW enrollees (Table 1a) in DY20 was 135,489 with an average age of 28.5 years and the number of FPW-eligible non-enrollees (Table 1b) was 533,845 with an average age of 31.5 years. Most enrollees identified as White (34.7%), Black (29.1%), or Hispanic (27.9%) while most FPW-eligible non-enrollees identified as Hispanic (35.1%), White (32.8%), or Black (21.6%). In DY21, the total number of FPW enrollees was 137,651 with an average age of 28.7 years while the number of FPW-eligible non-

enrollees was 577,334 with an average age of 31.0 years. Most enrollees identified as White (34.4%), Black (29.3%), or Hispanic (27.8%) while most non-enrollees identified as Hispanic (34.9%), White (31.8%), or Black (22.3%). In DY22, the total number of enrollees was 125,639 with an average age of 28.9 years and the number of non-enrollees was 614,962 with an average age of 30.3 years. Most enrollees identified as White (34.4%), Black (29.4%), or Hispanic (27.0%) while most non-enrollees identified as Hispanic (33.8%), White (31.4%), or Black (23.7%). Because these data are for the entire population of eligible women in Florida, all numbers above represent true differences between groups, thus testing for statistical significance is not necessary.

Interbirth Intervals (RQ2):

After controlling for age and race, interbirth intervals (IBI) were found to be statistically significant longer in all DYs (DY20-DY22) for FPW enrollees compared to eligible women who did not enroll. In DY20, the IBI for enrollees was 11.6% longer, in DY21 the IBI for enrollees was 10.7% longer, and in DY22, IBI for enrollees was 18.8% longer than non-enrollees. This is a positive outcome of the FPW program.

Unintended pregnancies (RQ3): From DY20-DY22, the percent of FPW enrollees who responded "No" to the question "Is this a good time for you to be pregnant?" decreased from 13.7% in DY20 to 12.3% in DY22 (Table 3a, question 5) as compared to an increase from 9.2% to 11.7% of FPW non-enrollees (Table 3b, question 5). Responses to the question "Thinking back to just before you got pregnant, did you want to be?" indicated that a decrease from 57.7% in DY20 to 54.5% in DY22 of FPW enrollees (Table 3a, question 14) answered "later" or "not pregnant" as compared to an increase from 41.3% to 49.4% of FPW non-enrollees (Table 3b, question 14). When combining all negative responses across both questions 5 and 14 to capture the overall rate of unintended pregnancies, a decrease from 58.0% to 55.8% of FPW enrollees indicated that their pregnancy was unintended as compared to an increase from 44.8% to 50.9% of FPW non-enrollees. Odds ratios for logistic regression models of reported unintended pregnancies were conducted by FPW enrollee status and demonstration year. FPW enrollees have significantly higher odds of a reported unintended pregnancy for all three demonstration years, compared with FPW non-enrollees, when controlling for age and race/ethnicity.

Low birth weight and preterm births (RQ4):

Table 4 shows the number of births considered "low birth weight" (<2,500 grams) and "pre-term births" (<37 weeks) to FPW enrollees and non-enrollees for DY20, DY21, and DY22. Note that "low birth weight"

and “pre-term births” are not mutually exclusive categories and may overlap. FPW enrollees have a slightly smaller proportion of low birth weight births and pre-term births than the FPW non-enrollees in each of the three demonstration years (DY20, DY21, and DY22). The rate of low birth weight remained stable (9.0% to 9.1%) for FPW enrollees over the three demonstration years, while it slightly increased over this time for FPW non-enrollees from 9.4% to 9.7%. Rates of pre-term birth decreased for both FPW enrollees (13.3% to 11.1%) and non-enrollees (13.6% to 11.2%) over the three demonstration years.

Cost savings (RQ5):

Cost savings are calculated based on differences in the birth rate between FPW enrollees and eligible women who did not enroll in FPW. Adjusted logistic regression model results showed statistically significant differences in birth rates for FPW enrolled women compared to those eligible but not enrolled resulting in substantial cost savings for the FPW program in each of the DYs.

As shown in Table 5a, women enrolled in the FPW program during DY20 had nearly 7,200 fewer births than women eligible but not enrolled in the FPW program for a total cost savings of approximately $103 million dollars. In DY21, women in the FPW program had 6,800 fewer births than women eligible but not enrolled in the FPW program resulting in cost savings of approximately $91.6 million. Lastly, women enrolled in the FPW program in DY22 had almost 6,200 fewer births than women eligible but not enrolled in the FPW program for a total cost savings of approximately $86.1 million.

Reasons for non-enrollment or non-participation (RQ6):

In surveys conducted in DY20 and DY22, women who were eligible for the FPW program but did not enroll (n=25) were asked reasons for non-enrollment. Nearly all women responded that they were not aware of the FPW program.

For the enrolled but not participated group in DY20, the most cited reason for not participating was a lack of awareness (n=20), moving out of state (n=3), and a general lack of interest in the program (n=1). Similar to DY20, the most cited reason for the individuals enrolled but not participated group not participating in DY22 was a lack of awareness (n=12); however, other reasons cited in DY22 included a lack of need for the program (n=6) and a lack of convenience (n=1).

Service utilization (RQ7):

The participation rate for FPW enrollees that used at least one covered service rose to 17.4% in DY22 from 10.8% in DY20. When comparing participation rates for women enrolled in the initial 12 months of FPW enrollment (first-year) to women enrolled in months 13-24 (second-year) of the program, the participation rate of first-year enrollees, defined as the number of first-year enrollees that used at least one covered service as a proportion of total first-year enrollees for a given DY, rose to 15.9% in DY22 from 9.5% in DY20. Similarly, the participation rate of second-year enrollees rose to 17.8% in DY22 from 11.2% in DY20. These general trends are also seen at the detailed covered service category level, which indicates that from DY20 to DY22 recipients who enroll in the FPW program are increasingly utilizing covered services.

Coverage gaps (RQ8):

Table 8.1 shows the total number of FPW enrollees for DY20, DY21, and DY22, by number of years enrolled. The proportion of individuals who maintain coverage during their second year of eligibility has increased since DY20. In DY22, 84.4% of all enrollees maintained coverage into their second year of eligibility, compared with 76.2% in DY20 and 77.1% in DY21.

Satisfaction with services (RQ9):

For both DY20 and DY22, a total of 4500 FPW enrollees who utilized at least one FPW service were contacted to obtain 300 completed surveys in each year (6.7% response rate). In DY20, a vast majority of individuals who received care and were aware of using FPW services reported being satisfied (i.e., either "Satisfied" or "Very Satisfied") with services including 88% of enrollees (n=7) for contraceptive care, all enrollees for STD testing (n=7), and all enrollees for cervical cancer screening (n=8) (Table 1). A similar trend of satisfaction was present in DY22 among women who were aware that they used FPW services, in which 85% (n=29) of enrollees reported satisfaction with contraceptive care services, 95% (n=19) of enrollees reported satisfaction with STD testing services, and all enrollees (n=13) reported satisfaction with cervical cancer screening.

Strategies being used by DOH clinics to increase participation in FPW (RQ10):

In accordance with the CMS approved Evaluation Design, a one-time survey was conducted in DY20. Only 9 of the 67 (13%) DOH clinics responded to our survey. Strategies to increase participation in the FPW identified included external outreach, staff incentivization, pre-appointment eligibility review, sharing information during appointments, and follow-up with eligible patients.

COVID-19 Context:

The COVID-19 pandemic began during the final few months of DY22 (the final year included in this summative report). Because it comprised such a small portion of time during the final DY covered by this summative report, COVID-19 was not fully factored into these results but will be addressed in future reports. The evaluation team did note, though, that beginning in March 2020, there was a sharp decline in the number of women enrolling in the program. This was most likely due to the U.S Department of Health and Human Services implementing a policy to continue Medicaid coverage of individuals during the pandemic regardless of whether they continued to meet the eligibility criteria. This was done to make sure that people did not lose their healthcare coverage during the pandemic.

Positive Outcomes

Overall, there were several positive outcomes of the FPW program. The total proportion of eligible women enrolled in the program increased between DY21 and DY22 as well as the proportion of enrolled women who used any FPW service. Women enrolled in the FPW program continue to have longer interbirth intervals, generating significant cost savings that average approximately $90 million per year. Additionally, the vast majority of women surveyed who used FPW services and were aware that they used those services indicated that they were satisfied with those services and found them easy to access.

Conclusions

Enrollment rates among women eligible for the FPW program remain very low, with about 17% of eligible women enrolling in the program. Additionally, only 17% of FPW enrollees use any FPW services in a given year, although both enrollment and participation rates increased from DY21. While the types of services provided through the FPW program have been shown to be effective and women are typically satisfied with the services they receive, the impact of the program is greatly reduced because of very low enrollment and participation rates. The vast majority of women who were interviewed indicated that they were unaware of the program, including women who used services provided through the FPW program.

Recommendations

Given the consistent finding of lack of knowledge of the FPW program, both among eligible women who do not enroll and enrolled women, future activities should focus on increasing enrollment and enrollee participation rates in the FPW program through interventions designed to increase awareness of the program.

Steps are already being taken by the State to improve the eligibility determination process for the FPW program by moving this activity from the DOH to the Department of Children and Families (DCF), which currently does all of the eligibility determinations for Florida's Medicaid program. Other potential strategies should be considered and could include using strategies identified by the DOH clinics, including outreach, education, and proactively engaging with women to get them enrolled in the FPW program if additional information is needed for their enrollment for the second 12-month period. Increasing enrollment and participation in the program will likely increase the number of women experiencing the positive outcomes of the program and potentially generate additional cost savings by improving or maintaining health outcomes.

Report Prepared By:

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Definitions and Acronyms

Aid category effective date: The first day of the month in which the enrollee became eligible. For example, if an enrollee became eligible on the 17th of the month, the effective date would be retroactive to the 1st of the month.

Enrollee: Refers to a woman who has a Family Planning (FP) Aid Category Code in the Medicaid Eligibility file and the Aid Category Effective Date falls within the study period. This includes a woman who has a Family Planning (FP) Aid Category Code in the Medicaid Eligibility file and whose eligibility period falls within the study period by any given day or span of days regardless of the Aid Category Effective Date.

Demonstration Year (DY): The period for which the Family Planning Waiver was approved (i.e., state fiscal year).

Demonstration Year (DY) 20: Represents the state fiscal year of July 1, 2017 to June 30, 2018.

Demonstration Year (DY) 21: Represents the state fiscal year of July 1, 2018 to June 30, 2019.

Demonstration Year (DY) 22: Represents the state fiscal year of July 1, 2019 to June 30, 2020.

Department of Health (DOH) frontline staff: Health care staff who work on the frontlines of FPW program services in DOH clinics, including DOH staff who interact directly with women who are 14 years of age through and including women who are 55 years of age who are potentially eligible for FPW services.

Eligibility period: The span of dates comprising the recipient's Family Planning Waiver eligibility.

Eligible: A woman who is 14 years of age through and including a woman who is 55 years of age with a family income at or below 191% of the Federal Poverty Level (FPL) who loses Medicaid pregnancy coverage after 60 days postpartum or a woman who is 14 years of age through and including a woman who is 55 years of age with a family income at or below 191% of the FPL for a period of two years after losing Medicaid coverage for reasons other than the expiration of the 60-day postpartum period.

Interbirth interval (IBI): A continuous variable measured in months of the average interval between the end of the most recent previous pregnancy and last menstrual date of the current pregnancy as indicated on the birth certificate.

Modified Adjusted Gross Income (MAGI) Conversion: MAGI-based eligibility standards that are used to determine Medicaid and CHIP eligibility.

Non-Enrollee: An eligible woman who does not enroll in the FPW program.

Observed birth: Refers to a live birth recorded in the DOH's annual Florida Vital Statistics file.

State Fiscal Year (SFY): Includes the time period beginning on July 1 and ending on June 30.

Study Population: Includes women who are enrolled in the FPW program. The study population will be categorized based on date of enrollment, participation, and eligibility category.

Target Population: All FPW program enrollees.

Introduction and Background

The Florida Medicaid Family Planning Waiver (FPW) program is a Section 1115(a) waiver demonstration approved by the U. S. Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS). The initial FPW demonstration was approved for a five-year period on August 23, 1998, and implemented October 1, 1998. The demonstration has been continually renewed, with the most recent renewal beginning on March 8, 2019, and going through June 30, 2023.

Since the program's inception on August 23, 1998, the Department of Health (DOH) has been the operational agency tasked with determining eligibility and maintaining participant enrollment for Family Planning Waiver services. The Bureau of Family Health Services within DOH works with the local county health departments to provide a vast array of both Medicaid and non-Medicaid community health and family planning services, including preconception counseling, pregnancy tests, screening and treatment of sexually transmitted infections, cancer screening, and contraception supplies.

The purpose of the program is to expand eligibility for family planning services for up to two years to individuals who otherwise are not financially eligible for full Medicaid. Eligibility is limited to women of childbearing age, 14 years of age up through and including women who are 55 years of age; who have a family income at or below 191 percent of the Federal Poverty Level (FPL) (post Modified Adjusted Gross Income (MAGI) conversion); who are not covered by a health insurance program that provides family planning services; and who have lost Medicaid coverage within the last two years, including women who lost Medicaid pregnancy coverage after 60 days postpartum.

On March 8, 2019, the Centers for Medicare and Medicaid Services (CMS) approved the State's request to extend Florida's 1115 Family Planning Waiver through June 30, 2023. As part of the extension review and approval process, it was determined that compliance with section 1943 of the Act and implementing regulations was required. To achieve this, the eligibility determination process for the Family Planning Waiver will need to be integrated into the Medicaid State Plan eligibility system, operated by the Department of Children and Families. The Department of Children and Families (DCF) is the Florida agency responsible for determining all Medicaid eligibility, with the exception of the Family Planning Waiver. They have ownership of the Access Florida System where Medicaid applications are submitted and eligibility

determinations are made. This system works in conjunction with the Florida Medicaid Management Information System to track individuals' Medicaid eligibility.

