Alabama Medicaid Agency

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Governor

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STEPHANIE MCGEE AZAR
Commissioner

June 15, 2017

Mr. Brian Neale
Director
Center for Medicaid and CHIP Services
Centers for Medicare & Medicaid Services
Mail Stop: S2-26-12
7500 Security Boulevard
Baltimore, MD 21244

Dear Mr. Neale,

The Alabama Medicaid Agency's current Section 1115 Family Planning Waiver Demonstration will end effective December 31, 2017. The State wishes to extend this Waiver Demonstration for an additional five (5) years. Included is the Waiver Demonstration application for review and consideration. Please let us know if you have any questions.

Sincerely,

[redacted]

Sylisa Lee-Jackson, RN, ASN, BSMHR
Associate Director
Maternity, Nurse Midwife and
Family Planning Plan First Programs
Managed Care Division

Enclosures

Alabama's Application Certification Statement - Section 1115(a) Extension

This document, together with the supporting documentation outlined below, constitutes Alabama's application to the Centers for Medicare & Medicaid Services (CMS) to extend the 1115 Family Planning Waiver Demonstration for a period of five (5) years pursuant to section 1115(a) of the Social Security Act.

Type of Request (*select one only*):

____X___ Section 1115(a) extension <u>with no</u> program changes

This constitutes the state's application to the Centers for Medicare & Medicaid Services (CMS) to extend its demonstration without any programmatic changes. The state is requesting to extend approval of the demonstration subject to the same Special Terms and Conditions (STCs), waivers, and expenditure authorities currently in effect for the period January 1, 2015 through December 31, 2017 (i.e., Demonstration Years 15, 16 and 17).

The state is submitting the following items that are necessary to ensure that the demonstration is operating in accordance with the objectives of title XIX and/or title XXI as originally approved. The state's application will only be considered complete for purposes of initiating federal review and federal-level public notice when the state provides the information as requested in the below appendices.

- **Appendix A:** A historical narrative summary of the demonstration project, which includes the objectives set forth at the time the demonstration was approved, evidence of how these objectives have or have not been met, and the future goals of the program.
- **Appendix B:** Budget/allotment neutrality assessment, and projections for the projected extension period. The state will present an analysis of budget/allotment neutrality for the current demonstration approval period, including status of budget/allotment neutrality to date based on the most recent expenditure and member month data, and projections through the end of the current approval that incorporate the latest data. CMS will also review the state's Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) expenditure reports to ensure that the demonstration has not exceeded the federal expenditure limits established for the demonstration. The state's actual expenditures incurred over the period from initial approval through the current expiration date, together with the projected costs for the requested extension period, must comply with CMS budget/allotment neutrality requirements outlined in the STCs.
- **Appendix C:** Interim evaluation of the overall impact of the demonstration that includes evaluation activities and findings to date, in addition to plans for evaluation activities over the requested extension period. The interim evaluation should provide CMS with a clear analysis of the state's achievement in obtaining the outcomes expected as a direct effect of the demonstration program. The state's interim evaluation must meet all of the requirements outlined in the STCs.
- **Appendix D:** Summaries of External Quality Review Organization (EQRO) reports, managed care organization and state quality assurance monitoring, and any other documentation of the quality of and access to care provided under the demonstration.

- **Appendix E:** Documentation of the state's compliance with the public notice process set forth in 42 CFR 431.408 and 431.420.

Please list all enclosures that accompany this document constituting the state's whole submission.

1. Section 1115(a) Extension Application Attestation
2. **Attachment A** Annual Public Forum Sign-in Sheet
3. **Attachment B** Annual Public Forum Presentation
4. **Attachment C** Annual Public Forum Questions and Responses
5. **Attachment D** Six (6) Month Post Award Public Forum Sign-in Sheet
6. **Attachment E** Six (6) Month Post Award Public Forum Presentation
6. **Attachment F** Covered Services List for Plan First Recipients
7. **Attachment G** Budge Neutrality Worksheet
8. **Attachment H** List of covered smoking cessation products
9. **Attachment I** Annual Plan First Evaluation Report Demonstration Year 15
10. **Attachment J** AL FP Extension CMS Approved STCs 12.29.14
11. **Attachment K** AL FP Extension CMS Approved Expenditure Authority 12.29.14
12. **Attachment L** Plan First Volume Indicator Report
13. **Attachment M** Plan First Care Coordination 4th Quarter FY 2016 Report
14. **Attachment N** 2017 Waiver Extension Tribal Notice
15. **Attachment O** 2017 Waiver Extension 5.11.17 Public_Forum_Questions/ Answers
16. **Attachment P** 2017 Waiver Extension 5.12.17 Public_Forum_Questions/ Answers
17. **Attachment Q** 2017 Waiver Extension List Serv Posting to the Alabama Media Portal
18. **Attachment R** 2017 Public Forums Sign-in Sheets

The state attests that it has abided by all provisions of the approved STCs and will continuously operate the demonstration in accordance with the requirements outlined in the STCs.

Signature: [redacted] **Date:** 6/14/17

[Governor]

CMS will notify the state no later than 15 days of submitting its application of whether we determine the state's application meets the requirements for a streamlined federal review. The state will have an opportunity to modify its application submission if CMS determines it does not meet these requirements. If CMS reviews the state's submission and determines that any proposed changes significantly alter the original objectives and goals of the existing demonstration as approved, CMS has the discretion to process this application full scope pursuant to regular statutory timeframes for an extension or as an application for a new demonstration.

Contents

Appendix A: A historical narrative summary of the demonstration project, which includes the objectives set forth at the time the demonstration was approved, evidence of how these objectives have or have not been met, and the future goals of the program.

The Plan First Program was predicated on the recognized need for continued family planning services once Medicaid eligibility for pregnancy ended and for those women who would not otherwise qualify for Medicaid unless pregnant. Women were able to obtain family planning services during their pregnancy related eligibility period, but often lost benefits when postpartum eligibility ended. The Plan First Program afforded the state the ability to extend Medicaid eligibility after the birth of the baby and provided an avenue for extending eligibility to women who may not otherwise qualify for Medicaid. The program goal is to reduce unintended pregnancies.

Recipients have freedom of choice in deciding to receive or reject family planning services. Acceptance of any family planning service must be voluntary without any form of duress or coercion applied to gain such acceptance. Recipients are required to give written consent prior to receiving family planning services. Medicaid recipients and Plan First beneficiaries are exempt from co-payment requirements for family planning services. There are to be no co-payments on prescription drugs/supplies that are designated as family planning.

When the program began, approximately 60,000 women were automatically enrolled. Enrollment increased steadily for the first five years of the program to over 100,000 women, after which there was a decline. The requirement to re-enroll annually, which was implemented in the beginning of the second Demonstration period, caused enrollment initially to decline, as did the requirement for citizenship and identification in 2006. The Alabama Medicaid Agency (AMA) implemented a Social Security Administration data match effective January 2010 to verify citizenship. This has helped streamline the enrollment process. In February 2013, AMA implemented automated Express-Lane Eligibility (ELE) renewals for Plan First women as well as children. This expedited renewal process, completed by the system, requires no participation from the case worker or recipient, enhancing the enrollment process.

AMA uses the Federal hub services (IRS, SSA, Equifax), SSN, citizenship and alienage, (DHS) as well as other sources (SVES, SDX, PARIS, SNAP, TANF, EDB, vital statistics,) to verify income and other points of eligibility as listed in the Alabama verification plan.

Alabama also has a hub waiver through which we use The SAVE web system (Systematic Alien Verification for Entitlements) for the VLP (verify lawful presence) steps 2 and 3 as needed. VLP 1 is completed through the federal hub. Alabama uses the hub service for on-line identity verification.

For income, Alabama uses the following reasonable compatibility model:

1. If available databases find no match, self-attestation will be accepted.
2. If individual self-attestation of income and data match are both below the Medicaid/CHIP MAGI eligibility level, individual will be determined eligible for Medicaid/CHIP benefits.

3. If individual self-attestation of income and data match are both above the Medicaid/CHIP MAGI eligibility level, individual will be determined ineligible, and account transferred to FFM for APTC eligibility.
4. If individual self-attestation of income is above Medicaid/CHIP MAGI level, but data match puts applicant below the Medicaid/CHIP MAGI eligibility level, individual will be determined ineligible and account transferred to FFM for APTC eligibility.
5. If individual self-attestation of income is below Alabama Medicaid/CHIP MAGI level, but data match puts applicant above the Medicaid/CHIP MAGI eligibility level, reasonable compatibility level of 10% will be applied. If less than 10% difference, data is considered reasonably compatible and individual will be determined eligible for Medicaid/CHIP benefits. If more than 10% difference and individual can provide a reasonable explanation (either already indicated on the application, or after formal request from the state), the individual will be determined eligible for Medicaid/CHIP benefits. If more than 10% difference and individual cannot provide a reasonable explanation, the individual will be determined ineligible for Medicaid/CHIP.

Individuals may also renew on-line and receive a real-time eligibility renewal without worker intervention with real time eligibility verification through the federal hub. Upon eligibility approval, recipients receive an award letter informing them of their Medicaid coverage. A letter is also generated if the recipient's services are denied, terminated, suspended, or changed. Appeal rights are included in the letter.

The current Plan First 1115 Demonstration Waiver was approved for three (3) years, effective December 29, 2014 through December 31, 2017. During this renewal, two new covered services were added, removal of migrated or embedded intrauterine devices in an office setting or outpatient surgical facility and coverage of vasectomies for eligible males 21 years of age or older.

Services under this Demonstration is designed to improve the well-being of children and families in Alabama by extending Medicaid eligibility for family planning services to eligible women between the ages of 19-55 whose income is at or below 141% of the Federal Poverty Level (FPL). A standard income disregard of 5% of the FPL is applied if the individual is not eligible for coverage due to excess income.

Eligible individuals are females of childbearing age between 19 through 55 and men ages 21 or older who meet the eligibility criteria described below. Men can receive vasectomies/vasectomy related services only under this Demonstration.

Group 1

Women 19 through 55 years of age who have Medicaid eligible children (poverty level), who become eligible for family planning without a separate eligibility determination. They must answer "yes" to the Plan First question on the application. Income is verified at initial application and re-verified at recertification of their children. Eligibility is re-determined every 12 months.

Group 2

Poverty level pregnant women 19 through 55, whose pregnancy ends while she is on Medicaid. The Plan First Waiver system automatically determines Plan First eligibility for every female

Medicaid member entitled to Plan First after a pregnancy has ended. Women automatically certified for the Plan First Program receive a computer generated award notice by mail. If the woman does not wish to participate in the program, she can notify the caseworker to be decertified. Women who answered "no" to the Plan First question on the application and women who do not meet the citizenship requirement do not receive automatic eligibility. Income is verified at initial application and re-verified at re-certification of their children. Eligibility is re-determined every 12 months.

Group 3

Other women age 19 through 55 who are not pregnant, postpartum or who are not applying for a child must apply using a simplified shortened application. A Modified Adjusted Gross Income (MAGI) determination will be completed using poverty level eligibility rules and standards. Recipient declaration of income will be accepted unless there is a discrepancy. The agency will process the information through data matches with state and federal agencies. If a discrepancy exists between the recipient's declaration and the income reported through data matches, the recipient will be required to provide documentation and resolve the discrepancy. Eligibility is re-determined every 12 months.

Group 4

Males, ages 21 and older, wishing to have a vasectomy may complete a simplified shortened Plan First application (Form 357). An eligibility determination must be completed using poverty level eligibility rules and standards. Eligibility will only be for a 12-month period; therefore, retro-eligibility and renewals are not allowed. If the individual has completed the sterilization procedure but has not completed authorized follow-up treatments by the end of the 12-month period, a supervisory override will be allowed for the follow-up treatments. If the individual does not receive a vasectomy within the 12-month period of eligibility, then he will have to reapply for Medicaid eligibility.

Women can check on their initial application whether they want to renew their eligibility automatically up to 5 years using income data from tax returns.

Eligible women qualify for most family planning services and supplies, including birth control pills, the Depo-Provera shot, vaginal ring, diaphragm, contraceptive patch, doctor/clinic visits (for family planning only), smoking cessation products and counseling, and tubal ligations. Reference Attachment H for a list of covered smoking cessation products. Recipient may also receive smoking cessation services through the Alabama Tobacco Quitline. The Quitline offers online and telephone counseling services at QuitNowAlabama.com for any Alabamian who is ready to quit tobacco. Those who begin counseling can receive, if medically eligible, a free, eight-week supply of the nicotine patch to assist in their attempt to quit. The Quitline is not a waiver service.

Eligible men qualify for doctor/clinic visits related to vasectomy services only as a waiver service. The Plan First Program does not cover any other medical services, and individuals who have been previously sterilized are not eligible to participate in this program. See Attachment F for a list of covered services.

Participation in the Plan First Program is open to any provider who wishes to be Medicaid enrolled and executes a Plan First agreement. Only those Plan First enrolled providers are able to

service Plan First eligibles. Providers can be clinics, private physicians, nurse midwives, nurse practitioners, or physician assistants. As of December 2016, there were 2,727 Plan First Provider locations servicing Plan First recipients. Providers are bound by the requirements in the Appendix C, Family Planning Chapter of the Alabama Medicaid Provider Manual and the approved 1115 Plan First Demonstration Waiver.

Medicaid maintains a listing of all providers who have enrolled to provide services to Plan First eligibles. The list, which includes the addresses and telephone numbers, is made available to all Plan First care coordinators and staff of the Plan First toll free hotline, and any other party who may be assisting individuals in locating a Plan First provider. The list is available online at the Alabama Medicaid Agency's web site (www.medicaid.alabama.gov) as well as in printed form.

Direct services are augmented with care coordination and tracking for "high risk" and "at risk" women to ensure compliance with the woman's chosen birth control method. Care coordination allows for enhanced education on appropriate use of the chosen method and further assurance of correct and continued usage. Care coordination services are designed to provide special assistance to those women who are at high risk for an unintended pregnancy and allow for enhanced contraceptive education, encouragement to continue with pregnancy spacing plans and assistance with the mitigation or removal of barriers to successful pregnancy planning. Care coordination services are available to all Plan First recipients, except males, regardless of the service provider. These services must be provided by licensed social workers or registered nurses associated with the Department of Public Health. Should care coordination services be needed, a referral can be made by calling the local health department and asking for the Plan First Care Coordinator.

The goal of care coordination is to form a partnership with the recipient to address impediments to successful family planning. The bio-psychosocial model of care coordination is used to achieve this goal and includes:

- A bio-psychosocial assessment and development of case plan for all patients who accept care coordination.
- Counseling regarding sexuality, family planning, HIV/AIDS, STDs, and psychosocial issues identified in the assessment, such as substance abuse or domestic violence.
- Referrals and follow up to ensure appointments are kept, including subsequent family planning visits.
- Answers to general questions about family planning.
- Low-literacy family planning education based on the PT+3 model.
- Consultation with providers regarding problems with the selected family planning method.

The care coordinator work diligently with family planning providers to ensure that recipients receive care coordination services in a timely manner. All female recipients are eligible to receive an initial risk assessment to determine if and what type of care coordination services is needed.

In November 2016, the AMA submitted a Waiver amendment to CMS to add care coordination for males as a covered service. The care coordination for males will provide assistance with the application process for Plan First through the AMA, identify Medicaid approved vasectomy providers, facilitate the initial appointment process, and provide appointment reminders. Services

will be provided as encounters and will consist of face to face contact, telephone contact, and sending letters and postcard reminders. The state is awaiting an approval of this request.

By several measures, the Plan First Program continues to reduce the likelihood that potentially Medicaid eligible women will become pregnant. Compared to estimates of the number of babies that would have been born to Plan First service users if their fertility rates reflected those of the general population before the start of the program, Plan First averted an estimated 11,215 births in DY10, decreasing slightly to 10,703 averted births in DY11, a result of an increase of births to Demonstration participants. In DY14, 8,406 births were averted. Using a cost estimate of $7,000 per birth, including the infant's first year of life, Plan First resulted in overall savings of $58,842,000 over what would have been spent without the program. As evaluated, birth rates to Plan First recipients met the performance target of 100 births or less per thousand per enrollee.

AMA identified six (6) goals and objectives for Demonstration Years 15, 16 and 17. The goals and how these goals were met /not met are outlined below:

Goal 1: Increase the portion of women eligible for Plan First who actually enroll, and reduce race/ethnicity and geographic disparities in enrollment.

Finding: Enrollment for African American women residents of Alabama who are ages 19-24 and 25-34 is somewhat below the target rate, at 68% and 67% of those estimated to be eligible, respectively. Enrollment is lower for Caucasian women, 51% for those age 19-24 and 56% for those age 25-34. More urban areas of the state tended to have more racial disparity in enrollment. Those most likely to renew their enrollment from one year to the next are women who had contact with a Plan First provider. See Table 1.1., for estimated portion of Plan First eligibles enrolled statewide, by age and race/ethnicity. Census estimates are based on county-level American Community Survey (ACS) data, averaged over 2010-2014.

Table 1.1. Estimated portion of Plan First Eligibles Enrolled Statewide, by age and race/ethnicity

	Age 19-24			Age 25-34			Age 35-44		
	ACS Estimate	Enrollment DY15	% Enrolled	ACS Estimate	Enrollment DY15	% Enrolled	ACS Estimate	Enrollment DY15	% Enrolled
White	45,356	23,007	50.7	42,591	23,744	55.7	33,786	6,856	20.3
Black	38,084	26,038	68.4	45,999	30,662	66.7	30,616	9,446	30.9
Other	7,632	1,949	25.5	10,818	1,967	18.2	7,042	747	10.6
Total	**91,133**	**50,994**	**56.0**	**99,465**	**56,373**	**56.7**	**71,502**	**17,049**	**23.8**

Goal 2. Maintain a high level of awareness of the Plan First Program among enrollees.

Finding: The awareness of Plan First among enrollees exceeds the target of 90%. The percentage of those who are aware of Plan First and know that they are enrolled in program meets the 85% target. Overall awareness of Plan First remains quite high (>90%) among enrollees. However, just over 20% of enrollees are not aware of their enrollment status,

including the 7% who report they have never heard of Plan First, and another 14% who have heard of the program but did not know they were enrolled. Some of these are women who prefer not to use contraception and thus do not have an incentive to learn about Plan First. However, others are women who do use contraception, and have concerns about affordability and access to services which reflect the fact that they are not aware of their enrollment status. See Table 2.1., for results of the enrollees who are aware of Plan First Program.

Table 2.1. Awareness of Plan First

	Had heard of Plan First Before Call (%)	Aware of enrollment (%)	
Demonstration Year		Among all surveyed	Among those who had heard of Plan First
DY1	76.8	56.2	73.1
DY2	82.5	64.2	77.9
DY3-4	81.0	64.9	80.2
DY5	85.3	63.6	74.9
DY6	86.8	70.2	82.5
DY7	92.9	80.8	87.1
DY8	88.9	85.3	85.9
DY9	90.8	79.7	87.8
DY10	88.7	78.3	88.2
DY11	90.1	79.3	88.1
DY12	88.7	77.2	87.0
DY13	89.9	79.9	88.9
DY14	90.1	74.9	83.2
DY15	92.6	78.8	85.0

Goal 3. Increase the portion of Plan First enrollees who use family planning services, both in the initial year of enrollment and in subsequent years. Increase the portion of Plan First enrollees using family planning services initially after enrollment and in subsequent years of enrollment by improving access to services and increasing the rate of return visits for care. Our goal is to have 70% utilization of services by the end of the three year period, along with a 70% rate for 12 and 24 month return visits for individuals using services during the renewal period.

In previous Plan First evaluations, overall rates of participation without exploring differences across sub-groups of enrollees, and without differentiating between participation for first year enrollees and for enrollees in subsequent years were reported. With this analysis, it is clear that there is a sub-group of enrollees whose participation meets the target rate of 70% use: enrollees who have used shorter acting reversible contraception (e.g. Depo, pills) for at least a year. Women using long-acting reversible contraception (LARC) for at least a year also participate in subsequent years, but at a lower rate (45%). Participation is also lower for new enrollees who

are not postpartum (56%). Women with no evidence of any use of contraception services in previous years have the lowest participation (<15%). Women with Plan First participation but no actual clinical service use are evenly divided between those with case management contact only, and those who fill contraceptive prescriptions but have no clinical contact. Reference Table 3.1., for utilization assessment for Demonstration Year 15.

Table 3.1. Utilization Assessment for Demonstration Year 15

	N (%)	% Initial Plan First Participation	% Participation 12 months after initial visit	% Participation 24 months after initial visit
All Enrollees, DY15	**128,473**		40.3% Contact 31.3% Service	
New DY15 Enrollee, Postpartum	**7,080 (5.5)**	33.4% contact 23.0% service	--	--
Received LARC postpartum	17 (0.2)	100% contact 100% service	--	--
Received other method postpartum	36 (0.5)	100% contact 88.9% service	--	--
Received no method postpartum	7,027 (99.2)	32.9% contact 22.5% service	--	--
New DY15 Enrollee, Not Postpartum	**7,971 (6.2)**	55.7% contact 48.1% service	--	--
Enrolled DY14 & DY15	**27,963 (21.8)**	35.6% contact 26.5% service		--
Received LARC DY14	731 (2.6)	--	45.5% contact 31.7% service	--
Received other method DY14	10,204 (36.5)	--	100% contact 100% service	--
Received no method DY14	17,028 (60.9)	12.8% contact 0.7% service	--	--
Enrolled DY13 - DY15	**85,461 (66.5)**		41.0% contact 32.1% service	

Received LARC DY13 or DY14	4,112 (4.8)	--	--	47.6% contact 36.8% service
Received other method DY13 or DY14	43,792 (51.2)	--	--	100% contact 100% service
Received no method DY13 or DY14	37,557 (44.0)	13.9% contact 1.0% service	--	--

-- Not applicable

Goal 4. Increase the portion of Plan First enrollees who receive smoking cessation services. By report of enrollees, there has been an increase over time in the extent to which smoking cessation is discussed in family planning settings, and in the concrete advice that providers give to clients about quitting tobacco use. In DY 15, 64% of smokers reported receiving either a prescription for a Nicotine Reduction Therapy or a referral to the Quit Line. However, based on claims data, there is relatively little use of prescriptions among Plan First enrollees, and a very small percentage of the estimated smokers (<1%) have contacted the Quit Line and indicated they were referred by their care coordinator.

Enrollee survey data from Demo Year 15 shows a slight decrease in the portion of survey respondents who reported they were smokers. The percentage who were asked about smoking by their Plan First provider and the percentage that were advised by their provider to quit smoking were similar to the previous year, and notably higher than in DY11-DY13 when we began reporting on these outcomes. Although the portion receiving either a referral to the Quit Line or an NRT product did not meet the target 85% (currently at 64%), there was an increase from the previous year. Reference Table 4.1., Smoking Cessation Based on Enrollee Survey Data.

Table 4.1. Smoking Cessation Based on Enrollee Survey Data

	DY11 (baseline) N (%)	**DY12** (NRT covered) N (%)	**DY13** (NRT covered) N (%)	**DY14** (NRT covered) N (%)	**DY15** (NRT covered) N (%)
Reported Smoking	343 (36.3)	317 (30.8)	312 (30.5)	283 (28.6)	269 (25.8)
Asked about smoking at FP visit	313 (91.2)	281 (88.6)	268 (85.9)	265 (93.6)	248 (92.2)
Advised to quit by FP provider	245 (71.4)	267 (84.2)	215 (68.9)	212 (80.0)	205 (82.7)
Received NRT	94 (27.4)	104 (32.8)	100 (32.0)	111 (41.9)	121 (48.8)
Referred to Quit Line	115 (33.5)	122 (38.5)	119 (38.1)	110 (41.5)	132 (53.2)

Received either NRT or Quit Line referral	148 (43.1)	155 (48.9)	151 (48.4)	149 (56.2)	158 (63.7)
Paid out of pocket for NRT products	--	--	--	--	30 (12.1)

-- Not asked in Enrollee Survey

Goal 5. Maintain birth rates among Plan First participants which are lower than the birth rates estimated to have occurred in the absence of the Plan First demonstration. Birth rates vary from year to year, but remain low enough for Plan First to be budget neutral. In DY 14, the most recent year for which a count of the births occurring to participants during the demonstration year can be counted, overall birth rates for participants was 58.3 per thousand and the birth rate for women who were enrolled but did not use services was 84.9 per thousand. In contrast, the estimate of expected births, given the fertility rates before the start of the Plan First demonstration, was 203.1 per thousand for the women enrolled in the program. Reference Table 5.1., for birth rates per 1000.

Table 5.1. Birth Rates per 1000

	Estimated birth rate if fertility rates continued at pre-waiver levels	**Actual birth rates <u>all enrollees</u> – pregnancies starting during DY**	**Actual birth rates <u>service users</u> – pregnancies starting during DY**	**Actual birth rates <u>non-service users</u> – pregnancies starting during DY**
DY1	189.8	60.0	47.8	72.3
DY2	200.7	87.5	54.3	118.9
DY3	204.7	96.6	56.5	131.1
DY4	205.9	92.0	56.2	122.9
DY5	202.6	98.3	58.6	121.7
DY6	224.1	81.8	31.1	105.4
DY7	215.0	57.2	44.0	69.7
DY8	214.8	75.7	65.0	86.6
DY9	127.1	59.1	43.3	78.2
DY10	202.3	69.1	60.8	97.0
DY11	200.1	73.3	58.3	92.6
DY12	180.1	77.3	60.8	97.0
DY13	199.9	84.0	72.5	88.6
DY14	203.1	72.4	58.3	84.9

Goal 6. Make sterilization services available to income-eligible men over age 21. There were no claims for vasectomy services in DY15, the first year the service was covered by Plan First. The majority of women who get counseled about female sterilization do not receive counseling about vasectomy as well. By report of female enrollees who do not want more

children, 20% of male partners may be interested in vasectomy if they could get the procedure covered by Plan First.

In the DY15 enrollee survey, we asked several questions to assess the potential demand for vasectomy services. Less than one-third (29%) of the 202 women who reported counseling about female sterilization also reported that they received counseling about vasectomy, and a higher percenter of women who were seen at the health department reported vasectomy counseling than those who went to a private doctor or other source of care. Among the 465 women who reported that they do not want more children, 20% said their male partner may be interested in getting a vasectomy through Plan First. Reference Table 6.1., vasectomies provided to men through Plan First and Table 6.2., counseling female partners and their perception of men's interest in vasectomy.

Table 6.1. Vasectomies provided to men through Plan First

	DY15 (10/14-9/15)
Number of men enrolled	n/a
Number obtaining vasectomy	0
% enrolled obtaining vasectomy	--

n/a – information on gender was not included in the enrollment files

Table 6.2. Counseling female partners and their perception of men's interest in vasectomy

	DY15
	N (%)
Women who received counseling about female sterilization & vasectomy	58 (28.7)
Health Department	26 (34.2)
Private Doctor	25 (25.0)
Other source	7 (28.0)
Partner would be interested in vasectomy through Plan First, among women who do not want more children	
Yes	94 (20.2)
No	232 (49.9)
Don't know	124 (26.7)

Goals for Demonstration Year 18, 19, 20, 21 and 22:

(1) Increase the portion of women eligible for Plan First who enroll, and reduce race/ethnicity and geographic disparities in enrollment. The program goal is to enroll 80% of eligible women under age 40 into Plan First.

(2) Maintain a high level of awareness of the Plan First Program among enrollees. The program goal is that 90% of surveyed enrollees will have heard of Plan First, and 85% will be aware that they are enrolled in the program.

(3) Increase the proportion of Plan First enrollees who use family planning services in the initial year of enrollment and in subsequent years. The program goal is to achieve 70% in the initial year and increase service use to 60% in subsequent years.

(4) Increase the portion of Plan First enrollees who receive smoking cessation services or nicotine replacement products. The program goal is to have 85% of smokers receiving these services.

(5) Maintain birth rates among Plan First participants, which are lower than the estimated birth rates that would have occurred in the absence of the Plan First demonstration. A rate of about 100 births per 1000 enrollees is estimated to be sufficient to achieve budget neutrality for Plan First.

(6) Increase the number of income-eligible men age ≥21 years who are enrolled in the Plan First program and the proportion of male enrollees undergoing vasectomy by assisting with the application process for Plan First through AMA, identifying Medicaid approved vasectomy providers, facilitating the initial appointment process, and providing appointment reminders. The goal is that the number of men enrolled in Plan First for vasectomies and vasectomy related covered services will increase by 10% annually, 85% of male Plan First enrollees will receive care coordination services , and 75% of male enrollees will undergo the procedure within the enrollment year. This goal will be evaluated based on the number of male enrollees, claims for care coordination and sterilizations performed statewide.

H1.1: Use of vasectomy services by male enrollees will increase with increased provision of care coordination services.

	DY15 (10/14-9/15)	**DY16 (10/15-9/16)**	**DY17 (10/16-9/17)**	**DY18 (10/17-9/18)**
Number enrolled				
Number obtaining vasectomy				
Received care coordination				
No care coordination				
Number not obtaining vasectomy				
Received care coordination				
No care coordination				
% enrolled obtaining vasectomy				

Track the number of care coordination hours billed for male Plan First enrollees.

	DY17 (10/16-9/17)		**DY18 (10/17-9/18)**	
Received Care Coordination?	No	Yes	No	Yes
Number (%) of male clients				
Mean number of encounters (hours of contact)				

Appendix B: Budget/allotment neutrality assessment, and projections for the projected extension period. The state will present an analysis of budget/allotment neutrality for the current demonstration approval period, including status of budget/allotment neutrality to date based on the most recent expenditure and member month data, and projections through the end of the current approval that incorporate the latest data. CMS will also review the state's Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) expenditure reports to ensure that the demonstration has not exceeded the federal expenditure limits established for the demonstration. The state's actual expenditures incurred over the period from initial approval through the current expiration date, together with the projected costs for the requested extension period, must comply with CMS budget/allotment neutrality requirements outlined in the STCs.

See Attachment G Budge Neutrality Worksheet

Appendix C: Interim evaluation of the overall impact of the demonstration that includes evaluation activities and findings to date, in addition to plans for evaluation activities over the requested extension period. The interim evaluation should provide CMS with a clear analysis of the state's achievement in obtaining the outcomes expected as a direct effect of the demonstration program. The state's interim evaluation must meet all of the requirements outlined in the STCs.

The number of women participating (having any paid claim) in the Plan First Program declined slightly in DY15, to 58,009 women, compared to 68,199 in DY14. Enrollment in the program also decreased slightly, but the portion of enrollees participating in the Plan First Program was similar to DY14, 45.1% vs 46.1%. The portion of women with deliveries in the previous two years who used Plan First services decreased across all Maternity Care District. Participation in Plan First by non-Title X agencies (private physicians and community health centers) increased, but the portion of total visits and total participants using services in the non-Title X sector decreased slightly.

The decrease in participation and enrollment in the Plan First Program is contributed to the change in FPL guidelines which made more Plan First recipients eligible for full Medicaid coverage.

Use of any contraceptives and use of effective contraceptives remained stable in DY15 (86% and 81% respectively), according to the annual enrollee survey. The primary reason for not using contraceptives, as identified by survey respondents, is that they are not sexually active (38%), they don't think they can get pregnant (17%), or they want to get pregnant (14%). Some women do report that they do not use birth control because they can't afford it (10%) or can't find a provider that they want to see (9%). Affordability and difficulty finding a preferred provider are also listed as reasons for not making a visit to a family planning provider in the past year.

The portion of Plan First participants with a risk assessment, completed either in DY15 or in previous years, reached a high of 73% in DY 15. Risk assessment coverage remains high for

users of Health Department services (>90%) and decreased slightly for users of private sector services. Almost all of the clients assessed as high risk received some form of care coordination services, and those with care coordination more frequently received HIV counseling and effective contraception.

The portion of women with non-family planning medical problems who received referrals from their family planning providers for primary care was 61% (compared to a target of 80%). As in past years, about 60% of women with medical issues reported receiving primary care, with inability to afford care as the primary reason cited for not obtaining services.

Finally, this evaluation continues the approach of estimating birth rates from pregnancies starting during the Demonstration Year separately for enrollees who did and did not participate in Plan First, and, among participants, for clients visiting different provider types and whether they received risk assessment and/or care coordination. All participants except those with no clinical services had birth rates that were lower than the rates for enrollees without services. Participants with the lowest birth rates are those who received risk assessments or care coordination, who use Title X family planning services.

The state will continue its evaluation its interim evaluations of the overall impact of the demonstration that includes evaluation activities and findings for the requested extension period. The interim evaluation for the requested extension period will also contain evaluations for males receiving vasectomy related services. It is the state's goal that the interim evaluation will provide CMS with a clear analysis of the state's achievement in obtaining the outcomes expected as a direct effect of the demonstration program.

Reference Attachment I for a full Interim Evaluation of Plan First Program for Demonstration Year 15 (October 2014 through September 2015).

Appendix D: Summaries of External Quality Review Organization (EQRO) reports, managed care organization and state quality assurance monitoring, and any other documentation of the quality of and access to care provided under the demonstration.

AMA has a consistent and coordinated framework for authority and oversight to deliver timely, appropriate quality family planning services to Medicaid recipients. The
Services under this Demonstration Waiver are administered by various providers, however, AMA maintains authority over monitoring and oversight of the Plan First Program

The Demonstration Waiver has four major goals for quality assurance and monitoring:

- To assure accessibility of family planning services to eligible recipients
- To assure that recipient assessments include the assessment and care plan appropriate for the risk level
- To assure that the family planning encounters provided through enrolled providers follows the guidelines in the Provider Manual, Appendix C, Family Planning and the approved Waiver Demonstration.
- To ensure that an effective complaint and grievance system is in place for both providers and recipients
- To ensure quality and utilization management
- To ensure satisfaction of family planning services

Listed below are quality activities performed by AMA and its partnering Agency, Alabama Department of Public Health.

Internal Evaluations

The Demonstration Waiver has provisions for University of Alabama at Birmingham (UAB) to assist in providing outcome and summary reports to support effectiveness of the Program. This will enable comparisons between different sectors of populations and historical data.

