OFFICE OF THE GOVERNOR
Walter Sillers Building | 550 High Street, Suite 1000 | Jackson, Mississippi 39201

MISSISSIPPI DIVISION OF
MEDICAID

JUN 0 2 2014

Ms. Jackie Glaze
Associate Regional Administrator
Division of Medicaid
Centers for Medicare & Medicaid Services
61 Forsyth Street, SW, Suite 4T20
Atlanta, GA 30303-8909

RE: Family Planning Demonstration Waiver Renewal
Project Number 11-W-00157/4

Dear Ms. Glaze:

The Division of Medicaid is requesting a renewal of the Family Planning Demonstration Waiver, Project Number 11-W-00157/4, due to expire on June 30, 2014. A temporary extension was requested until December 31, 2014, and was approved on May 27, 2014. The effective dates of the renewal will be January 1, 2015, through December 31, 2017.

If any additional information is needed please contact Kristi Plotner at 601-359-6698 or Kristi.Plotner@medicaid.ms.gov.

Sincerely,

[redacted]

David J. Dzielak, Ph.D.
Executive Director

DJD/krp

Centers for Medicare & Medicaid Services
Office of Information Services
Information Services Design & Development Group
7500 Security Blvd
Baltimore, MD 21244-1850

Section 1115 Demonstration Program

Section I - Program Description

1) Provide a summary of the proposed Demonstration program, and how it will further the objectives of title XIX and/or title XXI of the Social Security Act (the Act).

   Mississippi Division of Medicaid (DOM) currently includes the following populations in the family planning demonstration per guidance from the Centers for Medicare and Medicaid Services:

   - Women:
     - Ages 13 through 44,
     - Capable of reproducing,
     - Not otherwise enrolled in Medicaid, Medicare, the Children's Health Insurance Program (CHIP) or other creditable health insurance coverage,
     - With income no more than 185 percent of the Federal Poverty Level (FPL) for their household size, and
     - Whose Medicaid eligibility has ended due to the conclusion of their 60-day postpartum period.

   Mississippi will continue the Family Planning Waiver (FPW) in the same manner with one proposed change per guidance from the Centers for Medicare and Medicaid Services which include eligibility for:

   - Men:
     - Ages 13 through 44,
     - Capable of reproducing,
     - With income no more than 185 percent of the Federal Poverty Level (FPL) for their household size, and
     - Not otherwise enrolled in Medicaid, Medicare, the Children's Health Insurance Program (CHIP) or other creditable health insurance coverage.

   The primary objective of the FPW program is to reduce the number of unintended pregnancies and subsequent births paid by MS DOM. The success of the FPW is supported by the following data:

   - The demonstration has increased the numbers of women receiving family planning services. Over 300,000 women have accessed family planning services through this demonstration from 2004 through 2013. These women may have otherwise been unable to obtain these family planning services.
   - Since 2004, Medicaid savings are well over $450 million from this demonstration.
   - The repeat birth rates for women accessing FPW services have dropped for

most age groups with significant decreases among teens.

The Family Planning Waiver improves access to family planning services by extending eligibility for family planning benefits and expanding outreach and education services.

2) Include the rationale for the Demonstration.

The MS Family Planning Waiver is designed to provide eligibility for family planning services and increase the number of low-income men and women receiving family planning and family planning-related services throughout the state of MS. This increased access to family planning and family planning-related services will continue to increase awareness by waiver participants of the importance and benefits of birth spacing, therefore, improving birth outcomes.

3) Describe the hypotheses that will be tested/evaluated during the Demonstration's approval period and the plan by which the State will use to test them.

The hypothesis of the FPW is enrollment of eligible men in the FPW and increasing awareness, importance and benefits of birth spacing reduces the number of unintended pregnancies in the Medicaid and FPW populations.

The evaluation parameters of the demonstration include:

- Number of eligible women who received a Medicaid State Plan pregnancy-related service enrolling in FPW.
- Birth outcomes and length of the inter-pregnancy interval among women in the target population.
- Number of men and women enrolled annually in the FPW.
- Number of teen pregnancies.
- Number of repeat births to teens.
- Number of deliveries reimbursed by the Division of Medicaid.
- Annual Medicaid expenditures for prenatal, delivery, newborn and infant care.
- Savings in annual Medicaid spending attributable to family planning services to women for one year postpartum.

4) Describe where the Demonstration will operate, i.e., statewide, or in specific regions within the State.

MS Family Planning Waiver operates on a state wide basis through a partnership with the MS Department of Health as well as private providers.

5) Include the proposed timeframe for the Demonstration.

The proposed demonstration renewal is requested for the period of January 1, 2015 through December 31, 2017.

6) Describe whether the Demonstration will affect and/or modify other components of the State's current Medicaid and CHIP programs outside of eligibility, benefits, cost sharing or delivery systems.

The demonstration will not affect and/or modify other components of the state's current Medicaid and CHIP programs outside of eligibility, benefits, cost sharing or delivery systems.

Section II – Demonstration Eligibility

1) Include a chart identifying any populations whose eligibility will be affected by the Demonstration.

Eligibility Group Name	N/A	Income Level
Men and Women 13 years of age	None	Income Level at or below
or older and through age 44		185% FPL

2) Describe the standards and methodologies the state will use to determine eligibility for any populations whose eligibility is changed under the Demonstration, to the extent those standards or methodologies differ from the State plan.

The Division of Medicaid uses a simplified application for the Family Planning Waiver program. Applications may be filed at a MS Department of Health office, Medicaid Regional offices or accessed online at www.medicaid.ms.gov. The completed application may be faxed to enrollment at (601) 576-4164, emailed to application@medicaid.ms.gov, or mailed to the regional office that serves individual's county of residence. Individuals may also call the DOM at 1-800-421 2408 or contact the regional office that serves individual's county of residence and request an application to be mailed. Presumptive eligibility is not allowed. Women losing Medicaid coverage at the conclusion of their 60 day postpartum period are auto-enrolled without having to complete an application form.

In the initial eligibility process, the applicant submits a completed, signed application to the DOM. Proof of family income which includes applicant, applicant's spouse and minor children under age 19, if applicable is required for the most recent full month. Documentation for proof of income is required with the initial application and each renewal application. DOM will utilize available data sources to assist the applicant with income verification if needed. No proof of income is required for applicants ages 13-15, nor for women who are auto-enrolled. For all auto-enrollees, the Medicaid file does include, as applicable, either hard copy or electronic verification of age and social security number from the prior enrollment process. Basic information that is not subject to change, such as age, citizenship and Social Security Number does not have to be re-verified at the time of renewal of eligibility.

As allowed under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), the Division of Medicaid uses State Verification and Exchange System (SVES) data from the Social Security Administration to establish citizenship. If the response does not substantiate citizenship, documentation is required. The applicants will be allotted a reasonable opportunity period to provide documentation should DOM be unable to independently verify citizenship or identity.

There is an automatic redetermination process for individuals losing Medicaid pregnancy coverage at the conclusion of 60 days postpartum. These individuals are auto-enrolled on the first day of the month following the conclusion of the 60 days postpartum. Eligibility for the individual is systematically rolled over into the Family Planning Waiver program. Since the eligibility requirements for the Medicaid pregnancy coverage have already been verified, no other verification takes place with this auto enrollment. The individual is notified via mail that she is now eligible for services through the Family Planning Waiver program. She is issued a separate Medicaid card to indicate to providers that this beneficiary is now eligible for services related to the Family Planning Waiver program.

All enrollees of the Family Planning Waiver are coded as a separate category of eligibility. The MMIS includes edits to prevent enrollment in more than one category of eligibility at the same time by validating name, social security number and date of birth against any other matches. Medicaid Eligibility Quality Check (MEQC) is used to monitor and ensure that eligibility determinations are conducted according to State and Federal requirements.

The Division of Medicaid will conduct eligibility redeterminations every 12 months. At redetermination, Family Planning Waiver participants are required to complete a new application form. The application is the same as used for initial eligibility determination. The applicant will check a box to indicate it is a redetermination. As previously stated, verification of income is required to be

submitted with the renewal application, but no other documentation is required. As indicated, the participant is not required to re-verify eligibility factors previously verified either by hard copy documents or through electronic sources and not subject to change. The application also asks for current insurance information.

All applications are reviewed for private insurance by self-declaration of coverage and as they are for the regular Medicaid enrollment process. The MS Division of Medicaid sends notices to all women identified with third party coverage who apply for the Family Planning Waiver advising them that they are not eligible under this program. Applicants must provide documentation from their insurance company indicating that coverage has lapsed in order to be reconsidered for processing.

3) Specify any enrollment limits that apply for expansion populations under the Demonstration.

The Division of Medicaid does not apply enrollment limits for eligible populations under the Family Planning Waiver.

4) Provide the projected number of individuals who would be eligible for the Demonstration, and indicate if the projections are based on current state programs.

The estimate in the expected increase in the annual enrollment is 798 individuals which represents an increase of three percent (3%) increase in the average enrollment of 26,600 participants. The estimate of the expected increase in annual expenditures is $150,000 which represents a three percent (3%) increase in the average annual expenditure of $5,000,000.

5) To the extent that long term services and supports are furnished (either in institutions or the community), describe how the Demonstration will address post-eligibility treatment of income, if applicable.

Long term care services and supports do not apply to the MS Family Planning Waiver.

Section III – Demonstration Benefits and Cost Sharing Requirements

1) Indicate whether the benefits provided under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan:

■ Yes ☐ No (if no, please skip questions 3-7)

2) Indicate whether the cost sharing requirements under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan:

■ Yes ☐ No (if no, please skip questions 8-11)

There is no cost sharing requirements under the MS Family Planning Waiver.

3) If changes are proposed, or if different benefit packages will apply to different eligibility groups affected by the Demonstration, please include a chart specifying the benefit package that each eligibility group will receive under the Demonstration:

Benefits Not Provided

Benefit	Description of Amount Duration and Scope	Reference
Inpatient Hospital	Only family planning services and family planning related services are covered.	Mandatory 1905(a)(1)
Outpatient Hospital	Only family planning services and family planning related services are covered.	Mandatory 1905(a)(2)
Rural Health Agency	Only family planning services and family planning related services are covered.	Mandatory 1905(a)(2)
FQHC	Only family planning services and family planning related services are covered.	Mandatory 1905 (a)(2)
Laboratory and X-Ray	Only family planning services and family planning related services are covered.	Mandatory 1905(a)(3)
Nursing Facility Services age 21 and older	Not Covered	Mandatory 1905(a)(4)
EPSDT	Not Covered	Mandatory 1905(a)(4)
Family Planning Services	Covered if both the procedure code and diagnosis code are both on the approved list of FPW covered services.	Mandatory 1905(a)(4)

Tobacco Cessation for Pregnant Women	Not Covered. Ineligible for FPW if pregnant.	Mandatory 1905(a)(4)
Physician's Services	Only family planning services and family planning related services are covered.	Mandatory 1905(a)(5)
Medical or Surgical Services by a Dentist	Not Covered	Mandatory 1905(a)(5)
Medical Care and Remedial Care-Podiatrist Services	Not Covered	Optional 1905(a)(6)
Medical Care and Remedial Care-Optometrists Services	Not Covered	Optional 1905(a)(6)
Medical Care and Remedial Care-Chiropractors Services	Not Covered	Optional 1905(a)(6)
Medical Care and Remedial Care-Other Practitioners	Only family planning services and family planning related services are covered.	Optional 1905(a)(6)
Home Health Services-Intermittent	Not Covered	Mandatory for certain individuals 1905(a)(7)
Home Health Services-Home Health Aide	Not Covered	Mandatory for certain individuals 1905(a)(7)
Home Health Services-Medical Supplies, Equipment and Appliances	Not Covered	Mandatory for certain individuals 1905(a)(7)
Home Health Services-Audiology, Physical, Occupational and Speech Therapy	Not Covered	Optional 1905(a)(7), 1902(a)(10)(D), 42CFR 440.70
Private Duty Nursing	Not Covered	Optional 1905(a)(8)
Agency Services	Not Covered	Optional 1905(a)(9)
Dental Services	Not Covered	Optional 1905(a)(10)
Physical Therapy	Not Covered	Optional 1905(a)(11)
Occupational Therapy	Not Covered	Optional 1905(a)(11)
Services for Individuals with Speech, Hearing, and Language Disorders	Not Covered	Optional 1905(a)(11)
Prescribed Drugs	Only family planning services and family planning related services are covered.	Optional 1905(a)(12)

	Comprehensive drug therapy for all diagnosis and medical needs are not covered.	
Dentures	Not Covered	Optional 1905(a)(12)
Prosthetic Devices	Not Covered	Optional 1905(a)(12)
Eyeglasses	Not Covered	Optional 1905(a)(12)
Diagnostic Services	Covered if both the procedure code and diagnosis code are both on the approved list of FPW covered services. Comprehensive services available to the Medicaid population are not covered under the waiver.	Optional 1905(a)(13)
Screening Services	Covered if both the procedure code and diagnosis code are both on the approved list of FPW covered services. Comprehensive services available to the Medicaid population are not covered under the waiver.	Optional 1905(a)(13)
Preventative Services	Covered if both the procedure code and diagnosis code are both on the approved list of FPW covered services. Comprehensive services available to the Medicaid population are not covered under the waiver.	Optional 1905(a)(13)
Rehabilitative Services	Not Covered	Optional 1905(a)(13)
Services for Individuals over 65 in IMDs-Inpatient Hospital	Not Covered	Optional 1905(a)(14)
Services for Individuals over 65 in IMDs-Nursing Facility	Not Covered	Optional 1905(a)(14)
Intermediate Care Facility Services for	Not Covered	Optional 1905(a)(15)

Individuals in a Public Institution for the Mentally Retarded		
Inpatient Psychiatric Service for Under 22	Not Covered	Optional 1905(a)(16)
Nurse- Midwife Services	Not Covered	Mandatory 1905(a)(17)
Hospice Care	Not Covered	Optional 1905(a)(18)
Case Management Services	Not Covered	Optional 1905(a)(19),1914(g)
Special TB Related Services	Not Covered	Optional 1905(a)(19),1902(z)(2)
Respiratory Care Services	Not Covered	Optional 1905(a)(20)
Certified Pediatric or Family Nurse Practitioner's Services	Covered if both the procedure code and diagnosis code are both on the approved list of FPW covered services. Comprehensive services available to the Medicaid population are not covered under the waiver.	Mandatory 1905(a)(21)
Home and Community Care for Functionally Disabled Elderly	Not Covered	Optional 1905(a)(22)
Personal Care Services	Not Covered	Optional 1905(a)(24), 42CFR 440.170
Primary Care Case Management	Not Covered	Optional 1905(a)(25)
PACE Services	Not Covered	Optional 1905(a)(26)
Sickle-Cell Anemia Related Services	Not Covered	Optional 1905(a)(27)
Free Standing Birth Centers	Not Covered	Optional 1905(a)(28)
Transportation	Not Covered	Optional 1905(a)(29)-42CFR 440.170. Administrative Required 42CFR 421.53
Services Provided in Religious Non-Medical Health Care Facilities	Not Covered	Optional 1905(a)(29)-42CFR 440.170(b)
Nursing Facility Services for Patients Under 21	Not Covered	Optional 1905(a)(29)-42CFR 440.170(d)
Emergency Hospital Services	Covered if both the procedure code and	Optional 1905(a)(29)-42CFR 440.170(e)

	diagnosis code are both on the approved list of FPW covered services. Comprehensive services available to the Medicaid population are not covered under the waiver.	
Expanded Services for Pregnant Women	Not Covered	Optional 1905(e)(5)
Emergency Services for Certain Legalized Aliens and Undocumented Aliens	Not Covered	Mandatory 1903(v)(2)(A)
Home and Community Based Services for Elderly and Disabled	Not Covered	Optional 1915(i)
Self-Directed Personal Assistance	Not Covered	Optional 1915(k)
Community First Choice	Not Covered	Optional 1905(a)(29)

MS Family Planning Waiver does not use bench-mark equivalent coverage for a population.