The expectation for the State to build the Family Planning Waiver eligibility process into the Medicaid State Plan process was codified in the Special Terms and Conditions (STCs) approved by CMS with the waiver extension request. The STCs outline mitigations the State will use prior to full compliance, and require the State to submit a three-year timeline with milestones to demonstrate the State's plan for aligning the Family Planning Waiver eligibility and the Medicaid State Plan eligibility processes. The State is required to fully implement this change within three years of CMS approval of the waiver extension, which is March 8, 2022.

In order to come into compliance with the approved STCs, the Agency, in coordination with DOH and DCF, has developed an implementation plan to seamlessly and efficiently transition the Family Planning Waiver eligibility determination process from DOH to DCF. The transition is primarily operational and focuses on systematic changes. Beginning in March 2022, the process for eligibility determinations under the waiver will transition from the Department of Health to the Department of Children and Families. Additionally, the State will be automatically enrolling all eligible women into the FPW program for the initial 12-month period as well as for the second 12-month period if no additional information is needed to determine eligibility. Thus, most eligible women will be automatically enrolled for the full 24-month period. This new enrollment process is also expected to be fully implemented by March 2022.

This document is part of a series of reports produced by Florida State University (FSU) with assistance from the University of Florida (UF) in evaluating the Florida Medicaid Family Planning Waiver (FPW) program during its renewal from March 8, 2019, through June 30, 2023. Contained within the Special Terms and Conditions (STCs) of the waiver renewal are requirements for an evaluation of the demonstration during the renewal period.

One of the goals of the FPW program is to increase the number of women receiving FPW services who are 14 years of age up through and including women who are 55 years of age and have incomes at or below 191% of the FPL (post MAGI conversion). Specifically, the FPW program has five objectives:

1. To increase access to family planning services;
2. To increase child spacing intervals through effective contraceptive use;
3. To reduce the number of unintended pregnancies in Florida;

4. To reduce Florida's Medicaid costs by slowing the birth rate among females who would otherwise be eligible for Medicaid pregnancy-related services; and,
5. To improve or maintain health outcomes for the target population as a result of access to family planning services and/or family planning-related services.

FPW Program Evaluation Research Questions

To evaluate whether Florida's FPW program achieved its objectives, the following 10 research questions are addressed:

- Research Question 1: What differences in recipient demographic characteristics exist between FPW enrollees and eligible women who do not enroll in FPW per Demonstration Year?
- Research Question 2: What are the interbirth intervals for FPW enrollees compared to eligible women who do not enroll in the FPW program who gave birth during the study period?
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- Research Question 9: Are FPW enrollees satisfied with services?
- Research Question 10: What strategies are being used by the Department of Health to increase FPW participation rates?

Data and Methods

Data

The data sources for this project come from the Florida Department of Health (DOH) and the Agency for Health Care Administration (AHCA or "the Agency"). The sources include: (1) Vital Statistics birth certificate data; (2) Healthy Start Prenatal Risk Screen data; (3) Qualitative survey data for FPW enrollees and non-enrollees as well as DOH staff; and (4) Medicaid enrollment, eligibility, and claims files. Each data source is described below.

DOH Birth Vital Statistics (BVS) birth certificates (CY2000-CY2020)

Birth certificate data include personal identifiers for both the infant and the mother, including names, date of birth, address, and social security number. The identifiers were used to link births that occurred during the evaluation period to previous births since year 2000 using the mother's personal identifiers. This linkage allowed the research team to estimate the length of the interbirth interval for FPW enrollees and eligible women not enrolled in FPW. Data elements to estimate gestational age and conception date were used to answer the research questions. There is an 18-month lag between the date of a birth and the date a final birth certificate is released by BVS. Preliminary birth certificate data may be generated earlier within the Florida DOH, but birth records are not available until reporting counties have had up to one year to resubmit final corrected versions to the State Register of Vital Statistics.

DOH Healthy Start Prenatal Screens (CY2011-CY2020)

Healthy Start Prenatal Risk Screen data include personal identifiers such as names, date of birth, address, and social security number. Data elements to estimate gestational age and conception date were used in combination with pregnancy intendedness responses to answer the research questions. There is an approximate ten-month lag between the completion of the Healthy Start Prenatal Risk Screen and the time the data is released by DOH.

Medicaid Eligibility Files (CY2015-CY2020)

Data on Medicaid eligibility include personal identifiers for all female recipients including names, date of birth, address, and social security number that are linked to the birth certificate and the Healthy Start Prenatal Screens. The aid category code and the eligibility begin and end dates were used to derive enrollment and participation in the program.

Medicaid Claims Files (CY2015-CY2020)

Monthly Medicaid claims files include all claims paid during the month, but may not include claims for all services provided during the month. There is a time lag between the time the service is provided and when the claim is submitted and paid. Most claims are submitted and paid within three months of the service date; however, providers have up to one year to submit claims. Data elements in the claims files include date of service, amount paid, program code, procedures and diagnosis to derive program participation measures.

Medicaid Enrollment Files (CY2015-CY2020)

Medicaid enrollment files include personal identifiers for all female recipients including names, date of birth, address, and social security number that are linked to the birth certificate and the Healthy Start Prenatal Screens.

FPW Eligibility and Enrollment Survey

Qualitative interviews were conducted with FPW enrollees and eligible women who do not enroll in FPW through telephone and text-based surveys in SFY2019-2020 (for DY20/21) and SFY2020-2021 (for DY22) to assess the reasons that women eligible for the FPW program choose to enroll or not enroll in the FPW program.

FPW Enrollee Participation Surveys

Qualitative telephone interviews were conducted with FPW enrollees about use FPW services in SFY2019-2020 (for DY20/21) and SFY2020-2021 (for DY22) to identify common themes for either using or not using services provided by the FPW program.

FPW Enrollee Satisfaction Survey

Quantitative/qualitative interviews were conducted with FPW enrollees who used FPW services through a telephone-based satisfaction survey in SFY2019-2020 (for DY20/21) and SFY2020-2021 (for DY22).

DOH Staff Survey

Qualitative interviews were conducted with DOH staff through an Agency approved web-based survey in SFY2019-2020 and SFY2020-2021 to determine common FPW strategies used by DOH staff to increase FPW engagement/participation rates.

Methods

The research team used a combination of quantitative and qualitative methods, to evaluate Florida's FPW program. Detailed descriptions of the methods used for each of the research questions are included in Appendix A.

To determine whether the FPW program achieved its goals, the research team analyzed measures associated with each of the five program objectives which included:

Objective 1 (To increase access to family planning services):

i. The number of eligible women receiving Title XIX funded family planning services each year of the demonstration. (RQ1)
    a. Hypotheses: The number/proportion of eligible women enrolled in the FPW program will increase over time.
ii. Reasons for non-enrollment or not using FPW services if enrolled. (RQ6)
    a. Hypothesis: N/A – this is descriptive and no hypothesis was tested.
iii. The proportion of women using FPW services by type of service. (RQ7)
    a. Hypothesis: The number/proportion of FPW enrollees using services provided through the FPW will increase over time.
iv. The proportion of women experiencing gaps in coverage and the length of those coverage gaps. (RQ8)
    a. Hypothesis: The proportion of women experiencing gaps in coverage will decline and the average length of the coverage gaps will decrease over time.
v. DOH clinic strategies for increasing enrollment and participation. (RQ10)
    a. Hypothesis: N/A – this is descriptive and no hypothesis was tested.

Objective 2 (To increase child spacing intervals through effective contraceptive use):

i. Average interbirth intervals (IBI) in number of months for FPW enrollees compared to eligible women who did not enroll in the FPW program. (RQ2)
    a. Hypothesis: Interbirth intervals will be longer for FPW enrollees than eligible non-enrollees.

Objective 3 (To reduce the number of unintended pregnancies in Florida):

i. The number of unintended pregnancies among FPW enrollees and eligible women who did not enroll in the FPW program. (RQ3)
    a. Hypothesis: The proportion of pregnancies that are unintended will be lower among FPW enrollees compared to eligible non-enrollees.

Objective 4 (To reduce Florida's Medicaid costs by slowing the birth rate of FPW enrollees compared to eligible women who did not enroll in the FPW program):

i. Cost savings to Medicaid based on the number of averted births. (RQ5)
    a. Hypothesis: The FPW program will generate cost savings by slowing the birth rate of FPW enrollees relative to eligible non-enrollees.

Objective 5 (To improve or maintain health outcomes for the target population as a result of access to family planning services and/or family planning-related services):

i. Number of low birth weight and preterm births. (RQ4)
    a. Hypothesis: Rates of low birth weight and preterm births will be lower among FPW enrollees compared to eligible non-enrollees.

ii. Satisfaction with services. (RQ9)
    a. Hypothesis: FPW enrollees who use FPW services will be satisfied with the services received.

FPW Program Study Population

The study population includes all women who were enrolled in the FPW program in DY20 (SFY2017-2018), DY21 (SFY2018-2019), and DY22 (SFY2019-2020). While not all evaluation questions will use a comparison population, those that do will use women who are eligible for the FPW program in a given year, but who do not enroll in the program. This will maximize comparability, as these women will also be of childbearing age and will have recently lost Medicaid coverage and will, thus, likely have similar incomes and sociodemographic characteristics as FPW enrollees. While selection bias using this population is possible, it will be minimal given that fewer than 20% of eligible women enroll in FPW in any given year. Because most of the eligible women who do not enroll are likely to still have need for and benefit from family planning services, it is unlikely that the decision to enroll or not enroll is strongly correlated with need for these services, which is the main cause of selection bias. Depending on the research question, qualitative analyses target eligible women who do not enroll in the FPW program, FPW enrollees, FPW enrollees who do not use FPW services, FPW enrollees who use services, and Department of Health (DOH) staff who administer the FPW program.

Additionally, some of the evaluation questions will compare first year FPW enrollees to second year FPW enrollees. First year enrollees are those enrollees within 12 months of their Aid Category Effective Date in the study period (e.g., for DY22, an Aid Category Effective Date between July 1, 2019, and June 30, 2020). Second year enrollees are those enrollees between 12 and 24 months of their Aid Category Effective Date within the study period.

General Findings

RQ1: What differences in recipient demographic characteristics exist between FPW enrollees and eligible women who do not enroll in FPW per Demonstration Year?

The basic analytic strategy for RQ1 was to provide demographic characteristics for each DY by FPW enrollee and program eligible non-enrollee. Data sources for RQ1 included Medicaid enrollment, claims, and eligibility data.

The number of FPW enrollees (Table 1a) in DY20 was 135,489 with an average age of 28.5 years and the number of FPW-eligible non-enrollees (Table 1b) was 533,845 with an average age of 31.5 years. Most enrollees identified as White (34.7%), Black (29.1%), or Hispanic (27.9%) while most FPW-eligible non-enrollees identified as Hispanic (35.1%), White (32.8%), or Black (21.6%). The enrollment rate among all eligible women in DY20 was 20.2%. In DY21, the total number of FPW enrollees was 137,651 with an average age of 28.7 years while the number of FPW-eligible non-enrollees was 577,334 with an average age of 31.0 years. Most enrollees identified as White (34.4%), Black (29.3%), or Hispanic (27.8%) while most non-enrollees identified as Hispanic (34.9%), White (31.8%), or Black (22.3%). The enrollment rate among all eligible women in DY21 was 19.3%.In DY22, the total number of enrollees was 125,639 with an average age of 28.9 years and the number of non-enrollees was 614,962 with an average age of 30.3 years. Most enrollees identified as White (34.4%), Black (29.4%), or Hispanic (27.0%) while most non-enrollees identified as Hispanic (33.8%), White (31.4%), or Black (23.7%). The enrollment rate among all eligible women in DY22 was 16.7%. Because these data are for the entire population of eligible women in Florida, all numbers above represent true differences between groups.

The hypothesis that the proportion of eligible women enrolling in the FPW program will increase was not supported, with enrollment rates declining each DY.

Table 1a: Demographic Characteristics of FPW Enrollees DY20, DY21, DY22

DY20	Age Group (years)					Total	
Race/Ethnicity	**14-19**	**20-29**	**30-34**	**35-44**	**45-55**	**Number**	**Percent***
Black	1,151	22,847	8,831	6,370	272	**39,471**	**29.1**
White	1,480	28,223	10,564	6,545	257	**47,069**	**34.7**
Asian	25	865	675	513	20	**2,098**	**1.5**
Hispanic	1,086	21,179	8,881	6,355	275	**37,776**	**27.9**
American/Asian Indian & Other	257	4,639	2,268	1,841	69	**9,074**	**6.7**
	3,999	**77,753**	**31,219**	**21,624**	**893**	**135,488**	

Total FPW Enrollees (%)*	**2.9**	**57.4**	**23.0**	**16.0**	**0.7**		**100**
DY21	**Age Group (years)**					**Total**	
Race/Ethnicity	**14-19**	**20-29**	**30-34**	**35-44**	**45-55**	**Number**	**Percent***
Black	1,078	22,824	9,388	6,802	261	**40,353**	**29.3**
White	1,368	27,964	11,003	6,813	261	**47,409**	**34.4**
Asian	22	770	612	475	14	**1,893**	**1.4**
Hispanic	1,020	21,234	9,270	6,510	282	**38,316**	**27.8**
American/Asian Indian & Other	254	4,955	2,403	1,997	70	**9,679**	**7.0**
Total FPW Enrollees (%)*	**3,742**	**77,747**	**32,676**	**22,597**	**888**	**137,650**	
	2.7	**56.5**	**23.7**	**16.4**	**0.6**		**100**
DY22	**Age Group (years)**					**Total**	
Race/Ethnicity	**14-19**	**20-29**	**30-34**	**35-44**	**45-55**	**Number**	**Percent***
Black	920	20,465	8,806	6,476	289	**36,956**	**29.4**
White	1,143	24,770	10,353	6,704	263	**43,233**	**34.4**
Asian	24	612	511	490	11	**1,648**	**1.3**
Hispanic	791	18,359	8,567	6,004	215	**33,936**	**27.0**
American/Asian Indian & Other	252	5,046	2,451	2,030	87	**9,866**	**7.9**
Total FPW Enrollees (%)*	**3,130**	**69,252**	**30,688**	**21,704**	**865**	**125,639**	
	2.5	**55.1**	**24.4**	**17.3**	**0.7**		**100**