UAB conducts ongoing internal evaluations for this Demonstration Waiver. The primary contact person is Dr. Kari White, Health Care Organization & Policy, University of Alabama at Birmingham. Her responsibility is to evaluate the program. UAB has designed data collection tools that collect, compile and analyze data, providing feedback annually to AMA and the Department of Public Health on program operation and outcomes. With UAB's assistance, a yearly Demonstration progress report that illustrates progress, goal achievement, and other areas for continued improvement. UAB is not involved in direct patient care for the Plan First Program. See Attachment I for details related to the Annual Demonstration Evaluation.

Monitoring

Public Health Area supervisors audit Plan First care coordination patient records quarterly utilizing a standardized audit tool. These audits are submitted to the Public Health Central Office and are available for review by Medicaid. All care coordination patient records are documented electronically and the Central Office conducts an annual desk review of the patient records for each Care Coordinator, submitting a written report to supervisors. Six weeks after Care Coordinators complete certification training, the Central Office training staff reviews their documentation and submits a written report to their supervisor. The Public Health Program Integrity staff randomly reviews patient records in county health departments for compliance with travel reimbursement, billing of appropriate time for services, and ensuring that all time coded to Plan First has appropriate documentation to justify billing. A total of 6,464 record reviews were conducted by the Medicaid's monitoring agency during DY15 and DY16 with a reported compliance rate of 99%. An example of Plan First Care Coordination monitoring and utilization is noted in Attachment M.

Complaints and Grievances

AMA has the primary responsibility of monitoring overall program performance, complaints and grievances. No complaints were received from recipients during this Waiver Demonstration period. Reference Attachment L, the Plan First Volume Indicator Report.

Claims Data Review

The agency conducted a review of claims to ensure appropriate billing of Procedure Codes. As result of this review, it was noted that a procedure Code for extended family planning counseling was not being utilized according to program description and guidelines. A complete analysis of claims for FY16 was requested from the provider. At the conclusion of this review, the provider agreed with the findings and claims were adjusted to reflect repayment of funds back to AMA.

Monthly Meetings

Monthly meeting are held with the ADPH to discuss program related concerns and updates related to the Plan First Program.

Comprehensive Desk Medical Record Reviews

Comprehensive desk medical record reviews were completed to monitor compliance with program guidelines. A random selection of records were requested from providers. The Following findings were identified:

- Finding-Providers did not have a mechanism for documenting complaints and grievances for auditing purposes.

  Action taken by the Agency-Education was provided regarding documentation of complaints and grievances.

- Finding-Although documentation of recipient education was noted, providers were not documenting the use of PT+3 Teaching Methodology.

  Action taken by the Agency-Education was provided regarding documentation of PT+3 Teaching Methodology.

- Finding-Provider records did not contain documentation of family planning consent for services.

  Action taken by the Agency-Education was provided regarding obtaining written consent for family planning services.

AMA will continue to work to maintain a quality program and educate providers regarding the requirements of the Plan First Program.

Utilization of Services

The state did not note any trends to indicate overutilization or underutilization of the Demonstration Waiver services. A random sampling of records were reviewed to determine if services were provided according to guidelines as outlined in the Provider Manual. This review provided an opportunity to provide education regarding the program requirements. Because it was difficult to determine face to face encounters, telephone and activities without a complete care coordination record review, effective May 1, 2017, Medicaid implemented program changes to mandate that the provider apply modifiers to care coordination CPT Procedure Codes. This data will be queried quarterly and will be used to conduct focus reviews.

Appendix E: Documentation of the state's compliance with the public notice process set forth in 42 CFR 431.408 and 431.420.

Post Award Forum
Within six months of the demonstration's implementation, the state provided the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30

days prior to the date of the planned public forum, the state published the date, time and location of the forum in a prominent location on its website. During this public forum, nine (9) attendees obtained knowledge about the progress of the demonstration through presentation and dialogue and were provided the opportunity to ask questions about the Demonstration.

The public notice announcement was posted on Medicaid's website on May 8, 2015. This notice can be viewed by accessing the following link: http://www.medicaid.alabama.gov/news_detail.aspx?ID=9624. The six month Post Award Public Forum sign-in sheet is noted as Attachment D and the presentation is noted as Attachment E. No comments were received as a result of this Forum.

Annual Public Forum

An annual Public Forum was held on July 21, 2016. At least 30 days prior to the date of the planned public forum, the state published the date, time and location of the forum in a prominent location on its website. During this public forum, eight (8) obtained knowledge about the progress of the demonstration through presentations and dialogue. The public notice announcement was posted on Medicaid's website on June 15, 2016. This notice can be viewed by accessing the following link: http://www.medicaid.alabama.gov/news_detail.aspx?ID=10570. Reference Attachment A for the Annual Public Forum sign-in sheet. The state's presentation is noted as Attachment B and the questions and response are noted in Attachment C.

Waiver Application Extension Public Notice

As a requirement of the STC, waiver application extension Public Forums were held on May 11, 2017 and May 12, 2017. The Public Forums were announced on Medicaid's website and the abbreviated Public Notice was posted in a prominent location on the website on April 15, 2017. This notice can be viewed by accessing the following links: http://www.medicaid.alabama.gov/ or http://www.medicaid.alabama.gov/news_detail.aspx?ID=12225. An abbreviated and full public notice and all applicable documents related to this waiver application extension can be accessed at the following link: http://medicaid.alabama.gov/content/4.0_Programs/4.2_Medical_Services/4.2.4_Family_Planning/4.2.4.2_FP_1115_Waiver.aspx

The abbreviated Public Notice was filed according to Medicaid's Administrative Procedure guidelines and was announced in the Alabama Administrative Monthly, Volume XXXV, Issue No. 6, April 28, 2017. Please access the following link to view this posting: http://www.alabamaadministrativecode.state.al.us/UpdatedMonthly/AAM-APR-17/AAM-APR-17.htm

The Public Forum Notice was also announced on the Alabama Media Portal, see attachment Q. A link was provided for public comments. A tribal notice was mailed on April 20, 2017, see Attachment N. No comments were received as a result of this notice.

One (1) person attended the Public Forum held on May 11, 2017, and four (4) people attended the Public Forum held on May 12, 2017. See Attachment R for the sign-in sheets. Medicaid presented information on the Plan First Program at both Public Forums. The PowerPoint presented is located on Medicaid website at the following link:

http://www.medicaid.alabama.gov/content/4.0_Programs/4.2_Medical_Services/4.2.4_Family_Planning.aspx.

Telephonic conferencing was available for both forums and webinar capability was available for the forum on May 12, 2017. Questions were asked and Medicaid provided responses. See Attachment O and Attachment P for questions and answers.

The open comment period began on April 15, 2017 and ended on May 30, 2017 at 5:00 p.m., CST. No questions were received through the comment link.

Appendix F: Special Terms and Conditions and Documentation and Centers for Medicaid and Medicaid Services Expenditure Authority

Attachment J and Attachment K, Special Terms and Conditions (STCs) and expenditure authorities, are applicable to the current waiver period of January 1, 2015 through December 31, 2017 (i.e., Demonstration Years 15, 16 and 17).

1115 Demonstration Waiver
An Extension of
Family Planning Services
for
Eligible Medicaid Recipients

Alabama Medicaid Agency
Public Forum
Thursday, July 21, 2016

Plan First Program

- A federally approved Research and Demonstration Waiver for family planning services
- A collaboration between the Alabama Department of Public Health and Medicaid
- Extends family planning and family planning-related services
- A program to prevent or delay pregnancy

Who Is Eligible?

Females who:

- are between 19-55 years of age
- have not previously been sterilized
- meet citizenship and alienage requirements
- meet poverty level guidelines
- meet Medicaid Eligibility Criteria

Men who:

- are age 21years of age or older
- have not previously been sterilized
- meet citizenship and alienage requirements
- meet poverty level guidelines
- meet Medicaid Eligibility Criteria

Changes in Services (January 2015)

- Increased income level for women ages 19-55 to 141% of FPL
- Surgical removal of migrated or embedded IUDs in an office or outpatient hospital setting
- Allow vasectomies for eligible men ages 21 or older

Savings for Medicaid

- Births Averted in DY12 -- 12,000
- At an average of $3,000 per delivery
- Savings of $36,000,000

Key Numbers

- Plan First Provider Locations: 2,586 (CY15)
- Plan First Participants: 117,312 (DY15)
- Budgeted Yearly Amount Spent:

2013	2014	2015
39 million	**35 million**	**32 million**

Provider Types

- Physicians
- Clinics
- Nurse Midwives
- Nurse Practitioners
- Physician Assistants

Covered Services

- Doctor/clinic visits for Medicaid covered family planning services
- Birth control methods such as pills, injections, contraceptive patch, vaginal ring, IUDS, diaphragms
- Tubal ligations and vasectomies in approved settings
- Plan First care coordination services for high risk women
- Surgical removal of migrated or embedded IUDs in an office or outpatient hospital setting
- Initial Visit (99205-FP)
- Annual Visit (99214-FP)
- Periodic Revisit (99213-FP)
- STD/HIV Risk Screening and Pre-HIV test Counseling (99401 with Diagnosis Code Z309
- STD/HIV post test counseling (99402 with Diagnosis Code Z309)
- Smoking cessation counseling and smoking cessation products

Care Coordination Services

- Perform initial risk assessment to determine if and what type of care coordination services needed
- Provides special assistance to women who:
  - are at high risk for unintended pregnancy
  - need enhanced contraceptive education
  - need assistance with removing barriers to successful pregnancy planning
  - need encouragement to continue with family spacing plans
- Provided by the Alabama Department of Public Health by licensed social workers and nurses.

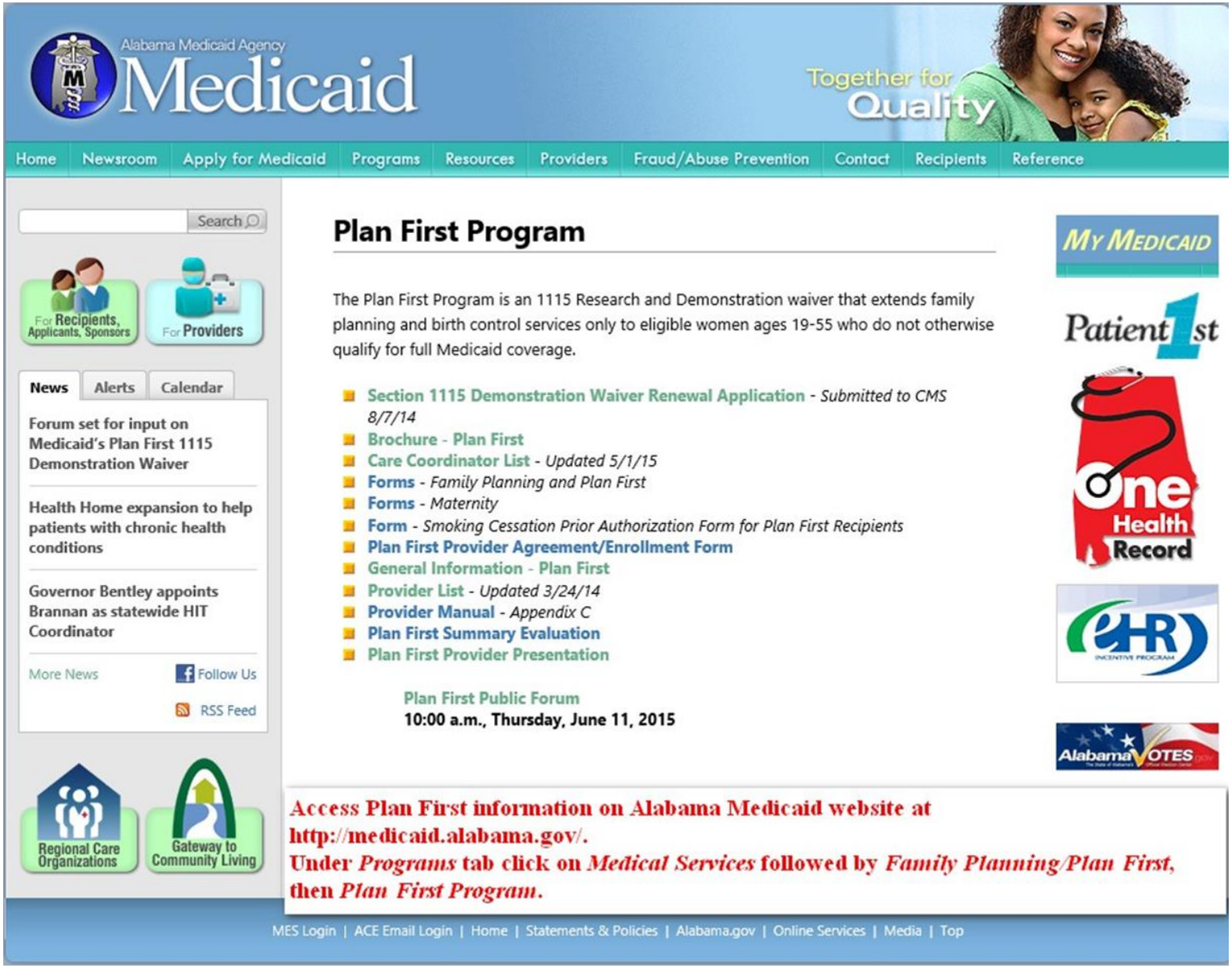
Goals for DY14-DY17

- Increase the portion of income eligible women, ages 19 –55 enrolled in Plan First and reduce race/ethnicity and geographic disparities among enrollees.
- Maintain the high level of awareness of the Plan First program among program enrollees.
- Telephone surveys of enrollees will be used to track changes in levels of awareness of the program and enrollment in the program.
- Increase the portion of Plan First enrollees using family planning services initially after enrollment and in subsequent years of enrollment by improving access to services and increasing the rate of return visits for care.
- Survey data suggest that approximately one third of Plan First enrollees are cigarette smokers, and 85% of these were advised by their family planning providers to quit smoking. Increase the number of enrollees who are cigarette smokers to receive either a Nicotine Reduction Therapy prescription, a referral to the Quit line or both.
- Maintain birth rates among Plan First service users that are lower than the estimated birth rates that would be occurring in the absence of the Plan First Demonstration.
- Increase the usage of the Plan First Waiver by making sterilizations available to males ages 21 years or older.

To Find Out More Information About Plan First:

- Call the Toll Free Hotline Number at: 1-888-737-2083
- Click the following link to access Medicaid's website for a list of providers: http://medicaid.alabama.gov/documents/4.0_Programs/4.4_Medical_Services/4.4.4_Family_Planning/4.4.4.1_Plan_First/4.4.4.1_Plan_First_Providers_5-13-16.pdf
- Contact the local Health Departments for a list of providers
- Click the following link to access Medicaid's Provider Manual, Appendix C, Family Planning: http://medicaid.alabama.gov/CONTENT/6.0_Providers/6.7_Manuals.aspx

To Find Out More Information About Plan First



Program Contact Information

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- Pamela Moore, Program Coordinator
  Maternity & Plan First/Family Planning Programs
  pamela.moore@medicaid.Alabama.gov
  334.353.9404

General Contact Information

- Alabama Department of Public Health 334-293-6525
- Program Questions 334-353-3562
- Provider Assistance Center 800-688-7989
- Recipient Call Center 800-362-1504
- Recipient Call Center Fax 334-215-4140

Medicaid's Website www.medicaid.alabama.gov

July 21, 2016 Plan First Public Forum Questions/Comments and Issues and Responses

Question: What happens to a Plan First recipient /patient who has a migrated or embedded IUD?

Answer: There is a new covered service that has been added to Plan First and is of great benefit to providers. Medicaid has now added coverage for migrated and embedded IUDS to the Plan First Program.

Question: (Katie Magoulich- MY CARE) Let's say a lot of women have full Medicaid. If a Plan First woman has high blood pressure and doesn't have full Medicaid coverage what happens to her then and who manages that?

Answer: (Meredith Adams-ADPH) The recipient can be referred to an FQHC or seen by a Care Coordinator who will then arrange a referral to a Primary Care M.D. or an FQHC or a rural health provider from an available list.

Answer #2: (Ruth Harris/Plan First Program Manager) In the past safe and effective hypertensive medicines have been given free by the ADPH who were unable to purchase these medications. Also with the assistance of a Care Coordinator free or low cost medications may be provided to a recipient by a drug manufacturer thru indigent medication programs.

Question: (Katie Magoulich- MY CARE) From an RCO perspective how can we be supportive of the Plan First Program? What is the role of the RCO in Plan First? Can collaboration be done with Plan First so there is quicker access to care for these recipient's to meet their needs, these would include women and now men.

Answer: (Sylisa) If a recipient has full Medicaid she will receive Family Planning in the RCO. If she's a Plan First recipient, she won't be carved into the RCOs. What RCO's can do now is to get familiar and make a collaboration effort to educate and establish relationships with Plan First Providers. A list of Providers can be found on the Medicaid website. Initial contact and communication with them is very important.

Question: Now that the gentleman are being included in Plan First will Care Coordination services be extended to them at the level the females receive?

Answer: #1 (Sylisa) Medicaid is currently reviewing a request to add care coordination for males to the Waiver. This will take a waiver amendment approved by CMS.

Answer #2 (Meredith): Care Coordination Services would not be needed at the extent that a female receive services because he is not at risk for pregnancy and does not have the same risk factors.

Alabama Medicaid Agency
Plan First 1115 Demonstration Waiver
Public Forum

Thursday, June 11, 2015

Plan First Services

- Most family planning services & supplies
- Smoking cessation counseling & products
- Birth control options

Changes in Services
(January 2015)

- **Increased income level for women ages 19-55 to 141% of FPL**
- **Allow IUD removal in medical office setting or outpatient hospital setting**
- **Allow vasectomies for eligible men ages 21 or older**

Savings for Medicaid

- **$74,921,000 would have been spent without the Plan First program (DY 2011)**

Key Numbers

- **Plan First Providers: 1,664 (CY 2013)**
- **Plan First Recipients: 247,108 (DY 13)**
- **Budgeted Yearly Amount Spent:**

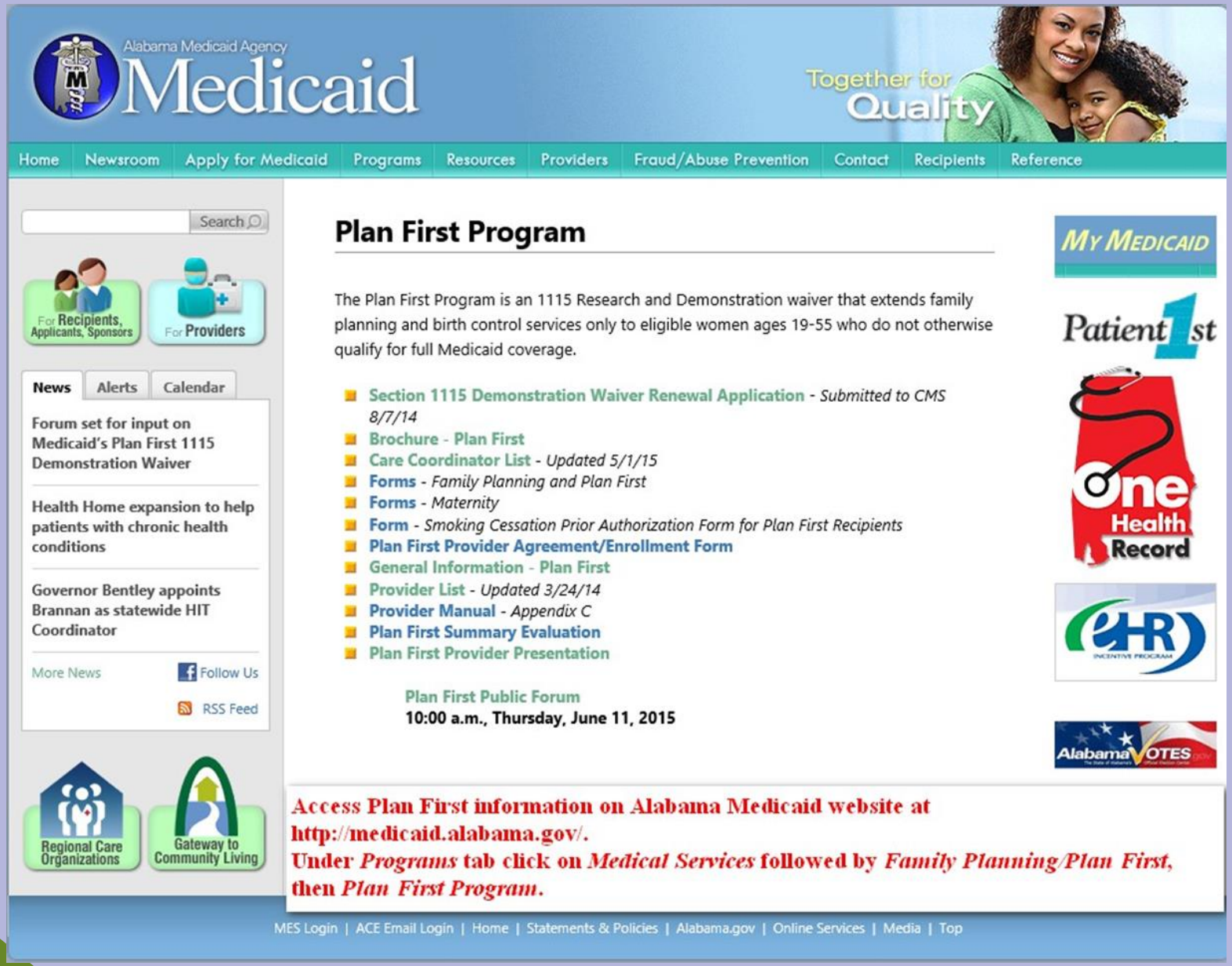
2011	2012	2013
$36,932,754	$39,299,089	$39,303,008

Goals: Plan First Moving Forward

- **Increase # of eligible women enrolled and reduce race/ethnicity & geographic disparities**
- **Maintain high level of program awareness among recipients**
- **Increase consistent use of family planning services by improving access**

Goals: Plan First Moving Forward

- **Provide smoking cessation therapy and/or Quit Line referrals to smokers advised to quit by family planning provider**
- **Maintain lower birth rates than estimated rates occurring without Plan First**
- **Increase # of Plan First sterilizations for men ages 21 years or older**


Alabama Medicaid Agency
Medicaid
Together for Quality
Home
Newsroom
Apply for Medicaid
Programs
Resources
Providers
Fraud/Abuse Prevention
Contact
Recipients
Reference
Search
For Recipients, Applicants, Sponsors
For Providers
News
Alerts
Calendar
Forum set for input on Medicaid's Plan First 1115 Demonstration Waiver
Health Home expansion to help patients with chronic health conditions
Governor Bentley appoints Brannan as statewide HIT Coordinator
More News
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Regional Care Organizations
Gateway to Community Living
Plan First Program
The Plan First Program is an 1115 Research and Demonstration waiver that extends family planning and birth control services only to eligible women ages 19-55 who do not otherwise qualify for full Medicaid coverage.
Section 1115 Demonstration Waiver Renewal Application - Submitted to CMS 8/7/14
Brochure - Plan First
Care Coordinator List - Updated 5/1/15
Forms - Family Planning and Plan First
Forms - Maternity
Form - Smoking Cessation Prior Authorization Form for Plan First Recipients
Plan First Provider Agreement/Enrollment Form
General Information - Plan First
Provider List - Updated 3/24/14
Provider Manual - Appendix C
Plan First Summary Evaluation
Plan First Provider Presentation
Plan First Public Forum
10:00 a.m., Thursday, June 11, 2015
My Medicaid
Patient 1st
One Health Record
eHR
AlabamaVOTES
Access Plan First information on Alabama Medicaid website at http://medicaid.alabama.gov/.
Under Programs tab click on Medical Services followed by Family Planning/Plan First, then Plan First Program.
MES Login | ACE Email Login | Home | Statements & Policies | Alabama.gov | Online Services | Media | Top

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334-353-3562

Attachment F
Covered Services List for Plan First Recipients

Code	Procedure Description
99420	Low Risk assessment; use with modifier 22 for high-risk assessment. *For Plan First* recipient*s only – to be billed only by health departments.*
T1017-FP	Targeted Case Management (Care Coordination)-Successful telephone interaction. For Plan First recipients only-to be billed by health departments only. Case Management/Care Coordination documentation must support units billed.
T1017-FP, U1	Targeted Case Management (Care Coordination)-Face-to-face interaction only. For Plan First recipients only-to be billed by health departments only. Case Management/Care Coordination documentation must support units billed.
T1017-FP, U2	Targeted Case Management (Care Coordination) - Unsuccessful telephone calls that are made to recipients. For Plan First recipients only-to be billed by health departments only. Case Management/Care Coordination documentation must support units billed.
T1017-FP, U3	Targeted Case Management (Care Coordination) - Other care coordination activities other than telephone calls and face to face interaction. For Plan First recipients only-to be billed by health departments only. Case Management/Care Coordination documentation must support units billed.
99402	STD/HIV Post-test Counseling (Must be billed in conjunction with a family planning visit) – Limited to two per recipient per calendar year. (Must use diagnosis code V259 for ICD-9 or Z309 for ICD-10)
99401	STD/HIV Risk Screening and HIV Pre-test Counseling (Must be billed in conjunction with a family planning visit) – Limited to two per recipient per calendar year. (Must use diagnosis code V259 for ICD-9 or Z309 for ICD-10)
88305	Level IV Surgical Pathology, gross and microscopic examination
88304	Level III Surgical Pathology, gross and microscopic examination
88302	Surgical pathology, gross and microscopic examination
88300	Level I Surgical Pathology, gross examination only
89300	Semen analysis; presence and/or motility of sperm
88175	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with screening by automated system and manual rescreening, under physician supervision.
88174	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision.
88167	Cytopathology, slides, cervical or vaginal
88166	Cytopathology, slides, computer assisted rescreening
88165	Cytopathology, slides, cervical or vaginal
88164	Cytopathology, slides, cervical or vaginal
88162	Cytopathology, any other source
88161	Cytopathology, any other source
88160	Cytopathology, smears, any other source
88155	Cytopathology, slides, cervical or vaginal
88154	Cytopathology, slides, computer assisted
88153	Cytopathology, slides, manual screening & rescreening under physician supervision (use in conjunction with 88142-88154, 88164-88167)
88152	Cytopathology, slides, cervical or vaginal
88150	Cytopathology, manual screening under physician supervision
88148	Cytopathology, screening by automated system with manual rescreening
88147	Cytopathology smears, screening by automated system under physician supervision
88143	Cytopathology, manual screening & rescreening under physician supervision
88142	Cytopathology, cervical or vaginal, automated thin layer preparation
88141	Cytopathology, cervical or vaginal; requiring interpretation by physician (use in conjunction with 88142-88154, 88164-88167)
88108	Cytopathology, concentration technique, smears and interpretation
87850	Neisseria gonorrhea
87801	Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; amplified probe(s) technique
87798	Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; amplified probe technique, each organism. (Not billable by ADPH effective June 30, 2015.)
87797	Infectious agent detection by nucleic acid (DNA or RNA); not otherwise specified, direct probe technique
87661	Trichomonas vaginalis, amplified probe technique

Code	Procedure Description
87660	Trichomonas vaginalis, direct probe technique
87625	Human Papillomavirus (HPV), types 16 & 18 only
87624	Human Papillomavirus (HPV), high-risk types
87623	Human Papillomavirus (HPV), low-risk types
87592	Neisseria gonorrhea, quantification
87591	Neisseria gonorrhea, amplified probe technique. (Not billable by ADPH effective June 30, 2015.)
87590	Neisseria gonorrhea, direct probe technique
87539	HIV-2, quantification
87538	HIV-2, amplified probe technique
87537	HIV-2, direct probe technique
87536	HIV-1, quantification
87535	HIV-1, amplified probe technique
87534	HIV-1, direct probe technique
87533	Herpes virus-6, quantification
87532	Herpes virus-6, amplified probe technique
87531	Herpes virus-6, direct probe technique
87530	Herpes simplex virus, quantification
87529	Herpes simplex virus, amplified probe technique
87528	Herpes simplex virus, direct probe technique
87512	Gardnerella vaginalis, quantification
87511	Gardnerella vaginalis, amplified probe technique
87510	Gardnerella vaginalis, direct probe technique
87491	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia Trachomatis. Amplified probe technique. (Not billable by ADPH effective June 30, 2015.)
87490	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia Trachomatis. Direct probe technique.
87482	Candida species, quantification
87481	Candida species, amplified probe technique
87480	Candida species, direct probe technique
87389	Infectious Agent Antigen
87220	Tissue examination for fungi
87210	Smear, primary source, with interpretation, wet mount with simple stain, for bacteria, fungi, ova, and/or parasites
87209	Smear, primary source with interpretation; complex special stain (eg, trichrome, iron hemotoxylin) for ova and parasites
87207	Smear, primary source, with interpretation, special stain for inclusion bodies or intracellular parasites (e.g., malaria, kala azar, herpes)
87206	Smear, primary source, with interpretation, fluorescent and/or acid fast stain for bacteria, fungi, or cell types
87205	Smear, primary source, with interpretation; routine stain for bacteria, fungi, or cell types
87177	Smear, primary source, with interpretation, wet and dry mount for ova and parasites, concentration and identification
87164	Dark field examination, any source; includes specimen collection
87110	Culture, chlamydia
87081	Culture, bacterial, screening only, for single organisms
86780	Antibody; Treponema Pallidum
86703	HIV – 1&2
86702	Antibody HIV-2
86701	HIV – 1
86695	Herpes simples, type 1
86694	Herpes simplex, non-specific type test
86689	HTLV or HIV antibody
86593	Syphilis
86592	Syphilis
85032	Manual cell count (erythrocyte, leukocyte or platelet) each
85027	Blood count; RBC only

Attachment F
Covered Services List for Plan First Recipients

Code	Procedure Description
85025	Blood count; hemogram and platelet count, automated, and automated complete differential WBC count (CBC)
85018	Blood count; hemoglobin
85014	Blood count; other than spun hematocrit
85013	Blood count; spun microhematocrit
85009	Blood count; differential WBC count, buffy coat
85008	Blood count; manual blood smear examination without differential parameters
85007	Blood count; manual differential WBC count (includes RBC morphology and platelet estimation)
84703	HCG qualitative
84702	HCG quantitative
81025	Urine pregnancy test
81020	Urinalysis; two or three glass test
81015	Urinalysis microscopic only
81007	Urinalysis; bacteriuria screen, by non-culture technique, commercial kit
81005	Urinalysis; qualitative or semiquantitative, except immunoassays
81003	Urinalysis; automated without microscopy
81002	Urinalysis; non-automated without microscopy
81001	Urinalysis; automated with microscopy
81000	Urinalysis by dip stick or tablet reagent
76881	Contraceptive surveillance, unspecified of a missing Nexplanon
76830	Transvaginal Ultrasound Non-OB
76857	Ultrasound, Pelvic (Nonobstetric), real time with image documentation; limited or follow-up (EG, for follicles) **(This procedure is to be used for locating missing IUDs Only)**
74740	Hysterosalpingography, radiological supervision and interpretation
73060	X-ray of Humerus-Purpose Location of Nexplanon Capsules
58671	Tubal ligation by laparoscopic surgery
58670	Tubal ligation by laparoscopic surgery
58615	Tubal ligation by suprapubic approach
58611	Tubal ligation done in conjunction with a c-section (*Not applicable for Plan first)*
58605	Tubal ligation by abdominal approach (postpartum) (*Not applicable for Plan first)*
58600	Tubal ligation by abdominal incision
58565	Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants (by Prior Approval only; **See note box below)
58562	Hysteroscopy, surgical; with removal of impacted foreign body
A4264	Intratubal occlusion device (by Prior Approval only; **See note box below)
58340	Catheterization and introduction of saline or contrast material for saline infusion sonohysterography (SIS) or hysterosalpingography
58301	IUD removal
58300	IUD insertion
57800-FP	Dilation of cervical canal, instrumental (separate procedure)
57410-FP	Pelvic examination under anesthesia (other than local)
57170	Diaphragm – fitting with instructions **only.** Does not include the device.
55250	Vasectomy –unilateral or bilateral, including postoperative semen examination(s)
55450	Vasectomy-ligation of vas deferensunilateral or bilateral
11980	Subcutaneous hormone pellet implantation(implantation of estradiol and/or testosterone beneath the skin)
11976	Removal, implantable contraceptive capsule (Nexplanon)
11981-FP	Insertion, non-biodegradable drug delivery implant (Nexplanon)
00921	Anesthesia for vasectomy, unilateral or bilateral
00952-FP	Anesthesia for hysteroscopy and/or hysterosalpingography procedures
00940-FP	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); not otherwise specified
00851	Anesthesia Intraperitoneal procedures in lower abdomen including laparoscopy; tubal ligation/transection.
J1050-FP	Depo-Provera-no less than 104 mg and no more than 150 mg per injection once every 70 days
J7297	Liletta IUD (Levonorgestrel-releasing intrauterine contraceptive system, 52 mg) limited to one every 3 calendar years. Exceptions are in the NOTE box below

Attachment F
Covered Services List for Plan First Recipients

Code	Procedure Description
J7298	Mirena IUD (Levonorgestrel-releasing intrauterine contraceptive system, 52 mg) limited to one every 5 calendar years. Exceptions are in the NOTE box below
J7301	Skyla IUD (limited to one every 3 years). Exceptions are in NOTE box below.
J7304-FP	Contraceptive Patch (For Health Department Billing Only) TPL exempt
J7304-SE	Contraceptive Patch (For FQHCs, PRHCs, IRHCs Billing only)
J7303-FP	Vaginal Ring (For Health Department billing only and is covered for Plan First)
99205-FP	Initial visit
99214-FP	Annual visit
99213-FP	Periodic visit
99347-FP	Home visit – Limited to one per 60 day post-partum period as a family planning covered service. (Not applicable for Plan First eligible recipients)
S4993-FP	Birth control pills (For Health Department billing only)
96372	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular.
99212-FP	Extended contraceptive counseling visit (May be billed in conjunction with the postpartum visit – Limited to one service during the 60 day postpartum period as a family planning covered service. (Not applicable for Plan First eligible recipients.)
S4993-SE	Birth Control Pills (For FQHCs, PRHCs, IRHCs Billing only)
J7307	Etonogestrel (contraceptive) implant system, including implants and supplies also known as Nexplanon Effective 1/1/2008, J7307 replaces S0180
J7300	Mechanical (Paragard) IUD
S4989	Hormonal (Progestasert) IUD
Q0091	Collection of Pap smear specimen
Q0111	Wet mounts
36415-90	Routine venipuncture for collection
36416-90	Collection of capillary blood specimen (eg, finger, heel, ear stick)

	A	B	C	D	E	F	G	H	I	J	K
1	**DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS**										
2											
3											
4	**ELIGIBILITY**	**TREND**	**MONTHS**	**BASE YEAR**	**TREND**	**DEMONSTRATION YEARS (DY)**					**TOTAL**
5	**GROUP**	**RATE 1**	**OF AGING**	**DY 00**	**RATE 2**	**2017**	**2018**	**2019**	**2020**	**2021**	**WOW**
6											
7	**Medicaid Pop 1**										
8	**Pop Type:**	**Medicaid**									
9	Eligible Member Months	-1.8%		1,069,348	-1.8%	1,050,567	1,031,762	1,013,293	995,155	977,342	
10	PMPM Cost	0.0%	0	$ 25.54	0.0%	$ 25.54	$ 25.54	$ 25.54	$ 25.54	$ 25.54	
11	Total Expenditure					$ 26,843,623	$ 26,351,189	$ 25,879,503	$ 25,416,260	$ 24,961,309	$ 129,451,884
12											

	A	B	C	D	E	F	G
1	**5 YEARS OF HISTORIC DATA**						
2							
3	**SPECIFY TIME PERIOD AND ELIGIBILITY GROUP DEPICTED:**						
4							
5	**Medicaid Pop 1**	**2012**	**2013**	**2014**	**2015**	**2016**	**5-YEARS**
6	**TOTAL EXPENDITURES**	40,057,737	41,344,489	38,224,716	31,809,996	27,315,612	$ 178,752,550
7	**ELIGIBLE MEMBER MONTHS**	1,149,592	1,277,918	1,301,043	1,194,096	1,069,348	
8	**PMPM COST**	$ 34.85	$ 32.35	$ 29.38	$ 26.64	$ 25.54	
9	**TREND RATES**						**5-YEAR**
10				**ANNUAL CHANGE**			**AVERAGE**
11	TOTAL EXPENDITURE		3.21%	-7.55%	-16.78%	-14.13%	-9.13%
12	ELIGIBLE MEMBER MONTHS		11.16%	1.81%	-8.22%	-10.45%	-1.79%
13	PMPM COST		-7.15%	-9.19%	-9.33%	-4.11%	-7.47%
14							89,112

DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP	DY 00	DEMO TREND RATE	DEMONSTRATION YEARS (DY) 2017	2018	2019	2020	2021	TOTAL WW
Medicaid Pop 1								
Pop Type: Medicaid								
Eligible Member Months	1,069,348	-1.8%	1,050,567	1,031,762	1,013,293	995,155	977,342	
PMPM Cost	$ 25.54	0.0%	$ 25.54	$ 25.54	$ 25.54	$ 25.54	$ 25.54	
Total Expenditure			$ 26,843,623	$ 26,351,189	$ 25,879,503	$ 25,416,260	$ 24,961,309	$ 129,451,884

NOTES

For a per capita budget neutrality model, the trend for member months is the same in the with-waiver projections as in the without-waiver projections. This is the default setting.