Benefit Specifications and Provider Qualifications

Name of Benefit or Service: MS Family Planning Waiver services

Scope of Benefit/Service: Procedure codes are covered only when paired with an approved diagnosis code. This is a limitation not found in the MS Medicaid State Plan for family planning services.

Amount of Benefit/Service: There is a limit of four (4) family planning visits per fiscal Year provided under the FPW.

Duration of Benefit/Service: There are no limitations on the duration of the service under the FPW.

Authorization Requirements: There are no prior, concurrent or post-authorization requirements.

Long term services will not be provided under the MS FPW.

No premium assistance for employer sponsored coverage will be available through the the MS FPW.

Section IV – Delivery System and Payment Rates for Services

The delivery system used to provide benefits to FPW participants will not differ from the Medicaid fee-for-service State Plan.

Section V – Implementation of Demonstration

The renewal of the MS Family Planning Waiver will begin on January 1, 2015.

The current enrollment process will continue to be used.

MS will not be contracting with managed care organizations to provide Family Planning Waiver benefits.

Section VI – Demonstration Financing and Budget Neutrality

Please refer to Attachment A for Demonstration Financing and Budget Neutrality.

Section VII – List of Proposed Waivers and Expenditure Authorities

MS is requesting waiver of selected Medicaid requirements to enable the operation of the MS Family Planning Waiver as a Demonstration that will effectively meet the objectives as well as budget neutrality expectations. All Medicaid requirements apply, except for the following:

Medicaid Requirement	Expenditure Authority	Waiver Request
Proper and Efficient 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.
Comparability: Amount, Duration and Scope of Services	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-related services.
Prospective Payment for Federally Qualified Health Centers and Rural Health Agencies	Section 1902(a)(15)	To the extent necessary for the State to establish reimbursement levels to these agencies that will compensate them solely for family planning and family planning-related services.
Comparability: Eligibility Procedures	Section 1902(a)(17)	To the extent necessary to allow the State to not include parental income when determining eligibility for individuals ages 13 through 15 for the Family Planning Waiver
Comparability: 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 population.

Section VIII – Public Notice

A notice requesting public comment on the proposed Family Planning Waiver renewal request was published in the Clarion Ledger on April 14, 2014. This notice announced a 30-day comment period from April 14, 2014 to May 14, 2014 on the Family Planning Waiver renewal request. The notice included instructions for accessing an electronic copy or requesting a hard copy of the waiver request. Instructions for submitting written comments were provided. In addition, the notice included information about two public hearings scheduled to provide stakeholders and other interested parties the opportunity to comment on the waiver request. The time and location for the two public hearings were provided. Finally, the notice provided a link to a web page for complete information on the Family Planning Waiver request including public notice process, the public input process, planned hearings and a copy of the waiver application. A copy of the Mississippi Family Planning Waiver Clarion Ledger notice published on April 14, 2014 is provided as Attachment B.

The DOM web page at http://www.medicaid.ms.gov/proposed-family-planning-waiver-demostration-extension/ apprises the public with information about the Family Planning Waiver renewal request. The website includes information about the public notice process, opportunities for public input and planned hearings. A copy of

the initial draft of the Family Planning Waiver renewal request is posted.

DOM convened two public hearings, of which one hearing included teleconference capability, 20 days prior to submitting the application to CMS. The public hearings were held to provide stakeholders and other interested parties the opportunity to comment on the waiver request. The first public hearing was held at the Woolfolk State Building, room 145 located at 501 N. West Street, Jackson, MS on April 18, 2014. Teleconference was available at this hearing to allow the option to participate in the hearing remotely for interested stakeholders. No members of the public attended or provided public testimony. The second public hearing was held at the War Memorial Building located at 120 North State Street, Jackson, MS. Two members of the public were in attendance; however no public testimony was given. A court reporter was utilized for both public hearings to capture and transcribe proceedings.

DOM received one written comment from stakeholders regarding the proposed Family Planning Waiver renewal request during the comment period from April 14, 2014 to May 14, 2014. A copy of the written comment received during the comment period is included in Attachment C.

On March 31, 2014 a letter was sent to the Mississippi Band of Choctaw Indians informing them of the State's intent to submit a letter of request to extend the Family Planning Waiver. Please refer to Attachment D for a copy of the March 31, 2014 letter. No comments were received from the Mississippi Band of Choctaw Indians.

Section IX – Demonstration Administration

Please provide the contact information for the state's point of contact for the Demonstration application.

Name and Title: Dorthy Young, PhD, MHSA, Medical Services Director
Telephone: (601) 359-6150
Email Address: dorthy.young@medicaid.ms.gov

Attachment A

Model Budget Neutrality Worksheet for : ALL COSTS

		2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	TOTAL
WITHOUT DEMONSTRATION												
FAMILY PLANNING SERVICES UNDER MEDICAID STATE PLAN -- All current Medicaid eligibles/participants	Persons	57,744	56,496	54,022	53,478	50,317	63,732	56,927	60,537	78,947	49,453	581,653
	Cost per Person	$203.20	$ 211.97	$ 221.12	$ 230.67	$ 240.62	$ 251.01	$ 261.85	$ 273.15	$ 284.94	$ 297.24	
	Total	$ 11,733,435	$ 11,975,429	$ 11,945,357	$ 12,335,556	$ 12,107,470	$ 15,997,469	$ 14,906,206	$ 16,535,785	$ 22,495,448	$ 14,699,641	$ 144,731,796
DELIVERIES UNDER MEDICAID STATE PLAN (include costs for prenatal care, deliveries, and 60- days postpartum)	Persons	30,609	30,343	30,367	35,781	31,113	37,867	33,655	26,778	29,438	14,162	300,112
	Cost per Person	$4,759.82	$4,965.30	$5,179.65	$5,403.25	$5,636.51	$5,879.84	$6,133.67	$6,398.46	$6,674.69	$6,962.83	
	Total	$ 145,691,319	$ 150,662,657	$ 157,288,292	$ 193,331,792	$ 175,369,803	$ 222,650,796	$ 206,429,046	$ 171,338,218	$ 196,490,335	$ 98,608,647	1,717,860,904
FIRST YEAR INFANT COSTS UNDER MEDICAID STATE PLAN	Persons	30,609	30,343	30,367	35,781	31,113	37,867	33,655	26,778	29,438	14,162	300,112
	Cost per Person	$3,227.32	$3,366.64	$3,511.98	$3,663.59	$3,821.75	$3,986.74	$4,158.84	$4,338.38	$4,525.67	$4,721.04	
	Total	$ 98,783,787	$ 102,154,527	$ 106,646,939	$ 131,085,687	$ 118,906,833	$ 150,964,992	$ 139,966,081	$ 116,173,278	$ 133,227,289	$ 66,860,096	1,164,769,509
TOTAL WITHOUT-WAIVER COSTS		$ 256,208,541	$ 264,792,613	$ 275,880,588	$ 336,753,034	$ 306,384,106	$ 389,613,257	$ 361,301,334	$ 304,047,281	$ 352,213,071	$ 180,168,385	3,027,362,209
WITH DEMONSTRATION												
FAMILY PLANNING SERVICES UNDER MEDICAID STATE PLAN -- All current Medicaid eligibles/participants	Persons	57,744	56,496	54,022	53,478	50,317	63,732	56,927	60,537	78,947	49,453	581,653
	Cost per Person	$376.34	$404.60	$496.89	$447.52	$282.73	$206.60	$63.46	$92.97	$69.60	$109.76	
	Total	$ 21,731,600	$ 22,858,538	$ 26,843,027	$ 23,932,431	$ 14,226,282	$ 13,167,155	$ 3,612,438	$ 5,628,184	$ 5,494,325	$ 5,427,730	$ 142,921,710
DELIVERIES UNDER MEDICAID STATE PLAN ADJUSTED FOR EFFECTS OF THE DEMONSTRATION (include costs for prenatal care, deliveries, and 60-days postpartum)	Persons	25,067	24,808	26,092	31,421	28,188	28,800	28,536	23,246	17,622	10,356	244,136
	Cost per Person	$5,048.85	$5,273.89	$5,419.02	$5,147.89	$5,825.47	$5,888.39	$4,819.42	$7,272.27	$7,272.26	$5,170.92	
	Total	$ 126,559,523	$ 130,834,663	$ 141,393,070	$ 161,751,852	$ 164,208,348	$ 169,585,632	$ 137,526,969	$ 169,051,188	$ 128,151,766	$ 53,550,048	$ 1,382,613,059
FIRST YEAR INFANT COSTS ADJUSTED FOR EFFECTS OF THE DEMONSTRATION	Persons	25,067	24,808	26,092	31,421	28,188	28,800	28,536	23,246	17,622	10,356	244,136
	Cost per Person	$ 2,680.00	$ 2,970.94	$ 3,857.34	$ 3,884.62	$ 4,358.68	$ 4,800.88	$ 5,050.64	$ 202.97	$ 214.28	$ 85.10	
	Total	$ 67,179,560	$ 73,703,080	$ 100,645,715	$ 122,058,645	$ 122,862,472	$ 138,265,344	$ 144,125,063	$ 4,718,241	$ 3,776,042	$ 881,296	$ 778,215,457
FAMILY PLANNING SERVICES FOR DEMONSTRATION PARTICIPANTS	Persons	21,071	33,124	36,797	36,450	29,845	47,100	28,179	22,115	56,019	24,176	334,876
	Cost per Person	$ 58.02	$ 133.30	$ 47.11	$ 192.70	$ 234.15	$ 116.46	$ 179.60	$ 255.00	$ 102.73	$ 250.00	
	Total	$ 1,222,611	$ 4,415,368	$ 1,733,606	$ 7,024,004	$ 6,988,091	$ 5,485,439	$ 5,060,880	$ 5,639,274	$ 5,754,715	$ 6,044,118	$ 49,368,106
TOTAL WITH DEMONSTRATION COSTS		$ 216,693,294	$ 231,811,649	$ 270,615,418	$ 314,766,931	$ 308,285,193	$ 326,503,570	$ 290,325,350	$ 185,036,887	$ 143,176,848	$ 65,903,191	$ 2,353,118,333
DIFFERENCE		$ 39,515,246	$ 32,980,964	$ 5,265,170	$ 21,986,103	$ (1,901,087)	$ 63,109,687	$ 70,975,983	$ 119,010,393	$ 209,036,223	$ 114,265,194	**$ 674,243,876**
PARAMETER ASSUMPTIONS												
FP FMAP		90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%
REGULAR FMAP		80.03%	77.08%	76.00%	75.89%	76.29%	75.84%	75.67%	74.73%	74.18%	73.43%	76.85%

Attachment B

PUBLIC NOTICE

Under the provisions of Title 42, Section 431.408, Code of Federal Regulations, public notice is hereby given to the submission of a Medicaid proposed demonstration extension request of the Family Planning Waiver, effective July 1, 2014 through June 30, 2017.

1. The Family Planning Waiver extension request expands the provision of family planning and family planning-related services to men and women ages 13 through 44, per guidance from the Center for Medicare and Medicaid Services (CMS), who:

   • Have ended Medicaid pregnancy coverage at the conclusion of their 60-day postpartum period (for women only);
   • Have family income at or below 185 percent of the Federal Poverty Level (FPL); and
   • Are not otherwise eligible for Medicaid, Medicare, Children's Health Insurance Program (CHIP) or other health insurance coverage.

2. A public hearing and teleconference on this proposed demonstration extension request is being held Friday, April 18, 2014, at 1:00 p.m., at the Woolfolk State Building, Room 145 located at 501 N. West Street, Jackson, MS. To join the teleconference dial toll-free 1-877-820-7831 and enter the attendee access code: 7251343.

3. A second public hearing is being held Friday, April 25, 2014, at 10:00 a.m. at the War Memorial Building located at 120 North State Street, Jackson, MS.

4. The proposed demonstration extension request and the full public notice are available for review at www.medicaid.ms.gov.

5. Written comments will be received by the Division of Medicaid, Office of the Governor, Bureau of Policy, Planning and Development, Walter Sillers Building, Suite 1000, 550 High Street, Jackson, Mississippi 39201, for thirty (30) days from the date of publication of this notice. Comments will be available for public review at the above address and at www.medicaid.ms.gov.

David J. Dzielak, Ph.D.
Executive Director
Division of Medicaid
Office of the Governor

April 14, 2014

Attachment C

Public Comments For the

Family Planning Waiver (FPW) Demonstration Extension Request

May 14, 2014

Dr. David Dzielak and Dr. Dorthy Young:

For the public, through our governing agencies, to dedicate any part of the treasury to promote childlessness and dispense contraceptives is to make the problem worse, for the problem in today's society is deeper than inconvenient pregnancies and out-of-wedlock births. The bigger cancer eating away at the very fabric of a sustainable culture is that the beauty of motherhood is being ignored, the value of motherhood is being cheapened, and the incalculable treasure in each child is being rejected. The Family Planning Waiver as implemented in county public health clinics and on billboards and other ad campaigns is not part of the solution, but makes the problem worse. The Division of Medicaid should let the FPW lapse and submit no application to extend it.