* Row/column totals may not equal 100% due to rounding

Table 1b: Demographic Characteristics of FPW Eligible Non-Enrollees DY20, DY21, DY22

DY20	Age Group (years)					Total	
Race/Ethnicity	**14-19**	**20-29**	**30-34**	**35-44**	**45-55**	**Number**	**Percent***
Black	13,330	40,437	17,606	27,661	12,620	**111,654**	**21.6**
White	24,131	53,990	26,968	40,055	24,164	**169,308**	**32.8**
Asian	1,101	2,096	1,314	2,006	838	**7,355**	**1.4**
Hispanic	20,364	59,020	29,534	45,513	26,710	**181,141**	**35.1**
American/Asian Indian & Other	9,085	13,548	6,229	10,515	7,227	**46,604**	**9.0**
Total Non-Enrollees	**68,011**	**169,091**	**81,651**	**125,750**	**71,559**	**516,062**	**100**
(%)*	**13.2**	**32.7**	**15.8**	**24.4**	**13.9**		
DY21	**Age Group (years)**					**Total**	
Race/Ethnicity	**14-19**	**20-29**	**30-34**	**35-44**	**45-55**	**Number**	**Percent***
Black	17,794	43,506	19,348	30,332	13,368	**124,348**	**22.3**
White	27,036	55,528	28,196	42,279	24,159	**177,198**	**31.8**
Asian	1,305	2,138	1,325	2,140	880	**7,788**	**1.4**
Hispanic	27,876	61,364	31,004	48,310	25,891	**194,445**	**34.9**
American/Asian Indian & Other	10,641	15,855	7,029	11,860	7,394	**52,779**	**9.5**
Total Non-Enrollees	**84,652**	**178,391**	**86,902**	**134,921**	**71,692**	**556,558**	**100**
(%)*	**15.2**	**32.0**	**15.6**	**24.2**	**12.9**		
DY22	**Age Group (years)**					**Total**	
Race/Ethnicity	**14-19**	**20-29**	**30-34**	**35-44**	**45-55**	**Number**	**Percent***
Black	19,621	55,749	24,129	33,271	12,973	**145,743**	**23.7**
White	28,984	65,737	32,096	43,781	22,695	**193,293**	**31.4**
Asian	1,336	2,370	1,389	2,129	825	**8,049**	**1.3**
Hispanic	31,002	72,000	34,154	48,691	21,860	**207,707**	**33.8**
American/Asian Indian & Other	11,984	19,480	8,640	12,966	7,100	**60,170**	**9.8**
Total Non- Enrollees	**92,927**	**215,336**	**100,408**	**140,838**	**65,453**	**614,962**	
(%)*	**15.1**	**35.0**	**16.3**	**22.9**	**10.6**		**100**

*** Row/column totals may not equal 100% due to rounding.**

RQ2: What are the interbirth intervals for FPW enrollees compared to eligible women who do not enroll in the FPW program who gave birth during the study period?

To measure the impact of the FPW in increasing the child spacing interval through effective contraceptive use, the research team compared the average Interbirth Intervals (IBI) of Enrollees and FPW Eligible Non-Enrollees in each of the DYs. For this report, the research team conducted comparisons of average IBI length in number of months by enrollment status. To answer this question, birth records are required for 24 months after the end of the demonstration year. In the analysis, the denominator includes only women who had at least two births within the 24-month index period. Only those women who have a second birth were included in the calculations, thus, dropping all women who did not give birth a second time during the study

period, which should be considered a positive outcome attributable to the program. By calculating the number of women who do not give birth within 24 months of enrollment in the program, women who do not have a second birth can be included in the calculations related to the positive outcomes of the program. The methods and inclusion and exclusion criteria for calculating the interbirth intervals are found in detail in *Appendix D.*

The unadjusted average interbirth intervals (IBIs) in number of months for FPW enrollees and FPW non-enrollees for DY20 through DY22 are found in Table 2. In DY20, the average IBI for women enrolled in the FPW program was 17.5 months and the average IBI for women not enrolled in the FPW program was 15.6 months. In DY21, the average IBI for women enrolled in the FPW program was 16.3 months. The average IBI for women not enrolled in the FPW program was 14.7 months in DY21. Finally, in DY22, the average IBI for women enrolled in the FPW program was 16.8 months and the average IBI for women not enrolled in the FPW program was 14.2 months for a difference of 2.6 months. To assess whether the interbirth intervals were statistically significantly different between FPW enrollees and eligible women not enrolled, the research team performed regression models adjusting for age, race, and ethnicity. The differences in the IBIs between FPW enrollees and non-enrollees were all significant at P<.001. The IBI in number of months between the index and subsequent births for FPW enrollees compared to eligible women who did not enroll in DY20 was 11.6% longer, in DY21 10.7% longer, and in DY22, 18.8% longer. After assessing several data sources for benchmarking, it was determined none of the sources contained data on interbirth intervals to allow comparisons to be made.

The hypothesis that IBI will be greater for FPW enrollees compared to non-enrollees was supported.

Table 2: Average Interbirth Intervals in Months for FPW Enrollees and Non-Enrollees by DY 20-DY22

	DY20 (2017-2018)	DY21 (2018-2019)	DY22 (2019-2020)
Average IBI for FPW Enrollees (months)	17.5	16.3	16.8
Average IBI for FPW Non-Enrollees (months)	15.6	14.7	14.2

RQ3: What is the rate of unintended pregnancies for FPW enrollees and eligible women who do not enroll in the FPW program per Demonstration Year?

The number of unintended pregnancies was measured by comparing responses to questions 5 and 14 on the Healthy Start Prenatal Risk Screen among FPW participants and non-participants. For women who became pregnant anytime during DY20, DY21, and DY22, the research team identified FPW enrollees who indicated on the Healthy Start Prenatal Risk Screens that their pregnancies were unwanted or unintended. The methods and inclusion and exclusion criteria for calculating the unintended pregnancies are found in detail in the Appendix E. Tables 3a and 3b illustrate the number of responses to each question on the Healthy Start Prenatal Risk Screen as well as the rates of unintended pregnancies. Table 3c shows odds ratios for logistic regression models of unintended pregnancies, by FPW enrollee status and demonstration year.

DY20. For DY20 (SFY2017-2018), 13.7% (Table 3a) of FPW enrollees indicated that it was not a good time to be pregnant (question 5) as compared to 9.2% (Table 3b) of FPW non-enrollees. Responses to question 14 indicated that 57.5% of FPW enrollees answered "later" or "not pregnant" as compared to 44.0% of FPW non-enrollees. When combining all negative responses across both questions 5 and 14 to capture the overall rate of unintended pregnancies, 58.0% of FPW enrollees indicated that their pregnancy was unintended as compared to 44.8% of FPW non-enrollees. In addition, FPW enrollees have significantly higher odds of a reported unintended pregnancy (OR: 1.52, $p < .001$) compared with FPW non-enrollees, when controlling for age and race/ethnicity (Table 3c).

The Centers for Disease Control and Prevention's Pregnancy Risk Assessment and Monitoring System (PRAMS) presents national and state-level estimates of pregnancy intention as four categories: 1) mistimed pregnancy, 2) unwanted pregnancy, 3) unsure whether wanted pregnancy, and 4) intended pregnancy. In 2018, PRAMS found that 19.4% of pregnancies were reported as mistimed, 6.5% were reported as unwanted, 15.6% were unsure whether they wanted the pregnancy, for a total unintended pregnancy rate of 41.5% among U.S. women,and a reported intended pregnancy rate of 58.5% (PRAMS, 2023). Thus, the rates of unintended pregnancies were higher in Florida compared to national rates. However, it is important to note that the national PRAMS estimates do not account for income or Medicaid status and are therefore not likely to be directly comparable to the FPW enrollee and FPW non-enrollee groups (which applies to DY21 and DY22 benchmark estimates as well).

DY21. For DY21 (SFY2018-2019), 12.7% (Table 3a) of FPW enrollees indicated that it was not a good time to be pregnant (question 5) as compared to 9.7% (Table 3b) of FPW non-enrollees. Responses to question 14 indicated that 57.4% of FPW enrollees answered "later" or "not pregnant" as compared to 41.3% of FPW non-enrollees. When combining all negative responses across both questions 5 and 14 to capture the overall rate of unintended pregnancies, 57.8% of FPW enrollees indicated that their pregnancy was unintended as compared to 42.1% of FPW non-enrollees. As with DY20, FPW enrollees have significantly higher odds of a reported unintended pregnancy (OR: 1.70, $p < .001$) compared with FPW non-enrollees, when controlling for age and race/ethnicity (Table 3c).

In 2019, PRAMS found that 19.3% of pregnancies were reported as mistimed, 6.5% were reported as unwanted, 15.7% were unsure whether they wanted the pregnancy, for a total unintended pregnancy rate of 41.5% among U.S. women, and a reported intended pregnancy rate of 58.5% (PRAMS, 2023). Rates of unintended pregnancies were higher in Florida compared to these national rates.

DY22. For DY22 (SFY2019-20), 12.3% (Table 3a) of FPW enrollees indicated that it was not a good time to be pregnant (question 5) as compared to 11.7% (Table 3b) of FPW non-enrollees. Responses to question 14 indicated that 54.5% of FPW enrollees answered "later" or "not pregnant" as compared to 49.4% of FPW non-enrollees. When combining all negative responses across both questions 5 and 14 to capture the overall rate of unintended pregnancies, 55.8% of FPW enrollees indicated that their pregnancy was unintended as compared to 50.9% of FPW non-enrollees. As with DY20 and DY21, FPW enrollees have significantly higher odds of a reported unintended pregnancy (OR: 1.20, $p < .001$) compared with FPW non-enrollees, when controlling for age and race/ethnicity (Table 3c).

In 2020, PRAMS found that 17.7% of pregnancies were reported as mistimed, 6.3% were reported as unwanted, 15.5% were unsure whether they wanted the pregnancy, for a total unintended pregnancy rate of 39.5% among U.S. women (and a reported intended pregnancy rate of 60.4%) (PRAMS, 2023). Rates of unintended pregnancies were higher in Florida compared to these national rates.

The hypothesis that rates of unintended pregnancies would be lower among FPW enrollees compared to eligible non-enrollees was not supported, with significantly higher rates among FPW enrollees.

Table 3a: Rate of Unintended Pregnancies for FPW Enrollees DY20 (SFY2017-2018)**, DY21** (SFY2018-2019)**, and DY22** (SFY2019-20)

Question 5. Is this a good time for you to be pregnant?	**DY20**	**DY21**	**DY22**
Yes (#)	10,636	7,471	6,721
No (#)	1,683	1,091	945
Total Responses Question 5 (#)	**12,319**	**8,562**	**7,666**
Question 5 Rate of Unintended Pregnancies (%)	**13.7**	**12.7**	**12.3**
Question 14. Thinking back to just before you got pregnant, did you want to be?			
Pregnant Now (#)	5,272	3,693	3,502
Pregnant Later (#)	5,301	3,627	3,150
Not Pregnant (#)	1,823	1,302	1,047
Total Pregnant Later & Not Pregnant (#)	7,124	4,929	4,197
Total All Responses Question 14 (#)	**12,396**	**8,622**	**7,699**
Question 14 Rate of Unintended Pregnancies (%)	**57.5**	**57.2**	**54.5**
Negative Responses Question 5 & Question 14			
Question 5 = No (#)	1,683	1,091	945
Question 5 = Yes & Question 14 = "pregnant later" or "not pregnant" (#)	5,510	3,894	3,354
Total Number of Negative Responses Question 5 & Question 14 (#)	**7,193**	**4,985**	**4,299**
Total Number of Responses Question 5 & Question 14* (#)	**12,396**	**8,622**	**7,699**
Overall Rate of FPW Participant Unintended Pregnancies (%)	**58.0**	**57.8**	**55.8**

***** The total number of responses for questions 5 and 14 represents those unique individuals who responded to either question 5 or question 14 or both.

Table 3b: Rate of Unintended Pregnancies for FPW Non-Enrollees DY20 (SFY2017-2018)**, DY21** (SFY2018-2019)**, and DY22** (SFY2019-20)

Question 5. Is this a good time for you to be pregnant?	**DY20**	**DY21**	**DY22**
Yes (#)	6,393	3,969	17,460
No (#)	650	426	2,323
Total Responses Question 5 (#)	**7,043**	**4,395**	**19,783**
Question 5 Rate of Unintended Pregnancies (%)	**9.2**	**9.7**	**11.7**
Question 14. Thinking back to just before you got pregnant, did you want to be?			
Pregnant Now (#)	3,966	2,593	10,063
Pregnant Later (#)	2,281	1,368	7,543
Not Pregnant (#)	837	454	2,289
Total Pregnant Later & Not Pregnant (#)	3,118	1,822	9,832
Total All Responses Question 14 (#)	**7,084**	**4,415**	**19,895**
Question 14 Rate of Unintended Pregnancies (%)	**44.0**	**41.3**	**49.4**
Negative Responses Question 5 & Question 14			
Question 5 = No (#)	650	426	2,323
Question 5 = Yes & Question 14 = “pregnant later” or “not pregnant” (#)	2,522	1,431	7,797
Total Number of Negative Responses Question 5 & Question 14 (#)	**3,172**	**1,857**	**10,120**
Total Number of Responses Question 5 & Question 14* (#)	**7,084**	**4,415**	**19,895**
Overall Rate of FPW Non-Participant Unintended Pregnancies (%)	**44.8**	**42.1**	**50.9**

* The total number of responses for questions 5 and 14 represents those unique individuals who responded to either question 5 or question 14 or both.