Budget Neutrality Summary

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY) 2017	2018	2019	2020	2021	TOTAL
Medicaid Populations						
Medicaid Pop 1	$ 26,843,623	$ 26,351,189	$ 25,879,503	$ 25,416,260	$ 24,961,309	$ 129,451,884

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY) 2016	2017	2018	2019	2020	TOTAL
Medicaid Populations						
Medicaid Pop 1	$ 26,843,623	$ 26,351,189	$ 25,879,503	$ 25,416,260	$ 24,961,309	$ 129,451,884

Note 1: Used the historic expenditures and member months from 2012-2016
Note 2: Added 30 eligible males to approximate member months in DY 2017
Note 3: Added $12,150 to the total projected total expenditures in DY2017 and calulated the PMPM by dividing total expenditure by eligible member months
Note 4: Changed PMPM trend rate to 0%

ALABAMA MEDICAID AGENCY
Covered Nicotine Products

Effective 1/1/14, Alabama Medicaid began covering smoking cessation products for all recipients. These products continue to be covered for Plan First recipients without prior authorization. Prior authorization is required for all other recipients. The list below contains nicotine products which are currently covered by the Alabama Medicaid Agency. **The list is subject to change.** For additional PDL and coverage information, visit our drug look-up site at https://www.medicaid.alabamaservices.org/ALPortal/NDC%20Look%20Up/tabId/39/Default.aspx.

NDC CODE	BRAND NAME	GENERIC NAME
00009540001	NICOTROL CARTRIDGE INHALER	NICOTINE INHALATION 10 MG CARTRIDGE
00009540101	NICOTROL NS 10 MG/ML SPRAY	NICOTINE NASAL 10 MG/ML SPRAY
87701041281	GNP NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
62011004702	HM NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
37205020371	LDR NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
00904573411	NICORELIEF 2 MG GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
00904573451	NICORELIEF 2 MG GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
00904573611	NICORELIEF 2 MG GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
00904573651	NICORELIEF 2 MG GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
00135015707	NICORETTE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
00135015710	NICORETTE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
00135015711	NICORETTE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
00135022502	NICORETTE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
00135022503	NICORETTE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
00135022905	NICORETTE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
00135024102	NICORETTE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
00135024105	NICORETTE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
00135024106	NICORETTE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
00135024108	NICORETTE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
00135046601	NICORETTE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
00135046602	NICORETTE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
00135046605	NICORETTE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
00135047401	NICORETTE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
00135047402	NICORETTE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
00135047403	NICORETTE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
00135047405	NICORETTE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
00135047408	NICORETTE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
00113020625	NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
00363036506	NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
00536136206	NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
00536136223	NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
00536136234	NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
00536302906	NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
00536302923	NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
00536302934	NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
00536311201	NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
00536311237	NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
00536338601	NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
00536338637	NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
00536340401	NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
11917015386	NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM

ALABAMA MEDICAID AGENCY
Covered Nicotine Products

NDC CODE	BRAND NAME	GENERIC NAME
24385059471	NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
36800002925	NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
36800020625	NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
36800035278	NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
36800045678	NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
37205096758	NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
37205096778	NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
45802020625	NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
46122017320	NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
37205020323	NICOTINE 2 MG GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
37205020367	NICOTINE 2 MG GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
37205020423	NICOTINE 4 MG GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
37205020467	NICOTINE 4 MG GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
49348057308	SM NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
49348057336	SM NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
49348069109	SM NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
49348069136	SM NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
49348078710	SM NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
49348078759	SM NICOTINE 2 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 2 MG GUM
62011017001	HM NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
37205020471	LDR NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
00904573511	NICORELIEF 4 MG GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
00904573551	NICORELIEF 4 MG GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
00904573711	NICORELIEF 4 MG GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
00904573751	NICORELIEF 4 MG GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
00135015807	NICORETTE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
00135015810	NICORETTE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
00135015811	NICORETTE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
00135022602	NICORETTE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
00135022603	NICORETTE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
00135023004	NICORETTE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
00135023005	NICORETTE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
00135024202	NICORETTE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
00135024205	NICORETTE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
00135024206	NICORETTE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
00135024208	NICORETTE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
00135046702	NICORETTE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
00135046705	NICORETTE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
00135047501	NICORETTE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
00135047502	NICORETTE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
00135047503	NICORETTE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
00135047505	NICORETTE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
00135047508	NICORETTE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
00113042225	NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
00113053278	NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
00536137206	NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM

ALABAMA MEDICAID AGENCY
Covered Nicotine Products

NDC CODE	BRAND NAME	GENERIC NAME
00536137223	NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
00536137234	NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
00536303006	NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
00536303023	NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
00536311301	NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
00536311337	NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
00536338701	NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
00536340501	NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
24385059871	NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
36800017025	NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
36800017071	NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
36800042271	NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
36800053278	NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
36800085478	NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
37205096858	NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
37205096878	NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
45802000125	NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
45802011078	NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
49348057208	SM NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
49348057236	SM NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
49348069209	SM NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
49348069236	SM NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
49348078810	SM NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
49348078859	SM NICOTINE 4 MG CHEWING GUM	NICOTINE POLACRILEX BUCCAL 4 MG GUM
62011004801	HM NICOTINE 2 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 2 MG LOZENGE
62011004803	HM NICOTINE 2 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 2 MG LOZENGE
00135051001	NICORETTE 2 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 2 MG LOZENGE
00135051002	NICORETTE 2 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 2 MG LOZENGE
00135051003	NICORETTE 2 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 2 MG LOZENGE
00135051005	NICORETTE 2 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 2 MG LOZENGE
00135051201	NICORETTE 2 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 2 MG LOZENGE
00135051205	NICORETTE 2 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 2 MG LOZENGE
00135051403	NICORETTE 2 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 2 MG LOZENGE
00135051404	NICORETTE 2 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 2 MG LOZENGE
00113034405	NICOTINE 2 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 2 MG LOZENGE
00536103881	NICOTINE 2 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 2 MG LOZENGE
36800034405	NICOTINE 2 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 2 MG LOZENGE
36800037555	NICOTINE 2 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 2 MG LOZENGE
36800073402	NICOTINE 2 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 2 MG LOZENGE
37205098769	NICOTINE 2 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 2 MG LOZENGE
45802034405	NICOTINE 2 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 2 MG LOZENGE
46122017608	NICOTINE 2 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 2 MG LOZENGE
49348085216	SM NICOTINE 2 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 2 MG LOZENGE
00135050802	NICORETTE 2 MG MINI LOZENGE	NICOTINE POLACRILEX BUCCAL 2 MG LOZENGE
00135050803	NICORETTE 2 MG MINI LOZENGE	NICOTINE POLACRILEX BUCCAL 2 MG LOZENGE
46122025415	NICOTINE 2 MG MINI LOZENGE	NICOTINE POLACRILEX BUCCAL 2 MG LOZENGE

ALABAMA MEDICAID AGENCY
Covered Nicotine Products

NDC CODE	BRAND NAME	GENERIC NAME
62011017101	HM NICOTINE 4 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 4 MG LOZENGE
62011017102	HM NICOTINE 4 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 4 MG LOZENGE
00135051101	NICORETTE 4 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 4 MG LOZENGE
00135051102	NICORETTE 4 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 4 MG LOZENGE
00135051105	NICORETTE 4 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 4 MG LOZENGE
00135051301	NICORETTE 4 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 4 MG LOZENGE
00135051305	NICORETTE 4 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 4 MG LOZENGE
00135051503	NICORETTE 4 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 4 MG LOZENGE
00113087305	NICOTINE 4 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 4 MG LOZENGE
00536103981	NICOTINE 4 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 4 MG LOZENGE
36800037554	NICOTINE 4 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 4 MG LOZENGE
36800087305	NICOTINE 4 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 4 MG LOZENGE
36800095702	NICOTINE 4 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 4 MG LOZENGE
37205098869	NICOTINE 4 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 4 MG LOZENGE
45802087305	NICOTINE 4 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 4 MG LOZENGE
46122017708	NICOTINE 4 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 4 MG LOZENGE
49348085316	SM NICOTINE 4 MG LOZENGE	NICOTINE POLACRILEX BUCCAL 4 MG LOZENGE
46122025515	NICOTINE 4 MG MINI LOZENGE	NICOTINE POLACRILEX BUCCAL 4 MG LOZENGE
00135050902	NICORETTE 4 MG MINI LOZENGE	NICOTINE POLACRILEX BUCCAL 4 MG LOZENGE
00135050903	NICORETTE 4 MG MINI LOZENGE	NICOTINE POLACRILEX BUCCAL 4 MG LOZENGE
62011005001	HM NICOTINE 7 MG/24HR PATCH	NICOTINE TRANSDERM 7MG/24HR PATCH TD24
00067500014	KRO NICOTINE 7 MG/24HR PATCH	NICOTINE TRANSDERM 7MG/24HR PATCH TD24
00135019602	NICODERM CQ 7 MG/24HR PATCH	NICOTINE TRANSDERM 7MG/24HR PATCH TD24
00135019605	NICODERM CQ 7 MG/24HR PATCH	NICOTINE TRANSDERM 7MG/24HR PATCH TD24
00067488007	NICOTINE 7 MG/24HR PATCH	NICOTINE TRANSDERM 7MG/24HR PATCH TD24
00067503607	NICOTINE 7 MG/24HR PATCH	NICOTINE TRANSDERM 7MG/24HR PATCH TD24
00067512407	NICOTINE 7 MG/24HR PATCH	NICOTINE TRANSDERM 7MG/24HR PATCH TD24
00067512414	NICOTINE 7 MG/24HR PATCH	NICOTINE TRANSDERM 7MG/24HR PATCH TD24
00363089488	NICOTINE 7 MG/24HR PATCH	NICOTINE TRANSDERM 7MG/24HR PATCH TD24
00536589433	NICOTINE 7 MG/24HR PATCH	NICOTINE TRANSDERM 7MG/24HR PATCH TD24
00536589488	NICOTINE 7 MG/24HR PATCH	NICOTINE TRANSDERM 7MG/24HR PATCH TD24
11917015692	NICOTINE 7 MG/24HR PATCH	NICOTINE TRANSDERM 7MG/24HR PATCH TD24
37205036374	NICOTINE 7 MG/24HR PATCH	NICOTINE TRANSDERM 7MG/24HR PATCH TD24
00067612814	SM NICOTINE 7 MG/24HR PATCH	NICOTINE TRANSDERM 7MG/24HR PATCH TD24
62011017201	HM NICOTINE 14 MG/24HR PATCH	NICOTINE TRANSDERM 14MG/24HR PATCH TD24
00067501014	KRO NICOTINE 14 MG/24 HR PATCH	NICOTINE TRANSDERM 14MG/24HR PATCH TD24
00135019502	NICODERM CQ 14 MG/24HR PATCH	NICOTINE TRANSDERM 14MG/24HR PATCH TD24
00135019503	NICODERM CQ 14 MG/24HR PATCH	NICOTINE TRANSDERM 14MG/24HR PATCH TD24
00135019505	NICODERM CQ 14 MG/24HR PATCH	NICOTINE TRANSDERM 14MG/24HR PATCH TD24
00363089588	NICOTINE 14 MG/24 HR PATCH	NICOTINE TRANSDERM 14MG/24HR PATCH TD24
11917015691	NICOTINE 14 MG/24 HR PATCH	NICOTINE TRANSDERM 14MG/24HR PATCH TD24
00067489014	NICOTINE 14 MG/24HR PATCH	NICOTINE TRANSDERM 14MG/24HR PATCH TD24
00067503707	NICOTINE 14 MG/24HR PATCH	NICOTINE TRANSDERM 14MG/24HR PATCH TD24
00067512507	NICOTINE 14 MG/24HR PATCH	NICOTINE TRANSDERM 14MG/24HR PATCH TD24
00067512514	NICOTINE 14 MG/24HR PATCH	NICOTINE TRANSDERM 14MG/24HR PATCH TD24
00536589533	NICOTINE 14 MG/24HR PATCH	NICOTINE TRANSDERM 14MG/24HR PATCH TD24

ALABAMA MEDICAID AGENCY
Covered Nicotine Products

NDC CODE	BRAND NAME	GENERIC NAME
00536589588	NICOTINE 14 MG/24HR PATCH	NICOTINE TRANSDERM 14MG/24HR PATCH TD24
37205036174	NICOTINE 14 MG/24HR PATCH	NICOTINE TRANSDERM 14MG/24HR PATCH TD24
00067612914	SM NICOTINE 14 MG/24HR PATCH	NICOTINE TRANSDERM 14MG/24HR PATCH TD24
00067505014	EQL NICOTINE 21 MG/24HR PATCH	NICOTINE TRANSDERM 21 MG/24HR PATCH TD24
62011017301	HM NICOTINE 21 MG/24HR PATCH	NICOTINE TRANSDERM 21 MG/24HR PATCH TD24
00067502014	KRO NICOTINE 21 MG/24HR PATCH	NICOTINE TRANSDERM 21 MG/24HR PATCH TD24
00135014502	NICODERM CQ 21 MG/24HR PATCH	NICOTINE TRANSDERM 21 MG/24HR PATCH TD24
00135019401	NICODERM CQ 21 MG/24HR PATCH	NICOTINE TRANSDERM 21 MG/24HR PATCH TD24
00135019402	NICODERM CQ 21 MG/24HR PATCH	NICOTINE TRANSDERM 21 MG/24HR PATCH TD24
00135019403	NICODERM CQ 21 MG/24HR PATCH	NICOTINE TRANSDERM 21 MG/24HR PATCH TD24
00135019405	NICODERM CQ 21 MG/24HR PATCH	NICOTINE TRANSDERM 21 MG/24HR PATCH TD24
00067490014	NICOTINE 21 MG/24HR PATCH	NICOTINE TRANSDERM 21 MG/24HR PATCH TD24
00067503807	NICOTINE 21 MG/24HR PATCH	NICOTINE TRANSDERM 21 MG/24HR PATCH TD24
00067503814	NICOTINE 21 MG/24HR PATCH	NICOTINE TRANSDERM 21 MG/24HR PATCH TD24
00067512607	NICOTINE 21 MG/24HR PATCH	NICOTINE TRANSDERM 21 MG/24HR PATCH TD24
00067512614	NICOTINE 21 MG/24HR PATCH	NICOTINE TRANSDERM 21 MG/24HR PATCH TD24
00067512628	NICOTINE 21 MG/24HR PATCH	NICOTINE TRANSDERM 21 MG/24HR PATCH TD24
00363089653	NICOTINE 21 MG/24HR PATCH	NICOTINE TRANSDERM 21 MG/24HR PATCH TD24
00363089688	NICOTINE 21 MG/24HR PATCH	NICOTINE TRANSDERM 21 MG/24HR PATCH TD24
00536589633	NICOTINE 21 MG/24HR PATCH	NICOTINE TRANSDERM 21 MG/24HR PATCH TD24
00536589688	NICOTINE 21 MG/24HR PATCH	NICOTINE TRANSDERM 21 MG/24HR PATCH TD24
11917015690	NICOTINE 21 MG/24HR PATCH	NICOTINE TRANSDERM 21 MG/24HR PATCH TD24
11917015693	NICOTINE 21 MG/24HR PATCH	NICOTINE TRANSDERM 21 MG/24HR PATCH TD24
37205035874	NICOTINE 21 MG/24HR PATCH	NICOTINE TRANSDERM 21 MG/24HR PATCH TD24
00067613014	SM NICOTINE 21 MG/24HR PATCH	NICOTINE TRANSDERM 21 MG/24HR PATCH TD24
00067604556	NICOTINE TRANSDERMAL SYSTEM	NICOTINE TRANSDERM 21-14-7MG PATCH DYSQ

Evaluation of Plan First

Demonstration Year 15 (October 2014-September 2015)

Kari White, Ph.D. MPH

UAB School of Public Health

December, 2016

Executive Summary

The Alabama Medicaid Plan First 1115 Demonstration Waiver was renewed in February 2015. The renewed waiver specified six goals for evaluation:

(1) Increase the portion of women eligible for Plan First who actually enroll, and reduce race/ethnicity and geographic disparities in enrollment. The program goal is to enroll 80% of eligible women under age 40 into Plan First.

(2) Maintain a high level of awareness of the Plan First program among enrollees.

(3) Increase the portion of Plan First enrollees who use family planning services, both in the initial year of enrollment and in subsequent years. The program goal is to achieve 70% initial year and 70% subsequent year utilization.

(4) Increase the portion of Plan First enrollees who receive smoking cessation services. The program goal is to have 85% of smokers receiving these services.

(5) Maintain birth rates among Plan First participants which are lower than the birth rates estimated to have occurred in the absence of the Plan First demonstration. A rate of about 100 births per 1000 enrollees is estimated to be sufficient to achieve budget neutrality for Plan First.

(6) Make sterilization services available to income-eligible men over age 21.

This report presents data for Demonstration Year 15, October 1, 2014 through September 30, 2015. Part I of this report provides baseline data for the six goals included in the renewal. Demonstration Year (DY) 15 is the first renewal year. Part II of this report continues the reporting of selected utilization measures that have been included in previous Plan First evaluations.

Findings in Part I

Goal 1*:* Increase the portion of women eligible for Plan First who actually enroll, and reduce race/ethnicity and geographic disparities in enrollment.

Enrollment for Black women residents of Alabama who are ages 19-24 and 25-34 is somewhat below the target rate, at 68% and 67% of those estimated to be eligible, respectively. Enrollment is lower for White women, 51% for those age 19-24 and 56% for those age 25-34. More urban areas of the state tended to have more racial disparity in enrollment. About 25% of enrolled women in DY 14 failed to re-enroll in DY 15. Those most likely to renew their enrollment from one year to the next are women who had contact with a Plan First provider. When service use is taken in to account, there is a fall-off in enrollment for White women and younger women.

Goal 2. Maintain a high level of awareness of the Plan First program among enrollees.

Overall awareness of Plan First remains quite high (>90%) among enrollees. However, just over 20% of enrollees are not aware of their enrollment status, including the 7% who report they have never heard of Plan First, and another 14% who have heard of the program but did not know they were enrolled. Some of these are women who prefer not to use contraception and thus do not have an incentive to learn about Plan First. However, others are women who do use contraception, and have concerns about affordability and access to services which reflect the fact that they are not aware of their enrollment status.

Goal 3. Increase the portion of Plan First enrollees who use family planning services, both in the initial year of enrollment and in subsequent years.

In previous Plan First evaluations, we have reported overall rates of participation without exploring differences across sub-groups of enrollees, and without differentiating between participation for first year enrollees and for enrollees in subsequent years. With this analysis, it is clear that there is a sub-group of enrollees whose participation meets the target rate of 70% use: enrollees who have used shorter acting reversible contraception (e.g. Depo, pills) for at least a year. Women using long-acting reversible contraception (LARC) for at least a year also participate in subsequent years, but at a lower rate (45%). Participation is also lower for new enrollees who are not postpartum (56%). Women with no evidence of any use of contraception services in previous years have the lowest participation (<15%). Women with Plan First participation but no actual clinical service use are evenly divided between those with case management contact only, and those who fill contraceptive prescriptions but have no clinical contact.

Goal 4. Increase the portion of Plan First enrollees who receive smoking cessation services.

By report of enrollees, there has been an increase over time in the extent to which smoking cessation is discussed in family planning settings, and in the concrete advice that providers give to clients about quitting tobacco use. In DY 15, 64% of smokers reported receiving either a prescription for a Nicotine Reduction Therapy or a referral to the Quit Line. However, based on claims data, there is relatively little use of prescriptions among Plan First enrollees, and a very small percentage of the estimated smokers (<1%) have contacted the Quit Line and indicated they were referred by their care coordinator.

Goal 5. Maintain birth rates among Plan First participants which are lower than the birth rates estimated to have occurred in the absence of the Plan First demonstration.

Birth rates vary from year to year, but remain low enough for Plan First to be budget neutral. In DY 14, the most recent year for which a count of the births occurring to participants during the demonstration year can be counted, overall birth rates for participants was 58.3 per thousand and the birth rate for women who were enrolled but did not use services was 84.9 per thousand. In contrast, the estimate of expected births, given the fertility rates before the start of the Plan First demonstration, was 203.1 per thousand for the women enrolled in the program.

Goal 6. Make sterilization services available to income-eligible men over age 21.

There were no claims for vasectomy services in DY15, the first year the service was covered by Plan First. The majority of women who get counseled about female sterilization do not receive counseling about vasectomy as well. By report of female enrollees who do not want more children, 20% of male partners may be interested in vasectomy if they could get the procedure covered by Plan First.

Findings in Part II

The number of women participating (having any paid claim) in Plan First declined slightly in DY 15, to 58,009 women, compared to 68,199 in DY 14. Enrollment in the program also decreased slightly, but the portion of enrollees participating in Plan First was similar to DY 14, 45.1% vs 46.1% (Part II, Section 1.1). The portion of women with deliveries in the previous two years who used Plan First services decreased across all Maternity Care District (Part II, Section 1.2). Participation in Plan First by non-Title X agencies (private physicians and community health centers) increased, but the portion of total visits and total participants using services in the non-Title X sector decreased slightly (Part II, Sections 1.3 and 3.1).

Use of any contraceptives and use of effective contraceptives remained stable in DY 15 (86% and 81% respectively), according to the annual enrollee survey (Part II, Section 4.3). The primary reason for not using contraceptives, as identified by survey respondents, is that they are not sexually active (38%), they don't think they can get pregnant (17%), or they want to get pregnant (14%). Some women do report that they do not use birth control because they can't afford it (10%) or can't find a provider that they want to see (9%) (Part II, Section 4.3). Affordability and difficulty finding a preferred provider are also listed as reasons for not making a visit to a family planning provider in the past year (Part II, Section 2.1).

The portion of Plan First participants with a risk assessment, completed either in DY 15 or in previous years, reached a high of 73% in DY 15. Risk assessment coverage remains high for users of Health Department services (>90%) and decreased slightly for users of private sector services. Almost all of the clients assessed as high risk received some form of care coordination services, and those with care coordination more frequently received HIV counseling and effective contraception (Part II, Sections 5.1 and 5.2).

The portion of women with non-family planning medical problems who received referrals from their family planning providers for primary care was 61% (compared to a target of 80%). As in past years, about 60% of women with medical issues reported receiving primary care, with inability to afford care as the primary reason cited for not obtaining services (Part II, Sections 6.1 and 6.2).

Finally, this evaluation continues the approach of estimating birth rates from pregnancies starting during the Demonstration Year separately for enrollees who did and did not participate in Plan First, and, among participants, for clients visiting different provider types and whether they received risk assessment and/or care coordination. All participants except those with no clinical services had birth

rates that were lower than the rates for enrollees without services. Participants with the lowest birth rates are those who received risk assessments or care coordination, who use Title X family planning services (Part II, Section7.1).

Contents

Part I: Progress Toward Evaluation Goals

Goal 1. Addressing Disparities in Enrollment

Increase the portion of income eligible women, ages 19 –55 enrolled in Plan First and reduce race/ethnicity and geographic disparities among enrollees. Our goal is to enroll 80% of all eligible clients (based on census estimates of the eligible population) under age 40 across all race/ethnicity and geographic area groups, thereby eliminating disparities across these groups. Census data will be used to generate estimates of the eligible population.

1.1. Findings: Statewide Disparities

Statewide, enrollment for Black women ages 19-24 and 25-34 is at approximately 85% of the goal. For non-Hispanic White women, enrollment is 63% of the goal for ages 19-24 and 70% of the goal for women ages 25-34. As expected, Plan First enrollment rates are much lower for women age 35 and older. Enrollment rates are also lower for women classified as "other" ethnicity, including Hispanic, Asian and American Indian women. Census estimates are based on county-level American Community Survey (ACS) data, averaged over 2010-2014.

Table 1.1. Estimated portion of Plan First Eligibles Enrolled Statewide, by age and race/ethnicity

	Age 19-24			**Age 25-34**			**Age 35-44**		
	ACS Estimate	Enrollment DY15	% Enrolled	ACS Estimate	Enrollment DY15	% Enrolled	ACS Estimate	Enrollment DY15	% Enrolled
White	45,356	23,007	50.7	42,591	23,744	55.7	33,786	6,856	20.3
Black	38,084	26,038	68.4	45,999	30,662	66.7	30,616	9,446	30.9
Other	7,632	1,949	25.5	10,818	1,967	18.2	7,042	747	10.6
Total	**91,133**	**50,994**	**56.0**	**99,465**	**56,373**	**56.7**	**71,502**	**17,049**	**23.8**

1.2. Findings – Disparities by PHA

Similar enrollment patterns are observable across all of the Public Health Areas. Black women ages 25-34 tend to have the highest enrollment rates, relative to the number eligible, followed by Black women ages 19-24. PHA 3 (Tuscaloosa County), PHA 4 (Jefferson County), and PHA 8 (Montgomery County) are notable for the relatively lower enrollment rates for non-Hispanic White women ages 19-24. PHA 5 (northeastern Alabama) and PHA 9 (southeastern Alabama) are notable for the relatively higher enrollment rates for Black and White women ages 19-24.

Table 1.2 Estimated portion of Plan First Eligibles Enrolled – by PHA

	Age 19-24			Age 25-34			Age 35-44		
	ACS Estimate	Enrollment DY15	% Enrolled	ACS Estimate	Enrollment DY15	% Enrolled	ACS Estimate	Enrollment DY15	% Enrolled
PHA1									
White	4,381	2,881	65.8	5,166	2,660	51.5	3,642	767	21.1
Black	888	648	73.0	968	656	67.8	623	193	31.0
Other	462	133	28.8	504	91	18.1	539	38	7.1
Total	**5,736**	**3,662**	**63.8**	**6,641**	**3,407**	**51.3**	**4,810**	**998**	**20.7**
PHA2									
White	5,978	4,183	70.0	7,827	4,652	59.4	6,098	1,286	21.1
Black	3,005	1,942	64.6	3,040	2,465	81.1	2,077	726	35.0
Other	1,866	464	24.9	3,154	456	14.5	1,521	150	9.9
Total	**10,857**	**6,589**	**60.7**	**14,028**	**7,573**	**54.0**	**9,701**	**2,162**	**22.3**
PHA3									
White	5,108	1,251	24.5	2,408	1,146	47.6	1,870	297	15.9
Black	3,108	2,164	69.6	3,334	2,291	68.7	1,870	648	34.7
Other	556	97	17.4	366	60	16.4	270	19	7.0
Total	**8,778**	**3,512**	**40.0**	**6,113**	**3,497**	**57.2**	**4,012**	**964**	**24.0**
PHA4									
White	4,287	952	22.2	3,009	1,353	45.0	2,651	469	17.7
Black	6,873	4,109	59.8	9,598	6,115	63.7	5,883	2,058	35.0
Other	748	157	21.0	1,424	199	14.0	899	99	11.0
Total	**11,908**	**5,218**	**43.8**	**14,033**	**7,667**	**54.6**	**9,434**	**2,626**	**27.8**
PHA5									
White	4,082	3,202	78.4	5,750	3,060	53.2	5,221	901	17.3

Black	770	748	97.1	1,040	886	85.2	917	265	28.9
Other	1,017	307	30.2	1,528	307	20.1	1,151	115	10.0
Total	**5,876**	**4,257**	**72.4**	**8,324**	**4,253**	**51.1**	**7,295**	**1,281**	**17.6**
PHA6									
White	3,152	2,466	78.2	4,025	2,198	54.6	3,510	542	15.4
Black	3,067	2,005	65.4	3,635	2,045	56.3	2,381	524	22.0
Other	233	93	39.9	556	80	14.4	254	34	13.4
Total	**6,458**	**4,564**	**70.7**	**8,226**	**4,323**	**52.6**	**6,152**	**1,100**	**17.9**
PHA7									
White	551	328	59.5	533	294	55.2	553	88	15.9
Black	3,031	2,306	76.1	3,875	2,251	58.1	2,901	787	27.1
Other	8	23	287.5	65	19	29.2	129	3	2.3
Total	**3,593**	**2657**	**73.9**	**4,477**	**2,564**	**57.3**	**3,588**	**878**	**24.5**
PHA8									
White	9,498	2,055	21.6	4,569	2,232	48.9	3,150	578	18.3
Black	8,377	4,977	59.4	8,961	5,797	64.7	5,618	1,573	28.0
Other	914	200	21.9	1,427	223	15.6	860	75	8.7
Total	**18,799**	**7,232**	**38.5**	**14,964**	**8,252**	**55.1**	**9,637**	**2,226**	**23.1**
PHA9									
White	2,374	2,198	92.6	3,288	2,212	67.3	2,640	689	26.1
Black	2,252	1,780	79.0	2,805	1,762	62.8	2,479	572	23.1
Other	583	139	23.8	593	130	21.9	356	47	13.2
Total	**5,217**	**4,117**	**78.9**	**6,693**	**4,104**	**61.3**	**5,481**	**1,308**	**23.9**
PHA10									
White	2,848	1,948	68.4	2,784	1,896	68.1	2,277	488	21.4
Black	2,691	2,154	80.0	3,098	2,087	67.4	2,286	593	25.9
Other	558	137	24.6	758	147	19.4	507	44	8.7
Total	**6,105**	**4,239**	**69.4**	**6,646**	**4,130**	**62.1**	**5,081**	**1,125**	**22.1**
PHA11									
White	3,097	1,543	49.8	3,232	2,041	63.1	2,174	751	34.5
Black	4,022	3,205	79.7	5,645	4,307	76.3	3,581	1,507	42.1
Other	687	199	29.0	443	255	57.6	556	123	22.1
Total	**7,806**	**4,947**	**63.4**	**9,320**	**6,603**	**70.8**	**6,311**	**2,381**	**37.7**

1.3. Findings – Statewide Disparities in Enrollment Renewal

Another way of looking at disparities in enrollment is to examine which groups of enrollees did not renew their Plan First enrollment in the following year. Overall, 23% of enrollees did not re-enroll in the following year, and this was similar across age groups. Re-enrollment is more common for Black enrollees and for women who made contact with a family planning provider or had a clinical visit.

Table 1.3 Portion of DY14 Enrollees who Re-Enrolled in 2015 - Statewide

	N	% Total		No Renewal	Renewal
All	148,062	--		23.4	76.6
Age 18-24	63,905	43.2		22.6	77.4
Age 25-34	61,532	41.6		23.7	76.3
Age 35-44	18,187	12.3		23.8	76.2
White	65,889	44.5		27.0	72.0
Black	76,718	51.8		20.2	79.8
Hispanic	2,746	1.8		23.8	76.2
Other race/ethnicity	2,709	1.8		25.1	74.9
No Plan First Contact	79,963	54.1		31.0	69.0
Any Plan First Contact	68,099	46.0		14.5	85.5
No Plan First Clinical Visit	96,866	65.4		29.7	70.3
Any Plan First Clinical Visit	51,196	34.6		11.5	88.5
Any Plan First Visit with LARC*	22,718	15.3		10.4	89.6
Any Plan First Visit with no LARC*	28,478	19.2		12.4	87.6
Any Case Management	25,654	17.3		14.8	85.2
No Case Management	122,408	82.7		25.2	74.8
Received Tubal	564	0.4		45.7	54.3

*Among those with a Plan First visit

1.4 Findings- Disparities in Enrollment Renewal by PHA

A similar pattern of renewals is seen across all Public Health Areas. Black women are somewhat more likely to renew enrollment relative to women in other racial/ethnic groups. The greatest difference in renewal is between women who have made contact with a family planning provider and those who have not. Renewals are highest in Public Health Areas 7 and 11. Public Health Area 7 also has the highest portion of women who have made contact with a family planning provider. Public Health Area 5 has the lowest rate of renewal between DY14 and DY15.