George Whitten
310 High Street
Greenwood, MS 38930

Attachment D

OFFICE OF THE GOVERNOR
Walter Sillers Building | 550 High Street, Suite 1000 | Jackson, Mississippi 39201

MISSISSIPPI DIVISION OF
MEDICAID

March 31, 2014

Ms. Mary Harrison
Deputy Health Director
Choctaw Health Center
210 Hospital Circle
Choctaw, MS 39350

Dear Ms. Harrison:

This letter is to inform the Mississippi Band of Choctaw Indians of the intent to submit the Family Planning Waiver renewal effective July 1, 2014.

The only change in the waiver renewal is to include Family Planning Waiver eligibility for men who are capable of reproducing.

Please send comments to me at Kristi.Plotner@medicaid.ms.gov or by faxing to (601) 359-6294 by April 30, 2014.

Sincerely,

Kristi R. Plotner, LCSW

Kristi R. Plotner, LCSW
Office Director
Policy, Planning & Development

Copy to: Merry Irons, Tina Scott, Wendy Moran, Durnene Farmer, Laura Dees, Myrana Hancock, Fenton Deweese and Elliot Milholland

State: MISSISSIPPI

Department: DIVISION OF MEDICAID

Name of Demonstration Program: MS FAMILY PLANNING PROGRAM

Date Proposal Submitted: April 6, 2011

Projected Date of Implementation: OCTOBER 1, 2011

Authorizing Signature& Title: ROBERT L. ROBINSON

Primary Family Planning Program Contact:

Name: ASHLYN N. BOOKER

Title: PROJECTS OFFICER IV, SPECIAL

Phone Number: 601-359-2562

Email Address: Ashlyn.booker@medicaid.ms.gov

The State of Mississippi, Division of Medicaid proposes the renewal the existing Section 1115 Family Planning Demonstration, which will increase the number of individuals receiving family planning services.

Date Proposal Submitted: April 6, 2011

Projected Date of Implementation: October 1, 2011

I. Enrollment Projections and Goals

This program will provide Family Planning services to an estimated XXXX residents of the State of Mississippi over the life of the demonstration. Specifically, the State estimates that it will cover the following number of enrollees for each demonstration. Renewal States should use the first three demonstration year lines to represent each year of the proposed renewal period:

*Demonstration Year 1: XXXX
*Demonstration Year 2: XXXX
*Demonstration Year 3: XXXX
Demonstration Year 4:
Demonstration Year 5:

***Please note that these projections will be provided upon development of the new per capita budget with CMS direction.**

Please describe the goals of the demonstration.

The purpose of renewal of the 1115 (a) Waiver for Family Planning services is to allow Mississippi Medicaid to continue to improve the provision of family planning services to a population of women who otherwise may be unable to access the services, with the expectation that decreasing unintended pregnancies, increasing the child spacing interval, and referring for continuance of care will improve future birth outcomes thereby leading to net savings for the Mississippi Medicaid program.

II. Family Planning Demonstration Standard Features

Please provide an assurance that the following requirements will be met by this demonstration, and include the signature of the authorizing official.

☒ The Family Planning Demonstration will be subject to Special Terms and Conditions (STCs).

The core set of STCs is included in the application package. Depending upon the design of the State's Family Planning Demonstration, additional STCs may apply.

☒ The State has utilized a public process to allow interested stakeholders to comment on its proposed Family Planning Demonstration.

☒ Family Planning Demonstrations are intended to provide family planning services to low-income men and women who would not otherwise have access to services for averting pregnancy. Eligible individuals are those who are uninsured, are not enrolled in Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), or who have creditable health insurance coverage.

Signature: _____

Title: Executive Director

III. Eligibility

A. Eligible Populations

Please indicate with check marks the populations which the State is proposing to include in the Family Planning Demonstration, and fill in the age, sex and income information where appropriate. Note that these demonstrations are intended to cover uninsured, low-income individuals with incomes no higher than 200 percent of the Federal poverty level (FPL).

☒ Women losing Medicaid pregnancy coverage at the conclusion of 60 days postpartum.

12 months Period for which individuals would have coverage (e.g. 12 months).

☒ Individuals losing Medicaid coverage with gross income up to and including 133 % FPL.

☐ Men ☒ Women

☒ Individuals losing SCHIP coverage with gross income up to and including 185% FPL.

☐ Men ☒ Women

☒ Uninsured individuals eligible based solely on income, with gross income from 133 % FPL up to and including 185 % FPL.

☐ Men, Ages _____

☒ Women, Ages 13-44 (A woman who has attained age 44 is eligible to participate through the end of the month in which she has her 45th birthday.

A. Initial Eligibility Process

1. **Please describe the initial eligibility process. Please note any differences in the eligibility process for different groups:**

The Division of Medicaid uses a simplified application for the Family Planning program. It is accepted at Medicaid eligibility sites, county health department clinics, or it may be sent in by mail. The application can be mailed, faxed or hand delivered. Point-of-service eligibility is not granted. Women losing Medicaid coverage at the conclusion of their 60 day postpartum period are auto-enrolled without having to complete an application form.

In the initial eligibility process, the applicant submits a completed application to the Division of Medicaid along with a copy of her birth certificate, Social Security card, photo identification (driver's license or student ID card), and a copy of her last paycheck stub, if applicable. Originals are not required. For all auto-enrollees, the Medicaid file does include a copy of the birth certificate and social security card received from the prior enrollment process.

An applicant is only required to present an original birth certificate if they were born in a state that does not utilize the birth certificate database known as Electronic Verification of Vital Events (EVVE). In the event an applicant was not born in in a state that utilizes this electronic verification system, the applicant is notified to present an original birth certificate at one of the 30 Medicaid Regional offices or one of the 94 out stationed Medicaid enrollment offices for verification. Verification of an original birth certificate may be obtained by Health Department staff for those applicants that receive their services and submitted with the completed application.

The applicant is not required to present the original Social Security card as Mississippi validates all social security numbers in the same manner that the regular Medicaid enrollment process is done. This process allows for electronic verification with the Social Security Administration. If the social security number on the application is not validated via the electronic match, the applicant will be notified for a correct number. If a correct number is not supplied the application will be denied.

The Division of Medicaid is in compliance with the citizenship documentation requirements of the Deficit Reduction Act in its Medicaid State Plan and therefore is in compliance for the Family Planning Demonstration. If no birth certificate is submitted with the initial application, the Division of Medicaid will utilize an electronic verification process through the State Department of Health, Vital Statistics Division to obtain the information. If no match is found in this process then the application is returned for the applicant to provide the appropriate documentation.

The Division of Medicaid will not make any confidentiality exceptions regarding eligibility.

2. **Will the State use an automatic eligibility process for any of the groups described under III (A)?** (E.g. Will the State automatically enroll women losing Medicaid after 60 days postpartum?)

☒ Yes
☐ No

If only for certain groups, please describe which groups. If yes, please describe the process for auto-enrollment, including (1) any information verification processes; (2) the process for notifying enrollees of their change in program eligibility; and (3) the timeframe for automatic eligibility.

There is an auto-enrollment process for individuals losing Medicaid pregnancy coverage at the conclusion of 60 days postpartum. These individuals are auto enrolled on the first day of the month following the conclusion of the 60 days postpartum. Eligibility for the individual is systematically rolled over into the Family Planning program. Since the eligibility requirements for the Medicaid pregnancy coverage have already been verified no other verification takes place with this auto enrollment. The individual is then notified via mail that she is now eligible for services through the Family Planning Waiver program. She is issued a separate Medicaid card to indicate to providers that this beneficiary is now only eligible for services related to the Family Planning program.

3. ☒ **Please assure (with a check mark) that the State will not enroll individuals who are enrolled in Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), have private insurance, pregnant or unable to become pregnant.**

All enrollees of the Waiver are coded as a separate category of eligibility. The MMIS includes edits to prevent enrollment of persons in more than one category of eligibility at the same time by validating name, social security number and date of birth against any other matches. Medicaid Eligibility Quality Check (MEQC) is used to monitor and ensure that eligibility determinations are conducted according to State and Federal requirements.

All applications are reviewed for private insurance by self-declaration of coverage and as they are for the regular Medicaid Enrollment process. The MS Division of Medicaid sends notices to all women identified with third party coverage who apply for the Family Planning Waiver Demonstration advising them that they are not eligible under this program. Applicants must provide documentation from their insurance company indicating that their coverage has lapsed in order to be reconsidered for processing.

4. **Where is the initial application accepted?**

- ☒ Medicaid eligibility sites
- ☒ County health department/ local health agency
- ☐ Provider
- ☒ Mail-In
- ☐ On-line
- ☐ Other (Please specify.)

5. **Is the application for Family Planning simplified or the same as full Medicaid? Please attach a copy of the application.**

- ☒ Simplified
- ☐ Same as full Medicaid

6. **Is point-of-service eligibility granted?**

- ☐ Yes
- ☒ No

If yes, please describe the process, including: the entity or entities that will make the point-of-service determination; the services available at initial eligibility determination; how the final eligibility determination is made by the State; how the information is verified; and what information the State receives to make a final eligibility determination.

7. ☒ **Please assure (with a check mark) that the State uses gross income prior to applying any income disregards.**

8. **What income disregards does the State use? Please indicate any differences by eligibility group or age.**

The State does not use income disregards to determine eligibility for the Family Planning Demonstration when the women enroll directly into the Demonstration. To ensure the gross income of the women participating in the Demonstration, documented proof of income is required with the application for validation.

Women who are losing Medicaid eligibility at the end of 60 days' postpartum coverage are auto enrolled without further assessment of income at the time of enrollment into the Family Planning Demonstration. However, the enrollee's gross income is tested against the maximum allowable amount of 185 percent of the Federal poverty level (FPL) at annual redetermination.

9. **Are these income disregards the same as the disregards used in the Medicaid State Plan?**

☐ Yes
☐ No

If no, please describe how income disregards differ from the Medicaid State Plan.

10. **What elements and verification must be provided in the initial application process?**
For those elements that are required, please check a box indicating whether the State allows self-declaration or requires documentation. Please also indicate whether there are differences by eligibility group or age.

a. **Proof of Income:**

☐ Self-declaration
☒ Documentation required

- What documents are sufficient to document income? Applicants are required to provide their last paycheck stub. This stub must be dated no more than one month prior to the date of the application. If the stub is not for a whole month's pay, the amount will be used to calculate monthly income. Additionally, the Income Verification and Eligibility System (IEVS) is used to determine other possible income.

- When are documents required? Documentation is required with the initial application and each renewal application. No documentation is required for women who are auto-enrolled.

- Are there differences by eligibility group or age? No proof of income is required for applicants ages 13-15, nor for women who are auto-enrolled.

☒ Income Verification and Eligibility System (IEVS)

b. Proof of Resources: ******Note that there is no resource test for this eligibility group.

☐ Self-declaration
☐ Documentation required

- What documents are sufficient to document resources?
- When are documents required?
- Are there differences by eligibility group or age?

c. **Social Security Number:**

☒ **Please assure (with a check mark) that the State requires a Social Security Number (SSN) for all Family Planning Demonstration enrollees.**

☒ Documentation required

- What documents are sufficient to document SSN? The applicant is not required to present the original Social Security card as Mississippi validates all social security numbers in the same manner the regular Medicaid enrollment process is done. This process allows for electronic verification with the Social Security Administration. If the social security number on the application is not validated via the electronic match, the applicant will be notified for a correct number. If a correct number is not supplied the application will be denied.
- When are documents required? Documents are required when there is no match with the electronic verification process.
- Are there differences by eligibility group or age? Women who are auto-enrolled are not required to submit a copy of their social security cards. Medicaid will have a copy on file because they were previously Medicaid eligible as pregnant women.

d. Citizenship Status:

☒ **Please assure (with a check mark) that the State is in compliance with the citizenship documentation requirements of the Deficit Reduction Act in its Medicaid State Plan and will require (or continue to require for renewals) the same documentation under the Family Planning Demonstration.**

11. **What entity is responsible for determining final eligibility for the Demonstration?**

☒ State agency
☐ County Agency

B. Eligibility Redetermination Process

1. ☒ **Please assure (with a check mark) that the State will conduct an eligibility redetermination at a minimum of every 12 months**.

2. **Is the eligibility redetermination process identical to the initial eligibility process?**

   ☐ Yes – This section is now complete. Please go to Section III: Program Integrity.

   ☒ No – Please complete question number 3 below.

3. **Please describe the eligibility redetermination process. Please note any differences in the eligibility process for different groups and whether the information and verification requirements differ from the initial application**. (Note: the process for eligibility redeterminations are not passive in nature, but will require an action by the Family Planning program recipient in order to continue eligibility. For example, the State may satisfy this requirement by having the recipient sign and return a renewal form to verify the current accuracy of the information previously reported to the State.)

   The Division of Medicaid conducts eligibility redetermination every 12 months. At redetermination, Family Planning Waiver participants are required to complete a new application form. The application is the same as used for initial eligibility determination. The applicant will check a box to indicate it is a redetermination. Verification of income is required to be submitted with renewal applications, but no other documentation is required. Because a copy of the birth certificate, social security card and photo identification are provided with the initial application, verified, and kept on file, resubmission is not required. The application also asks for current insurance information.

4. **Please describe the process for <u>verifying</u> the information that applicants provide at redetermination.** Because a copy of the birth certificate, social security card and photo identification was received with the initial application and it is kept on file at Medicaid, resubmission is not required and therefore are not re-verified.

IV. Program Integrity

1. **Please describe the State's overall program integrity plan including system edits and checks that the State uses to ensure the integrity of eligibility determinations.**

All enrollees of the Family Planning Waiver are coded as a separate category of eligibility. The enhanced MMIS includes edits to prevent enrollment of persons in more than one category of eligibility at the same time.

2. ☒ **Please assure (with a check mark) that the State assures that all claims made for Federal financial participation under this Demonstration, if approved by CMS, will meet all Medicaid financial requirements**.

3. **Please describe the process the State will use to monitor and ensure that eligibility determinations are conducted according to State and Federal requirements.**

   ☒ Medicaid Eligibility Quality Check (MEQC)
   ☐ Other (Please specify.)

   For sampling purposes, all Family Planning enrollees are included in the Medicaid universe with all other cases subject to MEQC sample selection. cases are identified as Category of Eligibility (COE) 029. All COE 029 cases will be included in the universe, and all will be subject to MEQC sample selection. The review findings are reported with other review findings. Individual sample cases found to be in error are referred to the appropriate unit for action and follow-up. Error patterns or trends identified in the MEQC review process will be used to enhance management controls. Family Planning management staff will review individual cases determined to be in error. The case in error will be returned to the individual staff member having determined eligibility for the case for the necessary corrective actions. The staff member will prepare a report on each cased to include specific corrective actions including dates corrections were made. Because Family Planning eligibility is determined within the Division responsible for family planning, any case determined to be in error will be used as an educational tool for all staff that perform Family Planning eligibility determination.