Table 3c: Adjusted Odds Ratios (95% CI) for Unintended Pregnancies by Demonstration Year

	Unintended Pregnancy (Total # of Negative Responses to Question 5 & Question 14)		
	DY20	**DY21**	**DY22**
FPW Enrollee	1.52***	1.70***	1.20***
	(1.43-1.61)	(1.58-1.84)	(1.14-1.27)
Age	0.96***	0.96***	0.96***
	(0.95-0.97)	(0.95-0.96)	(0.95-0.96)
Race/Ethnicity			
White	Reference	Reference	Reference
Black	2.09***	2.28***	1.77***
	(1.94-2.25)	(2.09-2.50)	(1.66-1.88)
Hispanic	1.00	1.10*	0.91*
	(0.93-1.07)	(1.00-1.20)	(0.86-0.97)
Asian	0.81†	0.87	0.70†
	(0.63-1.03)	(0.64-1.18)	(0.54-0.91)
American/Asian Indian & Other	1.09	1.21†	1.04
	(0.96-1.24)	(1.05-1.40)	(0.94-1.14)

†p<10;*p<05;**p<01;***p<001

RQ4: What is the rate of low birth weight and preterm births for FPW enrollees compared to women who are eligible but do not enroll in the FPW program?

For each demonstration year, births were identified by a date of birth occurring during the specified DY timeframe as follows:

- DY20 births were identified by a date of birth that occurred during DY20 (July 1, 2017-June 30, 2018).

- DY21 births were identified by a date of birth that occurred during DY21 (July 1, 2018-June 30, 2019).
- DY22 births were identified by a date of birth that occurred during DY22 (July 1, 2019-June 30, 2020).

Cases with missing birth weight and/or clinical conception dates were excluded. Low birth weight births were identified by reported birth weight less than 2,500 grams. Pre-term births were classified as births occurring before 37 weeks gestation. Gestation length was calculated using the estimated clinical conception dates and dates of birth. These birth records were then matched to FPW enrollees and FPW non-enrollees for each respective DY. For the FPW enrollees, births were excluded if they did not happen during the woman's enrollment span. Frequencies and proportions of low birth weight and pre-term births were calculated for FPW enrollees and non-enrollees. Additionally, logistic regression models were run to determine if there were significant differences in low birth weight and pre-term births between FPW enrollees and FPW non-enrollees.

Table 4a shows the number of births considered "low birth weight" (<2,500 grams) and "pre-term births" (<37 weeks) to FPW enrollees and non-enrollees for DY20, DY21, and DY22. Note that "low birth weight" and "pre-term births" are not mutually exclusive categories and may overlap. FPW enrollees have a slightly smaller proportion of low birth weight births and pre-term births than the FPW non-enrollees in each of the three demonstration years (DY20, DY21, and DY22).

In DY20, 9.0% (3,976) of births to FPW enrollees were classified as low birth weight, compared to 9.4% (4,414) of births to FPW non-enrollees. The proportion of pre-term births to FPW enrollees was also slightly smaller at 13.3% (5,858 births), compared with 13.6% (6,360) of births to FPW non-enrollees. National Vital Statistics Data show that 8.3% of all U.S. births in 2018 were classified as low birth weight, and 10.0% of all births were classified as pre-term (CDC, 2020). However, the national estimates do not account for income or Medicaid status, and are therefore not likely to be directly comparable to the FPW enrollee and FPW non-enrollee groups (which applies to DY21 and DY22 benchmark estimates as well). In DY21, 9.0% (4,072) of births to FPW enrollees were classified as low birth weight, compared to 9.6% (4,186) of births to FPW non-enrollees. The proportion of pre-term births to FPW enrollees was also slightly smaller at 13.2% (5,979 births), compared with 13.9% (6,024) of births to FPW non-enrollees. National Vital Statistics Data show

that 8.3% of all U.S. births in 2019 were classified as low birth weight, and 10.2% of all births were classified as pre-term (CDC, 2021).

In DY22, 9.1% (3,161) of births to FPW enrollees were classified as low birth weight, compared to 9.7% (5,684) of births to FPW non-enrollees. The proportion of pre-term births to FPW enrollees was also slightly smaller at 11.1% (3,857 births), compared with 11.2% (5,684) of births to FPW non-enrollees. National Vital Statistics Data show that 8.2% of all U.S. births in 2020 were classified as low birth weight, and 10.1% of all births were classified as pre-term (CDC, 2022).

Table 4a: Rates of Low Birth Weight and Preterm Births for FPW Enrollees and FPW Non-Enrollees

	DY20		DY21		DY22	
Low birth weight (<2,500 grams)	**Count**	**%**	**Count**	**%**	**Count**	**%**
FPW Enrollees	3,976	9.0%	4,072	9.0%	3,161	9.1%
FPW Non-Enrollees	4,414	9.4%	4,186	9.6%	4,923	9.7%
Pre-term births (<37 weeks)						
FPW Enrollees	5,858	13.3%	5,979	13.2%	3,857	11.1%
FPW Non-Enrollees	6,360	13.6%	6,024	13.9%	5,684	11.2%
Total births						
FPW Enrollees	44,037	100%	45,241	100%	34,733	100%
FPW Non-Enrollees	46,764	100%	43,473	100%	50,724	100%

Note: "Low birth weight" and "pre-term births" are not mutually exclusive categories.

Table 4b shows odds ratios for logistic regression models of low birth weight births, by FPW enrollee status and demonstration year. FPW enrollees have significantly lower odds of a low birth weight birth for all three demonstration years, compared with FPW non-enrollees, when controlling for age and race/ethnicity.

Table 4b: Odds Ratios (95% CI) for Low Birth Weight Births by Demonstration Year

	Low birth weight (<2,500 grams)		
	DY20	**DY21**	**DY22**
FPW Enrollee	0.93**	0.91***	0.91***
	(0.89-0.97)	(0.87-0.95)	(0.86-0.95)
Age	1.01***	1.01***	1.01***
	(1.00-1.01)	(1.01-1.02)	(1.01-1.02)
Race/Ethnicity			
Black	1.75***	1.89***	1.90***
	(1.65-1.85)	(1.78-2.00)	(1.80-2.01)

Hispanic	0.88***	0.91**	0.86***
	(0.83-0.93)	(0.86-0.97)	(0.81-0.92)
Asian	0.92	1.24*	1.28*
	(0.74-1.15)	(1.01-1.52)	(1.04-1.58)
American/Asian Indian & Other	1.03	1.03	1.07
	(0.93-1.14)	(0.93-1.14)	(0.97-1.18)

†p<10;*p<05;**p<01;***p<001

Table 4c shows odds ratios for logistic regression models of pre-term births, by FPW enrollee status and demonstration year. FPW enrollees have significantly lower odds of a pre-term birth for DY20 and DY21, compared with FPW non-enrollees, when controlling for age and race/ethnicity.

Table 4c: Odds Ratios (95% CI) for Pre-term Births by Demonstration Year

	Pre-term births (<37 weeks)		
	DY20	**DY21**	**DY22**
FPW Enrollee	0.97†	0.94**	0.97
	(0.93-1.00)	(0.90-0.97)	(0.93-1.01)
Age	1.02***	1.02***	1.03***
	(1.02-1.02)	(1.02-1.02)	(1.02-1.03)
Race/Ethnicity			
Black	1.60***	1.60***	1.49***
	(1.52-1.68)	(1.52-1.68)	(1.41-1.57)
Hispanic	1.14***	1.10***	0.90**
	(1.08-1.20)	(1.04-1.16)	(0.85-0.96)
Asian	0.95	1.06	1.02
	(0.80-1.14)	(0.89-1.28)	(0.83-1.24)
American/Asian Indian & Other	1.00	1.02	1.00
	(0.91-1.09)	(0.94-1.12)	(0.91-1.09)

†p<10;*p<05;p<01;***p<001**

The hypothesis that rates of low birthweight and preterm births would be lower among FPW enrollees compared to eligible non-enrollees was supported.

RQ5: Is the FPW achieving cost savings by slowing the birth rate?

The analytic strategy used for this question was to determine the total number of averted births that were attributed to the FPW program. This was done by comparing a combined birth and conception rate between women enrolled in FPW and eligible women who did not enroll in the FPW program. The birth rate numerator included the number of births, the number of conceptions, and the number of conceptions and births that occurred in the DY. However, for the women enrolled in FPW program, the births and/or conceptions in the DY must have occurred in after the date of enrollment in FPW. The denominators for the birth rate calculations included the total number of women in each group those enrolled in FPW and those eligible but not enrolled. Logistic regression models controlling for age race and ethnicity were conducted to assess whether there was a statistically significant difference in the birth rates between FPW enrollees and non-enrollees controlling for population demographics. In each of the DYs, estimated cost savings were driven by the statistically significant differences in birth rates for FPW enrolled women compared to those eligible but not enrolled after controlling for age, race, and ethnicity. Generally, the eligible but not enrolled group had higher rates of birth than FPW enrollees. The number of averted births were calculated using the difference of the estimated number of births of FPW enrollees assuming they had the same birth rate as eligible women not enrolled in FPW and the observed number of births among women enrolled in the FPW program in a given demonstration year.

To determine net cost savings, FPW program expenditures for each DY were deducted from the estimated cost savings attributed to averted births. The methods and inclusion and exclusion criteria for calculating the cost savings are found in detail in *Appendix F*.

The number of averted births among enrollees is estimated using the following formula:

Number of Births Averted = (Estimated number of births of FPW enrollees assuming they had the same birth rate as eligible women not enrolled in FPW in DY20 – Observed number of births in DY20 (SFY2017-2018) by FPW enrollees)

Total Medicaid birth/infant costs for DY20 (SFY2017-2018) is estimated using the following formula:

Total DY20 Medicaid Birth Costs = Cost of services for the birth + costs of services provided to infants from birth to age 1

Average DY20 (SFY2017-2018) FPW Medicaid birth costs is calculated using the following formula:

Average DY20 Medicaid Birth Costs for FPW Enrollees = Total DY20 Medicaid birth costs / Total number of FPW enrollee births during DY20

The estimated gross cost savings due to averted births calculation is:

DY20 (SFY2017-2018) Averted Births Gross Cost Savings = DY20 (SFY2017-2018) Number of FPW Enrollee Births Averted x Average DY20 Medicaid Birth Costs for FPW Enrollees

As shown in Table 5a, in DY20 women enrolled in the FPW program had nearly 7,200 fewer births than women eligible but not enrolled in FPW for a total cost savings of approximately $103 million dollars. In DY21, women in the FPW program had 6,800 fewer births than women not in the FPW program resulting in cost savings of $91.6 million. And last, women enrolled in the FPW program in DY22 had almost 6,200 fewer births than women eligible but not enrolled in FPW for a total cost savings of approximately $86.1 million. Publicly available data related to cost savings in other states relative to family planning waiver programs were not found, thus, benchmarking is unable to be performed for this question.

The hypothesis that the FPW program would achieve cost savings through lower birthrates among FPW enrollees compared to eligible non-enrollees was supported.

Table 5a: DY20-DY22 Medicaid Cost Savings

Demonstration Year (DY)	Difference in Number of Births	Average Medicaid Birth Costs ($)	Gross Cost Savings	FPW Program Expenditures*	Total Net Cost Savings ($)
DY20	7,193	$14,908	$107,243,600	$3,974,559	$103,269,041
DY21	6,822	$14,054	$95,870,486	$4,247,202	$91,623,284
DY22	6,171	$14,508	$89,531,614	$3,392,609	$86,139,005

RQ6: What are the reasons that women eligible for the FPW program choose to not enroll in the FPW program and the reasons women enrolled in the FPW program do not participate?

The primary data source for research question 6 is the responses to qualitative interviews conducted by the evaluation team in the Spring of 2020 (to assess DY20/21) and and the Spring of 2021 (to assess DY22) with eligible women who did not enroll in FPW as well as qualitative interviews with FPW enrollees who did not use services. Identification of common themes were analyzed using Nvivo software (Nvivo, 2015).

Survey Sample

Seventy-five (75) qualitative telephone interviews were conducted in each year by the University of Florida survey research center. The respondents in each year included:

- Twenty-five (25) women enrolled in the FPW program and using FPW services
- Twenty-five (25) women eligible for the FPW program but not enrolled, and
- Twenty-five (25) women enrolled in the FPW program but not using any FPW services

Eligible but no enrolled

For the eligible but not enrolled group in DY20/21, the most cited reason for not enrolling in the program was the lack of awareness (i.e., either lacking awareness of enrollment or lack of knowledge about the program) concerning the program (n=18) followed by incorrectly classified as eligible for the program (n=3), moving out of state (n=2), and deeming the services as unnecessary (n=2). For the eligible but not enrolled group in DY22, the most cited reason for not enrolling in the program, similar to DY20/21, was the lack of awareness concerning the program (n=18) followed by lack of interest (n=3), prior negative experience (n=2), and incorrectly classified as eligible for the program (n=1).

Enrolled but did not participate

For the enrolled but did not participate group in DY20/21, the most cited reason for not participating was a lack of awareness (n=20), moving out of state (n=3), and a general lack of interest in the program (n=1) Similar to DY20/21, the most cited reason for the individuals enrolled but not participated group not participating in DY22 was a lack of awareness (n=12); however, other reasons cited in DY22 included a lack of need for the program (n=6) and a lack of convenience (n=1).

Enrolled and participated

For the Enrolled but not participated group in DY20/21, the most cited reason for not participating was a lack of awareness (n=20), moving out of state (n=3), and a general lack of interest in the program (n=1) Similar to DY20/21, the most cited reason for the individuals enrolled but not participated group not participating in DY22 was a lack of awareness (n=12); however, other reasons cited in DY22 included a lack of need for the program (n=6) and a lack of convenience (n=1).

For the enrolled and participated group in DY20/21, none of the 14 enrollees in this group that responded to the survey provided reasons for participating in the program with most of the respondents reported not being aware of using the program (n=9) while the rest of the respondents reported either not being eligible for the program (n=1), not aware of their enrollment into the program (n=1), or a wrong number (n=1). For DY22, the individuals in the enrolled and participated group specified reasons for participating unlike DY20/21 in which the most commonly cited reason entailed the need to use it for their current or past pregnancy (n=8) followed by the need for birth control (n=6), financial considerations (n=4), and promoting their health (n=1).

RQ7: How do FPW enrollees utilize covered health services?

To address research question 7, the analysis team computed descriptive statistics of eligibility, enrollment, and covered service utilization for each DY. Medicaid enrollment and claims data was used to assess utilization rates of contraceptive services, cancer screening services, STD services, and other uncategorized covered services for all FPW enrollees per DY.