Table 1.4 Portion of DY14 Enrollees who Re-Enrolled in 2015 – by PHA

	N	% Total		No Renewal	Renewal
PHA 1					
All	9,587	--		23.5	76.5
Age 18-24	4,475	46.7		22.5	77.5
Age 25-34	3,764	39.3		24.0	76.0
Age 35-44	1,070	11.2		24.0	76.0
White	7,567	78.9		24.3	75.7
Black	1,748	18.2		20.7	79.3
Hispanic	168	1.7		19.0	81.0
Other race/ethnicity	104	1.1		19.2	80.8
Any Plan First Contact	5,087	53.1		16.0	84.0
No Plan First Contact	4,500	46.9		32.0	68.0
Any Plan First Clinical Visit	3,914	40.8		12.5	87.5
No Plan First Clinical Visit	5,673	59.2		31.1	68.9
Any Plan First Visit with LARC*	1,516	25.2		12.8	87.2
Any Plan First Visit with no LARC*	2,398	25.0		12.3	87.7
Any Case Management	2,417	25.2		17.1	82.9
No Case Management	7,170	74.8		25.7	74.3
Received Tubal	42	0.4		38.1	61.9
PHA 2					
All	19,531	--		24.8	75.2
Age 18-24	8,258	42.3		24.0	76.0
Age 25-34	8,306	42.5		25.1	74.9
Age 35-44	2,387	12.2		25.3	74.7
White	12,324	63.1		26.6	73.4
Black	5,996	30.7		21.5	78.5
Hispanic	705	3.6		21.4	78.6
Other race/ethnicity	506	2.6		24.3	75.7

	N	% Total		No Renewal	Renewal
Any Plan First Contact	7,804	40.0		14.5	85.5
No Plan First Contact	11,727	60.0		31.6	68.4
Any Plan First Clinical Visit	5,898	30.2		11.9	88.1
No Plan First Clinical Visit	13,633	69.8		30.4	69.6
Any Plan First Visit with LARC*	2,462	12.6		12.0	88.0
Any Plan First Visit with no LARC*	3,436	17.6		11.8	88.2
Any Case Management	2,045	10.5		15.1	84.9
No Case Management	17,486	89.5		25.9	74.1
Received Tubal	79	0.4		39.2	60.8

PHA 3

All	9,133	--		22.6	77.4
Age 18-24	4,231	46.3		22.0	78.0
Age 25-34	3,685	40.3		22.6	77.4
Age 35-44	1,017	11.1		23.2	76.8
White	3,231	35.4		28.0	72.0
Black	5,698	62.4		19.3	80.7
Hispanic	85	0.9		29.4	70.6
Other race/ethnicity	119	1.3		26.9	73.1
Any Plan First Contact	4,619	50.6		14.1	85.9
No Plan First Contact	4,514	49.4		31.3	68.7
Any Plan First Clinical Visit	3,540	38.8		10.4	89.6
No Plan First Clinical Visit	5,593	61.2		30.3	69.7
Any Plan First Visit with LARC*	1,772	19.4		10.2	89.8
Any Plan First Visit with no LARC*	1,768	19.4		10.7	89.3
Any Case Management	2,069	22.6		16.0	84.0
No Case Management	7,064	77.3		24.5	75.5
Received Tubal	26	0.3		46.1	53.8

PHA 4

All	19,516	--		24.5	75.5
Age 18-24	7,304	37.4		24.5	75.5
Age 25-34	8,819	45.2		24.9	75.1
Age 35-44	2,818	14.4		22.5	77.5
White	3,839	19.7		32.0	68.0
Black	15,118	77.5		22.6	77.4
Hispanic	285	1.5		27.0	73.0
Other race/ethnicity	274	1.4		25.2	74.8

	N	% Total		No Renewal	Renewal
Any Plan First Contact	6,241	32.0		14.3	85.7
No Plan First Contact	13,275	68.0		29.3	70.7
Any Plan First Clinical Visit	4,628	23.7		12.0	88.0
No Plan First Clinical Visit	14,888	76.3		28.4	71.6
Any Plan First Visit with LARC*	1,738	8.9		9.0	91.0
Any Plan First Visit with no LARC*	2,890	14.8		13.7	86.3
Any Case Management	1,192	6.1		14.9	85.1
No Case Management	18,324	93.9		25.1	74.8
Received Tubal	32	0.2		56.2	43.8

PHA 5

All	11,876	--		26.0	74.0
Age 18-24	5,338	45.0		25.0	75.0
Age 25-34	4,721	39.7		26.4	73.6
Age 35-44	1,467	12.3		26.6	73.4
White	8,843	74.5		27.4	72.6
Black	2,206	18.6		22.4	77.6
Hispanic	598	5.0		18.2	81.8
Other race/ethnicity	229	1.9		27.9	72.1
Any Plan First Contact	5,0.5	42.4		15.9	84.1
No Plan First Contact	6,841	57.6		33.4	66.6
Any Plan First Clinical Visit	3,702	31.2		12.2	87.8
No Plan First Clinical Visit	8,174	68.8		32.3	67.7
Any Plan First Visit with LARC*	1,433	12.1		11.6	88.4
Any Plan First Visit with no LARC*	2,269	19.1		12.6	87.4
Any Case Management	2,236	18.8		17.2	82.8
No Case Management	9,640	81.2		28.0	72.0
Received Tubal	52	0.4		40.4	59.6

PHA 6

All	11,400	--		22.4	77.6
Age 18-24	5,445	47.8		21.0	79.0
Age 25-34	4,490	39.4		22.6	77.4
Age 35-44	1,171	10.3		26.5	73.5
White	6,031	52.9		24.8	75.2
Black	5,137	45.1		19.5	80.5
Hispanic	110	1.0		18.2	81.8
Other race/ethnicity	122	1.1		26.3	73.7

	N	% Total		No Renewal	Renewal
Any Plan First Contact	5,868	51.5		14.4	85.6
No Plan First Contact	5,532	48.5		30.9	69.1
Any Plan First Clinical Visit	4,395	38.6		10.8	89.2
No Plan First Clinical Visit	7,005	61.4		29.6	70.4
Any Plan First Visit with LARC*	2,054	18.0		9.5	90.5
Any Plan First Visit with no LARC*	2,341	20.5		12.0	88.0
Any Case Management	2,424	21.3		15.0	85.0
No Case Management	8,976	78.7		24.4	75.6
Received Tubal	52	0.5		38.5	61.5

PHA 7

All	7,121	--		18.6	81.4
Age 18-24	3,249	45.6		17.8	82.2
Age 25-34	2,687	37.7		19.3	80.7
Age 35-44	740	12.6		18.8	82.2
White	876	12.3		26.6	73.4
Black	6,189	86.9		17.3	82.7
Hispanic	19	0.3		36.8	63.2
Other race/ethnicity	37	0.5		24.3	75.7
Any Plan First Contact	4,522	63.5		13.0	87.0
No Plan First Contact	2,599	36.5		28.4	71.6
Any Plan First Clinical Visit	3,488	49.0		9.9	90.1
No Plan First Clinical Visit	3,633	51.0		27.0	73.0
Any Plan First Visit with LARC*	1,971	27.7		8.6	91.4
Any Plan First Visit with no LARC*	1,517	21.3		11.5	88.5
Any Case Management	2,901	40.7		12.2	87.8
No Case Management	4,220	59.3		22.9	77.1
Received Tubal	20	0.3		40.0	60.0

PHA 8

All	20,929	--		23.3	76.7
Age 18-24	9,174	43.8		22.6	77.4
Age 25-34	8,739	41.8		23.4	76.6
Age 35-44	2,372	11.3		24.7	75.3
White	6,166	29.5		29.0	71.0
Black	14,175	67.7		20.6	79.4
Hispanic	231	1.1		32.5	67.5
Other race/ethnicity	357	1.7		26.9	73.1

	N	% Total		No Renewal	Renewal
Any Plan First Contact	9,440	45.1		13.7	86.3
No Plan First Contact	11,489	54.9		31.2	68.8
Any Plan First Clinical Visit	7,366	35.2		11.2	88.8
No Plan First Clinical Visit	13,563	64.8		29.9	70.1
Any Plan First Visit with LARC*	3,585	17.1		10.3	89.7
Any Plan First Visit with no LARC*	3,781	18.1		12.0	88.0
Any Case Management	2,679	12.8		14.9	85.1
No Case Management	18,250	87.2		24.6	75.4
Received Tubal	53	0.2		54.7	45.3

PHA 9

All	11,281	--		23.2	76.8
Age 18-24	5,019	44.5		21.4	78.6
Age 25-34	4,505	39.9		24.3	75.7
Age 35-44	1,372	12.2		24.3	75.7
White	6,254	55.4		26.8	73.2
Black	4,631	41.0		18.0	82.0
Hispanic	170	1.5		32.9	67.1
Other race/ethnicity	226	2.0		24.8	75.2
Any Plan First Contact	5,937	52.6		15.0	85.0
No Plan First Contact	5,344	47.4		32.3	67.7
Any Plan First Clinical Visit	4,288	38.0		11.4	88.6
No Plan First Clinical Visit	6,993	62.0		30.5	69.5
Any Plan First Visit with LARC*	1,989	17.6		10.3	89.7
Any Plan First Visit with no LARC*	2,299	20.4		12.4	87.6
Any Case Management	2,820	25.0		12.9	87.1
No Case Management	8,461	75.0		26.7	73.3
Received Tubal	60	0.5		51.7	48.3

PHA 10

All	10,706	--		22.3	77.7
Age 18-24	5,028	47.0		21.6	78.4
Age 25-34	4,258	39.8		22.5	77.5
Age 35-44	1,167	10.9		23.8	76.2
White	5,045	47.1		25.7	74.3
Black	5,288	49.4		18.8	81.2
Hispanic	187	1.7		22.5	77.5
Other race/ethnicity	186	1.7		30.6	69.4

	N	% Total		No Renewal	Renewal
Any Plan First Contact	5,705	53.3		14.1	85.9
No Plan First Contact	5,001	46.7		31.6	68.4
Any Plan First Clinical Visit	4,373	40.8		11.7	88.3
No Plan First Clinical Visit	6,333	59.2		29.7	70.3
Any Plan First Visit with LARC*	1,922	17.9		9.8	90.2
Any Plan First Visit with no LARC*	2,451	22.9		13.1	86.9
Any Case Management	3,155	29.5		14.3	85.7
No Case Management	7,551	70.5		25.7	74.3
Received Tubal	56	0.5		46.4	53.6

PHA 11

All	16,765	--		21.9	78.1
Age 18-24	6,308	37.6		22.0	78.0
Age 25-34	7,451	44.4		21.7	78.3
Age 35-44	2,417	14.4		21.1	78.9
White	5,608	33.4		27.6	72.4
Black	10,427	62.2		18.6	81.4
Hispanic	183	1.1		30.0	70.0
Other race/ethnicity	547	3.3		22.3	77.7
Any Plan First Contact	7,753	46.2		14.2	85.8
No Plan First Contact	9,012	53.8		28.5	71.5
Any Plan First Clinical Visit	5,541	33.0		11.7	88.3
No Plan First Clinical Visit	11,224	67.0		26.9	73.1
Any Plan First Visit with LARC*	2,257	13.5		10.2	89.8
Any Plan First Visit with no LARC*	3,284	19.6		12.6	87.4
Any Case Management	1,683	10.0		12.9	87.1
No Case Management	15,082	90.0		22.8	77.2
Received Tubal	85	0.5		45.9	54.1

1.5. Findings – Primary Factors Associated with Non-Renewal

In order to take into account the overlap across characteristics of women who do and don't renew their Plan First enrollment, we conducted a statistical analysis that takes all features into account, and examines which ones predict re-enrollment for DY14 into DY15. Cases where women received sterilization procedures in DY14 and cases where women had a delivery in 2015 were excluded. The analysis shows that the strongest predictor of re-enrolling in Plan First in DY15 is having a clinical encounter with a family planning provider in 2014. Taking this into account, older women are actually more likely to renew than younger women, as are Black and Hispanic women. Women entering Plan First in 2014 postpartum are more likely to renew. Women whose clinical encounters included LARC and women who received case management were also more likely to renew. Finally, when all of these factors are taken into account, residents of PHA 2 (Decatur/Huntsville), PHA 6 (Anniston), PHA 7 (Linden) and PHA 11 (Mobile) were more likely to renew their enrollment in 2015, compared to PHA 1.

This suggests that some part of the racial and geographic disparities in the portion of women enrolled in Plan First occurs because White women, younger women and some rural residents are more likely not to renew their enrollment over time.

Table 1.5 Factors associated with Re-enrollment in Plan First in 2015

	Odds Ratio	95% Confidence Limits		Probability compared to chance
Age				
Age 25-34 (vs 18-24)	1.059	1.031	1.088	More likely
Age 35-44 (vs 18-24)	1.166	1.120	1.215	More likely
Race/ethnicity				
Black (vs White)	1.338	1.301	1.376	More likely
Hispanic (vs White)	1.195	1.090	1.311	More likely
Other (vs White)	1.085	0.989	1.191	No difference
Recent program participation				
Pregnant in 2013	1.049	1.018	1.081	More likely
Entered postpartum in 2014	1.209	1.153	1.267	More likely
Service use 2015				
Clinical visit in 2014	3.121	3.015	3.231	More likely
Long Acting contraceptive in 2014 (IUD, implant)	1.249	1.101	1.416	More likely
Case Management in 2014	1.109	1.063	1.157	More likely
Public Health Area				
PHA 2 (vs PHA 1)	1.070	1.010	1.135	More likely
PHA 3 (vs PHA 1)	1.020	0.950	1.094	No difference
PHA 4 (vs PHA 1)	1.021	0.961	1.085	No difference
PHA 5 (vs PHA 1)	1.019	0.956	1.086	No difference
PHA 6 (vs PHA 1)	1.092	1.022	1.166	More likely
PHA 7 (vs PHA 1)	1.083	1.000	1.174	More likely
PHA 8 (vs PHA 1)	1.008	0.950	1.070	No difference
PHA 9 (vs PHA 1)	1.057	0.989	1.129	No difference
PHA 10 (vs PHA 1)	1.054	0.985	1.127	No difference
PHA 11 (vs PHA 1)	1.138	1.069	1.211	More likely

Conclusions- Reducing Disparities in Enrollment

Enrollment for Black women residents of Alabama who are ages 19-24 and 25-34 is somewhat below the target rate, at 68% and 67% of those estimated to be eligible, respectively. Enrollment is lower for White women, 51% for those age 19-24 and 56% for those age 25-34. More urban areas of the state tended to have more racial disparity in enrollment. About 25% of enrolled women in DY 14 failed to re-enroll in DY 15. Those most likely to renew their enrollment from one year to the next are women who had contact with a Plan First provider. When service use is taken in to account, there is a fall-off in enrollment for White women and younger women.

Goal 2. Maintaining High Levels of Awareness of Plan First

Maintain the high level of awareness of the Plan First program among program enrollees. Our goal is that 90% of surveyed enrollees will have heard of the program and 85% of these will be aware that they are enrolled in the program. Telephone surveys of enrollees will be used to track changes in levels of awareness of the program and enrollment in the program.

2.1. Findings- Awareness of Plan First and Enrollment Status

Awareness of Plan First among enrollees exceeds the target of 90%. The percentage of those who are aware of Plan First and know that they are enrolled in program meets the 85% target.

Table 2.1. Awareness of Plan First

	Had heard of Plan First Before Call (%)	Aware of enrollment (%)	
		Among all surveyed	Among those who had heard of Plan First
DY1	76.8	56.2	73.1
DY2	82.5	64.2	77.9
DY3-4	81.0	64.9	80.2
DY5	85.3	63.6	74.9
DY6	86.8	70.2	82.5
DY7	92.9	80.8	87.1
DY8	88.9	85.3	85.9
DY9	90.8	79.7	87.8
DY10	88.7	78.3	88.2
DY11	90.1	79.3	88.1
DY12	88.7	77.2	87.0
DY13	89.9	79.9	88.9
DY14	90.1	74.9	83.2
DY15	92.6	78.8	85.0

2.2. Findings – Characteristics of Women Who Do Not Know They are Plan First Enrollees

Overall, 239 (21%) of survey respondents did not know they were enrolled in Plan First, and 83 of these (35%) had not heard of Plan First. Comparing the responses of these women to those who did know they were enrolled, on selected survey questions, shows that those who did not know they were enrolled were less likely to have had a family planning visit, less likely to be using contraception, and were more concerned about the affordability of family planning and contraception. They also were more likely to be Hispanic and more likely to report having difficulty finding a provider they wanted to see or that accepted Medicaid.

Table 2.2. Characteristics of survey respondents according to awareness of enrollment in Plan First

Characteristic	Know Enrolled n=886 (78.8%)	Do Not Know Enrolled n=239 (21.2%)
	(%)	(%)
Family planning visit*		
In last year	65.2	51.5
More than year ago	27.0	22.2
Never	3.7	20.9
Reason for no visit in last year*		
I did not think I needed one	21.4	12.1
I was too busy to arrange an appointment	32.4	9.1
I couldn't afford it	2.9	24.2
I did not want to go to the place I went before	3.3	0
The place I went before could not see me	2.9	0
Other	34.5	47.0
Reasons for not using family planning		
Don't like exam*	4.7	7.1
No provider you wanted to see*	8.1	10.9
Hard to reach on the phone*	7.0	8.8
Couldn't get appointment soon enough*	11.6	12.1
Waiting time too long at location	12.4	12.5
Hours not convenient*	6.1	3.8
No transportation	4.1	5.9
Family member opposes	0.8	1.7
No child care	3.4	4.6
No money to pay for visit*	7.6	18.0
Preferred provider does not take Medicaid*	10.2	16.7
Any birth control method used*	87.6	75.2
Reasons for not using birth control		
Not having sex	38.1	37.1

Characteristic	Know Enrolled n=886 (78.8%)	Do Not Know Enrolled n=239 (21.2%)
Want to get pregnant	26.9	15.9
Concerned about side effects	62.5	54.5
Don't think birth control works	20.2	25.0
Religious reasons	2.9	2.3
Too much trouble	7.7	4.5
Don't think you can get pregnant	26.9	29.5
Partner doesn't want you to	10.6	11.4
Can't pay for method*	6.7	36.4
Can't find a place to go*	9.6	20.5
Demographics		
Ever pregnant	86.0	88.1
Mean age	28.4	28.4
Education		
< high school	6.9	8.0
high school	36.1	39.1
more than high school	57.0	56.1
Race/ethnicity*		
White	44.2	40.6
Black	50.4	50.6
Hispanic	2.3	5.9
Other	3.0	2.9
Marital Status		
Never married	59.5	63.9
Married	24.5	23.1
Previously married	15.9	13.0

*difference is significant between those who know they are enrolled and those who do not know they are enrolled

Conclusions – Maintaining High Levels of Awareness of Plan First

Overall awareness of Plan First remains quite high (>90%) among enrollees. However, just over 20% of enrollees are not aware of their enrollment status, including the 7% who report they have never heard of Plan First, and another 14% who have heard of the program but did not know they were enrolled. Some of these are women who prefer not to use contraception and thus do not have an incentive to learn about Plan First. However, others are women who do use contraception, and have concerns about affordability and access to services which reflect the fact that they are not aware of their enrollment status.

Goal 3. Increasing Family Planning Service Use among Plan First Enrollees

Increase the portion of Plan First enrollees using family planning services initially after enrollment and in subsequent years of enrollment by improving access to services and increasing the rate of return visits for care. Our goal is to have 70% utilization of services by the end of the three year period, along with a 70% rate for 12 and 24 month return visits for individuals using services during the renewal period. Data will be generated from eligibility data, Plan First service use and postpartum contraceptive use.

3.1. Findings – Participation and Clinical Service Use

Participation, or "contact," in Plan First is defined as having an interaction that generates a Medicaid claim, while clinical service use, or "service," is defined as having a Medicaid claim for an evaluation and management encounter, for the placement of an IUD, hormonal patch, or implant, for the receipt of a Depo-Provera injection, or for a surgical sterilization procedure. Table 3.1 shows that 40% of enrollees in Demonstration Year 15 had contact with Plan First, while almost one third received a clinical service.

Rates of contact exceed target levels for two sub-groups of Plan First enrollees: new enrollees who received LARC or other contraceptives at a postpartum visit and previous enrollees who received a non-LARC method in the prior year (100% contact). Rates of contact are lowest (<33%, or one-third of the target rate), for enrollees with no use of family planning services.

Clinical service use exceeds the target rate for new enrollees who received LARC or other contraceptives at a postpartum visit and previous enrollees who received a non-LARC method in the prior year (>89% use). Clinical service use is about half of the target rate for previous enrollees who received a LARC method in a prior year and about two-thirds of the target rate for new enrollees who were not postpartum. Service use is very low (<22%) among women who had no family planning use postpartum or in the years they were previously enrolled.

Table 3.1. Utilization Assessment for Demonstration Year 15

	N (%)	% Initial Plan First Participation	% Participation 12 months after initial visit	% Participation 24 months after initial visit
All Enrollees, DY15	**128,473**	40.3% Contact 31.3% Service		
New DY15 Enrollee, Postpartum	**7,080 (5.5)**	33.4% contact 23.0% service	--	--
Received LARC postpartum	17 (0.2)	100% contact 100% service	--	--
Received other method postpartum	36 (0.5)	100% contact 88.9% service	--	--
Received no method postpartum	7,027 (99.2)	32.9% contact 22.5% service	--	--
New DY15 Enrollee, Not Postpartum	**7,971 (6.2)**	55.7% contact 48.1% service	--	--
Enrolled DY14 & DY15	**27,963 (21.8)**	35.6% contact 26.5% service		--
Received LARC DY14	731 (2.6)	--	45.5% contact 31.7% service	--
Received other method DY14	10,204 (36.5)	--	100% contact 100% service	--
Received no method DY14	17,028 (60.9)	12.8% contact 0.7% service	--	--
Enrolled DY13 - DY15	**85,461 (66.5)**	41.0% contact 32.1% service		
Received LARC DY13 or DY14	4,112 (4.8)	--	--	47.6% contact 36.8% service
Received other method DY13 or DY14	43,792 (51.2)	--	--	100% contact 100% service
Received no method DY13 or DY14	37,557 (44.0)	13.9% contact 1.0% service	--	--

-- Not applicable

3.2. Findings – Content of Contacts Without Clinical Services

Overall, about one quarter of all Demonstration Year 15 enrollees who participated, or had any claim in Plan First did not receive clinical services. Table 3.2 shows that about of those without clinical service use had an interaction with a care manager. Approximately one third had laboratory testing, but no claim for a clinical service and another third filled a prescription. Some care manager contact represents attempted contacts in which the client was not actually reached.

Table 3.2 Content of contacts for those with and without clinical services

	Enrollees with Clinical Services n= 46,889 (74.3%)	**Enrollees without Clinical Services** n=16,186 (25.7%)
Risk Assessment by Social Worker	26,316 (51.0)	2,683 (16.6)
High Risk with Case Management	13,229 (28.2)	1,348 (8.3)
High Risk No Case Management	84 (0.2)	48 (0.3)
Low Risk with Case Management	1,110 (2.4)	108 (0.7)
Low Risk No Case Management	9,496 (20.2)	1,179 (7.3)
No Risk Assessment, with Case Management	3,223 (6.7)	4,115 (25.4)
HIV Counseling	19,949 (42.5)	1,222 (7.6)
Laboratory test	35,752 (76.2)	5,501 (34.0)
Pregnancy test	25,171 (53.7)	488 (3.0)
Prescription filled	8,692 (18.5)	5,349 (33.0)
BC Pills at pharmacy	1,745 (3.7)	2,033 (12.6)
BC Pills from Clinical Site	11,768 (25.1)	815 (5.0)

Conclusions – Increasing Family Planning Service Use

In previous Plan First evaluations, we have reported overall rates of participation without exploring differences across sub-groups of enrollees, and without differentiating between participation for first year enrollees and for enrollees in subsequent years. With this analysis, it is clear that there is a sub-group of enrollees whose participation meets the target rate of 70% use: enrollees who have used shorter acting reversible contraception (e.g. Depo, pills) for at least a year. Women using long-acting reversible contraception (LARC) for at least a year also participate in subsequent years, but at a lower rate (45%). Participation is also lower for new enrollees who are not postpartum (56%). Women with no evidence of any use of contraception services in previous years have the lowest participation (<15%). Women with Plan First participation but no actual clinical service use are evenly divided between those with case management contact only, and those who fill contraceptive prescriptions but have no clinical contact.

Goal 4. Increasing Use of Smoking Cessation Modalities

Survey data suggest that approximately one third of Plan First enrollees are cigarette smokers, and 85% of these were advised by their family planning provider to quit smoking. Our goal is that 25% of Plan First service users (85% of the 30% who are smokers) will receive either a covered Nicotine Reduction Therapy (NRT) prescription, a referral to the Quit Line, or both. Data will be generated from claims for NRT products, from client information provided by the Quit Line contractor, and from the enrollee survey.

4.1. Findings- Survey Data

Enrollee survey data from Demo Year 15 shows a slight decrease in the portion of survey respondents who reported they were smokers. The percentage who were asked about smoking by their Plan First provider and the percentage that were advised by their provider to quit smoking were similar to the previous year, and notably higher than in DY11-DY13 when we began reporting on these outcomes. Although the portion receiving either a referral to the Quit Line or an NRT product did not meet the target 85% (currently at 64%), there was an increase from the previous year.

Table 4.1. Smoking Cessation Based on Enrollee Survey Data

	DY11 (baseline) N (%)	**DY12** (NRT covered) N (%)	**DY13** (NRT covered) N (%)	**DY14** (NRT covered) N (%)	**DY15** (NRT covered) N (%)
Reported Smoking	343 (36.3)	317 (30.8)	312 (30.5)	283 (28.6)	269 (25.8)
Asked about smoking at FP visit	313 (91.2)	281 (88.6)	268 (85.9)	265 (93.6)	248 (92.2)
Advised to quit by FP provider	245 (71.4)	267 (84.2)	215 (68.9)	212 (80.0)	205 (82.7)
Received NRT	94 (27.4)	104 (32.8)	100 (32.0)	111 (41.9)	121 (48.8)
Referred to Quit Line	115 (33.5)	122 (38.5)	119 (38.1)	110 (41.5)	132 (53.2)
Received either NRT or Quit Line referral	148 (43.1)	155 (48.9)	151 (48.4)	149 (56.2)	158 (63.7)
Paid out of pocket for NRT products	--	--	--	--	30 (12.1)

-- Not asked in Enrollee Survey

4.2 Findings- Claims and Quit Line Data

Claims and data from the Quit Line vendor indicate that very few Plan First recipients are receiving these smoking cessation services.

Table 4.2. Smoking Cessation based on Claims and Quit Line Data

	DY13 (baseline) N (%)	DY14 (baseline) N (%)	DY15 N (%)
Number of service users	75,660	68,993	63,075
Estimated number of smokers	23,076	19,732	16,273
Number receiving NRT (paid claim)	586	442	527
Number receiving Quit Line referral from care coordinator	1163	692	124*
Number (%) reporting to care coordinator that Quit Line used	356 (30.6)	153 (22.1)	--
Number (%) reporting to care coordinator that script filled for NRT	388 (33.4)	236 (34.1)	--
Number reporting to care coordinator that NRT used	337 (30.0)	213 (30.8)	--
Number reporting receiving either NRT or Quit Line use	505 (43.4)	277 (40.0)	--

*Vendor did not begin tracking referrals until early 2015.

-- Information not collected.

Conclusion-Increasing Use of Smoking Cessation Modalities

By report of enrollees, there has been an increase over time in the extent to which smoking cessation is discussed in family planning settings, and in the concrete advice that providers give to clients about quitting tobacco use. In DY 15, 64% of smokers reported receiving either a prescription for a Nicotine Reduction Therapy or a referral to the Quit Line. However, based on claims data, there is relatively little use of prescriptions among Plan First enrollees, and a very small percentage of the estimated smokers (<1%) have contacted the Quit Line and indicated they were referred by their care coordinator.

Goal 5. Maintaining Low Birth Rates among Plan First Service Users

Maintain birth rates among Plan First service users that are lower than the estimated birth rates that would be occurring in the absence of the Plan First demonstration. Our goal is to maintain the overall birth rate of about 100 births per 1000 Plan First enrollees.

5.1. Findings- Birth Rates

An accurate calculation of birth rates can only be made two years after the Demonstration year, because births are counted if Plan First enrollees or service users became pregnant during the year. Birth rates for women enrolled in Plan First in DY 14 were less than one-third of the estimated birth rate that would have occurred without the waiver (based on fertility rates in 1999, before the start of Plan First). Birth rates to service users are less than those to enrollees. Both rates are lower than the estimated 100 births per 1000 enrollees required for the program to be budget neutral, in terms of the costs of maternity and delivery care.

Table 5.1. Birth Rates per 1000

	Estimated birth rate if fertility rates continued at pre-waiver levels	Actual birth rates <u>all enrollees</u> – pregnancies starting during DY	Actual birth rates <u>service users</u> – pregnancies starting during DY	Actual birth rates <u>non-service users</u> – pregnancies starting during DY
DY1	189.8	60.0	47.8	72.3
DY2	200.7	87.5	54.3	118.9
DY3	204.7	96.6	56.5	131.1
DY4	205.9	92.0	56.2	122.9
DY5	202.6	98.3	58.6	121.7
DY6	224.1	81.8	31.1	105.4
DY7	215.0	57.2	44.0	69.7
DY8	214.8	75.7	65.0	86.6
DY9	127.1	59.1	43.3	78.2
DY10	202.3	69.1	60.8	97.0
DY11	200.1	73.3	58.3	92.6
DY12	180.1	77.3	60.8	97.0
DY13	199.9	84.0	72.5	88.6
DY14	203.1	72.4	58.3	84.9

Conclusion – Maintaining Low Birth Rates among Plan First Service Users

Birth rates vary from year to year, but remain low enough for Plan First to be budget neutral. In DY 14, the most recent year for which a count of the births occurring to participants during the demonstration year can be counted, overall birth rates for participants was 58.3 per thousand and the birth rate for

women who were enrolled but did not use services was 84.9 per thousand. In contrast, the estimate of expected births, given the fertility rates before the start of the Plan First demonstration, was 203.1 per thousand for the women enrolled in the program.

Goal 6. Provide Vasectomy Services to Qualified Enrollees

Increase the usage of the Plan First Waiver by making sterilizations available to males ages 21 years or older. This goal will be evaluated based on the number of sterilizations performed statewide.

6.1. Findings- Use of Vasectomy Services

No vasectomies were provided through Plan First in DY15. The number of men who enrolled in the program is unknown because information on enrollee gender was not included in the enrollment files. This information will be included in future years, and we will continue to track vasectomy service delivery.

Table 6.1. Vasectomies provided to men through Plan First

	DY15 (10/14-9/15)
Number of men enrolled	n/a
Number obtaining vasectomy	0
% enrolled obtaining vasectomy	--

n/a – information on gender was not included in the enrollment files

6.2 Findings - Counseling and Potential Demand around Vasectomy

In the DY15 enrollee survey, we asked several questions to assess the potential demand for vasectomy services. Less than one-third (29%) of the 202 women who reported counseling about female sterilization also reported that they received counseling about vasectomy, and a higher percenter of women who were seen at the health department reported vasectomy counseling than those who went to a private doctor or other source of care. Among the 465 women who reported that they do not want more children, 20% said their male partner may be interested in getting a vasectomy through Plan First.

Table 6.2. Counseling female partners and their perception of men's interest in vasectomy

	DY15
	N (%)
Women who received counseling about female sterilization & vasectomy	58 (28.7)
Health Department	26 (34.2)
Private Doctor	25 (25.0)
Other source	7 (28.0)
Partner would be interested in vasectomy through Plan First, among women who do not want more children	
Yes	94 (20.2)
No	232 (49.9)
Don't know	124 (26.7)

Conclusions - Increasing Vasectomy Counseling and Use of Vasectomy Services

There were no claims for vasectomy services in DY15, the first year the service was covered by Plan First. The majority of women who get counseled about female sterilization do not receive counseling about vasectomy as well. By report of female enrollees who do not want more children, 20% of male partners may be interested in vasectomy if they could get the procedure covered by Plan First.

Evaluation of Plan First

Demonstration Year 15 (October 2014-September 2015)

Part II On-Going Monitoring of the Plan First Program

1. General Service Use Measured in Claims Data

1.1 Portion of Enrollees with Plan First Participation

The number of participants in Plan First declined between DY 14 and DY 15. The number of enrollees also decreased. Overall, 45% of enrollees used services, which was similar to DY14 (46%) but lower than service utilization in previous years.