4. **How does the State ensure that services billed to the Medicaid Family Planning Demonstration program are not also billed to Title X?**
   Patient records are reviewed by the Medicaid Program Nurse when audits are conducted at Health Department clinics to ensure that they are billing the appropriate Medicaid program for services. The Family Planning Demonstration program services with the Health Department can be identified in their PIMS account receivable with MO3 billing in the accounts receivable. Regular Medicaid is identified as MO1. Providers selected for review are determined through random selection. If the Medicaid Program Nurse identifies errors in billing, the Office Manager corrects those errors at that time and the billing clerks receive addition training at that time.

5. **How does the State ensure that enrollees are not dually-enrolled in Medicaid or SCHIP and also in the Family Planning Demonstration?**

All enrollees of the family planning waiver are coded as a separate category of eligibility. The MMIS includes edits to prevent enrollment of persons in more than one category of eligibility at the same time.

6. **How does the State ensure that the services billed to this Family Planning program are not also billed under the regular Medicaid State Plan or SCHIP State Plan?** All Family Planning Waiver participants are identified by a separate category of eligibility and the MMIS has edits to limit the services covered and paid based on this category of eligibility. Therefore, providers are unable to bill for services and obtain reimbursement for Medicaid State Plan services or SCHIP services.

7. **How does the State ensure that the enrollee does not have creditable health insurance coverage?** During the application process, applicants are required to divulge any third party coverage that they have at that time. Also, if the applicant has previously been determined eligible for Medicaid or the Family Planning program, the system will have that information stored and the eligibility worker must verify whether or not the coverage is currently active. The State uses the HIPAA definition of creditable coverage in all reviews of applicants' and recipients' available third party coverage.

V. Service Codes – Federal financial participation (FFP) will be considered for family planning services provided to individuals under the Section 1115 Family Planning Demonstration and will be available, as approved by CMS, at the following rates and as described in Attachment B (note: the State should fill out the template in Attachment B). Specifically:

- For services whose primary purpose is family planning (i.e., contraceptives and sterilizations), FFP will be available at the 90-percent matching rate. Procedure codes for office visits, laboratory tests, and certain other procedures must carry a primary diagnosis that specifically identifies them as family planning services.

- Family planning-related services, reimbursable at the Federal Medical Assistance Percentage (FMAP) rate, are defined as those services generally performed as part of, or as follow-up to, a family planning service for contraception. Such services are provided because a "family planning-related" problem was identified and/or diagnosed during a routine/periodic family planning visit. Services/surgery, which are generally provided in an ambulatory surgery center/facility, a special procedure room/suite, an emergency room, an urgent care center or a hospital for family planning-related services, are not considered family planning-related services and are not covered under the demonstration.

- 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.

VI. Delivery System

1. **Please describe the general delivery system for the Family Planning program.**

   ☒ Fee for Service
   ☐ Primary Care Case Management
   ☐ Other (Please specify.)

2. **Please describe the provider network being used under the Family Planning Demonstration. Please also provide the percentage of patients each of these provider types will be serving**:

☐ Managed Care Organizations	**Estimated Percentage of Patients:**	
☐ All Medicaid Providers	**Estimated Percentage of Patients:**	
☒ Health Departments	**Estimated Percentage of Patients:**	50%
☐ Family Planning Clinics	**Estimated Percentage of Patients:**	
☒ FQHCs/RHCs	**Estimated Percentage of Patients:**	15%
☒ Private Providers	**Estimated Percentage of Patients:**	35%

3. **Primary Care Referrals:** Under the Demonstration, the State is required to evaluate primary care referrals as described in Section IX: Evaluation.

   A. ☒ **Please assure (with a check mark) that the State will provide primary care referrals. (Please attach a letter of support from your State Primary Care Association in Attachment A.)**

   B. **How is information about primary care services given to people enrolled in the Demonstration?**

   ☐ Mailed to enrollees by State Medicaid agency
   ☒ Distributed at application sites during enrollment
   ☒ Given by providers during family planning visits
   ☐ Other (Please specify.)

   Brochures are provided which include names, addresses and telephone numbers of Federally Qualified Health Centers and Rural Health Centers. There is a toll-free telephone number and website included on the brochure. The brochure also includes some general information about the Family Planning Waiver Demonstration program.

   C. **Does the State verify that referrals to primary care services are being made? If so, how?**
   Yes, the State currently verifies that all family planning providers have made referrals by review of the medical records. Primary care referrals are a component of all medical record reviews.

Providers selected for review are determined through random selection. In order to be eligible for review, the provider must have seen a minimum of 25 family planning enrollees during the past year. No less than 10 percent (a minimum of 15 and a maximum of 35) of a provider's medical records are reviewed by a Medicaid Program Nurse. Program areas that may require a written plan of correction and/or a follow-up review are: billing, medical documentation, health education, primary care referral, lab, and contraceptive choices. Medical record compliance and plan of correction necessity for the on-site reviews are:

97% and above	No written plan of correction necessary
91% to 97%	Written plan of correction, but no follow-up review
90.9% and below	Written plan of correction and a 6-month follow-up review

At the conclusion of the site visit, the Medicaid Program Nurse conducts an exit interview with the appropriate staff. The findings of the review are discussed. Written findings to include both strengths and weaknesses will be submitted to the provider within 14 days of the completion date of the review. Effective with the last Waiver renewal period, it is now required that reviews of medical records include at least five cases where the family planning enrollee is less than 20 years old in order to review a cross-section of teens.

In Health Department clinics, the enrollee's file includes follow up to indicate whether or not she presented for the referral appointment. Although the private providers do generally indicate documentation of primary care referrals, they do not routinely follow up to ensure that the patient presented for the referral appointment. For the waiver extension period (2011-2014), the State will continue verification of referrals by all Family Planning providers for primary care services by medical records review. Private providers will also be encouraged to follow up to ensure that the patient presented for the referral appointment.

C. **How does the State notify primary care providers that enrollees in the demonstration will be receiving primary care referrals and may seek their services?** The State works with the appropriate provider associations to educate providers of the Family Planning program including the services offered and the intent to refer patients for necessary services. Information is and will continue to be presented during provider workshops regarding the Waiver Demonstration services and the requirement of primary care referrals. The State provides referral information in the Provider Bulletins and Policy Manual.

VII. Program Administration and Coordination

1. **What other State agencies or program staff coordinate or collaborate on the family planning demonstration program? Please describe the relationship and function of each office in this demonstration.**

☐ Primary care office **Relationship/Function:**
☐ Maternal and child health **Relationship/Function:**
☐ Family planning **Relationship/Function:**
☒ Public health **Relationship/Function:** Outreach and education
☐ Other (Please specify.) **Relationship/Function:**

Please describe how the Medicaid agency coordinates with the Title X family planning program. The Title X agency (Mississippi State Department of Health-MSDH) coordinates with the Medicaid agency in two ways. First, they act as a service provider for family planning demonstration enrollees. The Title X agency does not provide family planning services that are not covered by the demonstration to demonstration enrollees. As a service provider, MSDH clinics provide demonstration family planning services to demonstration enrollees and bill Medicaid for these services as do other family planning providers.

The State Department of Health (SDH) will continue to play an integral role with this program as the lead for outreach and education in addition to being a service provider.

- Outreach activities to improve access to family planning services are coordinated by SDH. SDH will continue to use family planning outreach to encourage participation and coordinate with the Division of Medicaid where necessary.
- Outreach tools to be developed and/or revised for informing the target population will include but not be limited to flyers, posters, fact sheets, news releases and audio/video tapes that are scripted using consistent messages.
- SDH will continue to conduct media campaigns throughout the state. This will be accomplished through broadcast and newspaper coverage to include press conferences with press kits, press releases, radio and television Public Service Announcements (PSAs), direct mail promotion, telephone hotline, community outreach partners, website and newsletters, etc.
- SDH will work with Division of Medicaid Public Relations staff in the development of brochures, flyers, etc.
- SDH will develop and/or revise a brochure which outlines the covered family planning services and will make it available at local public services offices.

How will the State provide training/monitoring to providers?
Provider workshops specifically regarding the Family Planning Program have been initiated and will continue to be conducted as necessary. Information regarding the Family Planning Program will be included in other provider workshops designed for other issues such as program changes and billing issues as necessary. Bulletin articles regarding the Family Planning Waiver will be included in the Provider Bulletin on a quarterly basis. Information has been placed on the Division of Medicaid website for provider convenience and education.

For monitoring purposes, audited family planning providers will receive an on-site medical records review and one-on-one training as needed. The Division of Medicaid has also included a separate and distinct section in the Medicaid Provider Policy Manual for family planning waiver services to provide on-line access to program policies and coverage. Additionally, participant satisfaction surveys will be conducted again to assess availability and accessibility of services, satisfaction with care and services and primary care referrals when appropriate.

How often will provider training/monitoring be offered? Provider workshops specifically regarding the Family Planning Program will be conducted annually. Information regarding the Family Planning Program will be included in other provider workshops designed for other issues such as program changes and billing issues. Bulletin articles regarding Family Planning Waiver will be included. Family planning providers will receive an on-site medical records review and one-on-one training annually. The Division of Medicaid has also included a separate and distinct section in the Medicaid Provider Policy Manual for family planning waiver services to provide on-line access to program policies and coverage.

2. **Will the State provide a written manual for providers on claiming for family planning demonstration services?** Claiming guidance to providers should be separate and distinct from the claiming guidance provided for family planning services under the Medicaid State plan.

   ☒ Yes
   ☐ No

   How does the State communicate information to providers in the demonstration program? Articles on family planning will appear in the Medicaid Provider Bulletin unless a special notice is required and in that instance the State will send individual notices to providers. In addition, the Division of Medicaid has included a separate and distinct section in the Medicaid Provider Policy Manual for family planning waiver services.

VIII. Evaluation

A. Demonstration Purpose, Aim, and Objectives/Hypotheses: Please describe the purpose, aim and objectives of the demonstration, including the overarching strategy, principles, goals, and objectives; the State's hypotheses on outcomes of the demonstration; and key interventions planned.

Primary Goal

The primary goal of the Family Planning Waiver Program for the renewal period is to reduce the number of unintended pregnancies and improve birth outcomes, thereby reduce cost of Medicaid-paid births. This program has and will continue to improve access to family planning services by extending Medicaid for family planning benefits and expanding outreach and education services. This increased access to family planning providers will increase awareness by waiver participants of the importance and benefits of birth spacing.

Objectives

For the renewal period, the Division of Medicaid has made modifications to the objectives based on the program evaluation findings as previous objectives could not be accurately measured.

Objectives of the waiver extension project are as follows:

1. Increase access to and use of family planning services by the target population.

2. Improve birth outcomes and the health of women by increasing the child spacing interval among the target population.

3. Decrease the number of Medicaid-paid deliveries which will reduce the growth of annual expenditures for prenatal, delivery, newborn and infant care.

4. Reduce the number of unintended and unwanted pregnancies among those who are eligible for Medicaid-paid deliveries.

5. Increase provider and beneficiary awareness of the Family Planning Waiver Demonstration program.

Hypotheses

1. It is expected that there will be an increase in use of family planning services because of an increase in access by the target population.

2. It is expected that there will be a decrease in the number of women who have repeat Medicaid deliveries less than 2 years apart.

3. It is expected that there will be a decrease in the state's Medicaid-paid births thereby reducing expenditures for delivery, newborn and infant care.

4. It is expected that there will be an increase in overall program awareness.

B. Evaluation Design

1. Coordination: Please describe the management/coordination of the evaluation, including: information about the organization conducting the evaluation; and timelines for implementation of the evaluation and reporting deliverables.

Upon approval of the waiver renewal, the Division of Medicaid will develop and release a Request for Proposals for the project evaluation. A contract with an independent evaluator will be procured through a competitive bid process as required by State law.

It is the intention of the Division of Medicaid to issue an RFP for the Family Planning Waiver Assessment by July 1, 2011 with a contract in place no later than January 1, 2012 to end March 31, 2014. The Division will expect the contractor to provide comprehensive, accurate and timely progress and status reports and a final report to address each objective for the program as outlined in the waiver application.

2. Performance Measures/Data Sources: Please describe the demonstration performance measures, including:

- **specific performance measures and the rationale for selection, including statistical reliability and validity;**
- **measurement methodology and specifications, including eligible / target populations and time period of study for the specific measure; and,**
- **data sources, method for data collection, rationale for the approach, and sampling methodology. Note: CMS recommends the following minimum data set for family planning demonstrations:**

Measure	Number	Percentage Change
Enrollment		
Averted Births		

The waiver extension project will be evaluated on the basis of these four hypotheses.

Hypotheses

1. It is expected that there will be an increase in use of family planning services because of an increase in access by the target population.

   Measure:
   (a) Unduplicated counts of enrollees.

   (b) Proportion of enrollees accessing waiver services.
   Numerator: Women in the waiver program accessing any waiver service, i.e., with at least one claim for any service covered by the waiver
   Denominator: Women in the waiver program

   (c) Proportion of eligible women in Mississippi between ages 13-44 enrolled in the waiver, i.e., participant women.
   Numerator: Women in the waiver program
   Denominator: Women eligible to enroll in the waiver program.

   (d) Proportion of enrollees obtaining contraceptive prescription services.
   Numerator: Women in the waiver program accessing contraceptive prescription services, i.e., with at least one claim for a contraceptive prescription.
   Denominator: Women in the waiver program.

   Frequency:
   Calculated annually for each waiver year.

   Data Sources:
   Enrollment data, claims data for all services covered by the waiver, pharmacy claims data.

2. It is expected that there will be a decrease in the number of women who have repeat Medicaid deliveries less than 2 years apart.

   Measure:
   (a) Proportion of enrollees with Medicaid-paid delivery who had an inadequately spaced delivery.
   Numerator: Enrollees who had a Medicaid-paid delivery that was less than two years apart from a previous delivery.
   Denominator: Enrollees who had a Medicaid-paid delivery.

Note: To calculate this measure, claims data for Medicaid-paid deliveries from the waiver year, plus nine months (to account for deliveries for women that got pregnant while enrolled in the waiver for that year) are required. In order to calculate the time frame between deliveries, claims data for Medicaid-paid deliveries for these women two years prior to the waiver year being considered is needed.

(b) Proportion of enrollees with a repeat Medicaid-paid delivery (following waiver program implementation) that had an inadequately spaced delivery.
Numerator: Enrollees who had a Medicaid-paid delivery that was less than two years following a prior delivery.
Denominator: Enrollee who had a repeat Medicaid delivery (following waiver implementation).