Table 7 presents the number and participation rate of enrollees that used at least one covered service, by covered service category and enrollee year, for DY20 through DY22.

Table 7. Utilization of Covered Services by FPW Enrollees, DY20 through DY22

	DY20						DY21						DY22					
	Enrollee Year						Enrollee Year						Enrollee Year					
	1st		2nd		Total		1st		2nd		Total		1st		2nd		Total	
Covered Service	N	PR*	N	PR*	N	PR*	N	PR*	N	PR*	N	PR*	N	PR*	N	PR*	N	PR*
Any Received	3,503	9.5	11,102	11.2	14,605	10.8	3,706	9.9	11,393	11.4	15,099	11.0	4,380	15.9	17,498	17.8	21,878	17.4
Contraception	1,319	3.6	4,118	4.2	5,437	4.0	1,469	3.9	4,538	4.5	6,007	4.4	1,669	6.1	7,839	8.0	9,508	7.6
STD Screening	1,253	3.4	4,272	4.3	5,525	4.1	1,412	3.8	4,469	4.5	5,881	4.3	1,727	6.3	6,608	6.7	8,335	6.6
Cancer Screening	342	0.9	1292	1.3	1634	1.2	314	0.8	1180	1.2	1494	1.1	354	1.3	1373	1.4	1727	1.4
Other**	2,668	7.3	8,837	8.9	11,505	8.5	2,830	7.6	8,960	8.9	11,790	8.6	3,717	13.5	14,992	15.3	18,709	14.9

*Participation rates (%) are based on corresponding enrollment figures in Table 8.1.
**Other services category contains CPT codes that are services not categorized as contraceptive, STD, or cancer screening services from the "Medicaid Family Planning Waiver Services CPT Codes and ICD-10 Diagnosis Codes" document provided by the Agency.

The participation rate for FPW enrollees that used at least one covered service rose to 17.4% in DY22 from 10.8% in DY20. The participation rate of first-year enrollees, defined as the number of first-year enrollees that used at least one covered service as a proportion of total first-year enrollees for a given DY, rose to 15.9% in DY22 from 9.5% in DY20. Similarly, the participation rate of second-year enrollees rose to 17.8% in DY22 from 11.2% in DY20. These general trends are also seen at the detailed covered service category level, which indicates that from DY20 to DY22 recipients who enroll in the FPW program are increasingly utilizing covered services.

Nationwide, we see similar trends in Medicaid enrollee metrics sourced from the 'CMS Medicaid/CHIP Child and Adult Core Sets' and weighted by the Medicaid-enrolled populations of children and/or adults in each state, as derived from the 'State Medicaid and CHIP Applications, Eligibility Determinations, and Enrollment Data' for a given federal fiscal year (FFY). The percentage of postpartum women provided a most effective or moderately effective method of contraception within 60 days of delivery, ages 15-44, rose to 38.2% from 31.8% from FFY2018 to FFY2020. The percentage of sexually active women screened for chlamydia, ages 16-24, rose to 59.8% from 58.9% from FFY2018 to FFY2020. Lastly, the percentage of women screened for cervical cancer, ages 21-64, rose to 57.9% from 56.2% from FFY2018 to FFY2020.

The hypothesis that participation rates will increase over time among FPW enrollees was supported.

RQ8: What gaps in coverage are experienced by FPW enrollees over time?

Table 8.1 shows the total number of FPW enrollees for DY20, DY21, and DY22, by number of years enrolled. The proportion of individuals who maintain coverage during their second year of eligibility has

increased since DY20. In DY22, 84.4% of all enrollees maintained coverage into their second year of eligibility, compared with 76.2% in DY20 and 77.1% in DY21.

Among the 135,489 enrollees in DY20, 23.8% (32,253 individuals) only had coverage during their first 12 months, while 76.2% (103,236) maintained coverage during their second year of eligibility. Among the 137,651 enrollees in DY21, 22.9% (31,524) only had coverage during their first 12 months, while 77.1% (106,651) maintained coverage during their second year. There are 125,641 enrollees in DY22, and among these enrollees, 15.6% (19,547 individuals) only have coverage during their first 12 months, while 84.4% (106,094) maintain coverage during their second year of eligibility.

Table 8.1: First and Second Year FPW Enrollment in DY20, DY21, and DY22

Enrollment	DY20 Enrollees	DY21 Enrollees	DY22 Enrollees
First Year Only	32,253 (23.8%)	31,524 (22.9%)	19,547 (15.6%)
Second Year	103,236 (76.2%)	106,127 (77.1%)	106,094 (84.4%)
Total	135,489 (100%)	137,651 (100%)	125,641 (100%)

Note: Second year includes individuals with more than 12 months of enrollment, but may not be a full 24 months of enrollment. “First year only” includes individuals with 1-12 months of enrollment, and “second year” includes individuals with more than 12 months enrollment.

Table 8.2 shows the total number of women who maintain coverage beyond the first year, broken down by those who lose coverage after two years, and those who maintain coverage beyond 2 years. In comparison with DY20 and DY21, a smaller proportion of DY22 women lost coverage after two years (among individuals enrolled beyond one year). However, the proportion who lost coverage after two years slightly increased from 83.36% in DY20 to 84.04% in DY21, and then decreased to 62.43% in DY22.

Table 8.2: Enrollees who Lose Coverage after Two Years in DY20, DY21, and DY22, among Individuals Enrolled Beyond 1 Year

Enrollment	DY20 Enrollees	DY21 Enrollees	DY22 Enrollees
Lose Coverage after 2 Years	86,053 (83.36%)	89,185 (84.04%)	66,237 (62.43%)
Maintain Coverage beyond 2 years	17,183 (16.64%)	16,942 (15.96%)	39,857 (37.57%)
Total	103,236 (100%)	106,127 (100%)	106,094 (100%)

Note: Length of enrollment for DY22 enrollees may not be fully completed. The number of individuals enrolled beyond 1 year includes individuals with more than 12 months of enrollment, but may not be a full 24 months of enrollment. Those who maintain coverage beyond 2 years have more than 24 months of consecutive enrollment.

Table 8.3 looks at gaps in FPW coverage between enrollment spans. The average length of time between prior enrollments ending and new enrollments beginning was shortest for DY22 enrollees at 6.98 months compared with 7.37 months for DY20 enrollees and 7.49 months for DY21 enrollees. Among the DY20 enrollees, 23,548 individuals had a prior enrollment span in the last 5 years. The average length of time between prior enrollment ending and DY20 enrollment beginning is 7.37 months, and ranges from 1 to 27 months. There were 24,507 DY21 enrollees who had a prior enrollment span in the last 5 years. The average length of time between prior enrollment ending and DY21 enrollment beginning is 7.49 months, and ranges from 1 to 26 months. Among the DY22 enrollees, 22,020 individuals had a prior enrollment span in the last 5 years. The average length of time between prior enrollment ending and DY22 enrollment beginning is 6.98 months, and ranges from 1 to 25 months.

Table 8.3: Average length of time between FPW enrollees' most recent enrollment period and the previous enrollment period (limited to previous 5 years)

DY	N	Mean	Std Dev	Min	Max
DY20	23,548	7.37	5.33	1	27
DY21	24,507	7.49	5.38	1	26
DY22	22,020	6.98	4.98	1	25

Note: only individuals who had a prior enrollment span and had a gap in coverage are included in N.

The hypothesis that a greater proportion of women will maintain their FPW coverage over time was supported, with more women remaining enrolled during the second year of eligibility and shorter gaps between eligibility spans.

RQ9: Are FPW enrollees satisfied with services?

The primary data source for research question 9 is the responses to the quantitative telephone-based surveys completed by FPW enrollees who used FPW services in DY20/21 and DY22. No surveys were conducted in DY21. Survey results are shown in Table 9.

In DY20, a vast majority of individuals who received care reported being satisfied (i.e., either "Satisfied" or "Very Satisfied") with services including 88% of enrollees (n=7) for contraceptive care, all enrollees for STD testing (n=7), and all enrollees for cervical cancer screening (n=8) (Table 1). A similar trend of satisfaction was present in DY22 in which 85% (n=29) of enrollees reported satisfaction with contraceptive care services, 95% (n=19) of enrollees reported satisfaction with STD testing services, and all enrollees (n=13) reported satisfaction with cervical cancer screening. It should be noted that the small sample sizes reported here are because satisfaction was only assessed among those women who completed the survey and knew that they used FPW services. Most women who used FPW services were not aware that they used these services, thus were not asked about their satisfaction with those services.

The hypothesis that the majority of FPW enrollees who used services would be satisfied with those services was supported.

Table 9: Satisfaction with Services in DY20/21 and DY22

	Satisfaction Category					
Response Category	**Contraceptive care**		**STD Testing**		**Cervical Cancer Screening**	
	% (n)		**% (n)**		**% (n)**	
	DY20/21 (n=8)	**DY22 (n=34)**	**DY20/21 (n=7)**	**DY22 (n=20)**	**DY20/21 (n=8)**	**DY22 (n=13)**
Very Satisfied	50 (4)	70 (24)	29 (2)	75 (15)	12 (1)	38 (5)

Satisfied	38 (3)	15 (5)	71 (5)	20 (4)	88 (7)	62 (8)
Dissatisfied	0 (0)	3 (1)	0 (0)	5 (1)	0 (0)	0 (0)
Very Dissatisfied	12 (1)	12 (4)	0 (0)	0 (0)	0 (0)	0 (0)

RQ10: What strategies are being used by the Department of Health to increase FPW participation rates?

The primary data source for research question 10 is the responses to a qualitative surveys completed by DOH frontline staff for DY20. These surveys with DOH staff were not repeated in DY21 or DY22. Results presented here are from the DY20 survey.

Among the nine DOH employees who participated in the survey, two stated their agency does not use any strategies to increase FPW participation rates. From the remaining responses (n=7), I strategies cited by DOH employees to increase FPW participation rates include 1) employee incentivization (i.e., conducting a competition for identifying and enrolling the most individuals into the program); 2) active external outreach (i.e., direct communication with community partners to facilitate the process for potential enrollees); 3) passive external outreach (i.e., using flyers and postings in outside clinics and agencies); 4) pre-appointment patient eligibility review (i.e., using systems such as FLMMIS Medicaid and Department of Labor's Suntax to determine eligibility of individuals); 5) pre-appointment and in-appointment information sharing (i.e., distributing FPW materials or information before or during the appointment); and 6) following up with potential enrollees post-appointment concerning application materials. Excerpts associated with each of these strategies are displayed in Table 10.1.

Table 10.1: Selected Quotes from Strategies (n=9)

Strategy	Quote(s)
Employee Incentivization	"In the pas' we've had competitions as to who can identify and obtain the most potentially eligible FPW applications."
External Outreach- Active	"Reached out to other community partners and set up a fax-in system for the FPW applications."
External Outreach- Passive	"We have signage posted in other departments such as WIC, Dental and Immunization clinics."

Strategy	Quote(s)
Pre-appointment Patient Eligibility Review	1. "We also review all schedules for patients coming in to determine if they would be eligible for FP Waiver program and enter a comment in the computer system to explain the program and provide the patient with an application." 2. "The appointment schedules are checked at least a day in advance and all women presenting have FLMMIS Medicaid computer system checked for potential FPW eligibility." 3. "Each and every time the client comes in for any services, we check to see if they qualify for FP Waiver and encourage them to fill out paperwork and return to office." 4. "Use Department of Labor Suntax and provide other assistance when possible to verify income." 5. "Check Medicaid on all clients and give application to anyone who has had Medicaid in the last year."
Pre-appointment and In-appointment Information Sharing	1. "Those'who've lost their Medicaid within the past 2 years are sent a letter with enclosed application regarding the FPW Medicaid Program." 2. "Clients who come in for family planning services are informed of FPW Medicaid program by clinic FP provider and given an application." 3. "Clients are educated when making appointments on needed documents to enroll in Family Planning wavier program they are also instructed again at reminder call for appointment."
Follow Up	1. "Sending letters and application." 2. "Also, I call the clients that were on the first year FP Waiver, and notify them of the second if qualified." 3. "We also follow-up with clients two weeks after they complete application if they are missing documents to process application."

Conclusions, Positive Outcomes, Challenges, and Lessons Learned

Positive Outcomes

Overall, there were several positive outcomes of the FPW program.

- The total proportion of eligible women who enrolled in the FPW program increased in DY22 compared to DY20 and DY21.
- Women enrolled in the FPW program continue to have longer interbirth intervals, generating significant cost savings that average approximately $90 million per year.
- Among those women who used FPW services and were aware that they used those services, they were overwhelmingly satisfied with those services and indicated that the services were easy to access.
- FPW enrollees have a slightly smaller proportion of low birth weight births and pre-term births than the FPW non-enrollees in DY20, DY21, and DY22.
- Logistic regression models show that the FPW enrollees have significantly lower odds of low birth weight births than FPW non-enrollees, when comparing for age and race/ethnicity, for DY20, DY21, and DY22. FPW enrollees also have significantly lower odds of pre-term births than FPW non-enrollees for DY20 and DY21.
- The proportion of individuals who maintain coverage during their second year of eligibility has increased since DY20, while the proportion of individuals who only had coverage during their first 12 months has decreased since DY20. In DY22, 84.4% of enrollees maintained coverage into their second year of eligibility, compared with 76.2% in DY20 and 77.1% in DY21.
- In comparison with DY20 and DY21, a smaller proportion of DY22 women lost coverage after two years (among individuals enrolled beyond one year). However, the proportion who lost coverage after two years slightly increased from 83.4% in DY20 to 84.0% in DY21, and then decreased to 62.4% in DY22.
- The average length of time between prior enrollments ending and new enrollments beginning was shortest for DY22 enrollees at 6.98 months, compared with 7.37 months for DY20 enrollees and 7.49 months for DY21 enrollees.

Challenges and Limitations

There were several notable challenges identified both with the FPW program and in the process of evaluating the program.