Table 1.1a. Number of Enrollees with Plan First Participation by Race and Age Group

	Number of Participants						Change in # of Participants	
Group	DY10	DY11	DY12	DY13	DY14	DY15	DY10-DY15	DY14-DY15
Total	63,068	70,365	69,611	75,660	68,199	58,009	-5,059	-10,190
Age <20	5,135	5,324	5,120	5,284	7,118	4,127	-1,008	-2,991
Black	2,643	2,699	2,768	2,748	3,842	2,263	-380	-1,579
White	2,370	2,347	2,139	2,295	3,034	1,732	-638	-1,302
Other	51	206	154	161	242	132	81	-110
Age 20 – 29	45,153	49,833	48,705	52,076	45,216	39,005	-6,148	-6,211
Black	25,427	27,427	26,906	28,678	25,363	22,578	-2,849	-2,785
White	18,627	21,099	20,434	21,866	18,421	15,149	-3,478	-3,272
Other	514	606	609	680	1,432	1,278	764	-154
Age 30 – 39	10,552	12,457	12,868	14,868	12,856	12,081	1,529	-775
Black	6,406	7,295	7,620	8,891	7,827	7,584	1,178	-243
White	3,818	4,735	4,784	5,480	4,605	4,087	269	-518
Other	166	196	213	257	424	410	244	-14
Age 40 +	2,228	2,751	2,918	3,432	3,009	2,796	568	-213
Black	1,221	1,530	1,666	1,934	1,763	1,714	493	-49
White	927	1,134	1,158	1,370	1,131	960	33	-171
Other	36	47	48	63	115	122	86	7
Race/Age not known	862	1,044	1,112	1,237	N/A	N/A	N/A	N/A

Table 1.1a (Continued) Portion of Enrollees with Plan First Participation by Race and Age Group

	Number of Enrollees					
Group	**DY10**	**DY11**	**DY12**	**DY13**	**DY14**	**DY15**
Total	120,359	127,035	134,495	147,263	148,060	128,473
Age < 20	18,175	9,760	7,002	7,281	10,568	6,028
Black	9,002	4,989	3,685	3,802	5,427	3,087
White	8,686	4,463	3,084	3,215	4,744	2,718
Other	487	308	225	264	397	223
Age 20 – 29	77,113	84,455	89,175	93,740	91,901	80,119
Black	39,350	42,960	45,151	47,515	46,951	41,800
White	35,377	38,957	41,232	43,086	41,699	35,431
Other	2,146	2,538	2,728	3,139	3,251	2,888
Age 30 – 39	20,837	26,220	30,235	35,637	34,982	32,566
Black	11,472	14,484	16,590	19,227	19,001	18,176
White	8,595	10,758	12,509	15,048	14,607	13,094
Other	770	978	1,119	1,362	1,374	1,296
Age 40 +	4,234	6,600	8,083	10,605	10,609	9,760
Black	2,334	3,613	4,321	5,331	5,337	5,184
White	1,743	2,721	3,449	4,835	4,839	4,147
Other	157	266	307	439	433	429

Table 1.1a (Continued) Portion of Enrollees with Plan First Participation by Race and Age Group

	% Participants of Enrollees						% Change in % Participants of Enrollees
Age Group	**DY10**	**DY11**	**DY12**	**DY13**	**DY 14**	**DY 15**	**DY10-DY15**
Total	52.4%	55.4%	51.8%	51.4%	46.1%	45.1%	-13.9%
Age <20	63.8%	54.6%	73.1%	72.6%	67.4%	68.5%	7.4%
Black	65.4%	54.1%	75.1%	72.3%	70.8%	73.3%	12.1%
White	62.6%	52.6%	69.4%	71.4%	64.0%	63.7%	1.8%
Other	23.7%	66.9%	68.4%	61.0%	61.0%	59.2%	149.8%
Age 20 – 29	54.6%	59.0%	54.6%	55.6%	49.2%	48.7%	-10.8%
Black	60.5%	63.8%	59.6%	60.4%	54.0%	54.0%	-10.7%
White	48.6%	54.2%	49.6%	50.7%	44.2%	42.8%	-11.9%
Other	22.5%	23.9%	22.3%	21.7%	44.0%	44.2%	96.4%
Age 30 – 39	43.3%	47.5%	42.6%	41.7%	36.8%	37.1%	-14.3%
Black	47.8%	50.4%	45.9%	46.2%	41.2%	41.7%	-12.8%
White	37.9%	44.0%	38.2%	36.4%	31.5%	31.2%	-17.7%
Other	19.4%	20.0%	19.0%	18.9%	30.9%	31.6%	62.9%
Age 40 +	42.2%	41.7%	36.1%	32.4%	28.4%	28.6%	-32.2%
Black	42.1%	42.4%	38.6%	36.3%	33.0%	33.1%	-21.4%
White	42.6%	41.7%	33.6%	28.3%	23.4%	23.1%	-45.8%
Other	17.5%	17.7%	15.6%	14.4%	26.6%	28.4%	62.3%

The greatest decline in portion participants of enrollees over the last six years was in Public Health Area 4 (Jefferson County). Participation among enrollees in PHA4 also has been lower than in areas of the state during this period.

Table 1.1b Number of Enrollees with Plan First Participation by Public Health Area

Public Health Area	Number of Participants						Change in # of Participants DY10-DY15
	DY10	DY11	DY12	DY13	DY14	DY15	
Total	66,384	70,233	69,521	75,588	68,199	58,009	-8,375
1	4,957	5,168	5,040	5,513	5,079	4,230	-727
2	7,890	8,566	8,348	9,108	7,822	6,320	-1,570
3	4,765	5,000	4,860	5,186	4,628	3,996	-769
4	7,476	7,575	7,506	7,376	6,266	5,438	-2,038
5	5,221	5,493	5,510	5,729	5,050	4,182	-1,039
6	5,581	6,040	5,903	6,380	5,890	5,066	-515
7	4,280	4,274	4,300	4,808	4,515	3,967	-313
8	8,774	9,388	9,339	10,188	9,476	8,059	-715
9	5,155	5,604	5,790	6,463	5,987	5,055	-100
10	4,652	5,576	5,644	6,447	5,703	5,055	403
11	7,633	7,549	7,281	8,390	7,783	6,641	-992

Public Health Area	Number of Enrollees					
	DY10	DY11	DY12	DY13	DY14	DY15
Total	120,359	127,035	134,495	147,183	148,060	128,473
1	8,398	8,362	8,925	9,463	9,587	8,309
2	15,793	16,897	18,251	19,599	19,530	16,845
3	7,832	8,015	8,550	9,098	9,144	8,161
4	15,436	16,693	17,873	19,297	19,516	16,004
5	9,679	10,158	11,085	11,998	11,898	10,099
6	9,919	10,046	10,769	11,481	11,466	10,251
7	6,070	6,153	6,522	7,103	7,121	6,370
8	16,916	18,003	18,602	20,663	20,959	18,312
9	9,039	9,573	10,052	11,285	11,350	9,864
10	8,321	8,724	9,238	10,535	10,724	9,737
11	12,956	14,166	14,628	16,661	16,765	14,481

Table 1.1b (Continued) Portion of Enrollees with Participation by Public Health Area

	Percent Participation of Enrollees						% Change in % Participants of Enrollees DY10-DY15
Public Health Area	**DY10**	**DY11**	**DY12**	**DY13**	**DY14**	**DY15**	
Total	55.1%	55.4%	51.7%	51.4%	46.1%	45.1%	-18.1%
1	59.0%	61.8%	56.5%	58.3%	53.0%	50.9%	-13.7%
2	50.0%	50.7%	45.7%	46.5%	40.0%	37.5%	-25.0%
3	60.8%	62.4%	56.8%	57.0%	50.6%	49.0%	-19.4%
4	48.4%	45.4%	42.0%	38.2%	32.1%	33.9%	-30.0%
5	53.9%	54.1%	49.7%	47.7%	42.4%	41.4%	-23.2%
6	56.3%	60.1%	54.8%	55.6%	51.4%	49.4%	-12.3%
7	70.5%	69.5%	65.9%	67.7%	63.4%	62.3%	-11.6%
8	51.9%	52.2%	50.2%	49.3%	45.2%	44.0%	-15.2%
9	57.0%	58.5%	57.6%	57.3%	52.7%	51.2%	-10.2%
10	55.9%	63.9%	61.1%	61.2%	53.2%	51.9%	-7.2%
11	58.9%	53.3%	49.8%	50.4%	46.4%	45.9%	-22.1%

1.2 Portion of Medicaid Postpartum Women With Plan First Participation

The portion of women with Medicaid deliveries who participate in Plan First in the year of and the year following their deliveries did not change significantly in DY 14, compared to DY 13. Participation rates are lowest in the district that includes Birmingham. This table does not take into account women who received contraception at their postpartum visit, see Part 1, Goal 3.

Table 1.2. Plan First Participation by Women with Recent Medicaid Maternity Care, by Maternity Care Program District

Maternity Care Program District	Demonstration Year (DY)					
	DY10	DY11	DY12	DY13	DY14	DY15
Total						
Women with SOBRA deliveries in the previous year and this year	44,746	44,949	47,827	48,313	49,760	38,575
Women with Plan First participation in DY	13,439	1,912	7,465	14,724	13,901	10,406
% of women with deliveries participating in Plan First	30.0%	37.1%	15.6%	30.5%	27.9%	27.0%
District 1 (Colbert, Franklin, Lauderdale, Marion)						
Women with SOBRA deliveries in the previous year and this year	2,017	2,077	2,168	2,165	2,194	1,627
Women with Plan First participation in DY	618	704	387	697	684	493
% of women with deliveries participating in Plan First	30.6%	33.9%	17.9%	32.2%	31.2%	30.3%
District 2 (Jackson, Lawrence, Limestone, Madison, Marshall, Morgan)						
Women with SOBRA deliveries in the previous year and this year	6,149	6,441	6,763	6,796	7,099	5,500
Women with Plan First participation in DY	1,602	1,724	980	1,834	1,658	1,242
% of women with deliveries participating in Plan First	26.0%	26.8%	14.5%	27.0%	23.4%	22.6%
District 3 (Calhoun, Cherokee, Cleburne, DeKalb, Etowah)						
Women with SOBRA deliveries in the previous year and this year	3,179	3,012	3,411	3,571	3,686	2,934
Women with Plan First participation in DY	883	899	515	1,046	953	764
% of women with deliveries participating in Plan First	27.8%	29.8%	15.1%	29.3%	25.8%	26.0%

District 4 (Bibb, Fayette, Lamar, Pickens, Tuscaloosa)						
Women with SOBRA deliveries in the previous year and this year	2,333	2,474	2,614	2,619	2,618	2,089
Women with Plan First participation in DY	6,99	772	378	751	731	550
% of women with deliveries participating in Plan First	30.0%	31.2%	14.5%	28.7%	27.9%	26.3%
District 5 (Blount, Chilton, Cullman, Jefferson, St. Clair, Shelby, Walker, Winston)						
Women with SOBRA deliveries in the previous year and this year	9,761	9,915	10,501	10,467	10,797	8,353
Women with Plan First participation in DY	2,615	2,719	1,373	2,393	2,277	1,692
% of women with deliveries participating in Plan First	26.8%	27.4%	13.1%	22.9%	16.4%	20.3%
District 6 (Clay, Coosa, Randolph, Talladega, Tallapoosa)						
Women with SOBRA deliveries in the previous year and this year	1,677	1,630	1,788	1,850	1,849	1,509
Women with Plan First participation in DY	469	493	269	578	550	445
% of women with deliveries participating in Plan First	28.0%	30.2%	15.0%	31.2%	29.7%	29.5%
District 7 (Greene, Hale)						
Women with SOBRA deliveries in the previous year and this year	315	319	338	310	332	257
Women with Plan First participation in DY	108	111	81	110	122	93
% of women with deliveries participating in Plan First	34.3%	34.8%	24.0%	35.5%	36.7%	36.2%
District 8 (Choctaw, Marengo, Sumter)						
Women with SOBRA deliveries in the previous year and this year	435	414	428	452	469	356
Women with Plan First participation in DY	160	132	67	168	172	131
% of women with deliveries participating in Plan First	36.8%	31.9%	15.6%	37.2%	36.7%	36.8%
District 9 (Dallas, Perry, Wilcox)						
Women with SOBRA deliveries in the previous year and this year	897	843	857	871	838	541

Women with Plan First participation in DY	370	359	186	401	390	233
% of women with deliveries participating in Plan First	41.2%	42.6%	21.7%	46.0%	46.5%	43.1%
District 10 (Autauga, Bullock, Butler, Crenshaw, Elmore, Lowndes, Montgomery, Pike)						
Women with SOBRA deliveries in the previous year and this year	4,674	4,551	4,846	4,808	5,062	4,019
Women with Plan First participation in DY	1,498	1510	797	1,591	1,465	1,120
% of women with deliveries participating in Plan First	32.0%	33.2%	16.4%	33.1%	28.9%	27.9%
District 11 (Barbour, Chambers, Lee, Macon, Russell)						
Women with SOBRA deliveries in the previous year and this year	2,181	2,275	2,487	2,671	2,783	2,125
Women with Plan First participation in DY	552	642	365	781	817	595
% of women with deliveries participating in Plan First	25.3%	28.2%	14.7%	29.2%	29.4%	28.0%
District 12 (Baldwin, Clarke, Conecuh, Covington, Escambia, Monroe, Washington)						
Women with SOBRA deliveries in the previous year and this year	3,487	3,476	3,598	3,612	3,660	2,778
Women with Plan First participation in DY	1,176	1,209	644	1,410	1,286	889
% of women with deliveries participating in Plan First	33.7%	34.8%	17.9%	39.0%	35.1%	32.0%
District 13 (Coffee, Dale, Geneva, Henry, Houston)						
Women with SOBRA deliveries in the previous year and this year	2,351	2,366	2,604	2,667	5,708	2,040
Women with Plan First participation in DY	634	880	494	1,029	2,022	605
% of women with deliveries participating in Plan First	27.0%	37.2%	19.0%	38.6%	35.4%	29.7%
District 14 (Mobile)						
Women with SOBRA deliveries in the previous year and this year	5,290	5,156	5,424	5,454	5,708	4,447
Women with Plan First participation in DY	2,055	1,912	929	1,935	2,022	1,554
% of women with deliveries participating in Plan First	38.8%	37.1%	17.1%	35.5%	35.4%	34.9%

1.3 Private Provider Participation in Plan First

The number of private providers providing services to Plan First participants increased in all public health areas in the state. The overall portion of Plan First visits that were made to private providers in DY 15 was similar compared to previous years. However, there was a marked decrease in the portion of Plan First visits made to private providers in PHA11 (Mobile), from 99.7% in DY14 to 61.9% DY15.

Table 1.3. Availability and Visit Volume for Private Providers

PHA	# Private Providers			# Visits to Private Providers			% Total Visits to Private Providers		
	DY13	DY14	DY15	DY13	DY14	DY15	DY13	DY14	DY15
Total	687	693	933	40,451	41,295	34,413	24.8%	28.0%	25.3%
1	68	49	66	1,400	1,278	1,407	14.6%	15.2%	17.6%
2	109	98	166	2,837	3,176	4,336	22.9%	28.6%	38.9%
3	39	26	29	569	756	897	6.2%	9.3%	11.8%
4	76	65	101	1,682	1,492	2,180	17.3%	17.5%	25.3%
5	51	46	59	1,053	862	987	11.3%	10.6%	13.2%
6	61	55	72	1,588	1,730	1,889	15.8%	17.7%	20.8%
7	36	37	45	1,375	1,906	2,092	17.0%	24.1%	26.7%
8	84	97	129	7,797	9,179	8,509	13.8%	18.4%	18.7%
9	68	86	102	5,139	5,147	3,725	46.2%	48.9%	40.8%
10	33	42	56	1,309	916	795	11.5%	9.1%	8.4%
11	62	92	111	15,702	14,853	7,596	97.7%	99.7%	61.9%

2. General Service Use Measured in Enrollee Survey Data

2.1 Reported Reasons for Not Using Family Planning Services in Past Year

Of the 1125 respondents to the enrollee survey, 375, or about 33%, reported not having had a family planning visit in the previous year. The reasons given for not having a family planning visit have remained consistent over the years. The two most frequently cited reasons are not being able to afford the visit, and preferred provider does not accept Medicaid. There are also concerns about the time it takes to get an appointment and whether the provider can be reached on the telephone.

Table 2.1a. Reasons for delay among those who did not use family planning services in the past year

Reasons for Delay with FP Visit	DY10	DY11	DY12	DY13	DY14	DY15
N	315	182	334	384	320	375
No money to pay for appointment	18.9%	17.1%	17.6%	16.6%	18.1%	14.4%
Provider you wanted to see did not take Medicaid	11.7%	18.4%	16.5%	12.3%	16.6%	14.9%
Had to wait too long at appointment	12.1%	22.5%	16.5%	12.3%	9.7%	12.0%
Couldn't get appointment soon enough	11.8%	17.3%	12.9%	11.5%	13.1%	12.8%
No provider in the area that you wanted to see	10.0%	16.4%	11.7%	11.3%	10.0%	10.7%
Dislikes family planning exam	9.4%	8.8%	7.8%	8.1%	3.4%	5.3%
Couldn't reach provider on the telephone	9.3%	14.9%	8.2%	7.1%	9.4%	6.9%
Office was not open when convenient	5.1%	5.5%	6.0%	6.8%	4.7%	5.6%
No transportation	6.7%	8.8%	6.2%	6.3%	8.7%	5.3%
No childcare	4.1%	7.8%	4.9%	3.3%	6.6%	4.0%
Family or partner did not want her to go	1.0%	0.0%	0.6%	0.7%	0.9%	1.1%

As in past years, affordability and availability of preferred providers was of greater concern for women who were not aware that they were enrolled in Plan First.

Table 2.1b. Reasons for delay among those who are and are not aware of their enrollment in Plan First

Reasons for Delay with FP Visit	DY12		DY13		DY14		DY15	
	Aware enrolled	Unaware enrolled	Aware enrolled	Unaware enrolled	Aware enrolled	Unaware enrolled	Aware enrolled	Unaware enrolled
	N=869	N = 127	N=883	N = 102	N=830	N=157	N=886	N=156
	%	%	%	%	%	%	%	%
No money to pay for appointment	8.6	27.4	7.9	16.4	7.3	15.3	7.6	18.0
Provider you wanted to see did not take Medicaid	12.0	25.8	9.0	12.4	13.0	17.8	10.2	16.7
Had to wait too long at appointment	18.0	19.8	13.5	11.1	13.1	9.6	12.4	12.8
Couldn't get appointment soon enough	11.7	14.9	8.9	6.5	11.1	8.3	11.6	12.8
No provider in the area that you wanted to see	10.8	13.8	10.7	4.7	10.1	8.3	8.1	11.5
Dislikes family planning exam	5.3	5.9	5.7	5.9	3.2	5.1	4.7	6.4
Couldn't reach provider on the telephone	8.9	9.1	6.5	4.7	7.7	8.9	7.0	7.7
Office was not open when convenient	3.8	9.0	5.3	1.9	3.5	6.4	6.1	2.6
No transportation	4.1	6.5	4.3	5.5	4.5	6.4	4.1	4.5
No childcare	3.3	6.4	3.7	4.6	2.3	7.6	3.4	4.5
Family or partner did not want her to go	0.6	0.0	1.1	0.0	0.4	1.3	0.8	0.6

3. Specific Content of Care Measured in Claims Data

3.1 Categories of Providers

Since DY10, there has been a 13% decrease in the number of Plan First participants. Nearly 50% of Plan First participants received clinical services from health department and 25% obtained services from private providers. Approximately 25% of participants received services without clinical encounters in DY15. These patterns in use are largely similar over the last 6 years.

Table 3.1 Service Users by Provider Type

	Demonstration Year (DY)						% Change in Number (%) Service Users
	DY10	DY11	DY12	DY13	DY14	DY15	DY10-DY15
Health Department Providers only	31,416 (46.9)	34,589 (49.2)	39,843 (57.2)	36,550 (48.3)	32,532 (47.4)	28,825 (49.7)	-8.2 (6.0)
Private Providers only	16,865 (25.2)	16,733 (23.8)	15,258 (22.0)	16,970 (22.4)	17,512 (25.7)	13,427 (23.1)	-20.4 (-8.3)
Both Health Department and Private Providers	1,786 (2.7)	1,671 (2.4)	4,063 (5.8)	1,953 (2.6)	1,409 (2.1)	1,337 (2.3)	-25.1 (-14.8)
Non-clinical services only	16,883 (25.2)	17,372 (24.7)	10,447 (15.0)	20,187 (26.7)	16,926 (24.8)	14,420 (24.9)	-14.6 (-1.2)
Total	66,950	70,365	69,611	75,660	68,199	58,009	-13.3

3.2 Types of Services by Providers

While rates of the provision of care coordination and sterilization services remained similar over time, in DY15 more clients received HIV counseling and Depo Provera injections than in previous years. The percentage of women receiving prescriptions or supplies of birth control pills decreased in DY15. Some clients of private providers may receive free samples of birth control pills, which are not captured in claims data. HIV counseling is more common in the health department than in private care settings.

Table 3.2 Portion of Each Provider Type's Clients Using Services

Service Type	**Provider Type**	**DY10**	**DY11**	**DY12**	**DY13**	**DY14**	**DY15**
Care Coordination	Health Department	47.6%	47.5%	53.0%	53.0%	52.5%	53.3%
	Private	10.3%	9.6%	0.0%	11.7%	11.6%	4.6%
	Both	59.9%	57.6%	64.6%	57.8%	60.6%	57.1%
	Neither	30.9%	26.3%	0.0%	25.8%	34.2%	33.4%
	Total with Service	22,983	23,579	23,729	27,709	25,654	21,559
	% All Clients	34.3%	33.5%	34.1%	36.6%	37.6%	37.2%
HIV Counseling	Health Department	31.4%	0.2%	0.2%	3.7%	44.6%	61.7%
	Private	3.0%	0.7%	2.1%	0.8%	1.7%	2.5%
	Both	30.9%	0.5%	4.9%	3.0%	37.1%	56.1%
	Neither	6.1%	0.4%	0.0%	2.5%	6.8%	8.1%
	Total with Service	11,960	259	593	2,049	16,391	20,042
	% All Clients	17.9%	0.4%	0.9%	2.7%	24.0%	34.5%
Tubal Ligations	Health Department	0.3%	0.2%	0.3%	0.3%	0.2%	0.1%
	Private	1.6%	1.5%	1.1%	1.3%	1.0%	1.2%
	Both	6.3%	7.1%	3.2%	5.2%	6.3%	5.8%
	Neither	2.7%	2.2%	2.9%	2.3%	1.5%	1.7%
	Total with Service	927	804	692	868	564	515
	% All Clients	1.4%	1.1%	1.0%	1.2%	0.8%	0.9%
Depo Provera	Health Department	34.0%	32.7%	28.8%	30.9%	40.6%	42.2%
	Private	26.4%	22.7%	20.4%	21.9%	37.3%	38.1%
	Both	31.1%	34.5%	22.1%	36.1%	42.2%	45.0%
	Neither	0%	0%	0%	0%	0%	0
	Total with Service	15,698	15,665	15,471	17,533	20,257	17,895
	% All Clients	23.5%	22.3%	22.2%	23.2%	29.7%	30.8%
Birth Control Pills	Health Department	36.9%	34.1%	2.3%	1.7%	28.5%	36.6%
	Private	8.5%	5.0%	30.1%	12.3%	18.0%	1.4%
	Both	34.9%	24.7%	25.0%	6.8%	24.8%	29.2%
	Neither	10.4%	5.5%	47.5%	11.5%	27.7%	6.3%
	Total with Service	15,421	13,996	11,480	5,153	17,406	12,036
	% All Clients	23.0%	19.9%	16.5%	6.8%	25.5%	20.7%

4. Specific Content of Care Measured in Enrollee Survey Data

4.1 Choice of Birth Control

Consistent with the past few years, about 86% of survey respondents with a family planning visit reported that they had been given a choice of birth control methods by their family planning provider.

Table 4.1a Choice of Birth Control

Did the doctor or nurse offer you several different choices of birth control methods and allow you to select the one you wanted?

	DY10	DY11	DY12	DY13	DY14	DY15
	N=1,075	N=1,021	N=1,028	N=1,020	N=1,107	N=1,042
Yes	97.3%	83.0%	84.1%	83.0%	83.9%	85.6%
No	1.9%	16.2%	15.0%	15.7%	14.6%	13.8%
Don't know, Not sure	0.7%	0.9%	1.0%	1.0%	1.4%	0.5%

Respondents seeing health department providers, private physician providers, and Planned Parenthood clinics reported equivalent rates of having choice in birth control methods, while those using other types of clinics reported having less choice.

Table 4.1b Choice of Birth Control by Provider Seen in Demo Year 15

Did the doctor or nurse offer you several different choices of birth control methods and allow you to select the one you wanted?

	Health Department	Private Doctor	Planned Parenthood or special clinic	Community Health Center	Other or Not Known
N	491	425	51	37	26
Yes	85.7%	85.9%	86.3%	81.1%	84.6%
No	13.6%	13.6%	11.8%	18.9%	15.4%

4.2 Reported Content of Family Planning Visit

Reported content of family planning visits within the enrollee survey remains consistent with previous years, with about three quarters of visits including a contraceptive method, and less than half including counseling on HIV.

Receipt of a contraceptive method or prescription is somewhat higher at the health department and other clinics (community health center, Planned Parenthood) than at private providers. Counseling on HIV and STDs occurs more frequently in health department settings than at other sources of care.

Table 4.2a Reported Content of Family Planning Visit

	DY11	DY12	DY13	DY14	DY15
All providers					
Receive counseling on birth control options	73.1	72.1	70.4	71.9	70.9
Receive a method or prescription	75.3	72.1	74.1	72.3	71.5
Pelvic Exam	70.3	70.8	68.5	68.9	69.7
Pap Test	68.9	69.7	69.1	64.9	67.4
HIV Testing or Counseling	52.0	49.3	47.8	44.7	41.9
STD Test or Counseling	64.4	61.1	61.3	57.4	59.1
Pregnancy Test	56.5	56.8	57.4	54.6	57.2
Counseling on Tubal Ligation	13.3	12.5	13.9	14.7	19.4
Health Department	(n=593)	(n=576)	(n=552)	(n=524)	(n=491)
Receive counseling on birth control options	76.7%	74.8%	77.4%	80.3%	75.4%
Receive a method or prescription	74.5%	76.4%	76.6%	75.9%	73.2%
Pelvic Exam	65.1%	66.0%	62.9%	63.9%	65.6%
Pap Test	65.1%	64.9%	64.7%	58.6%	62.5%
HIV Testing or Counseling	54.6%	54.3%	54.9%	50.8%	51.1%
STD Test or Counseling	67.8%	65.6%	69.9%	62.6%	67.8%
Pregnancy Test	57.7%	57.6%	62.9%	58.4%	64.4%
Counseling on Tubal Ligation	11.0%	10.8%	10.8%	11.1%	15.5%
Private Provider	(n=401)	(n=446)	(n=460)	(n=447)	(n=425)
Receive counseling on birth control options	74.1%	68.2%	70.5%	63.5%	66.8%
Receive a method or prescription	70.1%	65.9%	63.2%	67.1%	69.4%
Pelvic Exam	79.0%	74.7%	75.5%	74.9%	73.9%
Pap Test	74.8%	72.9%	74.5%	72.3%	72.5%
HIV Testing or Counseling	40.1%	37.0%	39.2%	36.8%	33.2%
STD Test or Counseling	55.9%	51.6%	50.7%	51.2%	50.6%
Pregnancy Test	49.4%	52.0%	50.9%	50.6%	51.5%
Counseling on Tubal Ligation	16.7%	14.6%	17.8%	18.3%	23.5%
Other or Not known	(n=27)	(n=6)	(n=5)	(n=19)	(n=114)

Receive counseling on birth control options	55.5%	50.0%	33.3%	57.9%	67.5%
Receive a method or prescription	66.6%	50.0%	50.0%	67.1%	71.9%
Pelvic Exam	55.5%	50.0%	50.0%	63.2%	70.2%
Pap Test	66.7%	50.0%	33.3%	68.4%	67.5%
HIV Testing or Counseling	44.4%	33.3%	33.3%	36.8%	36.0%
STD Test or Counseling	48.1%	33.3%	50.0%	57.9%	56.1%
Pregnancy Test	44.4%	50.0%	50.0%	47.4%	51.7%
Counseling on Tubal Ligation	3.7%	16.7%	0.0%	31.6%	21.9%

In DY 14, slightly more women chose to have tubal ligations after counseling, compared to DY 13. The table suggests that the decision to have a tubal ligation is made by the client, and is not consistently promoted or opposed by the care provider.

Table 4.2b Outcomes from Counseling on Tubal Ligations

Responses	DY 13	DY 14	DY15
	N=138 (%)	N=146 (%)	N=202 (%)
They helped me arrange to have my tubes tied.	18 (13.0)	33 (22.6)	38 (18.8)
They gave me a different kind of birth control and did not have my tubes tied.	59 (42.7)	66 (45.2)	96 (47.5)
I decided not to have my tubes tied after talking about it.	47 (34.0)	30 (20.6)	39 (19.3)
Advised against it (Health complications, too young, too few children)	9 (6.5)	3 (2.0)	4 (2.0)
Haven't decided yet.	5 (3.6)	4 (2.7)	4 (2.0)
Don't know	0	5 (3.4)	3 (1.5)

4.3 Use of Contraceptives since Plan First enrollment

In general, contraceptive use has been fairly consistent over time, with 84% using any contraception. More women reported having used an effective method in DY15 than in previous years. Additionally, use of the implant has increased overtime and in DY15, 36% of women reported having used a long-acting reversible method like the implant or IUD.

Table 4.3a Use of Contraceptives

Use of Contraceptives	DY10	DY11	DY12	DY13	DY14	DY15
N	1,125	1,102	1,097	1,109	1,070	1,080
% used any contraception	85.1	78.9	84.8	84.2	84.1	85.6
% used effective contraception*	54.1	69.9	79.1	77.8	75.8	81.3
% Tubal	2.2	1.3	2.8	2.6	5.3	5.0
% Vasectomy	1.9	2.1	1.5	2.4	1.3	2.0
% IUD	18.3	19.9	16.5	20.3	16.4	20.0
% Implanon/Nexplanon	7.7	9.3	10.4	10.8	15.1	15.6
% Depo	40.4	40.0	38.1	41.9	39.1	41.5
% BC Pills	58.8	59.6	58.9	58.0	58.0	53.5
Got BC pills from Health Dept.	66.3	66.1	63.0	57.1	58.4	51.7
Got BC pills from free sample	13.2	17.2	16.0	20.4	18.5	21.8
Got BC pills from drug store	20.0	16.4	20.4	21.7	22.7	26.1
Don't know, not sure	0.5	0.4	0.5	0.6	0.4	0.4
% Nuva-Ring	10.7	8.2	7.9	8.8	8.5	7.6
Got ring from Health Dept.	64.0	50.7	63.5	50.6	46.7	47.1
Got ring from free sample	19.0	29.6	25.7	33.3	29.9	31.4
Got ring from drug store	16.0	19.7	10.8	16.1	20.8	21.4
Don't know, not sure	1.0	0.0	0.0	0.0	2.6	0.0
% Patch	6.6	6.2	4.9	7.3	6.8	5.7
Got patch from Health Dept.	54.1	55.6	56.5	43.3	54.1	35.8
Got patch from free sample	31.2	25.9	26.1	37.3	24.6	26.4
Got patch from drug store	14.7	14.8	17.4	16.4	21.3	37.7
Don't know, not sure	0.0	3.7	0	3.0	0.2	0.0
% Plan B	5.9	6.8	7.6	7.4	9.3	7.8
% Condoms	77.4	76.5	73.8	76.2	78.6	71.0
% Natural FP	5.3	5.1	7.3	7.5	7.9	8.0
% Withdrawal	49.2	46.6	45.4	44.7	50.3	51.0

*includes any respondent reporting use of tubal ligation, partner vasectomy, IUD, Nexplanon, Depo-Provera, Birth Control Pills, Nuva Ring and/or Patch.

Use of Depo among women 19-24 has decreased over the last several years and among women ≥35, reported use of this method was higher in DY15 (45%) than in earlier years. Compared to younger and older women, those 25-34 are more likely to use long-acting reversible methods, especially the IUD.

Table 4.3b Use of contraceptives by age groups

	Age 19-24				Age 25-34				Age ≥35			
Methods	**DY12**	**DY13**	**DY14**	**DY15**	**DY12**	**DY13**	**DY14**	**DY15**	**DY12**	**DY13**	**DY14**	**DY15**
	N=432	N=405	N=385	N=345	N=499	N=502	N=515	N=594	N=172	N=181	N=170	N=184
% Used any method	88.8	87.2	88.0	88.5	83.6	83.3	85.6	85.6	80.6	82.3	70.6	80.6
% Used effective method*	82.6	81.1	80.6	85.0	74.6	76.5	77.6	81.6	68.2	74.3	58.7	73.9
Tubal	0.5	0.6	1.2	1.8	3.7	2.2	7.0	5.3	5.8	8.7	10.7	10.3
Vasectomy	0.5	0.6	0.3	0.3	1.2	1.9	1.8	2.2	5.1	8.1	2.5	4.8
IUD	12.0	13.6	11.5	14.8	22.0	27.5	21.5	24.9	13.1	16.1	11.6	13.7
Implanon/Nexplanon	13.4	10.5	16.5	16.6	9.9	11.7	14.9	17.4	5.1	9.2	11.6	7.5
Depo	38.8	50.7	46.8	43.0	37.8	36.4	35.1	39.5	38.7	36.2	32.2	45.2
BC pills	62.0	63.2	58.5	55.3	57.0	53.1	58.8	53.6	56.2	59.7	53.7	50.0
Nuva-Ring	7.2	7.1	10.3	5.6	8.0	10.8	8.1	9.3	1.6	7.4	5.0	5.5
Patch	4.0	5.1	6.5	3.5	5.9	9.6	7.9	6.7	4.4	6.0	3.3	6.8
Plan B	10.2	10.5	10.9	8.1	7.2	6.5	8.4	7.9	2.9	2.7	8.3	6.8
Condoms	75.1	77.6	81.5	72.2	72.4	74.6	79.2	71.5	76.6	77.2	68.6	67.1
Natural FP	7.5	5.4	5.0	4.9	6.7	8.4	9.3	9.3	9.5	10.1	10.7	9.6
Withdrawal	51.3	55.0	59.1	59.1	43.2	40.4	47.7	49.8	38.7	32.2	34.7	39.0

* includes any respondent reporting use of tubal ligation, partner vasectomy, IUD, Nexplanon, Depo-Provera, Birth Control Pills, Nuva Ring and/or Patch.

Overall satisfaction with current contraceptive method is high, except for women who rely on condoms.

Table 4.3c. Current Contraceptive Method Use and Preference, DY 15

Method Using Now	Age 19-24 N=284		Age 25-34 N=494		Age ≥35 N=146	
	% using method	% prefer using this method	% using method	% prefer using this method	% using method	% prefer using this method
Tubal ligation	2.0	100	5.1	95.6	10.5	92.9
Vasectomy	0.4	100	0.7	100	3.0	100
IUD	11.0	75.0	17.7	93.7	9.8	92.3
Implanon/Nexplanon	12.9	81.8	11.7	83.0	5.3	85.7
Depo Provera Injection	23.5	90.0	19.4	89.8	27.7	91.2
Birth Control Pills	31.4	95.0	23.0	91.3	22.6	86.7
Patch	0.8	100	1.1	100	0.7	100
Condoms	9.8	68.0	11.5	57.7	15.0	65.0
Natural Family Planning	0.4	100	0.7	66.7	0.7	0
Withdrawal	0.8	100	1.3	50.0	0.7	100
Other	6.3	93.7	7.5	82.3	5.3	57.1

Respondents' reasons for not using birth control were fairly consistent across DY 13 and DY 14. The most common reason cited was not being sexually active, but concern about side effects was also reported. In DY 14, more women stated that their partners did not want them to use birth control.