Note: The numerator is same as in (a) therefore same data would be required to calculate the measure. In order to calculate the time frame between deliveries, claims data for Medicaid-paid deliveries for these women since the start of the program is also needed.

Frequency:
Calculated annually for each waiver year.

Data Sources:
Claims data for enrolled women.

3. It is expected that there will be a decrease in the state's Medicaid-paid births thereby reducing expenditures for delivery, newborn and infant care.

Measure:
Births reduced due to the program.
Estimated Medicaid savings for deliveries, newborn care and infant care.

The baseline fertility rate for teens and women between 13-44 years old will be calculated. An estimate of the fertility rate in the waiver year will be compared to the baseline year to compute the volume of reduced births. Medicaid savings will be estimated by multiplying total reduced births during the waiver year to an average birth cost plus average cost of newborn and infant care.

Frequency:
Calculated annually for each waiver year.

Data Sources:

Claims data for baseline period and claims data for enrollees.

4. It is expected that there will be an increase in overall program awareness by providers and beneficiaries.

   Measure:
   Proportion of enrollees and providers who are acknowledge awareness of the program and services.

   Frequency:
   Surveyed each waiver year.

   Data Sources:
   Enrollee and provider surveys and focus groups.

   Note: Because on-site medical records reviews are conducted only on a sampling of enrollee medical records, an estimate will be provided.

3. Primary Care Referrals: Please describe how the State will evaluate the extent to which clinical referrals to primary care are provided since health concerns requiring follow-up by a primary care provider may be identified during a family planning visit. (For example, some States may be able to provide quantitative information about the frequency of these clinical referrals and how it has changed over time. Other States may prefer to evaluate clinical referrals using qualitative information, which might be obtained, for example, from a focus group of enrollees participating in the family planning demonstration.)

The Division of Medicaid review patient medical records for documentation to assure that they are in compliance with the requirement for primary care referrals. The Division will also evaluate clinical referrals by obtaining information from a focus group of enrollees participating in the program and/or a participant survey. Referral data will also be obtained from provider focus groups and surveys.

4. Integrate Earlier Findings: for renewal States, please describe how the evaluation design plan for the renewal will integrate earlier evaluation findings and recommendations. (Note: renewal States are also asked to provide their interim evaluation report as Attachment E.)

The Division of Medicaid conducted a survey of waiver enrollees to determine program awareness, satisfaction and effectiveness. Although 61% of enrollees indicated that they used Family Planning Waiver services, non-participant data revealed that 39% of enrollees did not participate due to lack of education or misinformation regarding eligibility, availability, and accessibility of services. It was also noted that 51% of non-participants reported not being aware they were

covered under the program and 42% were auto-enrolled but did not want to be enrolled. The Division of Medicaid and State Department of Health will strive to improve the knowledge and availability of public family planning services. Participation at health fairs and other public forums will be scheduled. All providers will be requested to question women between the ages of 13-44 about their use of birth control and inform them of this program. These providers will be asked to urge those women who are not enrolled in the family planning program to apply and those who are enrolled to utilize the services.

The Division of Medicaid will also communicate and explain the auto-enroll function to providers and beneficiaries so that participation rates can reflect numbers consistent with a knowledgeable population. The Division will also review and monitor correspondence generation from the fiscal agent to ensure that beneficiary correspondence is being disseminated according to policy and in a consistent manner that educates as well as informs the beneficiary of how to dis-enroll from the program if desired. As always, the Division will publish informative articles within the Medicaid Provider Bulletins in an effort to increase provider awareness thus, improving beneficiary awareness.

It was also noted that 73.8% of family planning participants were very satisfied with the program, which the Division attributes some of this satisfaction to the previous renewal's proposal to allow beneficiaries to receive contraceptives through Medicaid participating pharmacies.

According to the survey, the program effectiveness has a direct relationship with beneficiary education, as it was reported that participants possessed a higher level of program knowledge than non-participants. It is the intention of the Division of Medicaid to close this gap by initiating more program awareness for both providers and beneficiaries. During the upcoming Waiver years, we will work with the Evaluation team and Division staff to develop more effective communication avenues.

Another decision made from previous findings is to increase the quality assurance plan for the family planning waiver program to ensure that eligible enrollees are provided high quality and appropriate family planning services.

The Quality Assurance Plan consists of quality assurance activities designed to:

- **Ensure the provision of comprehensive, accessible, quality and appropriate services;**
- **Provide a system for accountability and measuring performance;**
- **Improve care outcomes and quality of life.**

Activities/functions will be performed by Division of Medicaid program staff in conjunction with the SDH quality monitoring and quality improvement activities for their clinics.

- **Ensure standards of care for family planning waiver services are evidence based best practices.**
- **Conduct periodic on site review of medical records in accordance with the details below:**

The Division of Medicaid has implemented a process for periodic on-site review of medical records to determine that participants have received appropriate medical care and are appropriately referred for needed primary care. Providers selected for review are determined through random selection. In order to be eligible for review, the provider must have seen a minimum of 25 family planning enrollees during the past year. No less than 10 percent (a minimum of 15 and a maximum of 35) of a provider's medical records are reviewed by a Medicaid Program Nurse. Program areas that may require a written plan of correction and/or a follow-up review are: medical documentation, health education, primary care referral, lab, and contraceptive choices. Medical record compliance and plan of correction necessity for the on-site reviews are:

97% and above	No written plan of correction necessary
91% to 97%	Written plan of correction, but no follow-up review
90.9% and below	Written plan of correction and a 6-month follow-up review

At the conclusion of the site visit, the Medicaid Program Nurse conducts an exit interview with the appropriate staff. The findings of the review are discussed. Written findings to include both strengths and weaknesses will be submitted to the provider within 14 days of the completion date of the review. Effective with the waiver renewal period, it will be required that reviews of medical records include at least five cases where the family planning enrollee is less than 20 years old in order to review a cross-section of teens.

The Division of Medicaid and the Evaluation team have developed instruments for evaluation of participant and provider satisfaction with the care and services provided and the overall family planning program. The conducted surveys will assist the Division of Medicaid with assessing whether family planning services are available, accessible and appropriate; whether the participants are satisfied with the services received; and whether the participants are referred for primary care when needed. These surveys should also assist in developing strategies for improving the program as well as identifying barriers to the success of the program.

Tracking and trending analyses of complaints and appeals for information that can be integrated into quality improvement for the program may be performed.

5. Please provide an evaluation design plan for analysis, including:

- **Evaluation of performance;**
- **Outcomes;**
- **Limitations/Challenges/Opportunities;**
- **Successes/Best Practices;**
- **Interpretations/Conclusions;**
- **Revisions to strategy or goals; and,**
- **Recommendations and implications at the State and Federal levels.**

The design for assessing overall programmatic impact associated with the family planning program is basically going to be analysis of the four hypotheses. The waiver program is expected to change family planning participation and associated outcomes. The evaluation is designed to link services received by the target population within the context of other conditions affecting participation and availability of services to desired short, immediate and long-term outcomes.

The target population of the waiver is women losing Medicaid pregnancy coverage at the conclusion of 60 days postpartum, women losing Medicaid coverage with gross income up to and including 133 % FPL, and uninsured women (ages 13-44) eligible based solely on income, with gross income from 133% FPL up to and including 185 % FPL.

The waiver program is within a context of Mississippi's economic conditions, health, and related policy initiatives and other state health programs for women and children. All of these factors have the potential to directly affect program outcomes.

One of the short term outcomes is that the waiver is expected to increase access and use of family planning services. Access to services will be improved by conducting outreach to both eligible populations and providers. These short term outcomes will be tracked.

Intermediate outcomes are expected to be influenced by short term outcomes. Improvements in short term outcomes should lead to improvements in intermediate outcomes that will be assessed through evaluation of birth spacing among women in the target population, the rate of subsequent deliveries and repeat births among the target population, and overall provider and beneficiary awareness of the program.

As short and intermediate indicators improve, there should also be improvement in long term measures of success for the program. For example, increased access and use of family planning services should result in fewer Medicaid-paid deliveries and therefore decrease cost savings to the Medicaid program or at least slow the growth rate of expenditures. The potential effect of the Waiver on these

long term outcomes will include evaluation of the number of births paid for by the Mississippi program and evaluation of the cost-effectiveness of the waiver program.

The evaluation model as currently proposed is designed to measure the overall impact of the Mississippi Family Planning Waiver program. Baseline data will be compared to demonstration year data. These comparisons will form the basis for assessing the program's impact.

Throughout the evaluation of the program, there will be documentation of limitations or challenges to the program. Opportunities for improvement will be studied and suggested for implementation when practical.

The evaluation vendor will assist the Division of Medicaid in determining successes and best practices. The Division will revise strategies and/or goals based on the conclusions of evaluations as information is gathered. Recommendations and implications at the State and Federal Levels will be included in the actual evaluations.

The preliminary analysis of the Family Planning Waiver program by HealthSystems of Mississippi does not necessarily indicate that the program has had a significantly positive effect to date, but overall contraceptive usage by participants and non-participants is impressive at 78%. However, staff of the Division of Medicaid believe that the changes proposed in this application could make a difference in family planning for the state of Mississippi. Likewise, modifications within the objectives were necessary to reveal meaningful data for the program that could actually be measured. With accessibility of contraceptives being addressed with the previous Waiver, the Division of Medicaid perceives the next avenue to promote the program effectiveness and attainment of objectives is to respond to the population's need for increased education and communication. It is anticipated that fine tuning our aim toward the expressed beneficiary and provider needs, that we will derive positive results from renewing the Waiver.

Attachment

A

Letter of Support

From the State Primary Care Association

MISSISSIPPI **PRIMARY**
HEALTH CARE ASSOCIATION

6400 lakeover road, suite a
jackson, mississippi 39213

po box 11745
jackson, mississippi 39283-1174

p 601.981.1817
f 601.981.1217

mphca.com

March 23, 2011

Ashlyn N. Booker, MBA
Projects Officer, IV Special
Office of the Governor, Division of Medicaid
Bureau of Maternal & Child Health
550 High Street, Suite 1000
Jackson, MS 39201

Dear Ms. Booker,

The Mississippi Primary Health Care Association, Inc. (MPHCA) is a membership organization representing 21 Community Health Centers in the State and other community-based health care providers. MPHCA is a non-profit 501 (c)(6) organization that represents the interests of its members in statewide efforts to improve access to health care for the medically underserved and indigent population of Mississippi. With this vast service network, we have the capability to provide primary care services to the clients of this waiver.

MPHCA continues to support the Medicaid Division's Family Planning efforts for the state, and we fully support the efforts of the Bureau of Maternal of & Child Health in their request for renewal of funding for this great cause. We look forward to working with them and performing integral roles for this demonstration waiver.

Sincerely,

Robert M. Pugh, MPH
Executive Director

RMP/vn

cc: Ms. Joyce Smith,
Clinical Services Coordinator/MPHCA

Attachment

B

Demonstration Service Codes

FAMILY PLANNING WAIVER PROCEDURE CODES

CODES	DESCRIPTION	BEGIN DATE	END DATE
00851	Anesthesia intraperitioneal procedures in lower abdomen including laparoscopy; tubal ligation	10-1-08	
11975	Insertion, implantable contraceptive capsules	10-1-08	
11976	Norplant removal	10-1-08	
11977	Removal of reinsertion, implantable contraceptive capsules	10-1-08	
49320	Diagnostic laproscopy, abdomen, peritoneum, and omentum	10-1-03	9-30-08
49321	Laproscopy, biopsy (sing or multiple)	10-01-03	9-30-08
57160	Fitting and insetion of pessary device or other intravaginal devices	10-1-03	9-30-08
57170	Diaphragm or cervical cap fitting with instruction	10-1-08	
57410	Pelvic exam under anesthesia	10-1-03	9-30-08
57505	Endocervical curettage(not done as part of D& C)	10-1-03	9-30-08
57700	Cerclage of uterine cervix, non-obstetrical)	10-1-03	9-30-08
57720	Trachelottaphy-plastic repair of uterine cervix, vaginal approach	10-01-03	9-30-08
57800	Dilation of cervical canal instrumental (separate procedure)	10-01-03	9-30-08
58100	Endometrial cervical biopsy	10-01-03	9-30-08
58120	Dilation and Curretage, diagnostic or nonobstetrical	10-01-03	9-30-08
58140	Myomectomy, excision of fibroid tumors, abdominal approach	10-01-03	9-30-08
58145	Myomectomy, excision of fibroid tumors, Vaginal approach	10-01-03	9-30-08
58300	Insertion of Intrauterine Device (IUD)	10-01-03	
58301	IUD Removal	10-01-03	
58340	Cath and introduction of saline or contrast material	10-01-03	9-30-08
58345	Trancervical introduction of fallopian tube	10-01-03	9-30-08
58350	Hydrotubation of oviduct; ; including material	10-01-03	9-30-08
58400	Uterine suspension, with or without shortening of round ligaments and etc	10-01-03	9-30-08
58540	Hysteroplasty, repair of utrine anominaly	10-01-03	9-30-08
58555	Hysteroscopy, diaaagnostice	10-01-03	9-30-08
58558	Hysteroscopy, biopsy	10-01-03	9-30-08
58559	Hysteroscopy, with lysis of adhesions	10-01-03	9-30-08
58560	Hysteroscopy, resection of intrauterine septum	10-01-03	9-30-08
58561	Hysteroscopy. Removal of myoma	10-01-03	9-30-08
58565	Hysteroscopy, surgical ; with bilateral fallopian tube cannulation to include by placement of permanent implants	10-01-08	
58600	Ligation or transaction to fallopian tubes (s), abdominal or vaginal	10-01-08	

	approach, unilateral or bilateral		
58605	Tubal ligation, post partum	10-01-08	9-30-08
58611	ligate oviducts-add on at time of c-section	10-01-03	9-30-08
58615	Occlusion of fallopian tube (s) by device, vaginal or suprapubic approach	10-01-03	
58670	Tubal ligation by laparoscopic surgery	10-1-03	
58671	Tubal ligation by laparoscopic surgery	10-01-03	
58672	Laparoscopy frimbia plasty	10-01-03	9-30-08
58752	Tubouterine implantable	10-01-03	9-30-08
58760	Frimbria plasty	10-01-03	9-30-08
58825	Transpositional ovaries	10-01-03	9-30-08
58920	Wedge resection of ovaries	10-01-03	9-30-08
74742	Xray of fallopian tubes	10-01-03	9-30-08
76856	Echography of pelvis nonobstectrical	10-01-03	9-30-08
A4260	Levonorgestral implant discontinued	10-01-03	12-30-05
A4261	Cervical cap contraceptive discontinued	10-01-03	9-30-08
76857	Ultrasound exam, pelvis	10-0103	9-30-08
76872	Ultrasound- transrectal	10-01-03	9-30-08
74740	Hysterosalpingography, radiological supervision and interpretation	Pending Approval	
93975	Duplex scan or arterial inflow and venous outflow	10-01-03	9-30-08
93976	Duplex scan follow-up	10-01-03	9-30-08
99050	Medical services, after hours	10-01-03	9-30-08
99201	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three components; problem focused history, problem focused examination, and straight forward medical decision-making.	10-01-08	
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three components; an expanded problem focused examination; and straight forward medical decision-making.	10-01-03	
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three components; a detailed examination and medical decision making of low complexity	10-1-03	
99204	Office or other outpatient visit for evaluation and management of a new patient, which requires thee three components; a comprehensive history, a comprehensive examination; and medical decision making of moderate complexity.	10-01-03	