- Because the evaluation was observational in nature and compared FPW enrollees to women who were eligible but not enrolled, causal analysis was not possible and the analysis was subject to selection bias. Multivariate analyses were conducted to adjust for differences in age, race, and ethnicity between the enrolled and non-enrolled to minimize this bias due to confounding, but other unmeasured characteristics between the two groups most likely remained and may impact the results.
- Methodological challenges primarily stemmed from managing and using the data to properly classify enrollees vs. non-enrollees. More specifically, enrollee data had many cases with multiple, short enrollment spans, that often overlapped. We were able to overcome this challenge by using the multiple dates to identify the full enrollment span.
- Enrollment rates among women eligible for the FPW program, while improving, still remain very low, with 17% of eligible women enrolling in the program in DY22. Additionally, only 17% of FPW enrollees used any FPW services in DY22, although this represents an increase from DY21, when only 11% of FPW enrollees used any services. While the types of services provided through the FPW program have been shown to be effective at producing positive outcomes, the impact of the program is greatly reduced because of low enrollment and participation rates. The majority of women who were interviewed indicated that they were unaware of the program, including women who used services provided through the FPW program.
- Evaluation related challenges primarily stemmed from managing and using the data to properly classify enrollees vs. non-enrollees. More specifically, enrollee data had many cases with multiple short enrollment spans, that often overlapped. We were able to overcome this challenge by using the multiple dates to identify the full enrollment span.
- Another challenge came from matching birth records to the appropriate demonstration year and FPW enrollee status. For example, some births occurred in DY22, but did not have an enrollment record (enrollee or non-enrollee) for DY22, and instead had an enrollment record in a different DY.
- Finally, there was some ambiguity on whether to use the estimated clinical conception date or the date or birth to classify the demonstration year of births as the span of a pregnancy can last through

parts of two demonstration years. For RQ4, date of birth was used because it gave the fewest missing cases, and the question is focused specifically on the birth outcomes.

COVID-19 Context:

The COVID-19 pandemic began during the final few months of DY22 (the final year included in this summative report). Because it comprised such a small portion of time during the final DY covered by this summative report, COVID-19 was not factored into these results but will be addressed in future reports. The evaluation team did note, though, that beginning in March 2020, there was a sharp decline in the number of women enrolling in the program. This was most likely due to the U.S Department of Health and Human Services implementing a policy to continue Medicaid coverage of individuals during the pandemic regardless of whether they continued to meet the eligibility criteria. This was done to make sure that people did not lose their healthcare coverage during the pandemic.

Lessons Learned and Recommendations

Given the consistent finding of lack of knowledge of the FPW program, both among eligible women who do not enroll and enrolled women, future activities should focus on increasing enrollment and enrollee participation rates in the FPW program. Steps are already being taken by the State to improve the eligibility determination process for the FPW program by moving this activity from the DOH to the DCF, which currently does all of the eligibility determinations for Florida's Medicaid program, and automatically enrolling all eligible women into the FPW program for the initial 12-month period as well as for the second 12-month period if no additional information is needed to determine eligibility. Thus, most eligible women will be automatically enrolled for the full 24-month period, improving enrollment rates, but this strategy is unlikely to increase awareness or participation in the FPW program. Going forward, qualitative surveys of FPW enrollee and eligible non-enrollees will ask about where these women get their information about the program to help inform and improve advertising and messaging about the FPW program.

As indicated in the Healthy People 2020 initiative (https://www.healthypeople.gov/2020/topics-objectives/topic/family-planning), increased awareness of family planning services is needed and can be achieved through public outreach and improved collaboration between health care providers. Marketing of the program through social media and other platforms such as television, radio, and billboards has successfully increased awareness of public health programs, as well as additional mailings and emails by the

Agency to inform eligible and/or enrolled women of the program and benefits of the program. The Agency should also attempt to collaborate more with providers of FPW services to encourage participation as well as using strategies identified by some of the DOH clinics, including outreach, education, and proactively engaging with women to get them enrolled in the FPW program.

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Appendices

Appendix A: Specific Methods for Each Research Question

For research question 1 (What differences in recipient demographic characteristics exist between FPW enrollees and eligible women who do not enroll in FPW per DY?), Medicaid eligibility files were used to identify women who are eligible for the FPW program as well as women enrolled in the FPW program. Medicaid eligibility files were also used to identify demographic characteristics for eligible and enrolled women, and descriptive statistics of the demographic characteristics of FPW enrollees as well as eligible women who did not enroll in the FPW program were calculated for each demonstration year in the study period (DY20-DY21. Eligible women were identified as women 14 years of age up through and including women who are 55 years of age who lost Medicaid eligibility for any reason in the two years prior to the DY being examined. FPW enrollees were identified from Medicaid eligibility files.

For research question 2 (What are the interbirth intervals for FPW enrollees compared to eligible women who do not enroll in the FPW program who gave birth during the study period?), Medicaid claims and eligibility data, as well as vital statistics birth certificate data, were merged and used to compare the average interbirth intervals (IBI) in number of months for FPW enrollees and eligible women who do not enroll in the FPW program. The IBI is the time between the first birth that occurred during the DY being examined and the second live birth observed with available birth certificate data. IBI rates were compared between FPW enrollees and eligible women who are not enrolled in the FPW program using descriptive statistics for each DY.

For research question 3 (What is the rate of unintended pregnancies for FPW enrollees and eligible women who do not enroll in the FPW program per DY?), Medicaid claims and DOH data were merged. Unintended pregnancies were identified using questions 5 and 14 on the Healthy Start Prenatal Risk Screen (see Appendix E) related to pregnancy intendedness. Unintended pregnancy rates were calculated as the number of unintended pregnancies for FPW enrollees divided by the total number of births by FPW enrollees. This rate was also calculated for eligible women who do not enroll in the FPW program and compared to the rate for FPW enrollees using descriptive statistics for each DY.

For research question 4 (What is the rate of low birth weight and preterm births for FPW enrollees compared to women who are eligible but do not enroll in the FPW program?), Medicaid eligibility and claims data

were merged with Vital Statistics birth certificate data and hospital discharge data to identify low birth weight births, defined as a baby that is less than 2,500 grams at birth, and preterm births, defined as a birth at less than 37 weeks gestation. The rate of preterm births and rates of low birth weight were calculated for both FPW enrollees and eligible women who do not enroll in the FPW program by dividing the total number of preterm or low birth weight births in a DY by the total number of births by each group in the DY. Preterm and low birth weight rates were compared between FPW enrollees and eligible women who are not enrolled in the FPW program using descriptive statistics for each DY.

For research question 5 (Is the FPW program achieving cost savings by lowering the birth rate?), the difference in the birth rate between FPW enrollees and eligible women who do not enroll in the FPW program were used to calculate the number of births averted. Total cost savings were calculated as the total number of births averted times the average cost of the birth, which included the cost of the birth as well as the Medicaid costs for the infant during the first year of life, minus the cost of administering the FPW program. This was calculated for each DY.

For research question 6 (What are the reasons that women eligible for the FPW program choose to enroll or not enroll in the FPW program and the reasons women enrolled in the FPW program do not participate?), qualitative interviews were administered to identify common themes. Separate qualitative interviews were administered to eligible women who do not enroll in the FPW program and FPW enrollees who do not use FPW services (non-participants). Eligible women who do not enroll were asked for reasons why they did not enroll. FPW non-participants were asked why they did not use any FPW services. The samples (FPW enrollee non-participants, eligible women who do not enroll in the FPW program) for the qualitative interviews were identified from Medicaid eligibility and claims data. A total of 25 women were interviewed from each group or until saturation was achieved, whichever came first. Interviews will not be repeated in future DYs as the evaluation team does not expect responses to change from year to year. Common themes were identified using a grounded theory approach utilizing NVivo qualitative data analysis software. Draft survey questions are included in Appendix B.

For research question 7 (How do FPW enrollees utilize covered health services?), Medicaid eligibility, enrollment, and claims data were used to assess enrollment rates, utilization rates (use of any service covered by FPW), contraceptive services utilization rates, cancer screening utilization rates, and sexually transmitted

disease (STD) screening utilization rates for all FPW enrollees per DY. Overall utilization rates were also compared between first year FPW enrollees and second year FPW enrollees. FPW contraceptive care rates were calculated as the total number of FPW enrollees who use contraceptive services/total number of FPW enrollees. FPW cancer screening rates were calculated as the total number of FPW enrollees who use any cancer screening services/total number of FPW enrollees. FPW STD screening rates were calculated as the total number of FPW enrollees who use STD screening services/total number of FPW enrollees. Each of these rates were calculated separately for each DY. The following algorithm was used to assign women as first or second year FPW enrollees as well as to a DY. First year enrollees are women who are within 12 months of their initial enrollment dates. Second year enrollees are women who are between 13-24 months of their initial enrollment dates. Service utilization was calculated based on the services that the enrollee used during either the first 12 months of enrollment or the second 12 months of enrollment, regardless of whether their service utilization during that year occurred over the course of two demonstration years. Women were assigned a demonstration year based on which of the demonstration years had 6 or more months of enrollment.

For research question 8 (What gaps in coverage are experienced by FPW enrollees over time?), Medicaid enrollment and eligibility data were used. The following measures will be calculated for each DY and used to assess coverage experience: (1) total number of FPW enrollees who are only enrolled for the first year/total number of FPW enrollees; (2) total number of FPW enrollees who are enrolled for the second year/total number of FPW enrollees; (3) average length of time between FPW enrollees' most recent enrollment period and the previous enrollment period (limited to the previous five years); and (4) total number of women who lose FPW coverage after the two year enrollment period.

For research question 9 (Are FPW enrollees satisfied with services?), satisfaction surveys were administered to FPW enrollees. Surveys will be administered during each DY. FPW enrollees will be randomly selected and administered a telephone-based satisfaction survey (see Appendix B for satisfaction survey instrument). Surveys will be administered each year until 300 completed surveys are achieved. Surveys were administered during the third quarter of CY2020 and will be subsequently administered during the fourth quarter of each calendar year. Descriptive statistics of survey responses will be used to summarize FPW enrollee experiences and satisfaction.

For research question 10, (What strategies are being used by the Department of Health to increase FPW participation rates?), qualitative interviews were administered to staff at all DOH clinics offering FPW services. Knowledgeable staff members were identified and asked what strategies are employed to increase use of FPW services. Interviews were administered during SFY2020-2021. These interviews will only take place during the first year of the evaluation. Common themes/strategies were identified using a grounded theory approach utilizing NVivo qualitative data analysis software. Interview questions are included in Appendix B.

Appendix B: Qualitative Surveys

Family Planning Waiver Satisfaction Surveys

You are currently enrolled in Florida's Family Planning Waiver program, which offers you access to family planning services including contraceptive services, cervical cancer screening services, and sexually transmitted disease screening services. We have been contracted with Florida's Agency for Health Care Administration to assess Family Planning Waiver enrollees' satisfaction with the services provided through the Family Planning Waiver program. You may refuse to answer any question and you may choose to end the survey at any time. None of your responses to the survey will be linked to you and will not impact your enrollment in the Family Planning Waiver program.

1. How satisfied are you with the types of services offered to you through the Family Planning Waiver program?
    a. Very satisfied
    b. Satisfied
    c. Dissatisfied
    d. Very Dissatisfied
    e. I have not used any family planning services
    f. I was not aware that I was enrolled in the Family Planning Waiver program (if selected, end survey)

2. How satisfied were you with the information and customer service provided to you about the Family Planning Waiver program?
    a. Very satisfied
    b. Satisfied
    c. Dissatisfied
    d. Very Dissatisfied

3. How easy was it to access these family planning services?
    a. Very easy
    b. Somewhat easy

c. Somewhat difficult
d. Very difficult
e. I did not attempt to access family planning services (if selected, exit survey)

4. Which of the following family planning services did you use? Please select all that apply.
    a. Contraceptive care (e.g., contraception, contraceptive counseling/education)
    b. Sexually transmitted disease testing (e.g., pap smears, pelvic exams)
    c. Cervical cancer screening (e.g., pap smears, pelvic exams)

5. How satisfied were you with [insert name of FPW service used by respondent in question 4]? (this question can be repeated up to 3 times depending on the number of types of FPW benefits used by the respondent)
    a. Very satisfied
    b. Satisfied
    c. Dissatisfied
    d. Very Dissatisfied

6. Do you have any recommendations for improving access or other aspects of the program?

Qualitative Survey of Reasons Why Eligible Women Do Not Enroll in the Family Planning Waiver Program

You are currently eligible for Florida's Family Planning Waiver program, which offers you access to family planning services including contraceptive services, cervical cancer screening services, and sexually transmitted disease screening services. We have been contracted with Florida's Agency for Health Care Administration to assess why women who are eligible for the Family Planning Waiver program are not enrolled. You may refuse to answer any question and you may choose to end the survey at any time. None of your responses to the survey will be linked to you and will not impact your eligibility for the Family Planning Waiver program.

1. Although you are eligible for the Family Planning Waiver program, you have not chosen to enroll in the program. Could you please provide the reasons why you have chosen not to enroll in this program?

Qualitative Survey of Reasons Why Enrolled Women Do Not Participate in the Family Planning Waiver Program

You are currently enrolled in Florida's Family Planning Waiver program, which offers you access to family planning services including contraceptive services, cervical cancer screening services, and sexually transmitted disease screening services. We have been contracted with Florida's Agency for Health Care Administration to assess why women who are enrolled in the Family Planning Waiver program choose not to use any of the family planning services provided through the program. You may refuse to answer any question and you may choose to end the survey at any time. None of your responses to the survey will be linked to you and will not impact your enrollment in the Family Planning Waiver program.

1. Although you are enrolled in the Family Planning Waiver program, you have not chosen to participate in the program by using any of the covered services. Could you please provide the reasons why you have chosen to not participate in the program?

Qualitative Survey of DOH Clinic Staff's Strategies to Increase Family Planning Waiver Program Participation Rates

Use of family planning services among women enrolled in Florida's Family Planning Waiver program are very low. We have been contracted with Florida's Agency for Health Care Administration to assess the strategies being used by Department of Health clinics to increase participation rates in the Family Planning Waiver program by enrolled women. You may refuse to answer the survey and end the survey at any time. None of your responses to the survey will be linked to you. All results of the survey will be presented anonymously.