Table 4.3d Reasons for Not Using Birth Control

Primary reason for <u>not</u> using birth control (more than one response possible)	**DY13 (N=239)**	**DY14 (N = 214)**	**DY15 (N=237)**
Not sexually active	37.2%	39.2%	38.0%
Concerned about side effects	24.3%	28.0%	37.1%
Don't think you can get pregnant	16.3%	14.0%	17.3%
Want to get pregnant	14.6%	10.7%	14.3%
Can't pay for birth control	13.8%	11.2%	9.7%
Don't think birth control methods work	13.4%	13.1%	13.5%
Can't find a place to get family planning services	6.3%	8.4%	8.9%
Too much trouble	3.3%	3.7%	3.8%
Religious reasons	1.7%	1.9%	1.7%
Partner does not want you to use	1.7%	6.1%	6.7%

5. Use of Risk Assessments and Care Coordination in Claims Data

5.1 Provision of Risk Assessments

Psychosocial risk assessments are provided to Plan First clients by care coordinators based in local health departments. Private Plan First providers may secure assessments for their clients upon request. Assessments do not need to be completed every year. The overall portion of Plan First clients assessed reached a peak of over 70% in DY15.

As in previous years, more health department clients received assessments in DY15 than clients of other provider types. There was also a slight increase in DY15 in proportion of clients who did not obtain clinical services receiving assessments.

Table 5.1a Provision of Risk Assessments to Plan First Clients Overall and by Provider Category

	Demonstration Year (DY)					
	DY10	DY11	DY12	DY13	DY14	DY15
All Providers						
Number of clients	63,058	70,365	69,611	75,660	68,199	58,009
This year only	12,667	18,796	13,530	14,849	9,208	5,910
Previous years only	13,206	10,402	16,308	16,391	19,020	17,345
This year and previous years	12,883	11,171	15,518	19,419	19,226	19,302
Total number ever assessed	38,756	40,369	45,356	50,659	47,454	42,557
% of clients ever assessed	61.5%	57.4%	65.1%	67.0%	69.6%	73.4%
Health Department						
Number of clients	36,871	40,835	39,843	36,550	32,352	28,825
This year only	11,279	16,906	11,997	11,146	7,096	4,730
Previous years only	8,675	4,730	9,419	5,944	6,441	5,968
This year and previous years	11,879	10,188	14,220	16,078	15,795	16,329
Total number assessed	31,833	31,824	35,636	33,168	29,332	27,027
% of clients ever assessed	86.3	77.9	89.4	90.7	90.7	93.8
Private Providers						
Number of clients	14,318	15,592	15,258	16,970	17,512	13,427
This year only	0	0	0	1,085	899	272
Previous years only	2,058	3,135	3,358	3,874	4,880	4,299
This year and previous years	0	0	0	988	1,247	484
Total number assessed	2,058	3,135	3,358	5,947	7,026	5055
% of clients ever assessed	14.4	20.1	22.0	35.0	40.1	37.6
Both Health Department/Private						
Number of clients	3,487	4,067	4,063	1,953	1,409	1,337
This year only	1,388	1,890	1,533	667	368	309
Previous years only	957	401	821	295	269	247
This year and previous years	1,004	983	1,298	730	618	646
Total number assessed	3,349	3,274	3,652	1,692	1,255	1202
% of clients ever assessed	96.0	80.5	90.6	86.6	89.1	89.9

Neither						
Number of clients	8,032	9,871	10,447	20,187	16,926	14,420
This year only	0	0	0	1,951	845	599
Previous years only	1,516	2,136	2,710	6,278	7,430	6,831
This year and previous years	0	0	0	1,623	1,566	1,834
Total number assessed	1,516	2,136	2,710	9,852	9,841	9264
% of clients ever assessed	18.9	21.6	25.9	48.8	58.1	64.2

In general, the relative rates of assessments by county varied in the same way that they have in previous years, with PHA 11 (Mobile) having the lowest assessment rates, and PHA 10 (southeastern Alabama) having among the highest assessment rates.

Table 5.1b Risk Assessments in DY 15 by County

	DY12		**DY13**		**DY14**		**DY15**	
	N assessed	% assessed	N assessed	% assessed	N assessed	% assessed	N assessed	% assessed
PHA1 (County)								
17	561	51.5	663	55.1	501	44.6	414	45.3
30	169	36.8	204	41.9	195	43.1	164	40.4
39	899	58.3	1,029	59.7	865	54.1	737	54.1
47	309	58.1	389	66.5	282	53.5	238	58.6
64	577	52.0	751	64.5	604	57.2	519	61.6
67	171	55.7	211	60.6	197	60.8	196	65.5
PHA2 (County)								
22	497	52.4	681	63.3	503	54.2	372	50.7
36	173	25.6	201	27.6	112	19.5	97	22.4
40	359	64.5	359	66.4	311	65.2	248	60.5
42	412	41.7	499	46.9	405	43.8	315	43.3
45	801	28.0	958	29.8	773	28.2	597	26.8
48	392	45.0	429	44.4	402	46.8	355	49.6
52	562	38.8	834	55.0	629	47.8	417	39.0
PHA3 (County)								
4	197	48.1	211	50.1	171	47.1	156	49.2
29	176	64.7	232	71.2	127	47.6	146	64.6
32	179	56.8	211	65.9	146	53.9	144	64.0
38	145	62.5	169	67.9	159	62.6	147	63.6
54	305	63.0	323	66.7	261	57.5	237	63.2
63	1,806	57.4	2,049	60.5	1,635	54.2	1,567	59.8

PHA4 (County)								
37	2,068	27.6	2,642	35.8	2,452	39.1	2,298	42.3
PHA5 (County)								
5	261	46.0	293	47.9	244	42.4	189	44.1
10	156	46.2	203	53.0	143	46.7	140	49.5
25	398	39.9	382	39.4	329	35.8	325	40.3
28	891	56.1	953	58.0	702	50.0	675	56.0
58	471	55.9	517	56.1	403	50.1	346	55.0
59	687	58.4	646	53.8	442	42.5	360	43.4
PHA6 (County)								
8	994	48.3	1,110	49.2	861	42.8	758	44.1
9	341	51.0	398	53.8	378	53.0	329	55.9
14	131	55.0	173	60.9	164	56.2	138	53.3
15	120	45.1	142	47.3	100	40.6	78	40.2
19	67	50.4	68	56.2	64	56.1	62	53.4
56	216	57.1	259	63.3	182	46.3	190	52.6
61	574	39.6	588	39.9	498	36.6	443	38.6
62	399	56.2	543	68.1	383	50.4	415	61.0
PHA7 (County)								
12	191	61.4	257	75.8	202	61.2	184	59.9
24	467	34.1	669	43.4	50	35.8	491	41.7
33	286	57.0	405	73.4	362	64.3	357	68.4
43	139	42.9	199	53.2	119	34.6	132	43.4
46	264	50.7	338	55.1	286	51.2	270	56.8
53	176	44.8	244	58.5	171	45.5	168	49.1
60	208	49.5	293	60.9	237	55.5	211	58.4
66	273	59.2	340	69.4	325	65.4	321	67.1
PHA8 (County)								
1	332	50.8	299	44.2	314	51.1	211	42.0
6	98	36.7	116	37.7	66	23.7	44	20.2
11	353	56.4	321	51.9	319	54.0	284	54.0
26	323	40.8	351	39.8	340	39.9	282	40.3
41	615	48.4	586	43.2	459	35.1	485	43.0
44	286	56.5	226	44.2	184	37.8	157	38.9
51	1,417	32.8	1,628	33.1	1,417	31.9	1,288	33.1
57	384	42.7	412	45.4	360	39.9	292	42.0

PHA9 (County)								
2	439	19.1	447	17.6	349	15.3	315	18.0
7	287	55.5	364	59.9	357	58.6	391	66.5
13	385	56.2	449	58.9	329	44.5	306	49.3
18	97	42.4	133	50.6	105	38.3	112	45.5
20	234	34.8	359	48.2	323	45.6	294	47.6
27	296	41.5	321	40.2	268	38.1	282	42.7
50	176	48.4	243	53.1	196	48.6	179	53.6
65	94	30.8	124	44.0	134	50.4	130	54.4
PHA10 (County)								
3	303	60.1	409	66.0	329	54.6	307	55.5
16	420	71.3	448	66.3	393	62.4	339	62.5
21	182	52.2	368	68.5	250	63.3	205	59.1
23	488	62.2	595	66.0	529	69.1	442	61.7
31	345	70.6	392	73.3	342	70.1	318	75.0
34	135	54.7	222	70.7	180	59.4	145	55.3
35	1,360	69.6	1,584	73.8	1,151	66.5	972	65.5
55	437	60.0	563	63.4	501	63.5	457	65.0
PHA11 (County)								
49	1,090	15.0	1,340	16.0	1,406	18.1	1,029	15.5
Total	29,044	41.8	34,365	53.9	28,434	41.7	25,212	43.5

5.2 Care Coordination Services

Clients who are assessed as being high risk are referred for care coordination services in order to facilitate their use of family planning care. Table 5.2a shows that a total of 13,844 clients were assessed as high risk in DY15. This is 24% of all 58,009 clients using services in DY15, and 55% of the 25,212 clients assessed in the year. An additional 10,268 Plan First participants in DY15 had been assessed as high risk in DY13 or DY14. Additionally, almost all of the clients assessed as high risk in DY15 received care coordination, while about two-thirds of those who had previously been assessed as high risk and who returned for services in DY14 continued to receive care coordination services. These rates are consistent with previous years.

Table 5.2a Portion of High Risk Clients Receiving Care Coordination Services

	Number Assessed as high risk	Number receiving care coordination services	Percent receiving care coordination services in DY15
Assessed as high risk in DY15 only	6,023	5,964	99.0%
Assessed as high risk in DY13 or DY14 and also in DY15	7,821	7,813	99.3%
Assessed as high risk in DY13 or DY14 only	10,268	6,665	64.9%

Table 5.2b compares service use for clients with and without care coordination. Proportions have remained fairly consistent over recent years. Care coordination clients had more public family planning visits in the year, on average, and were more likely to receive Depo-Provera injections, prescriptions or supplies of birth control pills, and HIV counseling.

Table 5.2b Use of Services by Clients With and Without Care Coordination

	DY12		DY13		DY14		DY15	
Received Care Coordination?	No	Yes	No	Yes	No	Yes	No	Yes
Number of clients	45,882	23,729	47,951	27,709	42,545	25,654	36,450	21,559
Mean number of visits (days of contact)	0	7.2	0	7.1	0	6.7	0	6.9
% with public visits	44.0	100.0	37.5	74.0	37.4	69.6	38.5	74.7
Mean number public visits for those with any	5.2	12.9	4.8	6.4	3.7	4.8	3.0	4.2
% with private visits	36.4	11.1	33.0	11.2	37.7	11.2	36.7	6.4
Mean number private visits for those with any	4.7	5.2	4.2	5.1	3.8	4.9	3.2	2.9
% with HIV counseling	1.1	0.5	2.1	3.8	18.0	34.0	25.5	49.8
% with tubal ligations	1.1	0.8	1.3	0.9	0.9	0.7	1.0	0.7
% with birth control pills	22.5	4.8	1.4	2.2	26.9	23.3	15.4	28.7
% with Depo Provera	15.3	35.6	15.4	36.6	24.2	38.8	25.0	40.7

6. Primary Care Referrals Measured in Enrollee Survey Data

6.1 Referral to and Receipt of Primary Care

For the past several years, enrollee surveys have included a series of questions on receipt of referrals to primary care from family planning providers. Consistently over time, just over 10% of enrollees reported talking with their family planning provider about another health or medical problem. The portion of those respondents who learned of a medical problem at the family planning visit and received a referral for care was 61% in DY15. This is lower than the percentage observed in the previous 2 years, and is lower than the original performance target for this measure (80% of those with an identified problem receiving a referral).

The proportion of clients who sought care and received care for their medical problem has remained consistent over time, and is higher for those that have a regular source of medical care than those without a usual source for care.

Table 6.1 Referrals for care and care seeking behavior for clients with and without a usual source of care for other medical problem(s)

	DY13			DY14			DY15		
	Total N (%)	Usual Source of Care (%)		Total N (%)	Usual Source of Care (%)		Total N (%)	Usual Source of Care (%)	
		Yes	No		Yes	No		Yes	No
Informed of other medical problem	117 (11.4)	14.3	8.0	110 (10.1)	10.6	8.9	127 (12.2)	13.0	11.1
Told about place for treatment*	80 (68.4)	66.7	72.2	76 (76.0)	78.0	71.0	78 (61.4)	61.2	61.7
Tried to get care for medical problem*	80 (68.4)	77.8	47.2	72 (72.0)	78.0	65.8	91 (71.6)	75.0	65.0
Received care for medical problem*	67 (60.9)	68.0	43.8	60 (60.0)	72.7	52.8	77 (64.7)	69.7	55.8

*Among those who were told they had a medical problem.

6.2 Reasons for Not Receiving Primary Care

As in previous years, lack of insurance coverage or concern about the cost of medical care is the primary reason why referred clients do not receive care for their identified medical problems.

Table 6.2a Reasons for Not Trying to get Care for Other Medical Problems

	DY13 N=37	**DY14** N=28	**DY15** N=36
I can't afford to get care	25 (73.5)	19 (67.8)	24 (66.7)
I don't know where to go to get treatment	5 (13.5)	4 (14.3)	4 (11.1)
I don't think these problems really need treatment	4 (10.8)	4 (14.3)	2 (5.6)
I don't have time to get treatment	3 (8.1)	2 (7.1)	3 (8.3)
I don't have transportation to get treatment	6 (16.2)	2 (7.1)	1 (2.8)
Other – uninsured or not aware of being insured, provider wouldn't take Medicaid	4 (13.5)	5 (17.8)	8 (22.2)
Waiting for Appointment	---	2 (7.1)	--

Table 6.2b Reasons for Not Receiving Care if Sought

	DY13 N=43	**DY14**	**DY15** N=40
I couldn't pay for the care	27 (62.8)	--	27 (67.5)
I couldn't find a doctor who would see me	4 (9.8)	--	3 (7.5)
Other reasons for not getting treatment	2 (4.7)	--	12 (30.0)

-- Information not available.

7. Birth Rates by FP Utilization

As in previous Plan First evaluations, we have calculated the birth rates for enrollees who did not use services and enrollees in four categories of service use. The count of births excludes deliveries that occurred immediately before service use (or enrollment, for non-service users) and excludes deliveries that occurred within nine months of the first service date (or enrollment date, for non-service users). Deliveries were included if they occurred up to nine months after the end of the demonstration year. Because of this time lag, data are only available to complete the estimates for Demonstration Year 14, counting births that occurred through August 2015.

Table 7.1 shows that birth rates for Plan First participants are much lower than birth rates of enrollees who do not use any Plan First services. In DY 14, the participant group with the lowest birth rates – from pregnancies occurring while they were participants – was the group of women who used the Health Department for family planning services. The group with the highest birth rates was those who had contact with Plan First, but received no clinical services.

Note that these birth rates are slightly higher than those shown for Goal 5, because they exclude recently pregnant women from the population count which serves as the denominator for the rate.

Table 7.1 Birth Rates for Enrollees and Service Users, Demonstration Year 14*

	Number Enrollees	Number of Births	Births/1000
Non-service users	70,018	5,945	84.9
Service Users	62,058	3,618	58.3
Any risk assessment or case management	35,531	1,820	51.2
No risk assessment or case management	26,527	1,798	67.8
Any visit to Title X clinic	32,083	1,359	42.3
No visit to Title X clinic	29,975	2,259	75.4
All Enrollees	132,076	9,563	72.4

*Does not include women who delivered prior to enrollment or who were pregnant at first Plan First visit.

Appendix: Demographics of Survey Respondents

Table A.1. Demographic composition of survey respondents

	DY10	DY11	DY12	DY13	DY14	DY15
	N=1,144	N=1,126	N=1,126	N=1,127	N=1,107	N=1,125
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
Age (years)						
19	39 (3.4)	16 (1.42)	55 (4.9)	45 (4.0)	22 (2.0)	5 (0.4)
20 – 29	748 (65.4)	529 (47.0)	710 (63.1)	686 (60.9)	704 (63.6)	702 (62.4)
30 – 39	288 (25.2)	244 (21.7)	267 (23.7)	309 (27.4)	306 (27.6)	368 (32.7)
40+	50 (4.4)	82 (7.3)	88 (7.8)	87 (7.7)	75 (6.8)	48 (4.3)
Not answered[1]	19 (1.7)	255 (22.6)	6 (0.5)	0	0	2 (0.2)
Race						
Black	630 (55.1)	388 (34.5)	561 (49.8)	593 (52.6)	565 (51.0)	570 (50.7)
White	468 (40.9)	444 (39.4)	504 (44.8)	495 (43.9)	493 (44.5)	503 (44.7)
American Indian	9 (0.8)	8 (0.7)	13 (1.1)	9 (0.8)	2 (0.2)	13 (1.2)
Asian/Pacific Islander	4 (0.4)	6 (0.5)	8 (0.7)	8 (0.7)	9 (0.8)	6 (5.3)
Other	30 (2.6)	23 (2.0)	38 (3.4)	19 (1.7)	32 (2.9)	29 (2.6)
Don't know/Refused	3 (0.3)	2 (0.2)	2 (0.2)	3 (0.3)	6 (0.6)	4 (0.4)
Not answered[1]	--	255 (22.6)	--	--	--	--
Hispanic						
Yes	31 (2.71)	30 (2.7)	42 (3.7)	20 (1.8)	36 (3.2)	34 (3.0)
No	1,113 (97.3)	839 (74.5)	1,080 (95.9)	1,107 (98.2)	1,070 (96.7)	1,091 (97.0)
Not Answered[1]	--	255 (22.6)	2 (0.4)	--	1 (0.1)	--
Marital status						
Never married	749 (65.5)	684 (60.7)	712 (63.2)	675 (59.9)	672 (60.7)	679 (60.4)
Married	214 (18.7)	248 (22.0)	22(20.2))	249 (22.1)	241 (21.8)	272 (24.2)
Previously married	177 (15.5)	190 (16.9)	185 (16.4)	199 (17.6)	189 (17.1)	172 (15.3)
Don't know/Refused	4 (0.4)	4 (0.4)	1 (0.1)	4 (0.4)	5 (0.5)	0 (0.2)
Education						
Less than high-school	112 (9.8)	94 (8.3)	96 (8.5)	80 (7.1)	77 (6.9)	80 (7.1)
High school or GED	377 (33.0)	344 (30.6)	415 (36.9)	424 (37.6)	395 (35.7)	413 (36.7)
More than high-school	653 (57.1)	433 (38.4)	612 (54.3)	622 (55.2)	633 (57.2)	631 (56.1)
Not answered	2 (0.2)	255 (22.6)	3 (0.3)	1 (0.1)	2 (0.2)	0
Ever pregnant						
Yes	879 (76.8)	871 (77.4)	816 (72.5)	844 (74.9)	823 (78.0)	934 (86.5)
No	262 (22.9)	254 (22.6)	260 (23.1)	240 (21.3)	229 (21.7)	142 (13.4)
Length of enrollment (months)						
< 6	12 (1.1)	221 (19.6)	1 (0.1)	214 (19.0)	197 (17.8)	151 (13.4)

6 – 12	545 (47.6)	313 (27.8)	223 (19.8)	240 (21.3)	266 (24.0)	202 (18.0)
13 – 24	578 (50.5)	291 (25.8)	873 (77.5)	296 (26.3)	271 (24.5)	240 (21.3)
> 24	9 (0.8)	301 (26.7)	29 (2.5)	268 (23.8)	373 (33.7)	532 (47.3)

[1] Due to an error in the skip patterns for the survey administration, age, race and education were not asked for women responding that they had never been pregnant.

Centers for Medicare & Medicaid Services
SPECIAL TERMS AND CONDITIONS

NUMBER: **11 -W-00 133/4**

TITLE: **Alabama Plan First Section 1115 Family Planning Demonstration**

AWARDEE: **Alabama Medicaid Agency**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Alabama family planning section 1115(a) Medicaid demonstration (hereinafter "demonstration"). The parties to this agreement are the Alabama Medicaid Agency and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS during the life of the demonstration. The STCs are effective January 1, 2015 through December 31, 2017, unless otherwise specified. All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below. This demonstration is approved through December 31, 2017.

The STCs have been arranged into the following subject areas:

II. PROGRAM DESCRIPTION AND HISTORICAL CONTEXT

Demonstration Description

Effective through December 31, 2017, the Alabama Plan First family planning section 1115(a) Medicaid demonstration expands the provision of family planning and family planning-related services to

1. Women ages 19 through 55 losing Medicaid 60 days postpartum with incomes up

to 141 percent of the Federal Poverty Level (FPL)(post Modified Adjust Gross Income (MAGI) conversion);

2. Women 19 -55 with incomes up to 141percent of the FPL who are not otherwise eligible for Medicaid; and

3. Men age of 21 with incomes up to 133 percent of the FPL (post MAGI conversion) for vasectomies.

Historical Context

The initial Plan First demonstration was approved for a 5-year period approved on June 29, 2003 and implemented October 1, 2000. The demonstration operated under temporary extensions until renewed for three (3) years in April 2006. The demonstration was extended for an additional three (3) years in September 2008. The demonstration operated under temporary extensions from September 2011 through April 2012 and was renewed through December 31, 2013. The demonstration was temporarily extended through December 31, 2014.

Demonstration Purpose

Under this demonstration, Alabama expects to promote the objectives of Title XIX by: Increasing the portion of eligible women enrolled in the Plan First and reducing age, race and geographic disparities among enrollees;

- Maintaining high levels of awareness of the Plan First enrollees using family planning services initially after enrollment and in subsequent years of enrollment by improving access to services and increasing the rate of return for care.
- Increasing the portion of the demonstration enrollees using family planning services initially after enrollment and in subsequent years of enrollment by improving access to services and increasing the rate of return visits for care;
- Increasing the number of Plan First enrollees who are cigarette smokers to receive either a covered Nicotine Reduction Therapy prescription, a referral to the Quit line or both.
- Increasing the portion of family planning visits that include referrals for primary care services where indicated;
- Maintaining birth rates among demonstration service users that are lower than the estimated birth rates that would be occurring in the absence of the Plan First demonstration; and
- Increasing the usage of the Plan First demonstration by making sterilizations available to men up to 141 percent of the FPL who are age 21 or older.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited

to, the Americans with Disabilities Act of 1990, Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid programs expressed in law, regulation, and policy statement not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), must apply to the demonstration.

3. **Changes in Medicaid Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, court order, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid programs that occur during this demonstration approval period, unless the provision being changed is explicitly waived or identified as not applicable.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy Statements.**

    a) To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change.

    b) If mandated changes in the federal law require state legislation, the changes must take effect on the day, such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements in these STCs must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Social Security Act (the Act). The state must not implement changes to these elements without prior approval by CMS. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 6 below. The state will notify CMS of proposed demonstration changes at the quarterly monitoring call, as well as in the written quarterly report, to determine if a formal amendment is necessary.

6. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required reports and other deliverables in a timely fashion according to the deadlines specified therein. Amendment requests must include, but are not limited to, the following:

a) An explanation of the public process used by the state consistent with the requirements of STC 13 to reach a decision regarding the requested amendment;

b) A data analysis which identifies the specific impact of the proposed amendment on the current budget neutrality expenditure limit.

c) A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and

d) If applicable, a description of how the evaluation design must be modified to incorporate the amendment provisions.

7. **Extension of the Demonstration.**

a) States that intend to request demonstration extensions under sections 1115(e) or 1115(f) are advised to observe the timelines contained in those statutes. Otherwise, no later than 12 months prior to the expiration date of the demonstration, the chief executive officer of the state must submit to CMS either a demonstration extension request or a phase-out plan consistent with the requirements of STC 8.

b) Compliance with Transparency Requirements at 42 CFR §431.412: As part of the demonstration extension request, the state must provide documentation of compliance with the public notice requirements outlined in STC 13, as well as include the following supporting documentation:

i) Demonstration Summary and Objectives: The state must provide a narrative summary of the demonstration project, reiterate the objectives set forth at the time the demonstration was proposed and provide evidence of how these objectives have been met as well as future goals of the program. If changes are requested, a narrative of the changes being requested along with the objective of the change and desired outcomes must be included.

ii) Special Terms and Conditions (STCs): The state must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address any of the following areas, they need not be documented a second time.

iii) Waiver and Expenditure Authorities: The state must provide a list along with a programmatic description of the waivers and expenditure authorities that are being requested in the extension.

iv) Quality: The state must provide summaries of External Quality Review Organization (EQRO) reports, managed care organization (MCO) and state quality assurance monitoring, and any other documentation of the quality of care provided under the demonstration.

v) Compliance with the Budget Neutrality Limit: The state must provide financial data (as set forth in the current STCs) demonstrating the state's detailed and aggregate, historical and projected budget neutrality status for the requested period of the extension as well as cumulatively over the lifetime of the demonstration. In doing so, CMS will take into account the best estimate of current trend rates at the time of the extension. In addition, the state must provide up to date responses to the CMS Financial Management standard questions. If Title XXI funding is used in the demonstration, a CHIP Allotment Neutrality worksheet must be included.

vi) Draft report with Evaluation Status and Findings: The state must provide a narrative summary of the evaluation design, status (including evaluation activities and findings to date), and plans for evaluation activities during the extension period. The narrative is to include, but not be limited to, describing the hypotheses being tested and any results available.

vii) Demonstration of Public Notice 42 CFR §431.408: The state must provide documentation of the state's compliance with public notice process as specified in 42 CFR §431.408 including the post-award public input process described in 42 CFR §431.420(c) with a report of the issues raised by the public during the comment period and how the state considered the comments when developing the demonstration extension application.

8. **Demonstration Transition and Phase-Out.** The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

a) Notification of Suspension or Termination: The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The state must submit its notification letter and a draft phase-out plan to CMS no less than six (6) months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the state must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation State Plan Amendment. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment and how the state incorporated the received comment into a revised phase-out plan.

b) Plan Approval: The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.

c) Transition and Phase-out Plan Requirements: The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the

affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities and community resources that are available.

d) Phase-out Procedures: The state must comply with all notice requirements found in 42 CFR §§431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §§431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as found in 42 CFR § 435.916.

e) Exemption from Public Notice Procedures 42.CFR Section 431.416(g): CMS may expedite the federal and state public notice requirements in the event it determines that the objectives of Titles XIX and XXI would be served or under circumstances described in 42 CFR section 431.416(g).

f) Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

g) Post Award Forum: Within six months of the demonstration's implementation, and annually thereafter, the state will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state can use either its Medical Care Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of this STC. The state must include a summary of the comments and issues raised by the public at the forum and include the summary in the quarterly report, as specified in STC 27 associated with the quarter in which the forum was held. The state must also include the summary in its annual report as required in STC 27.

9. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the demonstration, in whole or in part, at any time before the date of expiration, whenever it determines following a hearing that the state has materially failed to comply with the terms of the project. CMS will promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date.

10. **Finding of Non-Compliance.** The state does not relinquish its rights to challenge the CMS finding that the state materially failed to comply with the terms of this agreement.

11. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of Title XIX.

CMS must promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and must afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authorities, including services and administrative costs of disenrolling participants.

12. **Adequacy of Infrastructure.** CMS and the state acknowledge while funding is subject to appropriation from the state legislature, the state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems applicable to the demonstration; compliance with cost sharing requirements to the extent they apply; and reporting on financial and other demonstration components.

13. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must continue to comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) and the tribal consultation requirements set out at section 1902(a)(73) of the Act as added by section 5006(e) of the American Recovery and Reinvestment Act (P.L. 111-5) and the tribal consultation requirements as outlined in the state's approved state plan, when any program changes to the demonstration, including (but not limited to) those referenced in STC 5, are proposed by the state. In states with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal, amendment and/or renewal of this demonstration. The state must also comply with the Public Notice Procedures set forth in 42 CFR §447.205 for changes in statewide methods and standards for setting payment rates.

14. **FFP.** No federal matching funds for expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter.

IV. ELIGIBILITY

15. **Use of Modified Adjusted Gross Income (MAGI) Based Methodologies.** The state must use the state's CMS-approved MAGI standard for determination of eligibility for the demonstration. Any other Medicaid State Plan Amendments to the eligibility standards and methodologies for these eligibility groups, or any future CMS-approved revisions to the state's MAGI standard taking place during the approval period will apply to this demonstration.

16. **Eligibility Requirements.** Family planning and family planning related services are provided to eligible individuals, provided the individual is redetermined eligible for the program on an annual basis. Additionally, the state will provide 12 month continuous eligibility, and not require reporting of changes in income or household size for this 12-month period, for an individual found to be income-eligible for this demonstration upon initial application or annual redetermination.

    Effective through December 31, 2017, the state must enroll only:

a. Women ages 19 through 55 losing Medicaid 60 days postpartum with incomes up to 141 percent of the Federal Poverty Level (FPL)(post Modified Adjust Gross Income (MAGI) conversion);

b. Women 19 -55 with incomes up to 141percent of the FPL who are not otherwise eligible for Medicaid; and

b. Men age of 21 with incomes up to 133 percent of the FPL for vasectomies.

17. **Redeterminations.** The state must ensure that redeterminations of eligibility for the demonstration are conducted at least every 12 months. At the state's option, redeterminations may be administrative in nature.

18. **Express Lane Eligibility.** The Medicaid State agency may rely on a finding from an Express lane agency when determining whether the individual satisfies one or more components of eligibility derived through the Demonstration at the time of initial determination and redetermination. All procedures outlined in the companion Medicaid Express Lane Eligibility State Plan Amendment must also apply to Express Lane eligibility determinations for the Demonstration population.

19. **Demonstration Disenrollment.** If a woman becomes pregnant while enrolled in the demonstration, she may be determined eligible for Medicaid under the state plan. The state must not submit claims under the demonstration for any woman who is found to be eligible under the Medicaid state plan. In addition, women who receive a sterilization procedure and complete all necessary follow-up procedures will be disenrolled from the demonstration.

V. BENEFITS AND DELIVERY SYSTEMS

20. **Family Planning Benefits.** Family planning services and supplies described in section 1905(a)(4)(C) and are limited to those services and supplies whose primary purpose is family planning and which are provided in a family planning setting. As the Plan First demonstration is limited to a specific category of benefits to treat specific medical conditions, the demonstration is not recognized as Minimum Essential Coverage (MEC) consistent with the guidance set forth in the State Health Official Letter #14-002, issued by CMS on November 7, 2014. Family planning services and supplies are reimbursable at the 90 percent matching rate, including:

a) Approved methods of contraception;

b) Sexually transmitted infection (STI)/sexually transmitted disease (STD) testing, Pap smears and pelvic exams. Laboratory tests done during an initial family planning visit for contraception include a Pap smear, screening tests for STIs/STDs, blood count and pregnancy test. Additional screening tests may be performed depending on the method of contraception desired and the protocol established by the clinic, program or provider. Additional laboratory tests may be needed to address a family planning problem or need during an inter-periodic family planning visit for contraception.

b) Drugs, supplies, or devices related to women's health services described above that are prescribed by a health care provider who meets the state's provider enrollment requirements (subject to the national drug rebate program requirements);

c) Contraceptive management, patient education, and counseling; and

d) Vasectomies for Men over the age of 21 with incomes up to 141 percent FPL.

21. **Family Planning-Related Benefits.** Family planning-related services and supplies are defined as those services provided as part of or as follow-up to a family planning visit and are reimbursable at the state's regular Federal Medical Assistance Percentage (FMAP) rate. Such services are provided because a "family planning-related" problem was identified and/or diagnosed during a routine or periodic family planning visit. Examples of family planning-related services and supplies include:

a) Colposcopy (and procedures done with/during a colposcopy) or repeat Pap smear performed as a follow-up to an abnormal Pap smear which is done as part of a routine/periodic family planning visit.

b) Drugs for the treatment of STIs/STDs, except for HIV/AIDS and hepatitis, when the STI/STD is identified/ diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/drugs and subsequent follow-up visits to rescreen for STIs/STDs based on the Centers for Disease Control and Prevention guidelines may be covered.

c) Drugs/treatment for vaginal infections/disorders, other lower genital tract and genital skin infections/disorders, and urinary tract infections, where these conditions are identified/diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/ drugs may also be covered.

d) Other medical diagnosis, treatment, and preventive services that are routinely provided pursuant to family planning services in a family planning setting. An example of a preventive service could be a vaccination to prevent cervical cancer.

e) Treatment of major complications arising from a family planning procedure such as:
   i) Treatment of a perforated uterus due to an intrauterine device insertion;
   ii) Treatment of severe menstrual bleeding caused by a Depo-Provera injection requiring a dilation and curettage; or
   iii) Treatment of surgical or anesthesia-related complications during a sterilization procedure.

22. **Primary Care Referrals.** Primary care referrals to other social service and health care providers as medically indicated are provided; however, the costs of those primary care services are not covered for enrollees of this demonstration. The state must facilitate access to primary care services for participants, and must assure CMS that written materials

concerning access to primary care services are distributed to demonstration participants. The written materials must explain to the participants how they can access primary care services.

23. **Services.** Services provided through this demonstration are paid fee for service (FFS).

VI. GENERAL REPORTING REQUIREMENTS

24. **General Financial Requirements.** The state must comply with all general financial requirements under Title XIX set forth in section VII.

25. **Reporting Requirements Relating to Budget Neutrality.** The state must comply with all reporting requirements for monitoring budget neutrality as set forth in section VIII.

26. **Monitoring Calls.** CMS and the state will participate in quarterly conference calls following the receipt of the quarterly reports unless CMS determines that more frequent calls are necessary to adequately monitor the demonstration. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Areas to be addressed include, but are not limited to, health care delivery, enrollment, quality of care, access, benefits, anticipated or proposed changes in payment rates, audits, lawsuits, financial reporting and budget neutrality issues, progress on evaluations, state legislative developments, and any demonstration amendments the state is considering submitting. The state and CMS will discuss quarterly expenditure reports submitted by the state for purposes of monitoring budget neutrality. CMS will update the state on any amendments under review as well as federal policies and issues that may affect any aspect of the demonstration. The state and CMS will jointly develop the agenda for the calls.