99205	Initial Visit	10-01-08	
99211	Office or other outpatient visit for evaluation and management of an established patient that may not require the presence of a physician	10-01-03	
99212	Office or other outpatient visit for evaluation and management of established patient, which requires these three components; a problem focused history; a problem focused examination; and straightforward medial decision making	10-01-03	
99213	Office visit or other outpatient visit for the evaluation and management of an established patients, which requires at least two of these three key components; an expanded problem focused history; an expanded problem focused examination and medical decision making of low complexity.	10-01-08	
99214	Office visit or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components; an detailed history; a detailed examination ; and medical decision making of moderate complexity.	10-01-08	
99215	Office or other outpatient visit for evaluation and a management of an established patient, which requires these three components; a comprehensive history; a comprehensive examination; and a medial decision making of high complexity.	10-01-03	
99241	Office consultation for a new or established patient which requires these three components; a problem focused history, a problem focused examination; and straightforward medical decision making.	10-01-03	
99242	Office consultation for a new or established patient which requires these three components; an expanded problem focused history, an expanded problem focused examination; and straightforward medical decision making.	10-01-03	
99243	Office consultation for a new or established patient which requires these three components; a detailed history; a detailed examination; and medical decision making of low complexity.	10-01-03	
99244	Office consultation for a new or established patient which requires these	10-01-03	

	three components; a comprehensive history,a comprehensive examination; and medial decision making of high complexity.		
99245	Office consultation for new or established patient which requires these three components; a comprehensive history; a comprehensive examination and medial decision making of high complexity.	10-01-03	
J1055	Depo Provera, 150mg	10-01-03	
J7300	Intrauterine Copper Contraceptive system, (Paragard T380) IUD	10-01-03	
J7302	Levonorgestrel-releasing intrauterine contraceptive system 52 mg (Mirena) IUD	10-01-03	
J7303	Vaginal Ring	10-01-08	
J7304	Ortho Evra Patch	10-01-08	
J7307	Etonogestrel(contraceptive) implant system, including implants and supplies	01-01-08	
S4989	Hormonal (Progestasert) IUD including IMP	10-01-03	

FAMILY PLANNING WAIVER LABORATORY CODES

CODES	DESCRIPTION	BEGIN DATE	END DATE
81000	Urinalysis, by dip stick or tablet reagent	10-1-03	
81001	Urinalysis , automated without microscopy	10-1-03	
81002	Urinalysis ; non-automated	10-1-03	
81003	Urinalysis; automated without microscopy	10-1-03	
81005	Urinalysis; qualitative or semi quantitative, except immunoassays	10-1-03	
81007	Urinalysis; bacteriuria screen, by non-culture technique, commercial kit	10-1-03	
81015	Urinalysis microscopic only	10-1-03	
81025	Urine Pregnancy test	10-1-03	
82947	Glucose; quantitive	10-1-03	
82948	Glucose	10-1-08	
84702	HCG quantitative	10-1-03	
84703	HCG qualitative	10-1-03	
85007	Blood count ; manual differential WBC count(includes RBC morphology and platelet estimation)	10-1-03	

85008	Blood count; manual blood smear examination without differential parameters	10-1-08	
85009	Blood count; differential WBC count, buffy coat	10-1-08	
85013	Blood count; spun micro hematocrit	10-1-03	
85014	Blood count; other than spun hematocrit	10-1-03	
85018	Blood count; hemoglobin	10-1-03	
85025	Blood count; hemogram and platelet count, automated, and automated complete differential WBC count (CBC)	10-1-03	
86255	Fluorescent antibody	10-1-08	
86382	Neutralization Test; viral	10-1-03	
86592	Syphilis	10-1-03	
86593	Syphilis	10-1-03	
86689	HTLV or HIV antibody	10-1-03	
86694	Herpes simplex, non-specific type test	10-1-03	
86695	Herpes simplex, type 1	10-1-03	
86701	HIV-1	10-1-03	
86702	Antibody HIV 2	10-1-08	
86703	HIV 1& 2	10-1-03	
86706	Hepatitis B surface (HbsAb)	10-1-03	
86707	Hepatitis B antibody (HbeAb)	10-1-03	
86762	Rubella titer	10-1-03	
86781	Antibody; Treponema Pallidum (Syphilis Confirmatory)	10-1-03	
86803	Hepatitis C antibody	10-1-08	
87070	Culture, bacterial; definitive; any other source (GC)	10-1-03	
87075	Culture; bacterial any source; anaerobic (isolation)	10-1-08	
87077	Bacterial culture, aerobic isolate; additional methods require of definitive identification, each isolate	10-1-03	
87081	Culture, bacterial, screening only, for single organisms	10-1-03	
87086	Culture, bacterial urine; quantitative colony count	10-1-03	
87110	Culture, Chlamydia	10-1-03	
87164	Dark field examination, any source, includes specimen collection	10-1-03	
87205	Smear, primary source, with interpretation; routine stain for bacteria, fungi, or cell types	10-1-03	
87206	Smear, primary source, with interpretation, fluorescent and/or acid fast stain, for bacteria, fungi , or cell types	10-1-08	
87207	Smear, primary source, with interpretation, special stain for inclusion bodies or intracellular parasites(e.g. malaria, kala azar , herpes)	10-1-08	
87209	Smear, primary source, with interpretation, complex special stain(e.g.	10-1-03	

	trichrome, iron hemotoxylin) for ova and/or parasites		
87210	Smear, primary source, with interpretation, wet mount with simple stain, for bacteria, fungi, ova, and/or parasites	10-1-03	
87220	Tissue examination for fungi	10-1-08	
87252	Virus identification; tissue culture inoculation & observation	10-1-03	
87340	Hepatitis B surface antigen (HbsAg)	10-1-03	
87350	Hepatitis BE antigen (HbeAg)	10-1-03	
87480	Candida species, direct probe technique	10-1-03	
87481	Candida species, amplified probe technique	10-1-03	
87482	Candida species, quantification	10-1-08	
87490	Infectious agent detection by nucleic acid (DNA or RNA) Chlamydia Trachomatis. Direct Probe	10-1-03	
87491	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia Trachomatis. Amplified probe technique	10-1-03	
87510	Gardnerella vaginalis, direct probe technique	10-1-03	
87511	Gardnerella vaginalis, amplified probe technique	10-1-03	
87515	Hepatitis B. Virus, direct probe technique	10-1-03	
87516	Hepatitis B. Virus. Amplified probe technique	10-1-03	
87520	Hepatitis C Virus, direct probe technique	10-1-08	
87521	Hepatitis C Virus Direct amplified technique	10-1-08	
87528	Herpes simplex virus, direct probe technique	10-1-03	
87529	Herpes simplex virus, amplified probe technique	10-1-03	
87590	Neisseria gonorrhea, direct probe technique + C48	10-1-03	
87591	Neisseria gonorrhea, amplified probe technique	10-1-08	
87620	Papillomavirus, human, direct probe technique	10-1-08	
87621	Papillomavirus, human amplified probe technique	10-1-08	
87660	Trichomonas vaginalis, direct probe technique	10-1-03	
88141	Cytopathology, cervical or vaginal; requiring interpretation by physician (us in conjunction with 88142-88154	10-1-03	
88142	Cytopathology,cervical or vaginal, automated thinlayer preparation	10-1-03	
88143	Cytopathology, manual screening & rescreening under physician supervision		
88150	Cytopathology, manual screening under physician supervision	10-1-03	
88152	Cytopathology,slides, cervical or vaginal	10-1-03	
88153	Cytopathology, slides, manual screening & rescreening under physician supervision (use in conjunction with 88142-88154,88162-881667	10-1-03	
88154	Cytopathology, slides, cervical or vaginal	10-1-03	

88155	Cytopathology , slides, cervical or vaginal	10-1-03	
88160	Cytopathology, smears, any other source	10-1-08	
88161	Cytopathology, any other source	10-1-08	
88162	Cytopathology, any other source	10-1-08	
88164	Cytopathology, slides, cervical or vaginal	10-1-03	
88165	Cytopathology, slides, cervical or vaginal	10-1-03	
88166	Cytopathology, slides, computer assisted rescreening	10-1-03	
88167	Cytopathology, slides, cervical or vaginal	10-1-03	
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.	10-1-03	
88300	Level I Surgical Pathology, gross examination only	10-1-08	
88302	Surgical pathology, gross and microscopic examination	10-1-03	

FAMILY PLANNING WAIVER DIAGNOSIS CODES

DIAGNOSIS	DESCRIPTION	BEGIN DATE	END DATE
V25	ENCOUNTER FOR CONTRACEPTIVE MANAGEMENT	10-01-03	
V25.0	GENERAL COUNSEL; ADVICE FOR CONTRACEPTIVE	10-01-03	
V25.01	PRESCRIPTION; ORAL CONTRACEPTIVE	10-01-03	
V25.02	INITIATE CONTRACEPTIVE	10-01-03	
V25.09	CONTRACEPTIVE MANAGEMENT	10-01-03	
V25.1	INSERTION OF IUD	10-01-03	
V25.2	STERILIZATION	10-01-03	
V25.3	MENSTRUAL RXTRACTION	10-01-03	9-30-08
V25.4	SURVEILANCE OF PRESCRIBED CONTRACEPTIVE	10-01-03	
V25.40	CONTRACEPTIVE SURVELIANCE NOS	10-01-03	
V25.41	CONTRACEPTIVE PILL SURVELIANCE	10-01-03	
V25.42	IUD SURVELIANCE	10-01-03	
V25.43	SVRL IMPLANT SUBDERMAL CONTRACEPTIVE	10-01-03	
V25.49	CONTRACEPTIVE SURVELIANCE	10-01-03	
V25.5	INSERT IMPLANT SUBDERMAL CONTRACEPTIVE	10-01-03	
V25.8	CONTRACEPTIVE MANAGEMENT NEC	10-01-03	
V25.9	CONTRACEPTIVE MANAGEMENT NOS	10-01-03	
V26.0	TRUBOPLASTY OR VASOPLASTY AFTER PREVIOUS STERILIAZTION	10-01-03	9-30-08
V26.1	ARTIFICIAL INSEMINATION	10-01-03	9-30-08

V26.2	INVESTIGATE AND TESTING	10-01-03	9-30-08
V26.22	AFTERCARE FOLLOWING STERILIZATION REVERSAL	10-01-03	9-30-08
V26.29	INVESTIGATE AND TEST	10-01-03	
V26.4	PROCREATIVE MANAGEMENT	10-01-03	9-30-07
V26.4	PROCREATIVE MANAGEMENT COUNSEL	10-01-03	
V26.41	PROCREATIVE COUNSELLING AND ADVICE USING	10-01-03	
V26.49	OTHER PROCREATIVE COUNSELLING	10-01-03	
V26.5	STERILIZATION STATUS	10-01-03	
V26.51	TUBAL LIGATION STATUS	10-01-03	
V26.8	OTHER SPECIFIED PROCREATIVE MANAGEMENT	10-01-03	9-30-07
V72.3	GYNECOLOGICAL EXAM	10-1-03	9-30-08
V72.31`	ROUTINE GYNECOLOGICAL EXAM	10-01-03	9-30-08
V72.32	ENCOUNTER PAP SMEAR SCREENING	10-01-03	9-30-08
V76.2	SCREEN NEOP CERVIX	10-01-03	9-30-08

FAMILY PLANNING WAIVER ICD-9 CODES

DIAGNOSIS	DESCRIPTION	BEGIN DATE	END DATE
66.2	BILATERAL ENDOSCOPIC DESTRUCTION	10-1-03	
66.21	BILATERAL ENDOSCOPIC CRUSH TUBE	10-1-03	
66.22	BILATERAL ENDOSCOPIC DIVISION TUBE	10-1-03	
66.29	BILATERAL ENDOSCOPIC OOC TUBE NEC	10-1-03	
66.3	OTHER BILATERAL DESTRUCTION/OCCULSION FAL TUBE	10-1-03	
66.31	BILATERAL TUBE CRUSHING NEC	10-1-03	
66.32	BILATERAL TUBE DIV NEC	10-1-03	
66.39	BILATERAL TUBE DESTRUCTION NEC	10-1-03	
66.52	REMOVE SOLITARY FAL TUBE	10-1-03	
66.6	OTHER SALPINGECTOMY	10-1-03	

Attachment

C

Budget Neutrality Worksheet

Model Budget Neutrality Worksheet for : ALL COSTS		
		Base Year
		2001
WITHOUT DEMONSTRATION		
FAMILY PLANNING SERVICES UNDER MEDICAID STATE PLAN -- All current Medicaid eligibles/participants	Persons	54,414
	Cost per Person	$ 179
	Total	$ 9,754,751
DELIVERIES UNDER MEDICAID STATE PLAN (include costs for prenatal care, deliveries, and 60- days postpartum)	Persons	25,067
	Cost per Person	$ 4,193
	Total	$ 105,112,198
FIRST YEAR INFANT COSTS UNDER MEDICAID STATE PLAN	Persons	29,538
	Cost per Person	$ 2,843
	Total	$ 83,977,420
TOTAL BASE YEAR (WITHOUT DEMONSTRATION COSTS)		$ 198,844,369
PARAMETER ASSUMPTIONS		
REGULAR FMAP	76.82%	
FP FMAP =	90.00%	
MCPI COST TREND	4.317%	
DELIVERY REDUCTION	7.822%	
DELIVERY TO FIRST YEAR PERSON FACTOR	1 to 1	
BASE YEAR FERTLITY RATE	174 per 1,000	
AVERAGE GROWTH RATE FOR MEDICAID STATE PLAN ENROLLEES/PARTICIPANTS	5%	
PARTICIPANTS	3%	
Please note that the budget narrative for this entire worksheet is described in the application under Section I - Budget Neutrality Agreement.		