1. What strategies are being used by your clinic to increase Family Planning Waiver program participation rates among Family Planning Waiver enrollees?

Appendix C: Healthy Start Prenatal Screen

Help your baby have a healthy start in life!

Please answer the following questions to find out if anything in your life could affect your health or your baby's health. Your answers are confidential. You may qualify for free services from the Healthy Start Program or the Healthy Families Program, no matter what your income level is! (Please complete in ink.)*

Today's Date: _____

	YES	NO
1. Have you graduated from high school or received a GED?	☐	☐ 1
2. Are you married now?	☐	☐ 1
3. Are there any children at home younger than 5 years old?	☐	☐
4. Are there any children at home with medical or special needs?	☐	☐
5. Is this a good time for you to be pregnant?	☐	☐
6. In the last month, have you felt down, depressed or hopeless?	☐ 1	☐
7. In the last month, have you felt alone when facing problems?	☐	☐
8. Have you ever received mental health services or counseling?	☐	☐
9. In the last year, has someone you know tried to hurt you or threaten you?	☐	☐
10. Do you have trouble paying your bills?	☐	☐

11. What race are you? Check one or more.
☐ White ☐ 3 Black ☐ Other _____

12. In the last month, how many alcoholic drinks did you have per week?
_____ drinks 1 ☐ did not drink

13. In the last month, how many cigarettes did you smoke a day? *(a pack has 20 cigarettes)*
_____ cigarettes 1 ☐ did not smoke

14. Thinking back to just before you got pregnant, did you want to be.....?
☐ pregnant now ☐ pregnant later ☐ 1 not pregnant

15. Is this your first pregnancy?
☐ 2 Yes ☐ No If no, give date your last pregnancy ended: Date: (month/year)_____

16. Please mark any of the following that have happened.
☐ 3 Had a baby that was not born alive
☐ 3 Had a baby born 3 weeks or more before due date
☐ 3 Had a baby that weighed less than 5 pounds, 8 ounces
☐ None of the above

PATIENT INFORMATION

Name: First / Last / M.I.	Social Security Number:	Date of Birth (mo/day/yr):	17. Age:	☐ 1 <18
Street address (apartment complex name/number):	County:	City: / State: / Zip Code:		
Prenatal Care covered by: ☐ Medicaid ☐ Private Insurance _____ ☐ No Insurance ☐ Other _____	Best time to contact me:	Phone #1 _____ Phone #2 _____		

I authorize the exchange of my health information between the Healthy Start Program, Healthy Start Providers, Healthy Start Coalitions, Healthy Families Florida, WIC, Florida Department of Health, and my health care providers for the purposes of providing services, paying for services, improving quality of services or program eligibility. This authorization remains in effect until revoked in writing by me.

Patient Signature: _____ **Date:** _____

Please initial: _____ Yes _____ No I also authorize specific health information to be exchanged as described above, which includes any of my mental health, TB, alcohol/drug abuse, STD, or HIV/AIDS information.

** If you do not want to participate in the screening process, please complete the patient information section only and sign below:*

Signature: _____ *Date:* _____

PROVIDER ONLY

LMP (mo/day/yr):	EDD (mo/day/yr):	18. Pre-Pregnancy: Wt: _____lbs. Height: _____ft. _____in. BMI: _____	☐ 1 < 19.8 ☐ 2 > 35.0
Provider's Name:	Provider's ID:	19. Pregnancy Interval Less Than 18 Months? ☐ N/A ☐ No	☐ 1 Yes
		20. Trimester at 1st Prenatal Visit? _____	☐ 1 2nd
Provider's Phone Number:	Provider's County:	21. Does patient have an illness that requires ongoing medical care? Specify illness: _____ ☐ No	☐ 2 Yes
Healthy Start Screening Score: _____	Check One: ☐ Referred to Healthy Start. If score <6, specify:_____ ☐ Not Referred to Healthy Start.		
Provider's/Interviewer's Signature and Title _____ Date (mo/day/yr)_____			

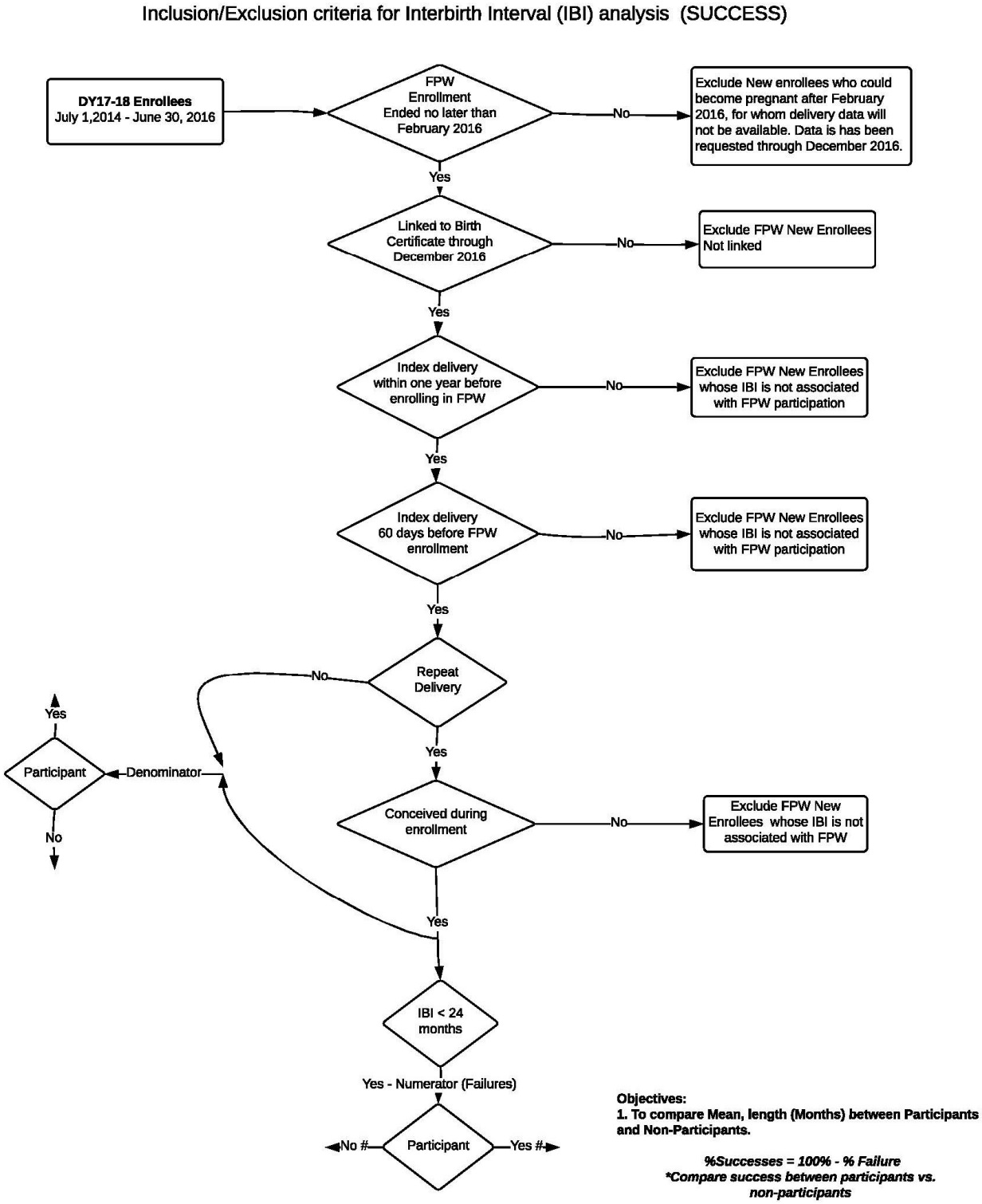
DH 3134, 04/08, stock number 5744-100-3134-7 Distribution of copies: WHITE & YELLOW—County Health Department in county where screening occurred PINK—Retained in patient's record GREEN—Patient's Copy

Appendix D: Interbirth Interval (IBI) Methodology and Flowchart

To measure the impact of the FPW in increasing the child spacing interval through effective contraceptive use, the research team compared the average Interbirth Intervals (IBI) of Enrollees and FPW Eligible Non-Enrollees in each of the DYs. For this report, the research team conducted comparisons of average IBI length by enrollment status.

1. Inclusion Criteria for enrollees and eligible non-enrollees for IBI
    a. For DY20 enrollees, FPW enrollment ended no later than March 2018; for DY21 enrollees, FPW enrollement ended no later than March 2019; and for DY22 enrollees, FPW enrollment ended no later than March 2020
    b. For DY20, linked to birth certificate data through December 2018; for DY21, linked to birth certificate through December 2019; for DY22, linked to birth certificate data through December 2020
    c. Conceived after enrolling in FPW
    d. Conceived no later than one year after the end of FPW enrollment
    e. Previous delivery within one year before enrolling in FPW.
2. Exclusion Criteria for IBI
    a. For DY20, exclude enrollees who could become pregnant after March 2018 for whom 2018 birth certificate data is not available; for DY21, exclude enrollees who could become pregnant after March 2019 for whom 2019 birth certificate data is not available For DY22, exclude enrollees who could become pregnant after March 2020 for whom 2020 birth certificate data is not available
    b. Exclude enrollees not linked to a birth certificate
    c. Exclude enrollees whose IBI cannot be extended by FPW services
    d. Exclude FPW non- enrollees who received Family Planning Services through Title X (Planned Parenthood).

Inclusion/Exclusion criteria for Interbirth Interval (IBI) Analysis



Appendix E: Unintended Pregnancies Methodology and Flowchart

To measure the impact of the FPW in reducing the number of unintended pregnancies through provision of Family Planning services, the research team assessed whether there was a difference in the rate of unintended pregnancies during each DY among FPW enrollees and eligible non-enrollees. Using DY20 aas an example, the research team employed the following steps for determining and comparing the rate of unintended pregnancies between FPW enrollees and non-enrolllees:

1. Identify DY20 enrollees who meet the following three conditions:
    a. Are linked to at least one Healthy Start Prenatal Risk Screen record dated July 1, 2017 through June 30, 2019.
    b. Their date of last menses as reported on at least one linked Healthy Start Prenatal Risk Screen record is not missing.
    c. Their date of last menses as reported on at least one linked Healthy Start Prenatal Risk Screen record occurred on or after their date of enrollment and on or before the end of the waiver period, June 30, 2024.
2. Identify women who were eligible for FPW but did not enroll in the program in DY20 who met the following conditions.
    a. Are linked to at least one Healthy Start Prenatal Risk Screen record dated July 1, 2017 through June 30, 2019.
    b. Their date of last menses as reported on at least one linked Healthy Start Prenatal Risk Screen record is not missing.
    c. Their date of last menses as reported on at least one linked Healthy Start Prenatal Risk Screen record occurred on or after the start of the DY and on or before the end of the waiver period, June 30, 2024.

Appendix F: Cost Saving Methodology

To estimate the overall cost-savings associated with implementing the FPW, the research team followed the process outlined below:

1. The research team calculated births averted. The term births averted refers to the difference in the observed birth rate of women enrolled in FPW program in a given demonstration year versus the expected birth rate of women enrolled in the FPW program if they instead had the birth rate of women eligible for the FPW program who did not enroll.
2. The research team calculated the average delivery and first-year costs by summing all amounts either FFS claims and/or MMA claims in a given demonstration year and dividing by the total number of births. The summed costs are for both the cost of the birth and the costs of the infant that occurred from the date of birth through the child's first birthday.
3. The research team multiplied the average annual costs in a given demonstration year by the number of births averted, to arrive at the annual gross savings to Medicaid of the FPW program in a given demonstration year.
4. The research team determined how much the Agency spent in a given demonstration year to provide family planning services.
5. The research team deducted the cost to the Agency of providing family planning services in a given demonstration year from the gross savings calculated in step three, above, to arrive at the net savings to Medicaid of implementing the FPW program in a given demonstration year.

Appendix G: Procedure Codes for All FPW Services

CPT Code	Description of Covered Codes
	Evaluation and Management
99384FP	Family planning new visit
99385FP	
99386FP	
99394FP	Family planning established visit
99395FP	
99396FP	
99401FP	HIV counseling (pre-test) 15 min
99402FP	HIV counseling (post-test) 30 min
99403FP	Family planning counseling visit
99211FP	Family planning supply visit
99201	Extended family planning services-new patient (treatment of STI)
99211	Extended family planning services-established patient (treatment of STI)
	Medication/Device
J1050	Injection medroxyprogesterone acetate (Depo-Provera)
J7300	Intrauterine copper device (Paraguard)
J7301	Levonorgestrel-releasing intrauterine contraceptive system (Skyla), 13.5 mg
J7297	Levonorgestrel-releasing intrauterine contraceptive system (Liletta), 52 mg
J7298	Levonorgestrel-releasing intrauterine contraceptive system (Mirena), 52 mg
J7307	Etonogestrel implant system, including implant and supplies (Nexplanon)
J7296	Levonorgestrel-releasing intrauterine contraceptive (Kylenna), 19.5 mg
	Anesthesia, Surgical and Radiology
00840	Anesthesia for Intraperitoneal procedures in lower abdomen including laparoscopy
00851	Anesthesia for tubal ligation/transection
11976	Removal of implantable contraceptive capsules
11981	Insertion, non-biodegradable drug delivery implant
11982	Removal, non-biodegradable drug delivery implant
11983	Removal with reinsertion, non-biodegradable drug delivery implant
57170	Diaphragm or cervical cap fitting with instructions
57410	Pelvic examination under anesthesia
57452	Colposcopy of the cervix
57454	Colposcopy with biopsy(s) of the cervix and endocervical curettage
57460	Colposcopy with loop electrode biopsy(s)
58300	Insertion of intrauterine device
58301	Removal of intrauterine device
58340	Catheterization and introduction of saline or contrast material for saline infusion for hysterosalpingography
58600	Ligation or transection of fallopian tube(s)
58615	Occlusion of fallopian tube(s) by device (e.g., band, clip, Falope ring)
58670	Surgical laparoscopy, with fulguration of oviducts (with or without transection)
58671	Surgical laparoscopy, with occlusion of oviducts by device (e.g., band, clip, or Falope ring)
74740	Radiological supervision and interpretation x-ray of uterine tubes and ovaries