27. **Quarterly Operational Reports.** The state must submit progress reports no later than 60 days following the end of each quarter for every demonstration year (DY) within the format outlined in Appendix A. The intent of these reports is to present the state's data along with an analysis of the status of the various operational areas under the demonstration. These quarterly reports must include, but are not limited to:

    a) Quarterly expenditures for the demonstration population, with administrative costs reported separately;

    b) Quarterly enrollment reports for demonstration enrollees (enrollees include all individuals enrolled in the demonstration) that include the member months for each DY, as required to evaluate compliance with the budget neutral agreement and as specified in STC 35;

    c) Total number of participants served monthly during the quarter for each DY (participants include all individuals who obtain one or more covered family planning services through the demonstration);

    d) Events occurring during the quarter, or anticipated to occur in the near future that affect health care delivery, benefits, enrollment, systems, grievances, quality of care, access,

payment rates, pertinent legislative activity, eligibility verification activities, eligibility redetermination processes (including the option to utilize administrative redetermination), and other operational issues;

e) Notification of any changes in enrollment and/or participation that fluctuate 10 percent or more in relation to the previous quarter within the same DY and the same quarter in the previous DY;

f) Action plans for addressing any policy, administrative or budget issues identified;

g) An updated budget neutrality monitoring worksheet; and

h) Evaluation activities and interim findings.

i) Contraceptive Methods. Using the Contraceptive Methods chart in Appendix B, the Template for the Annual Report, report the number of each contraceptive method dispensed in the previous demonstration year and the number of unique contraceptive users. This data will be used to identify the number of unique beneficiaries who received a given method in the previous year.

28. **Annual Report.** The annual report is due 90 days following the end of the fourth quarter of each DY within the format outlined in Appendix B. The report must include a summary of the year's preceding activity as well as the following:

a) Total annual expenditures for the demonstration population for each DY, with administrative costs reported separately;

b) The average total Medicaid expenditures for a Medicaid-funded birth each DY. The cost of a birth includes prenatal services and delivery and pregnancy-related services and services to infants from birth up to age 1 (the services should be limited to the services that are available to women who are eligible for Medicaid because of their pregnancy and their infants);

c) The number of actual births that occur to family planning demonstration participants within the DY. (participants include all individuals who obtain one or more covered medical family planning services through the family planning program each year);

d) Yearly enrollment reports for demonstration enrollees for each DY (enrollees include all individuals enrolled in the demonstration) that include the member months, as required to evaluate compliance with the budget neutral agreement and as specified in STC 34

e) Total number of participants for the DY (participants include all individuals who obtain one or more covered family planning services through the demonstration);

f) A summary of program integrity and related audit activities for the demonstration, including an analysis of point-of-service eligibility procedures;

g) Evaluation activities and interim findings; and

h) An updated budget neutrality monitoring worksheet.

29. **Final Report.** The state must submit a final demonstration report to CMS to describe the impact of the demonstration, including the extent to which the state met the goals of the demonstration. The draft report will be due to CMS 180 days after the expiration of the demonstration. CMS must provide comments within 60 days of receipt of the draft final demonstration report. The state must submit a final demonstration report within 60 days of receipt of CMS comments.

VII. GENERAL FINANCIAL REQUIREMENTS

30. **Quarterly Expenditure Reports.** The state must provide quarterly expenditure reports using the Form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS must provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section VIII.

31. **Reporting Expenditures Subject to the Title XIX Budget Neutrality Agreement.** The following describes the reporting of expenditures subject to the budget neutrality limit:

    a) Tracking Expenditures. In order to track expenditures under this demonstration, Alabama must report demonstration expenditures through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES); following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual. All demonstration expenditures claimed under the authority of Title XIX of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS, including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made.

    b) Cost Settlements. For monitoring purposes, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any other cost settlements not attributable to this demonstration, the adjustments should be reported on lines 9 or 10C as instructed in the State Medicaid Manual.

    c) Use of Waiver Forms. The state must report demonstration expenditures on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver each quarter to report Title XIX expenditures for demonstration services.

32. **Title XIX Administrative Costs.** Administrative costs will not be included in the budget

neutrality agreement, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the Forms CMS-64.10.

33. **Claiming Period.** All claims for expenditures subject to the budget neutrality agreement (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

34. **Reporting Member Months.** The following describes the reporting of member months for the demonstration:

    a. For the purpose of calculating the budget neutrality expenditure limit, the state must provide to CMS, as part of the quarterly and annual reports as required under STC 27 and 28 respectively, the actual number of eligible member months for all demonstration enrollees. The state must submit a statement accompanying the quarterly and annual reports, certifying the accuracy of this information.

    b. The term "eligible member months" refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months each contribute two eligible member months to the total, for a total of four eligible member months.

35. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the demonstration. The state must estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

36. **Extent of Federal Financial Participation (FFP) for the Demonstration.** CMS shall provide FFP for family planning and family planning-related services and supplies at the applicable federal matching rates described in STC 20 and 21, subject to the limits and processes described below:

a) For family planning services, reimbursable procedure codes for office visits, laboratory tests, and certain other procedures must carry a primary diagnosis or a modifier that specifically identifies them as a family planning service.

b) Allowable family planning expenditures eligible for reimbursement at the enhanced family planning match rate, as described in STC 20, should be entered in Column (D) on the Forms CMS-64.9 Waiver.

c) Allowable family planning-related expenditures eligible for reimbursement at the FMAP rate, as described in STC 21, should be entered in Column (B) on the Forms CMS-64.9 Waiver.

d) FFP will not be available for the costs of any services, items, or procedures that do not meet the requirements specified above, even if family planning clinics or providers provide them. For example, in the instance of testing for STIs as part of a family planning visit, FFP will be available at the 90 percent federal matching rate. The match rate for the subsequent treatment would be paid at the applicable federal matching rate for the state. For testing or treatment not associated with a family planning visit, no FFP will be available.

e) Pursuant to 42 CFR 433.15(b)(2), FFP is available at the 90 percent administrative match rate for administrative activities associated with administering the family planning services provided under the demonstration including the offering, arranging, and furnishing of family planning services. These costs must be allocated in accordance with OMB Circular A-87 cost allocation requirements. The processing of claims is reimbursable at the 50 percent administrative match rate.

37. **Sources of Non-Federal Share.** The state must certify that matching the non-federal share of funds for the demonstration are state/local monies. The state further certifies that such funds must not be used to match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

    a) CMS shall review the sources of the non-federal share of funding for the demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS must be addressed within the time frames set by CMS.

    b) Any amendments that impact the financial status of the program must require the state to provide information to CMS regarding all sources of the non-federal share of funding.

38. **State Certification of Funding Conditions.** The state must certify that the following conditions for non-federal share of demonstration expenditures are met:

a) Units of government, including governmentally operated health care providers, may certify that state or local tax dollars have been expended as the non-federal share of funds under the demonstration.

b) To the extent the state utilizes certified public expenditures (CPEs) as the funding mechanism for Title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under Title XIX (or under section 1115 authority) for purposes of certifying public expenditures.

c) To the extent the state utilizes CPEs as the funding mechanism to claim federal match for payments under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such tax revenue (state or local) used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match.

d) The state may use intergovernmental transfers to the extent that such funds are derived from state or local tax revenues and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of Title XIX payments. Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between health care providers and state and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, (including health care provider-related taxes), fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

39. **Monitoring the Demonstration.** The state must provide CMS with information to effectively monitor the demonstration, upon request, in a reasonable time frame.

VIII. MONITORING BUDGET NEUTRALITY

40. **Limit on Title XIX Funding.** The state shall be subject to a limit on the amount of federal Title XIX funding it may receive on selected Medicaid expenditures during the period of approval of the demonstration. The budget neutrality expenditure targets are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. Actual expenditures subject to budget neutrality expenditure limit shall be reported by the state using the procedures described in STC 30.

41. **Risk.** Alabama shall be at risk for the per capita cost (as determined by the method described below in this section) for the Medicaid family planning enrollees, but not for the number of demonstration enrollees. By providing FFP for enrollees in this eligibility group, Alabama

shall not be at risk of changing economic conditions that impact enrollment levels. However, by placing Alabama at risk for the per capita costs for enrollees in the demonstration, CMS assures that federal demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no demonstration.

42. **Budget Neutrality Annual Expenditure Limits.** For each DY, an annual budget limit will be calculated for the demonstration. For the purposes of this demonstration, the DY is based off the calendar year (CY) of January 1 to December 31. The budget limit is calculated as the projected per member/per month (PMPM) cost times the actual number of member months for the demonstration multiplied by the Composite Federal Share.

PMPM Cost. The following table gives the PMPM (Total Computable) costs for the calculation described above by DY. The PMPM cost was constructed based on state expenditures for DY 14 and increased by the rate of growth included in the President's federal fiscal year 2015 budget for DYs 15 through 17 as outlined below.

		CY 2015	CY 2016	CY 2017
	Trend	DY 15	DY 16	DY 17
Demonstration Enrollees	5.0 %	$42.10	$40.48	$38.93

a) Composite Federal Share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period, as reported on the forms listed in STC 30 above, by total computable demonstration expenditures for the same period as reported on the same forms. Should the demonstration be terminated prior to the end of the approval period (see STCs 8 and 9), the Composite Federal Share will be determined based on actual expenditures for the period in which the demonstration was active. For the purpose of interim monitoring of budget neutrality, a reasonable Composite Federal Share may be used.

b) Structure. The demonstration is structured as a "pass-through" or "hypothetical" population. Therefore, the state may not derive savings from the demonstration.

c) Application of the Budget Limit. The budget limit calculated above will apply to demonstration expenditures, as reported by the state on the CMS-64 forms. If at the end of the demonstration period, the costs of the demonstration services exceed the budget limit, the excess federal funds will be returned to CMS.

43. **Future Adjustments to the Budget Neutrality Expenditure Limit.** CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under the demonstration.

44. **Enforcement of Budget Neutrality.** CMS will enforce budget neutrality over the life of the demonstration, rather than annually. However, no later than 6 months after the end of each DY or as soon thereafter as the data are available, the state will calculate annual expenditure targets for the completed year. This amount will be compared with the actual claimed FFP for Medicaid. Using the schedule below as a guide, if the state exceeds these targets, it will submit a corrective action plan to CMS for approval. The state will subsequently implement the approved corrective action plan.

Year	Cumulative Target Expenditures	Percentage
DY 2015	DY 10 budget limit amount	+2 percent
DY 2016	DYs 10 through 11 combined budget limit amount	+1.5 percent
DY 2017	DYs 11 through 12 combined budget limit amount	+0 percent

Failure to Meet Budget Neutrality Goals. The state, whenever it determines that the demonstration is not budget neutral or is informed by CMS that the demonstration is not budget neutral, must immediately collaborate with CMS on corrective actions, which must include submitting a corrective action plan to CMS within 21 days of the date the state is informed of the problem. While CMS will pursue corrective actions with the state, CMS will work with the state to set reasonable goals that will ensure that the state is in compliance.

IX. EVALUATION

45. **Submission of Draft Evaluation Design.** A draft evaluation design report must be submitted to CMS for approval within 120 days from the award of the demonstration extension. At a minimum, the evaluation design should include a detailed analysis plan that describes how the effects of the demonstration will be isolated from those of other initiatives occurring in the state. The evaluation must include an analysis of the costs and benefits of the utilization of point-of-service eligibility. The report should also include an integrated presentation and discussion of the specific hypotheses (including those that focus specifically on the target population for the demonstration) that are being tested. The report will also discuss the outcome measures that will be used in evaluating the impact of the demonstration, particularly among the target population. It will also discuss the data sources and sampling methodology for assessing these outcomes. The state must implement the evaluation design and report its progress in each of the demonstration's quarterly and annual reports.

46. **Final Evaluation Plan and Implementation.** CMS shall provide comments on the draft design within 60 days of receipt, and the state must submit a final plan for the overall evaluation of the demonstration described in STC 44, within 60 days of receipt of CMS comments.

X. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION

Timeline	Deliverable	STC Reference
Within 120 days from the award of the demonstration	Submit Draft Evaluation Design	Section IX, STC 44
Within 60 days receipt of CMS comments	Submit Final Evaluation Plan	Section IX, STC 45
Annually within 90 days following the end of the 4th quarter for each DY	Submit Annual Report	Section VI, STC 27
Quarterly within 60 days following the end of each quarter	Submit Quarterly Operational Reports	Section VI, STC 26
Within 180 days after the expiration of the demonstration	Submit Draft Final Report	Section VI, STC 28
60 days receipt of CMS comments	Submit Final Report	Section VI, STC 28

APPENDIX A: Template for Quarterly Operational Report

[Insert Name of Demonstration]
Section 1115 Quarterly Report
Demonstration Year, Quarter X
Fiscal Quarter
Date Submitted

Introduction
Narrative on a brief introduction of demonstration, provide historical background from previous demonstration years and trends.

Executive Summary
- *Brief description of demonstration populations*
- *Goal of demonstration (list out)*
- *Program highlights* (e.g. summary of benefits provided to the demonstration population)

(Fill in chart- Indicate when each quarter begins and when it ends, see example below)

Demonstration Year (DY)	Begin Date	End Date	Quarterly Report Due Date (60 days following end of quarter)
Quarter 1			
Quarter 2			
Quarter 3			
Quarter 4			

- *Significant program changes*
  - Narrative describing any administrative and operational changes to the demonstration, such as eligibility and enrollment processes, eligibility redetermination processes (including the option to utilize administrative redetermination), systems, health care delivery, benefits, quality of care, anticipated or proposed changes in payment rates, and outreach changes; and
  - Narrative on any noteworthy demonstration changes, such as changes in enrollment, service utilization, education and outreach, and provider participation. Discussion of any action plan if applicable.

- *Policy issues and challenges*
  - Narrative providing an overview of any policy issues the state is considering, including pertinent legislative/budget activity and potential demonstration amendments; and
  - Discussion of any action plans addressing any policy, administrative or budget issues identified, if applicable.

Enrollment

- Provide narrative on observed trends and explanation of data. As per STC 27, the state must include a narrative of any changes in enrollment and/or participation that fluctuate 10 percent or more in relation to the previous quarter with the same demonstration year (DY) and the same quarter in the previous DY.

- Enrollment figures- Please utilize the chart below to provide data on the enrollees and participants within the demonstration in addition to member months. The chart should provide information to date, over the lifetime of the demonstration extension.
    - As outlined in STCs 27 and 34,

        1. Enrollees are defined as all individuals enrolled in the demonstration,
            - The number of newly enrolled should reflect the number of individuals enrolled for the quarter reported.
            - The number of total enrollees should reflect the total number of individuals enrolled for the current DY.

        2. Participants are defined as all individuals who obtain one or more covered family planning services through the demonstration, and

        3. Member months refer to the number of months in which persons enrolled in the demonstration are eligible for services. For example, a person who is eligible for 3 months contributes to 3 eligible member months to the total.

    - This demonstration has three eligible populations, as described in STC 16.

      *Population 1: **XXXXX***.

      *Population 2: **XXXXX***.

      Population 3: ***XXXXX***.

DY 12: 2014	**Quarter 1 (fill in quarter dates)**				**Quarter 2 (fill in quarter dates)**			
	Population 1	Population 2	Population 3	Total Population	Population 1	Population 2	Population 3	Total Population
# of Newly enrolled								
# of Total Enrollees								
# of Participants								
# of Member Months								

DY 12: 2014	**Quarter 3**	**Quarter 4**

	(fill in quarter dates)				(fill in quarter dates)			
	Population 1	Population 2	Population 3	Total Population	Population 1	Population 2	Population 3	Total Population
# of Newly enrolled								
# of Total Enrollees								
# of Participants								
# of Member Months								

DY 13: 2015	**Quarter 1 (fill in quarter dates)**				**Quarter 2 (fill in quarter dates)**			
	Population 1	Population 2	Population 3	Total Population	Population 1	Population 2	Population 3	Total Population
# of Newly enrolled								
# of Total Enrollees								
# of Participants								
# of Member Months								

DY 13: 2015	**Quarter 3 (fill in quarter dates)**				**Quarter 4 (fill in quarter dates)**			
	Population 1	Population 2	Population 3	Total Population	Population 1	Population 2	Population 3	Total Population
# of Newly enrolled								
# of Total Enrollees								
# of Participants								
# of Member Months								

DY 14: 2016	**Quarter 1 (fill in quarter dates)**	**Quarter 2 (fill in quarter dates)**

	Population 1	Population 2	Population 3	Total Population	Population 1	Population 2	Population 3	Total Population
# of Newly enrolled								
# of Total Enrollees								
# of Participants								
# of Member Months								

DY 14: 2016	**Quarter 3 (fill in quarter dates)**				**Quarter 4 (fill in quarter dates)**			
	Population 1	Population 2	Population 3	Total Population	Population 1	Population 2	Population 3	Total Population
# of Newly enrolled								
# of Total Enrollees								
# of Participants								
# of Member Months								

Service and Providers

- *Service Utilization*
  - Provide a narrative on trends observed with service utilization. Please also describe any changes in service utilizations or change to the demonstration's benefit package.

- *Provider Participation*
  - Provide a narrative on the current provider participation in point-of-service eligibility during this quarter highlighting any current or expected changes in provider participation, planned eligibility provider outreach and implication for health care delivery.
  - Provide a narrative on the current provider participation in rendering services during this quarter highlighting any current or expected changes in provider participation, planned provider outreach and implications for health care delivery.

Program Outreach Awareness and Notification

- *General Outreach and Awareness*
  - Provide information on the public outreach activities conducted this quarter; and
  - Provide a brief assessment on the effectiveness of outreach programs.

- *Target Outreach Campaign(s) (if applicable)*

- Provide a narrative on who the targeted populations for these outreaches are, and reasons for targeted outreach; and
- Provide a brief assessment on the effectiveness of the targeted outreach program(s).

Program Evaluation, Transition Plan and Monitoring

- Identify any quality assurance and monitoring activities in current quarter. Also, please discuss program evaluation activities and interim findings;

- Provide a narrative of any feedback and grievances made by beneficiaries, providers and the public, including any public hearings or other notice procedures, with a summary of the state's response or planned response.

Quarterly Expenditures

- The state is required to provide quarterly expenditure reports using the Form CMS-64 to report expenditures for services provided under the demonstration in addition to administrative expenditures. Please see Section VII of the STCs for more details.

- Please utilize the chart below to include expenditure data, as reported on the Form CMS-64. Provide information to date, over the lifetime of the demonstration extension.

	Demonstration Year 12 (fill in dates)			
	Service Expenditures as Reported on the CMS-64	Administrative Expenditures as Reported on the CMS-64	Total Expenditures as Reported on the CMS-64	Expenditures as requested on the CMS- 37
Quarter 1 Expenditures				
Quarter 2 Expenditures				
Quarter 3 Expenditures				
Quarter 4 Expenditures				
Total Annual Expenditures				

	Demonstration Year 13

	(fill in dates)			
	Service Expenditures as Reported on the CMS -64	Administrative Expenditures as Reported on the CMS -64	Total Expenditures as Reported on the CMS -64	Expenditures as requested on the CMS- 37
Quarter 1 Expenditures				
Quarter 2 Expenditures				
Quarter 3 Expenditures				
Quarter 4 Expenditures				
Total Annual Expenditures				

	Demonstration Year 14 (fill in dates)			
	Service Expenditures as Reported on the CMS -64	Administrative Expenditures as Reported on the CMS -64	Total Expenditures as Reported on the CMS -64	Expenditures as requested on the CMS- 37
Quarter 1 Expenditures				
Quarter 2 Expenditures				
Quarter 3 Expenditures				
Quarter 4 Expenditures				
Total Annual Expenditures				

Activities for Next Quarter

- Provide details and report on any anticipated activities for next quarter.

APPENDIX B: Template for Annual Report

State
Name of Demonstration
Section 1115 Annual Report
Demonstration Year, Annual Report (list dates covered)
Fiscal Year
Date Submitted

*****Please include a cover page and a table of contents***

Introduction
Narrative on a brief introduction of demonstration, provide historical background, such as amendment changes, extension request and dates of CMS approvals.

Executive Summary

- *Brief description of demonstration population*
- *Goal of demonstration* (list out)
- *Program highlights* (e.g. summary of benefits provided to the demonstration population)

Demonstration Year	Begin Date	End Date	Annual Report Due Date (90 days following end of Annual date)

(Fill in chart- Indicate when each annual year begins and when it ends, see example below)

- *Significant program changes from previous demonstration years*
  - Narrative describing any administrative and operational changes to the demonstration, such as eligibility and enrollment processes, eligibility redetermination processes (including the option to utilize administrative redetermination), systems, health care delivery, benefits, quality of care, anticipated or proposed changes in payment rates, and outreach changes; and
  - Narrative on any noteworthy demonstration changes, such as changes in enrollment, service utilization, education and outreach, and provider participation. Please include a description of action plan if applicable.

- *Policy issues and challenges*
  - Brief narrative on noteworthy policy issues and challenges from previous Demonstration years and actions if applicable;
  - Narrative providing an overview of any policy issues the state has dealt with in the reporting year, including pertinent legislative/budget activity and potential demonstration amendments;

- Discussion of any action plans addressing any policy, administrative or budget issues identified, if applicable; and
- Narrative on any budget neutrality issues the state has identified. Please include a description of action plan if applicable.

Enrollment and Renewal

- Enrollment figures- Please utilize the chart below to provide data on the enrollees and participants within the demonstration in addition to member months. The chart should provide information to date, over the lifetime of the demonstration extension.
  - As outlined in STCs 28 and 34,
    1. Enrollees are defined as all individuals enrolled in the demonstration,
       i. The number of newly enrolled should reflect the number of individuals enrolled for the quarter reported.
       ii. The number of total enrollees should reflect the total number of individuals enrolled for the current DY.
    2. Participants are defined as all individuals who obtain one or more covered family planning services through the demonstration
    3. Member months refers to the number of months in which persons enrolled in the demonstration are eligible for services. For example, a person who is eligible for 3 months contributes to 3 eligible member months to the total.

  - This demonstration has three eligible populations, as described in STC 16.

    Population 1: ***XXXXX***

    Population 2: ***XXXXX***

    Population 3: ***XXXXX***

	Demonstration Year 12 (fill in dates)			
	Population 1	Population 2	Population 3	Total Demonstration Population
# of Total Enrollees				
# of Participants				
# of Member Months				

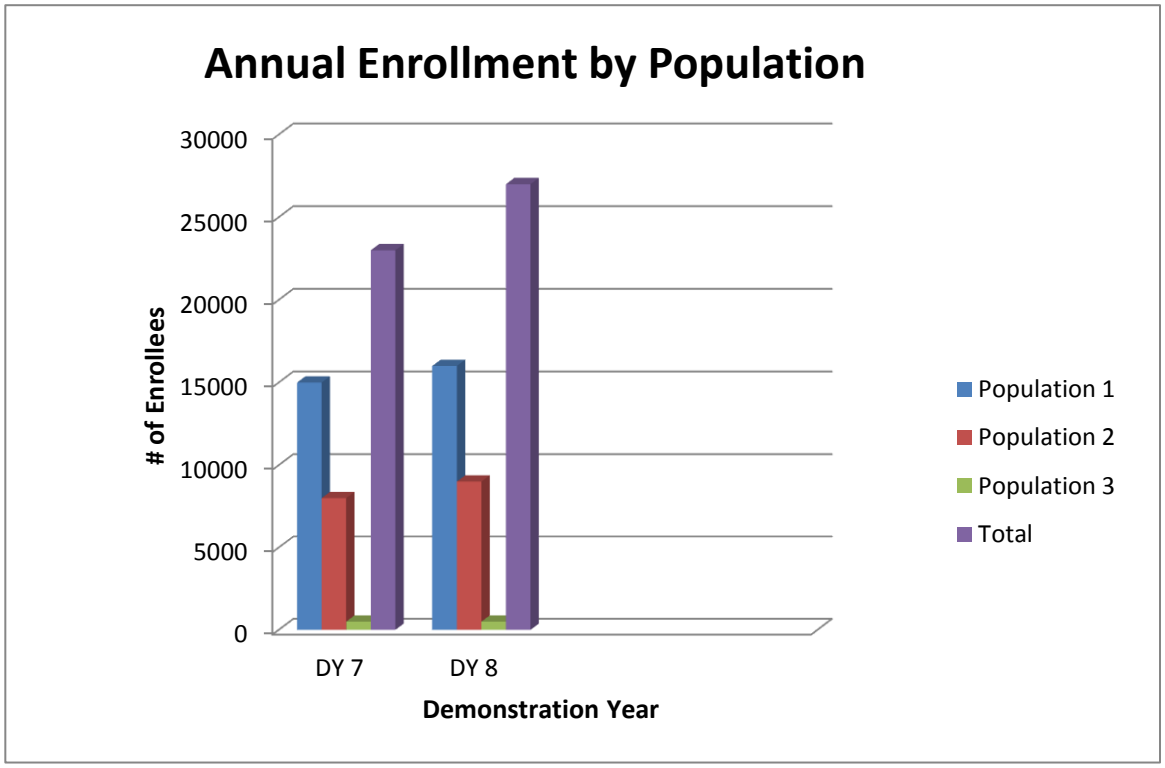
	Demonstration Year 13 (fill in dates)			
	Population 1	Population 2	Population 3	Total Demonstration Population
# of Total Enrollees				
# of Participants				
# of Member Months				

	Demonstration Year 14 (fill in dates)			
	Population 1	Population 2	Population 3	Total Demonstration Population
# of Total Enrollees				
# of Participants				
# of Member Months				

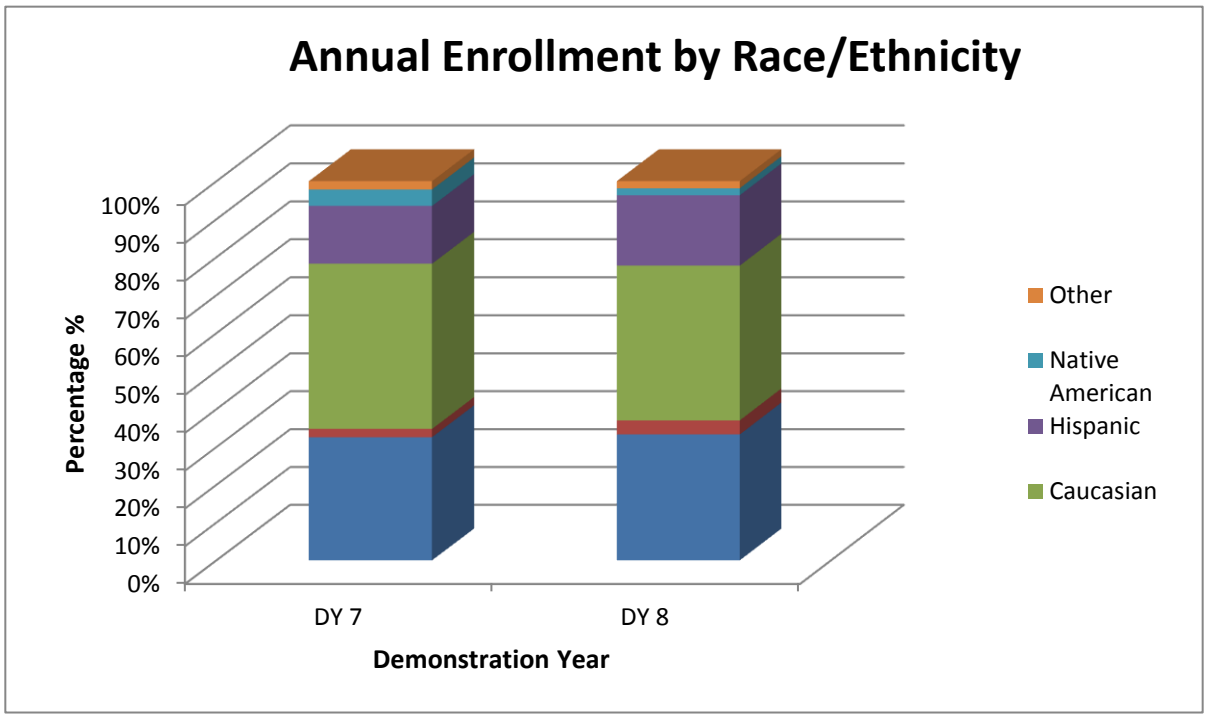
- Provide narrative on observed trends and analysis of data, including any proposed actions for improvement. As per STCs 27 and 28, the state must include a narrative of any changes in enrollment and/or participation that fluctuate 10 percent or more in relation to the previous demonstration year (DY). Also discuss actions identified that could improve enrollment numbers, if applicable.

- Provide graphs/charts for the data indicated below (***samples of the graph structure are included):***

  1) Annual enrollment by population for each demonstration year over the lifetime of the demonstration.

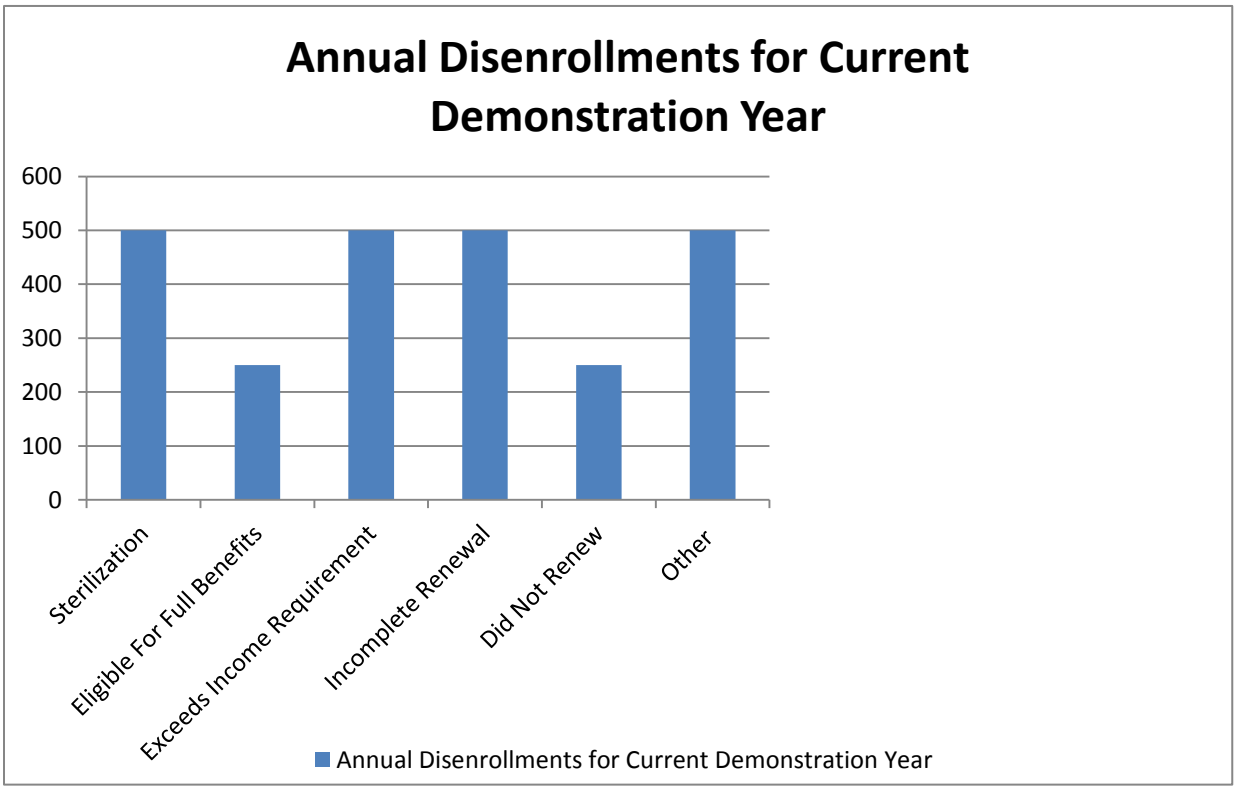


2) It is the state's option to provide graphs and analysis of annual enrollment by characteristics, such as race/ethnicity, and age. Two examples of such information is included below.



	African American (Enrollees/ Percentage %)	Asian American	Caucasian	Hispanic	Native American	Other	Total enrollees
DY 9	7500(32.6%)	500 (2.17%)	10000(43.4%)	3500(15.2%)	1000(4.34%)	500(2.17%)	23000
DY 10	9000(33.3%)	1000(3.70%)	11000(40.7%)	5000(18.5%)	500(1.85%)	500(1.85%)	27000
DY 11							

3) Annual Disenrollment and Retention figures
   - Discuss the current demonstration year's retention and disenrollment figures, including top reasons for disenrollment, compared to last demonstration year and trends observed throughout the current demonstration year's quarters.
   - Provide charts/graphs to illustrate the data, please see examples below on disenrollment figures.