Model Budget Neutrality Worksheet for : ALL COSTS

		2004	2005	2006	2007	2008	2009	2010	2011	T
WITHOUT DEMONSTRATION										
FAMILY PLANNING SERVICES UNDER MEDICAID STATE PLAN -- All current Medicaid	Persons	57,744	56,496	54,022	53,478	50,317	63,732	56,927	59,773	
	Cost per Person	$203.20	$ 211.97	$ 221.12	$ 230.67	$ 240.62	$ 251.01	$ 261.85	$ 273.15	
	Total	$ 11,733,435	$ 11,975,429	$ 11,945,357	$ 12,335,556	$ 12,107,470	$ 15,997,469	$ 14,906,206	$ 16,327,193	$
DELIVERIES UNDER MEDICAID STATE PLAN (include costs for prenatal care, deliveries, and 60- days postpartum)	Persons	30,609	30,343	30,367	35,781	31,113	37,867	33,655	35,926	
	Cost per Person	$4,759.82	$4,965.30	$5,179.65	$5,403.25	$5,636.51	$5,879.84	$6,133.67	$6,398.46	
	Total	$ 145,691,319	$ 150,662,657	$ 157,288,292	$ 193,331,792	$ 175,369,803	$ 222,650,796	$ 206,429,046	$ 229,873,905	
FIRST YEAR INFANT COSTS UNDER MEDICAID STATE PLAN	Persons	30,609	30,343	30,367	35,781	31,113	37,867	33,655	35,926	
	Cost per Person	$3,227.32	$3,366.64	$3,511.98	$3,663.59	$3,821.75	$3,986.74	$4,158.84	$4,338.38	
	Total	$ 98,783,787	$ 102,154,527	$ 106,646,939	$ 131,085,687	$ 118,906,833	$ 150,964,992	$ 139,966,081	$ 155,862,512	
TOTAL WITHOUT-WAIVER COSTS		$ 256,208,541	$ 264,792,613	$ 275,880,588	$ 336,753,034	$ 306,384,106	$ 389,613,257	$ 361,301,334	$ 402,063,609	
WITH DEMONSTRATION										
FAMILY PLANNING SERVICES UNDER MEDICAID STATE PLAN -- All current Medicaid eligibles/participants	Persons	57,744	56,496	54,022	53,478	50,317	63,732	47,827	50,218	
	Cost per Person	$376.34	$404.60	$496.89	$447.52	$282.73	$206.60	$75.53	$78.79	
	Total	$ 21,731,600	$ 22,858,538	$ 26,843,027	$ 23,932,431	$ 14,226,282	$ 13,167,155	$ 3,612,438	$ 3,956,806	$
DELIVERIES UNDER MEDICAID STATE PLAN ADJUSTED FOR EFFECTS OF THE DEMONSTRATION (include costs for prenatal care, deliveries, and 60- days postpartum)	Persons	25,067	24,808	26,092	31,421	28,188	28,800	28,536	30,768	
	Cost per Person	$5,048.85	$5,273.89	$5,419.02	$5,147.89	$5,825.47	$5,888.39	$4,819.42	$5,027.47	
	Total	$ 126,559,523	$ 130,834,663	$ 141,393,070	$ 161,751,852	$ 164,208,348	$ 169,585,632	$ 137,526,969	$ 154,685,763	$
FIRST YEAR INFANT COSTS ADJUSTED FOR EFFECTS OF THE DEMONSTRATION	Persons	25,067	24,808	26,092	31,421	28,188	28,800	28,536	30,768	
	Cost per Person	$ 2,680.00	$ 2,970.94	$ 3,857.34	$ 3,884.62	$ 4,358.68	$ 4,800.88	$ 5,050.64	$ 5,268.68	
	Total	$ 67,179,560	$ 73,703,080	$ 100,645,715	$ 122,058,645	$ 122,862,472	$ 138,265,344	$ 144,125,063	$ 162,107,080	$
FAMILY PLANNING SERVICES FOR DEMONSTRATION PARTICIPANTS	Persons	21,071	33,124	36,797	36,450	29,845	47,100	28,179	29,024	
	Cost per Person	$ 58.02	$ 157.83	$ 168.03	$ 199.23	$ 234.47	$ 108.71	$ 167.16	$ 174.38	
	Total	$ 1,222,611	$ 5,227,843	$ 6,183,136	$ 7,261,847	$ 6,997,686	$ 5,120,285	$ 4,710,503	$ 5,061,271	$
TOTAL WITH DEMONSTRATION COSTS		$ 216,693,294	$ 232,624,124	$ 275,064,948	$ 315,004,774	$ 308,294,788	$ 326,138,416	$ 289,974,973	$ 325,810,920	$
DIFFERENCE		$ 39,515,246	$ 32,168,489	$ 815,640	$ 21,748,260	$ (1,910,682)	$ 63,474,841	$ 71,326,360	$ 76,252,689	$
PARAMETER ASSUMPTIONS										
FP FMAP		90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	
REGULAR FMAP		80.03%	77.08%	76.00%	75.89%	76.29%	75.84%	75.84%	75.84%	

Model Budget Neutrality Worksheet for: FEDERAL COSTS

		2004	2005	2006	2007	2008	2009	2010	2011	T
WITHOUT DEMONSTRATION										
FP SERVICES UNDER MEDICAID STATE PLAN -- All current Medicaid eligibles/participants	Persons	57,744	56,496	54,022	53,478	50,317	63,732	56,927	59,773	$
	Cost per Person	$182.88	$190.77	$199.01	$207.60	$216.56	$225.91	$235.66	$245.84	
	Total	$ 10,560,091	$ 10,777,886	$ 10,750,821	$ 11,102,000	$ 10,896,723	$ 14,397,723	$ 13,415,586	$ 14,694,473	$
DELIVERIES UNDER MEDICAID STATE PLAN (include costs for prenatal care, deliveries, and 60- days postpartum)	Persons	30,609	30,343	30,367	35,781	31,113	37,867	33,655	35,926	
	Cost per Person	$ 3,809.28	$ 3,827.25	$ 3,936.53	$ 4,100.53	$ 4,300.10	$ 4,459.27	$ 4,651.78	$ 4,852.60	
	Total	$ 116,596,762	$ 116,130,776	$ 119,539,102	$ 146,719,497	$ 133,789,623	$ 168,858,363	$ 156,555,789	$ 174,336,370	$
FIRST YEAR INFANT COSTS UNDER MEDICAID STATE PLAN	Persons	30,609	30,343	30,367	35,781	31,113	37,867	33,655	35,926	
	Cost per Person	$ 2,582.82	$ 2,595.01	$ 2,669.11	$ 2,780.30	$ 2,915.61	$ 3,023.54	$ 3,154.07	$ 3,290.23	
	Total	$ 79,056,665	$ 78,740,710	$ 81,051,674	$ 99,480,928	$ 90,714,023	$ 114,491,850	$ 106,150,276	$ 118,206,129	$
TOTAL WITHOUT-WAIVER COSTS		$ 206,213,518	$ 205,649,371	$ 211,341,597	$ 257,302,425	$ 235,400,369	$ 297,747,936	$ 276,121,650	$ 307,236,972	$
WITH DEMONSTRATION										
FAMILY PLANNING SERVICES UNDER MEDICAID STATE PLAN -- All current Medicaid eligibles/participants	Persons	57,744	56,496	54,022	53,478	50,317	63,732	47,827	50,218	
	Cost per Person	$ 338.71	$ 364.14	$ 447.20	$ 402.77	$ 254.46	$ 185.94	$ 67.98	$ 70.91	
	Total	$ 19,558,440	$ 20,572,684	$ 24,158,724	$ 21,539,188	$ 12,803,654	$ 11,850,440	$ 3,251,194	$ 3,561,126	$
DELIVERIES UNDER MEDICAID STATE PLAN ADJUSTED FOR EFFECTS OF THE DEMONSTRATION (include costs for prenatal care, deliveries, and 60- days postpartum)	Persons	25,067	24,808	26,092	31,421	28,188	28,800	28,536	30,768	
	Cost per Person	$ 4,040.59	$ 4,065.11	$ 4,118.46	$ 3,906.73	$ 4,444.25	$ 4,465.75	$ 3,655.05	$ 3,812.84	
	Total	$ 101,285,586	$ 100,847,358	$ 107,458,733	$ 122,753,480	$ 125,274,549	$ 128,613,743	$ 104,300,453	$ 117,313,683	$
FIRST YEAR INFANT COSTS ADJUSTED FOR EFFECTS OF THE DEMONSTRATION	Persons	25,067	24,808	26,092	31,421	28,188	28,800	28,536	30,768	
	Cost per Person	$ 2,144.80	$ 2,290.00	$ 2,931.58	$ 2,948.04	$ 3,325.24	$ 3,640.99	$ 3,830.41	$ 3,995.76	
	Total	$ 53,763,802	$ 56,810,334	$ 76,490,744	$ 92,630,306	$ 93,731,780	$ 104,860,437	$ 109,304,448	$ 122,942,009	$
FAMILY PLANNING SERVICES FOR DEMONSTRATION PARTICIPANTS	Persons	21,071	33,124	36,797	36,450	29,845	47,100	28,179	29,024	$
	Cost per Person	$ 52.22	$ 142.04	$ 151.23	$ 179.30	$ 211.02	$ 97.84	$ 150.45	$ 156.94	
	Total	$ 1,100,350	$ 4,705,058	$ 5,564,822	$ 6,535,662	$ 6,297,917	$ 4,608,257	$ 4,239,453	$ 4,555,144	$
TOTAL WITH WAIVER COSTS		$ 175,708,178	$ 182,935,435	$ 213,673,023	$ 243,458,636	$ 238,107,900	$ 249,932,876	$ 221,095,548	$ 248,371,962	$
DIFFERENCE		$ 30,505,340	$ 22,713,937	$ (2,331,427)	$ 13,843,789	$ (2,707,531)	$ 47,815,060	$ 55,026,102	$ 58,865,010	$

PARAMETER ASSUMPTIONS

90.00%		MCPI COST TREND =	4.317%
76.85%			

Administrative Costs

	2004	2005	2006	2007	2008	2009	2010	2011	TOTAL
Administrative Costs									
*PERSONNEL**	$65,600.00	$65,600.00	$69,986.00	$69,986.00	$69,986.00	$69,986.00	$17,496.51	$0.00	$428,640.51
*SYSTEMS CHANGES***	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
*PUBLIC AWARENESS****	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
EVALUATION	$24,764.00	$4,764.00	$0.00	$34,558.00	$34,558.00	$0.00	$107,423.28	$179,038.72	$385,106.00
ANNUAL PROVIDER WORKSHOPS	$0.00	$0.00	$0.00	$0.00	$0.00	$2,000.00	$2,000.00	$2,000.00	$6,000.00
									$819,746.51
**Includes fringe benefits - position vacated - responsibilities split among 5 EPSDT Medical Review Nurses*									
***No special reimbursement required for the FP waiver system changes; all DOM system changes/needs are incorporated into the MMIS Contract*									
**** Brochures continue to be provided by the MS State Departement of Health.*									

	Year	Data from BLS
Year 1	2004	313%
Year 5	2007	356%

# steps	3
avg. growth	4.317%

If you are completeing this budget for a renewal, please use this worksheet to calculate the annualized rate of without demonstration deliveries. In Year 1, input the number of without demonstration deliveries calculated for the first year of the demo. In Year X, put the last year of the demonstration for which you have a births averted calculation that was used to create the without demonstration deliveries, and then input the number of deliveries. The formula will then calculate the trend rate. Use this trend rate to project forward the without demonstration deliveries for the renewal years.

	Year	**Number of Without Demonstration Deliveries**
Year 1	2004	25,067
Year 4	2007	31,421
# steps		3
avg. growth		7.822%

Base Year CY 2001

Age Grouping	Base Year Fertility Rate
Under 15	14.80
15 - 19	257.37
20 - 24	388.31
25 - 29	164.06
30 - 34	103.38
35 - 39	53.54
40 - 44	9.86

Base Year fertility rate is calculated by dividing the number of live births by the population of women for the age group for the waiver program. Per 1000

FFY 2004 (Demonstration Yr 1)	Under 15	Age 15 - 19	Age 20 - 24	Age 25 - 29	Age 30 - 34	Age 35 - 39	Age 40 - 44	Totals
Base Year Fertility Rate	0.014796972	0.257373511	0.388308307	0.164055655	0.103381643	0.053535489	0.009856787	
Waiver Participants	246	7,485	7,828	3,383	1,352	559	218	21,071
Expected Births	3.6	1,926.4	3,039.7	555.0	139.8	29.9	2.1	5,697
Actual Births	0.0	0.0	49.0	67.0	28.0	9.0	2.0	155
Births Averted	3.6	1,926.4	2,990.7	488.0	111.8	20.9	0.1	5,542
Estimated Prenatal/Delivery Cost Averted	$18,378.09	$9,726,310.29	$15,099,481.72	$2,463,840.22	$564,319.96	$105,653.94	$ 751.17	$27,978,735.40
Estimated Birth to 1 Yr Cost Averted	$9,755.35	$5,162,861.16	$8,015,015.50	$1,307,840.75	$299,548.91	$56,082.59	$398.73	$14,851,502.99
						Total Costs Averted/Annual Budget Limit:		**$42,830,238.38**
						Waiver Expenditures:		**$1,222,611.42**
						Savings:		**$41,607,626.96**

FFY 2005 (Demonstration Yr 2)	Under 15	Age 15 - 19	Age 20 - 24	Age 25 - 29	Age 30 - 34	Age 35 - 39	Age 40 - 44	Totals
Base Year Fertility Rate	0.014796972	0.257373511	0.388308307	0.164055655	0.103381643	0.053535489	0.009856787	
Waiver Participants	176	7,502	13,397	6,591	2,978	1,647	833	33,124
Expected Births	2.6	1,930.8	5,202.2	1,081.3	307.9	88.2	8.2	8,621
Actual Births	0.0	8.0	970.0	1,310.0	535.0	198.0	65.0	3,086
Births Averted	2.6	1,922.8	4,232.2	(228.7)	(227.1)	(109.8)	(56.8)	5,535
Estimated Prenatal/Delivery Cost Averted	$13,734.62	$ 10,140,720.51	$ 22,319,979.99	$(1,206,187.05)	$ (1,197,855.83)	$ (579,215.78)	$ (299,500.50)	$ 29,191,675.95
Estimated Birth to 1 Yr Cost Averted	$ 7,737.12	$ 5,712,571.21	$ 12,573,512.41	$ (679,481.25)	$ (674,788.02)	$ (326,289.57)	$ (168,717.59)	$ 16,444,544.30
						Total Costs Averted/Annual Budget Limit:		**$45,636,220.24**
						Waiver Expenditures:		**$5,227,843**
						Savings:		**$ 40,408,377.66**