CPT Code	Description of Covered Codes
76856	Ultrasound of pelvis, non-obstetric (to check placement of intrauterine devices)
76882	Ultrasound of extremity, limited, anatomic specific (to check for implantable contraceptive device)
	Laboratory
81000	Urinalysis, non-automated, with microscopy
81001	Automated, with microscopy
81002	Non-automated, without microscopy
81003	Automated, without microscopy
81005	Urinalysis; qualitative or semi-qualitative
81007	Urinalysis; bacteriuria screen, by kit
81015	Urinalysis; bacteriuria screen, microscopic only
81025	Urine pregnancy test, by visual color comparison
82947	Glucose; quantitative, blood
84702	Gonadotropin, chorionic (hCG); quantitative
84703	Gonadotropin, chorionic (hCG); qualitative
85007	Blood count; manual differential WBC count
85014	Hematocrit
85018	Hemoglobin
86255	Fluorescent antibody; screen, each antibody (HIV & herpes)
86382	Neutralization test, viral
86403	Rubella screen (IgG)
86580	Tuberculosis, intradermal
86592	Syphilis test; qualitative (e.g., VDRL, RPR, ART)
86593	Syphilis test; quantitative
86689	HTLV or HIV antibody, confirmatory test (western blot)
86694	Herpes simplex, non-specific type test
86695	Herpes simplex, type I
86696	Herpes simplex, type 2
86701	Antibody; HIV-1
86702	Antibody; HIV-2
86703	Antibody; HIV-1 and HIV-2, single assay
86706	Hepatitis B surface antibody (HBsAb)
86707	Hepatitis Be antibody (HBeAb)
86762	Rubella titer
86780	Treponema pallidum
86803	Hepatitis C antibody
87070	Culture, bacterial, definitive; any other source (GC)
87075	Culture, bacterial, any source; anaerobic (isolation)
87081	Culture, bacterial, screening only (GC)
87086	Culture, bacterial, urine; quantitative, colony count
87088	Culture, bacterial, urine; quantitative colony count, with isolation and presumptive identification of each isolate
87110	Culture, chlamydia
87164	Dark field examination, any source, includes specimen collection

CPT Code	Description of Covered Codes
87205	Smear, primary source, with interpretation; Gram or Giemsa stain for bacteria, fungi, or cell types; (gonorrhea)
87206	Smear, primary source, with interpretation; (chlamydia)
87210	Smear, primary source, wet mount isolation, with stain
87252	Virus identification; tissue culture inoculation & observation
87270	Infectious agent antigen detection by immunofluorescent technique, chlamydia trachomatis
87273	Infectious agent antigen detection by immunofluorescent technique, herpes simplex virus type 2
87274	Infectious agent antigen detection by immunofluorescent technique, herpes simplex virus type 1
87340	Hepatitis B surface antigen (HBsAg)
87341	Hepatitis B surface antigen (HBsAg) neutralization
87350	Hepatitis Be antigen (HBeAg)
87390	HIV-1
87480	Candida species, direct probe technique
87481	Candida species, amplified probe technique
87490	Chlamydia trachomatis, direct probe technique
87491	Chlamydia trachomatis, amplified probe technique
87510	Gardnerella vaginalis, direct probe technique
87511	Gardnerella vaginalis, amplified probe technique
87516	Hepatitis B virus, amplified probe technique
87520	Hepatitis C virus, direct probe technique
87521	Hepatitis C virus, amplified probe technique
87522	Hepatitis C virus, quantification
87528	Herpes simplex virus, direct probe technique
87529	Herpes simplex virus, amplified probe technique
87530	Herpes simplex, quantification
87534	HIV-1, direct probe technique
87535	HIV-1, amplified probe technique
87590	Neisseria gonorrhoeae, direct probe technique
87591	Neisseria gonorrhoeae, amplified probe technique
87592	Neisseria gonorrhoeae, quantification
87623	HPV low-risk type detection test
87624	HPV high-risk type detection test
87660	Trichomonas vaginitis, direct probe technique
87661	Trichomonas vaginitis, amplified probe technique
87810	Infectious agent antigen detection by immunoassay with direct optical observation; chlamydia trachomatis
87850	Infectious agent antigen detection by immunoassay with direct optical observation; Neisseria gonorrhoeae
88141	Cytopathology, cervical or vaginal (any system) requiring physician interpretation
88142	Cytopathology, cervical or vaginal (preservative fluid) under physician supervision

88143	Cytopathology, cervical or vaginal with manual screen & re-screen under physician supervision
88150	Cytopathology, slides, cervical or vaginal, manual screen under physician supervision
88152	Cytopathology, slides, cervical or vaginal with manual screening and computer-assisted rescreen under physician supervision
88153	Cytopathology, slides, with manual screen & re-screen under physician supervision
88155	Cytopathology, slides, cervical or vaginal, with definitive hormonal evaluation
88164	Cytopathology, slides, cervical or vaginal, (Bethesda System); with manual screening under physician supervision
88165	Cytopathology. slides, cervical or vaginal (Bethesda System);with manual screen & re-screen under physician supervision
88166	Cytopathology, slides, cervical or vaginal (Bethesda System), manual screen & computer-assisted re-screen under physician supervision
88167	Cytopathology, slides, cervical or vaginal, (Bethesda System), using cell selection and review under physician supervision
88174	Cytopathology, cervical or vaginal, (any reporting system), collected in preservative fluid, automated thin layer preparation, screen by automated system, under physician supervision
88175	With screen by automated system and manual rescreening or review, under physician supervision
88302	Level II surgical pathology, gross and microscopic (sterilization)
88305	Level IV surgical pathology, gross and microscopic (colposcopy)
ICD-10 Code	**Description of Covered Diagnosis Codes**
A51	Early syphilis (Select appropriate diagnosis code)
A51.0 – A51.9	
A53.9	
A60	Anogenital herpesviral(herpes simplex) infections (Select appropriate diagnosis code)
A60.0 - A60.9	
A54	Gonococcal infection (Select appropriate diagnosis code)
A54.0 – 54.21	
A54.24 – A54.29	
A54.5 – A54.6	
A54.9	
A55	Chlamydial Infections (Select appropriate diagnosis code)
A56.0 – A56.8	
A74.89-A74.9	
A57	Chancroid
A58	Granuloma Inguinale
A59	Trichomoniasis (Select appropriate diagnosis code)
A59.0 – A59.9	

A60	Anogenital herpesviral Infections (Select appropriate diagnosis code)
A60.00	
A60.03–A60.9	

A63	Other predominantly sexually transmitted diseases, not elsewhere classified (Select appropriate diagnosis code)
A63.0 - A64	
B37	Candidiasis (Select appropriate diagnosis code)
B37.3-B37.49	
B07.8-B07.9	Other viral warts
N34.1	Nonspecific urethritis
N86	Erosion and ectropion of cervix uteri
N87.0 - N87.9	Cervical dysplasia
N87.1	Moderate cervical dysplasia
N87.9	Dysplasia of cervix uteri, unspecified (Select appropriate diagnosis code)
N88	Other noninflammatory disorders of cervix uteri (Select appropriate diagnosis code)
N88.0 - N88.9	
R87.6	Abnormal cytological findings in specimens from female genital organs (Select appropriate diagnosis code)
R87.610 - R87.9	
Z01.41	Encounter for gynecological examination (Select appropriate diagnosis code)
Z01.411 - Z01.42	
Z11.5	Encounter for screening for other viral diseases (Select appropriate diagnosis code)
Z11.51-Z11.9	
Z30	Encounter for contraceptive management (Select appropriate diagnosis code)
Z30.0 - Z30.09	
Z30.2	Encounter for sterilization
Z32.0	Encounter for pregnancy test (Select appropriate diagnosis code)
Z32.00- Z32.02	

Appendix H: Procedure Codes to Identify Family Planning Services, Cancer Screening Services, and STD Screening Services

Family Planning Evaluation and Management Services	
Evaluation and Management CPT Code	***Description of Covered Codes***
99384FP	Family planning new visit
99385FP	
99386FP	
99394FP	Family planning established visit
99395FP	
99396FP	
99403FP	Family planning counseling visit
99211FP	Family planning supply visit
Contraceptive Services	
Medication/Device CPT Code	***Description of Covered Codes***
J1050	Injection medroxyprogesterone acetate (Depo-Provera)
J7300	Intrauterine copper device (Paraguard)
J7301	Levonorgestrel-releasing intrauterine contraceptive system (Skyla), 13.5 mg
J7297	Levonorgestrel-releasing intrauterine contraceptive system (Liletta), 52 mg
J7298	Levonorgestrel-releasing intrauterine contraceptive system (Mirena), 52 mg
J7307	Etonogestrel implant system, including implant and supplies (Nexplanon)
J7296	Levonorgestrel-releasing intrauterine contraceptive (Kylenna), 19.5 mg
Anesthesia, Surgical and Radiology CPT Code	***Description of Covered Codes***
11981	Insertion, non-biodegradable drug delivery implant
11983	Removal with reinsertion, non-biodegradable drug delivery implant
57170	Diaphragm or cervical cap fitting with instructions
58300	Insertion of intrauterine device
58600	Ligation or transection of fallopian tube(s)
58615	Occlusion of fallopian tube(s) by device (e.g., band, clip, Falope ring)
58670	Surgical laparoscopy, with fulguration of oviducts (with or without transection)
58671	Surgical laparoscopy, with occlusion of oviducts by device (e.g., band, clip, or Falope ring)
76856	Ultrasound of pelvis, non-obstetric (to check placement of intrauterine devices)
76882	Ultrasound of extremity, limited, anatomic specific (to check for implantable contraceptive device)

88302	Level II surgical pathology, gross and microscopic (sterilization)
Laboratory CPT Code	***Description of Covered Codes***
81025	Urine pregnancy test, by visual color comparison

Cancer Screening Services	
Anesthesia, Surgical and Radiology CPT Code	***Description of Covered Codes***
57410	Pelvic examination under anesthesia
57452	Colposcopy of the cervix
57454	Colposcopy with biopsy(s) of the cervix and endocervical curettage
57460	Colposcopy with loop electrode biopsy(s)
88141	Cytopathology, cervical or vaginal (any system) requiring physician interpretation
88142	Cytopathology, cervical or vaginal (preservative fluid) under physician supervision
88143	Cytopathology, cervical or vaginal with manual screen & re-screen under physician supervision
88150	Cytopathology, slides, cervical or vaginal, manual screen under physician supervision
88152	Cytopathology, slides, cervical or vaginal with manual screening and computer-assisted rescreen under physician supervision
88153	Cytopathology, slides, with manual screen & re-screen under physician supervision
88305	Level IV surgical pathology, gross and microscopic (colposcopy)
Laboratory CPT Code	***Description of Covered Codes***
88155	Cytopathology, slides, cervical or vaginal, with definitive hormonal evaluation
88164	Cytopathology, slides, cervical or vaginal, (Bethesda System); with manual screening under physician supervision
88165	Cytopathology. slides, cervical or vaginal (Bethesda System);with manual screen & re- screen under physician supervision
88166	Cytopathology, slides, cervical or vaginal (Bethesda System), manual screen & computer-assisted re-screen under physician supervision
88167	Cytopathology, slides, cervical or vaginal, (Bethesda System), using cell selection and review under physician supervision
88174	Cytopathology, cervical or vaginal, (any reporting system), collected in preservative fluid, automated thin layer preparation, screen by automated system, under physician supervision

STD Screening Services	
Evaluation and Management CPT Code	***Description of Covered Codes***
99401FP	HIV counseling (pre-test) 15 min
99402FP	HIV counseling (post-test) 30 min
Laboratory CPT Code	***Description of Covered Codes***
86255	Fluorescent antibody; screen, each antibody (HIV & herpes)
86592	Syphilis test; qualitative (e.g., VDRL, RPR, ART)
86593	Syphilis test; quantitative
86689	HTLV or HIV antibody, confirmatory test (western blot)
86694	Herpes simplex, non-specific type test
86695	Herpes simplex, type I
86696	Herpes simplex, type 2
86701	Antibody; HIV-1
86702	Antibody; HIV-2
86703	Antibody; HIV-1 and HIV-2, single assay
86706	Hepatitis B surface antibody (HBsAb)
86707	Hepatitis Be antibody (HBeAb)
86803	Hepatitis C antibody
87110	Culture, chlamydia
87205	Smear, primary source, with interpretation; Gram or Giemsa stain for bacteria, fungi, or cell types; (gonorrhea)
87206	Smear, primary source, with interpretation; (chlamydia)
87270	Infectious agent antigen detection by immunofluorescent technique, chlamydia trachomatis
87273	Infectious agent antigen detection by immunofluorescent technique, herpes simplex virus type 2
87274	Infectious agent antigen detection by immunofluorescent technique, herpes simplex virus type 1
87340	Hepatitis B surface antigen (HBsAg)
87341	Hepatitis B surface antigen (HBsAg) neutralization
87350	Hepatitis Be antigen (HBeAg)
87390	HIV-1
87490	Chlamydia trachomatis, direct probe technique
87491	Chlamydia trachomatis, amplified probe technique

STD Screening Services continued	
Laboratory CPT Code	***Description of Covered Codes***
87516	Hepatitis B virus, amplified probe technique
87520	Hepatitis C virus, direct probe technique
87521	Hepatitis C virus, amplified probe technique
87522	Hepatitis C virus, quantification
87528	Herpes simplex virus, direct probe technique
87529	Herpes simplex virus, amplified probe technique
87530	Herpes simplex, quantification
87534	HIV-1, direct probe technique
87535	HIV-1, amplified probe technique
87590	Neisseria gonorrhoeae, direct probe technique
87591	Neisseria gonorrhoeae, amplified probe technique
87592	Neisseria gonorrhoeae, quantification
87623	HPV low-risk type detection test
87624	HPV high-risk type detection test
87810	Infectious agent antigen detection by immunoassay with direct optical observation; chlamydia trachomatis
87850	Infectious agent antigen detection by immunoassay with direct optical observation; Neisseria gonorrhoeae