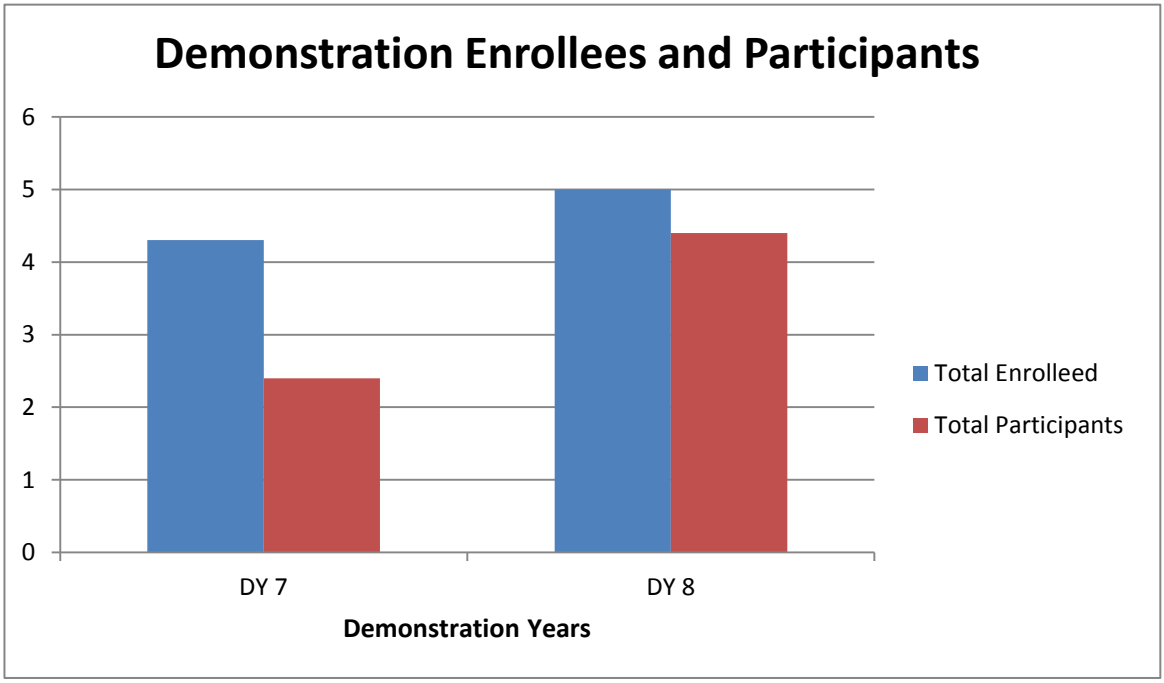


	Sterilization (Enrollees/ Percentage %)	Eligible for Full Benefits	Exceeds income requirement	Incomplete Renewal	Did not Renew	Other	Total Disenrollment Numbers
DY 9	500(20.0%)	250(10.0%)	500(20.0%)	500(20.0%)	250(10.0%)	500(20.0%)	2500
DY 10	500(16.67%)	750(25%)	500(16.67%)	250(8.33%)	500(16.7%)	500(16.7%)	3000
DY 11							

Service and Providers

- *Service Utilization*
  - Provide a narrative on trends observed with family planning and family planning-related services and supplies utilization. Please also describe any changes in service utilizations or change to the demonstration's benefit package. Provide any relevant charts/graphs illustrating data found.

  - Provide a cumulative graph highlighting the enrollees and participants over the lifetime of the demonstration.



- *Provider Participation*
  - Provide a narrative on the current provider participation in point-of-service eligibility during this quarter highlighting any current or expected changes in provider participation, planned eligibility provider outreach and implication for health care delivery.
  - Provide a narrative on the current provider participation in rendering services during this demonstration year highlighting any current or expected changes in

provider participation, planned provider outreach and implications for health care delivery.

Program Outreach Awareness and Notification

- *General Outreach and Awareness*
  - Provide information on the public outreach activities conducted this demonstration year, and
  - Provide a brief assessment on the effectiveness of outreach programs throughout the demonstration Year.

- *Target Outreach Campaign(s) (if applicable)*
  - Provide a narrative on who the targeted populations for these outreaches are, and reasons for targeted outreach,
  - Provide a brief assessment on the effectiveness of the targeted outreach program(s); and
  - Describe any trends observed and any identified actions that could improve the outreach programs.

Program Evaluation, Transition Plan and Monitoring

- A summary of program integrity and related audit activities for the demonstration, including an analysis of point-of-service eligibility procedures;

- Identify any quality assurance and monitoring activities in current quarter. Also, please discuss program evaluation activities and interim findings; and

- Provide a narrative of any feedback and grievances made by beneficiaries, providers and the public, including any public hearings or other notice procedures, with a summary of the state's response or planned response.

Provide an Interim Evaluation of Goals and Progress

Goal 1:
Progress Update:

Goal 2:
Progress Update:

Goal 3:
Progress Update:

Annual Expenditures

- The state is required to provide quarterly expenditure reports using the Form CMS-64 to report expenditures for services provided under the demonstration in addition to administrative expenditures. Please see Section VII of the STCs for more details.

- Please utilize the chart below to include this expenditure data, as reported on the Form CMS-64. The chart should provide information to date, over the lifetime of the demonstration extension.

	Service Expenditures as reported on the CMS-64		Administrative Expenditures as reported on the CMS-64		Expenditures as requested on the CMS-37	Total Expenditures as reported on the CMS-64
	Total Computable	Federal Share	Total Computable	Federal Share		
Demonstration Year 12						
Demonstration Year 13						
Demonstration Year 14						

	Demonstration Year 12 (fill in dates)			
	Population 1	Population 2	Population 3	Total Demonstration Population
# Member Months				
PMPM				
Total Expenditures *(Member months multiplied by PMPM)*				

	Demonstration Year 13 (fill in dates)			
	Population 1	Population 2	Population 3	Total Demonstration Population
# Member Months				
PMPM				
Total Expenditures *(Member months multiplied by PMPM)*				

	Demonstration Year 14 (fill in dates)			
	Population 1	Population 2	Population 3	Total Demonstration Population
# Member Months				
PMPM				
Total Expenditures				

(Member months multiplied by PMPM)				

Actual Number of Births to Demonstration Population

- Provide the number of actual births that occur to family planning demonstration participants within the DY over the lifetime of the demonstration (participants include all individuals who obtain one or more covered family planning services each year).

	# of Births to Demonstration Participants
Demonstration Year 12	
Demonstration Year 13	
Demonstration Year 14	

Cost of Medicaid Funded Births

- For each demonstration year, provide the average total Medicaid expenditures for a Medicaid-funded birth. The cost of a birth includes prenatal services and delivery and pregnancy-related services and services to infants from birth up to age 1 (the services should be limited to the services that are available to women who are eligible for Medicaid because of their pregnancy and their infants);

Activities for Next Year

- Report on any anticipated activities for next year.

Contraceptive Methods

- Please insert the state name, demonstration year, and start and end dates for the demonstration year into the chart below. Using this chart, please indicate the *number of each contraceptive method dispensed* in the previous demonstration year. If a state did not receive any claims for a specific contraceptive method in the last year, enter a zero ("0"). If a state does not cover a specific method under its demonstration, enter not applicable ("N/A"). The *number of unique contraceptive users* should identify the number of unique beneficiaries who received a given method in the previous year. The *data source* column should specify the type of data used to describe the specified contraceptive method (i.e., MMIS data, claims data, chart review, etc.).

STATE Family Planning Demonstration – Contraceptive Methods			
Demonstration Year X (MM/DD/YY – MM/DD/YY)			
	Number of contraceptive method dispensed	Number of unique contraceptive users	Data source
Male Condom			
Female Condom			
Sponge			
Diaphragm			
Pill			

Patch			
Ring			
Injectable			
Implant			
IUD			
Emergency Contraception			
Sterilization			

CENTERS FOR MEDICARE & MEDICAID SERVICES

EXPENDITURE AUTHORITY

NUMBER: **11 -W-00 133/4**

TITLE: **Alabama Plan First Section 1115 Family Planning Demonstration**

AWARDEE: **Alabama Medicaid Agency**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by Alabama for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period of this demonstration extension, be regarded as expenditures under the state's Title XIX plan. All requirements of the Medicaid statute will be applicable to such expenditure authorities (including adherence to income and eligibility system verification requirements under section 1137(d) of the Act), except those specified below as not applicable to these expenditure authorities.

The following expenditure authorities and the provisions specified as "not applicable" enable Alabama to operate its demonstration effective January 1, 2015 through December 31, 2017, unless otherwise stated.

Effective through December 31, 2017, expenditures for extending Medicaid eligibility for family planning and family planning-related services, subject to an annual redetermination, to:

1. Women ages 19 through 55 losing Medicaid 60 days postpartum with incomes up to 141 percent of the Federal Poverty Level (FPL) (post Modified Adjust Gross Income (MAGI) conversion);

2. Women ages 19 through 55 with incomes up to 141 percent of the FPL who are not otherwise eligible for Medicaid; and

3. Men age of 21 with incomes up to 141 percent of the FPL (post MAGI conversion) for vasectomies.

Medicaid Requirements Not Applicable to the Medicaid Expenditure Authorities:

All Medicaid requirements apply, except the following:

1. Methods of Administration: Transportation **Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53**

To the extent necessary to enable the state to not assure transportation to and from providers for the demonstration population.

2. Amount, Duration, and Scope of Services (Comparability) Section 1902(a)(10)(B)

To the extent necessary to allow the state to offer the demonstration population a benefit package consisting only of family planning services and family planning-related services.

3. Retroactive Coverage Section 1902(a)(34)

To the extent necessary to enable the state to not provide medical assistance to the demonstration population for any time prior to when an application for the demonstration is made.

4. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Section 1902(a)(43)(A)

To the extent necessary to enable the state to not furnish or arrange for EPSDT services to the demonstration populations.

5. Eligibility Procedures and Standards Section 1902(a)(17)

To the extent necessary to enable the state to use Express Lane eligibility determinations and redeterminations, for the demonstration populations.

PLAN FIRST VOLUME INDICATORS REPORT

	FY 2015- Qtr 1	FY 2015 -Qtr 2	FY 2015 -Qtr 3	FY 2015 Qtr 4	FY 2015	Fy 2016 - Qtr 1	Fy 2016 - Qtr 2	Fy 2016 -Qtr 3	Fy 2016 - Qtr 4	**FY 2016**
Volume Indicators	**Oct-Dec 14**	**Jan-Mar15**	**April-June15**	**JUL-SEPT15**	**Year End**	**Oct-Dec 15**	**Jan-Mar16**	**April-June16**	**JUL-SEPT 16**	**Year End**
1. # of contacts for recruitment	2598	3245	2530	2313	10686	2017	3013	2579	2597	10206
2. Updduplicated count of patients	17,977	18,789	16,818	15,632	69216	13,848	15,501	14,255	12,588	56192
3. All care coordination contacts	39,815	41,118	36,749	38,378	156060	35,062	34,070	35,404	36,393	140929
4. Total # of assessments	6,222	15,802	8,405	5,802	36231	4,499	9,576	6,709	5,324	26108
5. # of low-risk assessments	2,783	8,785	3,960	2,579	18107	1,952	3,835	2,654	1,957	10398
6. # of high-risk assessments	3,439	7,017	4,445	3,223	18124	2,547	5,741	4,055	3,367	15710
7. # of pts refusing c/c & cases closed	2,419	2,377	2,356	2,301	9453	2,379	2,388	2,503	2,146	9416
8. # of audits	855	907	843	755	3360	775	775	798	756	3104
9. State compliance rate	99	99	99	99	396	99	99	99	99	396
10. # of grievances/complaints	0	0	0	0	0	0	0	0	0	0
11. # of unresolved grievances/complaints	0	0	0	0	0	0	0	0	0	0

PlanFirst Care Coordination 4th Quarter FY2016

Area/County	Recruitment	Unduplicated Patients	Face to Face	Phone	Documentation	Total Assessments	Low-Risk Assessments	High-Risk Assessments	Cases Closed	Record Reviews Complete	Complaints/Grievances Resolved	Unresolved
AREA I												
Colbert (17)	62	310	72	0	704	148	79	69	54	13		
Franklin (30)	28	164	64	0	742	47	16	31	36	9		
Lauderdale (39)	131	415	98	0	1,256	229	88	141	72	16		
Marion (47)	26	124	10	0	237	68	41	27	35	8		
Walker (64)	81	288	117	0	1,121	127	44	83	58	15		
Winston (67)	9	58	6	0	131	26	17	9	14	8		
TOTAL:	**337**	**1,359**	**367**	**0**	**4,191**	**645**	**285**	**360**	**269**	**69**	**0**	**0**
AREA II												
Cullman (22)	61	142	11	0	408	92	29	63	16	10		
Jackson (36)	17	88	11	0	287	29	8	21	18	10		
Lawrence (40)	23	103	9	0	237	52	28	24	16	8		
Limestone (42)	30	138	0	0	195	70	33	37	17	10		
Madison (45)	37	185	0	0	235	139	93	46	2	11		
Marshall (48)	47	208	12	0	646	94	45	49	33	10		
Morgan (52)	59	239	16	0	437	141	80	61	40	10		
TOTAL:	**274**	**1,103**	**59**	**0**	**2,445**	**617**	**316**	**301**	**142**	**69**	**0**	**0**
AREA III												
Bibb (04)	14	104	17	0	383	31	7	24	19	10		
Fayette (29)	16	89	47	0	248	23	2	21	9	5		
Greene (32)	8	63	27	0	219	12	2	10	9	7		
Lamar (38)	13	76	5	0	264	27	8	19	6	10		
Pickens (54)	24	120	51	0	278	47	22	25	26	10		
Tuscaloosa (63)	91	676	263	0	1,729	207	66	141	131	20		
TOTAL:	**166**	**1,128**	**410**	**0**	**3,121**	**347**	**107**	**240**	**200**	**62**	**0**	**0**

AREA IV												
Jefferson (37)						0						
Total:	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
AREA V												
Blount (05)	35	125	6	0	418	55	20	35	18	10		
Cherokee (10)	22	125	52	0	383	30	6	24	19	10		
DeKalb (25)	30	241	81	0	1,299	58	5	53	40	15		
Etowah (28)	68	527	42	0	1,109	204	78	126	73	20		
St. Clair (58)	56	166	24	0	584	94	32	62	37	10		
Shelby (59)	45	162	5	0	388	114	59	55	21	20		
TOTAL:	**256**	**1,346**	**210**	**0**	**4,181**	**555**	**200**	**355**	**208**	**85**	**0**	**0**
AREA VI												
Calhoun (08)	88	399	127	0	828	223	111	112	87	30		
Chambers (09)	38	247	141	0	753	73	26	47	27	12		
Clay (14)	0	46	0	0	93	26	12	14	6	10		
Cleburne (15)	11	60	28	0	136	20	9	11	9	10		
Randolph (56)	13	118	5	0	263	50	20	30	12	10		
Talladega (61)	51	179	17	0	508	101	45	56	25	19		
Tallapoosa (62)	47	262	59	0	432	131	70	61	68	16		
TOTAL:	**248**	**1,311**	**377**	**0**	**3,013**	**624**	**293**	**331**	**234**	**107**	**0**	**0**
AREA VII												
Choctaw (21)	40	191	20	0	585	62	1	61	33	6		
Dallas (24)	120	552	269	0	1,739	149	5	144	70	17		
Hale (33)	22	219	59	0	681	43	11	32	28	10		
Lowndes (43)	29	131	50	0	337	45	7	38	17	10		
Marengo (46)	31	250	48	0	673	52	9	43	35	10		
Perry (53)	25	169	58	0	422	40	3	37	26	7		
Sumter (60)	43	148	6	0	306	78	25	53	23	10		
Wilcox (66)	33	234	49	0	609	74	11	63	40	10		
TOTAL:	**343**	**1,894**	**559**	**0**	**5,352**	**543**	**72**	**471**	**272**	**80**	**0**	**0**

AREA VIII												
Autauga (01)	11	171	21	0	445	63	28	35	20	10		
Bullock (06)	5	31	8	0	62	20	9	11	1	7		
Chilton (11)	15	168	16	0	398	58	26	32	21	11		
Elmore (26)	21	130	7	0	161	80	59	21	26	10		
Lee (41)	53	185	44	0	333	82	27	55	36	10		
Macon (44)	12	149	35	0	362	29	4	25	19	7		
Montgomery (51)	67	418	69	0	640	229	159	70	71	32		
Russell (57)	43	224	60	0	494	124	69	55	38	10		
TOTAL:	**227**	**1,476**	**260**	**0**	**2,895**	**685**	**381**	**304**	**232**	**97**	**0**	**0**
AREA IX												
Baldwin (02)	65	283	103	0	725	75	5	70	29	21		
Butler (07)	31	265	14	0	685	75	14	61	30	13		
Clarke (13)	27	213	90	0	483	44	9	35	16	10		
Conecuh (18)	13	81	5	0	136	26	2	24	14	7		
Covington (20)	56	248	6	0	1,210	85	16	69	41	12		
Escambia (27)	22	179	3	0	682	60	14	46	29	13		
Monroe (50)	15	110	11	0	379	28	2	26	20	6		
Washington (65)	2	107	9	0	199	15	0	15	28	5		
TOTAL:	**231**	**1,486**	**241**	**0**	**4,499**	**408**	**62**	**346**	**207**	**87**	**0**	**0**
AREA X												
Barbour (03)	49	213	7	0	628	75	14	61	21	13		
Coffee (16)	60	250	22	0	678	79	12	67	47	11		
Crenshaw (21)	21	177	21	0	777	35	8	27	32	10		
Dale (23)	42	234	35	0	568	74	20	54	50	8		
Geneva (31)	28	134	33	0	361	50	17	33	16	11		
Henry (34)	29	118	9	0	328	74	10	64	20	10		
Houston (35)	150	569	28	0	1,144	278	111	167	131	22		
Pike (55)	27	315	6	0	923	80	17	63	42	15		
TOTAL:	**406**	**2,010**	**161**	**0**	**5,407**	**745**	**209**	**536**	**359**	**100**	**0**	**0**
AREA XI												

Mobile (49)	109	475	78	0	1,289	155	32	123	23			
TOTAL:	**109**	**475**	**78**	**0**	**1,289**	**155**	**32**	**123**	**23**	**0**	**0**	**0**
STATE TOTAL	**2,597**	**13,588**	**2,722**	**0**	**36,393**	**5,324**	**1,957**	**3,367**	**2,146**	**756**	**0**	**0**

1. Recruitment: Total number of times PFCCs spent time explaining care coordination to high risk patients prior to their acceptance of the service.
2. Number of unduplicated patients seen during the quarter.
3. Total number of face-to-face contacts during the quarter.
4. Total numbe of phone contacts during the quarter.
5. Documentation of encounters.
4. Total number of risk assessments completed.
5. Number of low-risk assessments.
6. Number of high-risk assessments.
7. Number of cases closed because of CC refusal and/or no contact for 6 months.
8. Audit compliance rate: 98.22

Alabama Medicaid Agency

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P.O. Box 5624
Montgomery, Alabama 36103-5624

www.medicaid.alabama.gov
e-mail: almedicaid@medicaid.alabama.gov

KAY IVEY
Governor

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STEPHANIE MCGEE AZAR
Commissioner

April 20, 2017

Mr. Buford L. Rolin
Tribal Chairman
Poarch Band Indian Health Department
5811 Jack Springs Road
Atmore, Alabama 36502

91 7108 2133 3936 7111 3180

Dear Mr. Rolin:

As directed by the Tribal Consultation Section 1902(a) (73) of the Social Security Act and Federal Regulation, this notice to the Tribal Government is hereby given for the anticipated submission of a request to renew the Family Planning Section §1115 Demonstration Waiver which governs the provision of family planning services under the Plan First Program.

Medicaid will provide the Tribal Government the opportunity to review and provide input on the Demonstration Waiver that will be submitted to the Centers for Medicare and Medicaid Services (CMS). The proposed effective dates for the Waiver extension are January 1, 2018 through December 31, 2022. The Waiver application is seeking continued flexibility in administering and managing the Plan First Program delivery model for the provision of family planning services to eligible individuals. It is designed to reduce unintended pregnancies and improve the well-being of women, men and infants in Alabama. The Agency does not anticipate a change in expenditures due to this Demonstration extension request.

This notice provides details about the waiver submission and serves to open the 30-day public comment period, which closes on Tuesday, May 30, 2017 at 5:00 PM (CST). In addition to the 30-day public comment period in which the Tribal Government will be able to provide written comments to the agency via the US postal service or electronic mail, Medicaid will also host two public hearings in which the Tribal Government may provide verbal comments directly to the Agency. The public hearings will be held on the following dates and times at the following geographically distinct locations:

Thursday, May 11, 2017, 10:00 AM-11:00 AM (CST)
Alabama Medicaid Agency District Office
468 Palisades Blvd.
Birmingham, AL 35209

Friday, May 12, 2017, 10:00 AM -11:00 AM (CST)
Alabama Medicaid Agency Boardroom
501 Dexter Avenue
Montgomery, AL 36104

Medicaid will be presenting on the renewal at the public hearings. Teleconference access will be available for individuals who cannot attend in person. Dial in instructions will be posted on Medicaid's website at: http://www.medicaid.alabama.gov/content/4.0_Programs/4.2_Medical_Services/4.2.4_Family_Planning.aspx. All information regarding the Demonstration Waiver, including a full public notice, the waiver application and other documentation regarding the proposal are available at:

http://www.medicaid.alabama.gov/content/4.0_Programs/4.2_Medical_Services/4.2.4_Family_Planning.aspx. A copy of the draft Demonstration renewal application will also be available upon request for public review at each county office of the Department of Human Resources and the State Office of the Alabama Medicaid Agency.

Written comments concerning the §1115 Demonstration Waiver should be submitted on or before 5:00 p.m. on Tuesday, May 30, 2017 to the following e-mail address: sylisa.lee-jackson@medicaid.alabama.gov or mailed to Sylisa Lee-Jackson R.N., Associate Director Maternity, Family Planning/Plan First and Nurse Midwife Programs, Managed Care Division, Alabama Medicaid Agency, 501 Dexter Avenue, Montgomery, Alabama 36103-5624. Comments can also be submitted via email to PublicComment@medicaid.alabama.gov or mailed to Administrative Secretary, Alabama Medicaid Agency, 501 Dexter Avenue, P.O. Box 5624, Montgomery, Alabama 36103-5624.

All written comments will be available for review by the public during normal business hours at the above address. Prior to finalizing the proposed waiver, Medicaid will consider all of the Tribal Government and public comments received during the public comment period, both written and verbal. The comments will be summarized and addressed in the final draft of the waiver to be submitted to CMS.

If you have any questions or concerns, please contact me at (334) 353-4599.

Sincerely

[redacted]

Sylisa Lee-Jackson
Associate Director
Maternity, Family Planning/Plan First and Nurse Midwife Programs
Alabama Medicaid Agency

Plan First Program 1115 Waiver Extension Public Forum

Birmingham, Alabama

Thursday, May 11, 2017

Questions and Answers

Question: Will the Plan First Program pay for males to have the physical exam required for the vasectomy?

Answer: An initial visit is a covered service for Plan First males. Two periodic visits are allowed post sterilization procedure. The initial visit is allowed to one provider per lifetime and can only be billed by the provider performing the vasectomy. In the initial visit, the provider completes the pre-surgical process which includes a complete physical exam.

Question: Who will complete the physical exam?

Answer: The provider performing the procedure will need to complete any pre-surgical processes related to the vasectomy which includes the physical exam in the initial visit. The initial visit is also the time to educate the recipient regarding the procedure and obtain consent for the sterilization.

Question: Can a list of Medicaid enrolled Urologist be provided?

Answer: Yes, the Family Planning unit staff will work on posting this list to Medicaid's website under the Family Planning/Plan First Program tab.

Question: Can Plan First enrollment by zip code be obtained so that service utilization can be identified by zip code?

Answer: This will have to be verified with the developer of the Annual Demonstration Report.

Comment: In area 4, Jefferson County, in regards to the group of women ages 44-55, there were no demographics noted in DY-15 Annual

Demonstration Report. Did anyone between the ages of 44-55 receive family planning services?

Answer: Yes, but this age utilization is very small therefore it was not captured in the report. However, this data will be provided in future reports.

Question: In the past, providers had problem with getting paid for Tobacco Cessation products covered by the Plan First Program. Can you explain why?

Response: Selective Tobacco Cessation products are covered by Medicaid. Prescription are filled by pharmacies. A list of covered products are included in your packet. If providers are having difficulty getting paid for the products or if recipients are having difficulty filling prescriptions, they need to contact the Alabama Medicaid Agency.

Question: Is a Sterilization Consent Form required for a vasectomy?

Answer: Yes, a Sterilization Consent Form is required for vasectomy procedures. The consent for a sterilization procedure must contain the recipient's signature with date and shall reflect at least 30 days have passed prior to the procedure being performed.

Plan First Program 1115 Waiver Extension Public Forum

Montgomery, Alabama

Friday, May 12, 2017

Questions and Answers

Question: What fiscal year/calendar year is Demonstration Year (DY) 2014?

Answer: The Demonstration years are calendar years. This Waiver extension is on calendar years. The Annual Report has a Demonstration year but fiscal year dates. We will have to verify these dates with the developer of the report.

Additional Follow-up Response:

According to Centers for Medicare and Medicaid (CMS) the upcoming renewal extension will start with DY18. Based on the date of original implementation of the Waiver, (October 2000), the AL Family Planning Demonstration should be on an October – September DY cycle. During one of the renewals, CMS set the Demonstration cycle to coincide with the period of a temporary extension, which was incorrect. Therefore, CMS will work with the State to go back to the Oct-Sept cycle.

In light of this additional information, the Demonstration year timeframe as indicated in the Annual Demonstration Report is correct.

Question: Are births averted in Demonstration Year 2014 reflecting the fiscal year or calendar year?

Answer: The births averted data is based on fiscal year.

Question: Is there a difference between an eligible and enrollee?

Answer: An eligible is a recipient who meets Medicaid guidelines for Plan First services. An enrollee is a recipient who is enrolled in the Plan First Program. These words are used interchangeably.

Question: If a person is enrolled but does not receive a service, is that person a participant or enrollee?

Answer: That person is an enrollee.

Question: If a household is deemed eligible for Medicaid, is the male automatically eligible to receive Plan First?

Answer: No, the male is not automatically deemed eligible for Plan First services. Because the males can only receive vasectomy and vasectomy related, he must complete an application for the Plan First Program if a decision is made to receive this service.

Question: Does the physician have to execute a Plan First agreement, to be a Medicaid provider?

Answer: In order to be reimbursed for Plan First services, the physician must be a Medicaid enrolled Plan First provider. The Urologists must be a Medicaid enrolled provider but does not have to be a Plan First provider.

Question: In the application process to be considered for a vasectomy, does the male applicant need to check a box on the application indicating that he wants family planning?

Answer: If a male applicant is applying for Plan First, it is automatically assumed that he wants a vasectomy, because a vasectomy is the only Plan First service offered to male applicants at this time.

Question: Is the key number for Plan First recipient as of December 2016 shown as 17,252 accurate?

Answer: Yes, this number is accurate. The data is pulled from claims. The agency is aware of the decrease in participation. One of the future goals in the waiver extension is to increase recipient participation. The Agency will be working with Alabama Department of Public Health on recipient and provider outreach.


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Public Hearings Set for Medicaid's Plan First Section 1115 Demonstration Waiver Extension Application
Medicaid:
4/25/2017 - Providers, recipients and other interested individuals will have the opportunity to provide input on the Alabama Medicaid Agency's Plan First program during public hearings in May in Birmingham and Montgomery.
Read more »
Identification required to request Alabama restricted vital records
Public Health, Alabama Department of:
4/25/2017 - Valid identification will be required to obtain Alabama restricted vital records effective May 1, 2017.
Read more »
Sustainable Forest and Wildlife Management Workshop
Forestry Commission, Alabama:
4/21/2017 - Interactive workshop bringing resource professionals and landowners together
Read more »
Warren, Michigan Man (Robert Craig Rudder) Pleads Guilty to Conspiracy to Commit Securities Fraud
Alabama Securities Commission:
4/21/2017 - Robert Craig Rudder, of Warren, Michigan, plead guilty to one count of Conspiracy to Commit Securities Fraud, a Class C felony, punishable from one year and a day to 10 years' imprisonment and a $15,000 fine per charge upon conviction. The Alabama Securities Commission recommended a sentence of three years imprisonment with conditions that Rudder fully cooperate with any further state or federal investigations, pay $600,000 restitution and be permanently barred from any future work in the securities industry. Rudder made application for probation and remains in the Jefferson County Jail.
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ALEA - Fugitive Alerts
ALEA - Missing Adult Alerts
ALEA - Missing Children Alerts
ALEA - Missing Senior Alerts
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Bar, Alabama State
Conservation, Alabama Dept. of
Cybersecurity.Alabama.gov
Emergency Management Agency
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Hurricane Center, Nat'l - Atlantic
ISD Training
Medicaid Agency, Alabama
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4-25-2017
Public Hearings Set for Medicaid's Plan First Section 1115 Demonstration Waiver Extension Application
Medicaid

FUNDING QUESTIONS

1. The following questions are being asked and should be answered in relation to all payments made to all providers under the section 1115 demonstration under review. Section 1903(a)(1) provides that federal matching funds are only available for expenditures made by states for services under the approved state plan.

    a. Do providers receive and retain the total Medicaid expenditures claimed by the state (includes normal per diem, DRG, DSH, fee schedule, global payments, supplemental payments, enhanced payments, capitation payments, other), including the federal and non-federal share (NFS) or is any portion of any payment returned to the state, local governmental entity, or any other intermediary organization?

    Medicaid's response: Yes, the providers receive and retain the total Medicaid expenditures claimed by the state (includes normal per diem, DRG, DSH, fee schedule, global payments, supplemental payments, enhanced payments, capitation payments, other), including the federal and non-federal share (NFS) and no portion of any payment is returned to the state, local governmental entity, or any other intermediary organization.

    b. If providers are required to return any portion of any payment, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned, and the disposition and use of the funds once they are returned to the state (i.e., general fund, medical services account, etc.).

    Medicaid's response: Please see response in 1.a. Providers are not required to return any portion of any payment.

2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in the lowering of the amount, duration, scope, or quality of care and services available under the plan.

    a. Please describe how the NFS of each type of Medicaid payment (normal per diem, DRG, fee schedule, global payments, supplemental payments, enhanced payments, capitation payments, other) is funded.

    Medicaid's response: The NFS of each type of Medicaid payment under this Demonstration Waiver is funded by Medicaid's partnering agency, Alabama Department of Public Health via contract agreement.

    b. Please describe whether the NFS comes from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer (IGT) agreements, certified public expenditures (CPEs), provider taxes, or any other

mechanism used by the state to provide the NFS. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please also indicate if any managed care organizations, prepaid inpatient health plans or prepaid ambulatory health plans participate in IGT or CPE arrangements.

Medicaid's response: Not applicable. The NFS does not come from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer (IGT) agreements, certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state. The Plan First Program is not a managed care organization, prepaid inpatient health plan or prepaid ambulatory health plan participating in IGT or CPE arrangements.

a. Please provide an estimate of total expenditures and NFS amounts for each type of Medicaid payment.

Medicaid's response: Medicaid payments for services under this Demonstration are paid fee-for-service. Below is an estimate of total expenditures and NFS amounts for DY 15 and DY 16.

	Service Expenditures as reported on the CMS-64			Administrative Expenditures as reported on the CMS-64			Expenditures as requested on the CMS-37	Total Expenditures as reported on the CMS-64
	Total Computable	Federal Share	Non-Federal Share	Total Computable	Federal Share			
DY 15	$34,504,758.94	$31,054,283.05	3,450,475.89	$180,231.88	$162,208.69	18,023.19	$36,759,039.00	$34,684,990.82
DY 16	$31,415,107.85	$28,273,597.07	3,141,510.79	$189,651.21	$170,686.09	18,965.12	$34,908,360.00	$31,604,759.06

b. If any of the NFS is being provided using IGTs or CPEs, please fully describe the matching arrangement, including when the state agency receives the transferred amounts from the local government entity transferring the funds.

Medicaid's response: Not applicable. NFS for services under this Demonstration is not being provided using IGTs or CPEs.

c. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for federal matching funds is in accordance with 42 CFR 433.51(b).

Medicaid's response: Not applicable. CPEs are not used for this Demonstration.

d. For any payment funded by CPEs or IGTs, please provide the following:

(i) a complete list of the names of entities transferring or certifying funds;

(ii) the operational nature of the entity (state, county, city, other);

(iii) the total amounts transferred or certified by each entity;

(iv) clarify whether the certifying or transferring entity has general taxing authority; and

(v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

Medicaid's response: Not applicable. Payments are not funded by CPEs or IGTs.

3. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for federal financial participation to states for expenditures for services under an approved state Plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

   Medicaid's response: Not applicable. Providers providing services under this Demonstration are not paid supplemental or enhanced payments.

4. Please provide a detailed description of the methodology used by the state to estimate the upper payment limit for each class of providers (state owned or operated, non-state government owned or operated, and privately owned or operated).

   Medicaid's Response: Not applicable. Upper limit payments are not made to providers providing services under this Demonstration.

5. Does any governmental provider or contractor receive payments (normal per diem, DRG, fee schedule, global payments, supplemental payments, enhanced payments, other) that, in the aggregate, exceed its reasonable costs of providing services?

   Medicaid's Response: No, the governmental provider or contractor payments do not exceed its reasonable costs of providing services.

   a. If payments exceed the cost of services (as defined above), does the state recoup the excess and return the federal share of the excess to CMS on the quarterly expenditure report?

   Medicaid's Response: Not applicable.

6. In the case of risk-based MCOs, PIHPs, and PAHPs:

   a. Are there any payments to MCOs, PIHPs, PAHPs, or providers that are outside of the actuarial sound capitation rates in 42 CFR 438.4?

      Medicaid's Response: The Plan First Program administered under this Demonstration is not a MCO, PHIP or a PAHP Program.

   b. Are there any actual or potential payments which would be subject to 42 CFR 438.6(b), 438.6(c), 438.6(d), 438.60, or 438.74? (These payments could be for such things as managed care plan incentive arrangements, risk sharing

mechanisms such as stop-loss limits, risk corridors, medical loss ratios with a remittance, or contractual requirements that direct the managed care plans on how to pay providers, or direct payments from the State to providers such as DSH hospitals, academic medical centers, or FQHCs.)

Medicaid's Response: No, there any not any actual or potential payments which would be subject to 42 CFR 438.6(b), 438.6(c), 438.6(d), 438.60, or 438.74.

c. If so, how do the arrangements in Item (b) comply with the requirements on payments in §438.6(b)(2), 438.6(c), 438.6(d), 438.60 and/or 438.74 of the managed care regulations?

Medicaid's Response: Not applicable.

d. In situations, where MCOs, PIHPs, or PAHPs are not permitted to retain some or all of the recoveries of overpayments under the policies required in 42 CFR 438.608(d), does the state return the federal share of the recovery to CMS on the quarterly expenditure report?

Medicaid's Response: Not applicable.

7. In the case of non-risk-based PIHPs, and PAHPs:

a. How do the arrangements comply with the upper payment limits specified in §447.362 limits on payments?

Medicaid's Response: Upper payment limits are not applicable under this Demonstration.

b. If payments exceed the cost of services, does the state recoup the excess and return the federal share of the excess to CMS on the quarterly expenditure report?

Medicaid's Response: Upper payment limits are not applicable under this Demonstration.