FFY 2006 (Demonstration Yr 3)	Under 15	Age 15 - 19	Age 20 - 24	Age 25 - 29	Age 30 - 34	Age 35 - 39	Age 40 - 44	Totals
Base Year Fertility Rate	0.014796972	0.257373511	0.388308307	0.164055655	0.103381643	0.053535489	0.009856787	

Waiver Participants	119	6,712	15,790	7,897	3,451	1,849	979	36,797
Expected Births	1.8	1,727.5	6,131.4	1,295.5	356.8	99.0	9.6	9,622
Actual Births	0.0	64.0	2,209.0	2,027.0	693.0	288.0	66.0	5,347
Births Averted	1.8	1,663.5	3,922.4	(731.5)	(336.2)	(189.0)	(56.4)	4,275
Estimated Prenatal/Delivery Cost Averted	$ 9,542.03	$ 9,014,491.04	$ 21,255,499.92	$(3,963,755.69)	$ (1,822,036.83)	$(1,024,264.58)	$ (305,362.89)	$ 23,164,112.99
Estimated Birth to 1 Yr Cost Averted	$ 6,792.16	$ 6,416,650.40	$ 15,129,984.77	$(2,821,460.96)	$ (1,296,953.24)	$ (729,086.95)	$ (217,361.90)	$ 16,488,564.28
							Total Costs Averted/Annual Budget Limit:	**$ 39,652,677.26**
							Waiver Expenditures:	**$ 6,183,135.98**
							Savings:	**$ 33,469,541.28**

FFY 2007 (Demonstration Yr 4)	**Under 15**	**Age 15 - 19**	**Age 20 - 24**	**Age 25 - 29**	**Age 30 - 34**	**Age 35 - 39**	**Age 40 - 44**	**Totals**
Base Year Fertility Rate	0.014796972	0.257373511	0.388308307	0.164055655	0.103381643	0.053535489	0.009856787	
Waiver Participants	71	5,537	16,158	8,385	3,483	1,872	944	36,450
Expected Births	1.1	1,425.1	6,274.3	1,375.6	360.1	100.2	9.3	9,546
Actual Births	1.0	128.0	2,548.0	1,726.0	553.0	192.0	38.0	5,186
Births Averted	0.05	1,297.1	3,726.3	(350.4)	(192.9)	(91.8)	(28.7)	4,360
Estimated Prenatal/Delivery Cost Averted	$ 260.41	$ 6,677,210.40	$ 19,182,508.49	$(1,803,786.34)	$ (993,139.89)	$ (472,481.40)	$ (147,719.70)	$ 22,442,851.97
Estimated Birth to 1 Yr Cost Averted	$ 196.50	$ 5,038,651.77	$ 14,475,203.66	$(1,361,144.95)	$ (749,427.65)	$ (356,536.50)	$ (111,469.92)	$ 16,935,472.91
							Total Costs Averted/Annual Budget Limit:	**$ 39,378,324.87**
							Waiver Expenditures:	**$ 7,261,847.06**
							Savings:	**$ 32,116,477.81**

FFY 2008 (Demonstration Yr 5)	**Under 15**	**Age 15 - 19**	**Age 20 - 24**	**Age 25 - 29**	**Age 30 - 34**	**Age 35 - 39**	**Age 40 - 44**	**Totals**
Base Year Fertility Rate	0.014796972	0.257373511	0.388308307	0.164055655	0.103381643	0.053535489	0.009856787	
Waiver Participants	44	3,525	13,442	7,300	3,063	1,626	845	29,845
Expected Births	0.7	907.2	5,219.6	1,197.6	316.7	87.0	8.3	7,737
Actual Births	0.0	136.0	2,446.0	1,523.0	489.0	184.0	34.0	4,812
Births Averted	0.7	771.2	2773.6	(325.4)	(172.3)	(97.0)	(25.7)	2,925
Estimated Prenatal/Delivery Cost Averted	$ 3,792.77	$ 4,492,844.96	$ 16,157,758.13	$(1,895,571.35)	$ (1,003,973.32)	$ (564,786.86)	$ (149,545.73)	$ 17,040,518.61
Estimated Birth to 1 Yr Cost Averted	$ 2,837.79	$ 3,361,595.46	$ 12,089,410.33	$(1,418,287.10)	$ (751,183.75)	$ (422,579.67)	$ (111,891.74)	$ 12,749,901.32
							Total Costs Averted/Annual Budget Limit:	**$ 29,790,419.92**
							Waiver Expenditures:	**$ 6,997,686.00**
							Savings:	**$ 22,792,733.92**

FFY 2009 (Demonstration Year 6)	**Under 15**	**Age 15 - 19**	**Age 20 - 24**	**Age 25 - 29**	**Age 30 - 34**	**Age 35 - 39**	**Age 40 - 44**	**Totals**
Base Year Fertility Rate	0.014796972	0.257373511	0.388308307	0.164055655	0.103381643	0.053535489	0.009856787	
Waiver Participants	72	5,928	20,589	11,249	5,067	2,736	1,459	47,100
Expected Births	1.1	1,525.7	7,994.9	1,845.5	523.8	146.5	14.4	12,052
Actual Births	0.0	103.0	1,551.0	883.0	314.0	110.0	24.0	2,985
Births Averted	1.1	1,422.7	6,443.9	962.5	209.8	36.5	(9.6)	9,067

Estimated Prenatal/Delivery Cost Averted	$ 6,273.38	$ 8,377,472.37	$ 37,944,076.97	$ 5,667,351.98	$ 1,235,589.04	$ 214,767.83	$ (56,640.12)	$ 53,388,891.44
Estimated Birth to 1 Yr Cost Averted	$ 5,114.77	$ 6,830,260.83	$ 30,936,293.32	$ 4,620,664.86	$ 1,007,391.61	$ 175,102.97	$ (46,179.42)	$ 43,528,648.94
							Total Costs Averted/Annual Budget Limit:	**$ 96,917,540.38**
							Waiver Expenditures:	**$ 5,120,285.00**
							Savings:	**$ 91,797,255.38**

FFY 2010 (Demonstration Year 7)	**Under 15**	**Age 15 - 19**	**Age 20 - 24**	**Age 25 - 29**	**Age 30 - 34**	**Age 35 - 39**	**Age 40 - 44**	**Totals**
Base Year Fertility Rate	0.014796972	0.257373511	0.388308307	0.164055655	0.103381643	0.053535489	0.009856787	
Waiver Participants	47	3,623	13,087	6,748	2,858	1,231	576	28,170
Expected Births	0.7	932.5	5,081.8	1,107.0	295.5	65.9	5.7	7,489
Actual Births	0.0	81.0	1,254.0	649.0	276.0	97.0	13.0	2,370
Births Averted	0.7	851.5	3,827.8	458.0	19.5	(31.1)	(7.3)	5,119
Estimated Prenatal/Delivery Cost Averted	$ 3,351.70	$ 4,103,563.75	$ 18,447,731.60	$ 2,207,523.57	$ 93,808.73	$ (149,873.42)	$ (35,290.16)	$ 24,670,815.76
Estimated Birth to 1 Yr Cost Averted	$ 3,512.51	$ 4,300,439.31	$ 19,332,793.39	$ 2,313,433.32	$ 98,309.37	$ (157,063.86)	$ (36,983.27)	$ 25,854,440.77
							Total Costs Averted/Annual Budget Limit:	**$ 50,525,256.53**
							Waiver Expenditures:	**$ 4,710,503.00**
							Savings:	**$ 45,814,753.53**

FFY 2011 (Proposed Year 8)	**Under 15**	**Age 15 - 19**	**Age 20 - 24**	**Age 25 - 29**	**Age 30 - 34**	**Age 35 - 39**	**Age 40 - 44**	**Totals**
Base Year Fertility Rate	0.014796972	0.257373511	0.388308307	0.164055655	0.103381643	0.053535489	0.009856787	
Waiver Participants	48.4	3,731.7	13,479.6	6,950.4	2,943.7	1,267.9	593.3	29,015
Expected Births	0.7	960.4	5,234.2	1,140.3	304.3	67.9	5.8	7,714
Actual Births	0.0	87.3	1,352.1	699.8	297.6	104.6	14.0	2,555
Births Averted	0.7	873.1	3,882.2	$ 440.5	$ 6.7	$ (36.7)	$ (8.2)	5,158
Estimated Prenatal/Delivery Cost Averted	$ 3,601.29	$ 4,389,499.62	$ 19,517,443.06	$ 2,214,573.33	$ 33,884.96	$ (184,548.97)	$ (41,069.57)	$ 25,933,383.71
Estimated Birth to 1 Yr Cost Averted	$ 3,774.07	$ 4,600,093.45	$ 20,453,826.10	$ 2,320,821.31	$ 35,510.65	$ (193,403.02)	$ (43,039.95)	$ 27,177,582.60
							Total Costs Averted/Annual Budget Limit:	**$ 53,110,966.31**
							Waiver Expenditures:	**$ 5,061,271.08**
							Savings:	**$ 48,049,695.24**

Attachment

D

Implementation Schedule

Family Planning Waiver
Project Timeline

FP Waiver Action	Scheduled Completion Date
• Submit Q_1 Narrative Report	January 31, 2012, 2013, 2014
• Submit Q_1 CMS 64.9 Report	January 31, 2012, 2013, 2014
• Submit Q_2 Narrative Report	April 30, 2012, 2013, 2014
• Submit Q_2 CMS 64.9 Report	April 30, 2012, 2013, 2014
• Annual Provider Workshops	May 2012, 2013
• Submit Q_3 Narrative Report	August 31, 2012, 2013, 2014
• Submit Q_3 CMS 64.9 Report	August 31, 2012, 2013, 2014
• Submit Q_4 & Annual Narrative Report	October 31, 2012, 2013, 2014
• Submit Q_4 CMS 64.9 Report	October 31, 2012, 2013, 2014
• Submit Waiver Assessment Report	March 31, 2013
• Final Report and Evaluation	March 31, 2014

Attachment

E

Interim Evaluation Report

eQ·Health solutions

175 East Capitol Street, Ste. 250 • Jackson, MS 39201 • (601) 352-6353 • Fax: (601) 352-6358

eQHealth Solutions/DOM Family Planning Waiver Communication Tracking Form

Control #: FPW 10-058

To: Ashlyn Booker

From: Becky Rau **Signature:**

Date: 02/28/2011

Subject: FPW Interim Report – Detailed Report

Requested Response Date:

EQH Comments: The attached report is the "heavy duty" research report. Under separate copy is the Executive Summary – a smaller report with highlights/snapshots of the current measurement period.

Attachment? ☐ **Yes** ☐ **No**

DOM Response:
- ☐ **Receipt Acknowledgement (if applicable)**
- ☐ **Approved**
- ☐ **Approved with Comments**
- ☐ **Denied**

DOM Comments:

DOM Authorized Representative:

Signature **Date**

February

2011

eQ·Health solutions

Mississippi Medicaid Family Planning Waiver Program

Interim Report

Becky Rau, Project Director
Silvia Morales, Statistical Analyst
Dennis Hardy, Project Manager

Are we hitting the objective?

Table of Contents

APPENDIX A – Detailed Method

Objective 1: Increase access to and use of family planning services by the target population.

- Measure 1.1 – Proportion of eligible women enrolled in each waiver year
- Measure 1.2 – Proportion of enrolled women seeking family planning services in each waiver year
- Measure 1.3 – Proportion of participants in a prior year returning for service in the following year
- Measure 1.4 – Proportion of Medicaid providers providing family planning services
- Measure 1.5 –Reasons for not seeking family planning services offered by the waiver for each waiver year

Objective 2: Improve birth outcomes and the health of women by increasing the child spacing interval among the target population

- Measure 2.1 – Proportion of enrolled women with two Medicaid paid births whose spacing is inadequate for each waiver year
- Measure 2.2 –Comparing the proportion of FPW women with inadequately spaced births among those who seek family planning services and those who don't seek family planning services
- Measure 2.3 – Average number of days between births for each waiver year
- Measure 2.4 – Comparing the average days between births of women on the waiver who seek family planning services to those who don’t seek family planning services
- Measure 2.5 – Proportion of enrolled women with births giving birth to low or very low birth weight infants
- Measure 2.6 – Comparing this proportion of women on the waiver who seek family planning services to those who don’t seek family planning services

Objective 3: Decrease the number of Medicaid paid deliveries which will reduce the growth of annual expenditures for prenatal care, delivery, newborn and infant care

- Measure 3.1 – Proportion of enrollees who had a Medicaid paid birth in each waiver year
- Measure 3.2 – Compare proportion of Medicaid paid births in each waiver year among participating enrollees and enrollees that do not seek any family planning services
- Measure 3.3 – Births averted based on baseline fertility rates
- Measure 3.4 –Use births averted to calculate Medicaid birth costs averted and hence cost savings to assess budget neutrality
- Measure 3.5 –Proportion of enrollees who had continuous use of contraceptive methods during the waiver years

Objective 4: Reduce teen pregnancy and repeat births among teens

- Measure 4.1 – Proportion of enrollees with Medicaid paid births who are

Introduction

Section 1115 of the Social Security Act allows the Secretary of Health and Human Services (HHS) to conduct research and demonstration projects and waive certain Medicaid requirements. These projects are referred to as "Section 1115 waiver projects" and may include federal financial participation. [1] One type of such a program is the family planning demonstration. An evaluation of Medicaid family planning expansions conducted in 2003 suggested these programs had been successful in their objective of averting unintended Medicaid pregnancies, subsequently yielding notable savings to both state and federal governments.[2,3] As a result, CMS established Family Planning Waivers with a goal of expanding access to family planning services for low-income women. CMS proceeded with the understanding that these services could provide a cost-effective way to reduce the number of unintended pregnancies and improve the health and lives of participants who use the services.

The Mississippi Medicaid Family Planning Waiver (FPW) provides family planning services to a population of women who otherwise may be unable to access these services. The goal of this program is to increase the number of women receiving preventative services and reproductive health counseling, thereby reducing unintended pregnancies. DOM projects that by decreasing unintended pregnancies and increasing child spacing intervals, that future birth outcomes will improve, thereby leading to net savings for the Mississippi Medicaid program.

The Mississippi Family Planning Waiver demonstration was originally approved for five years from October 2003 to October 2008. CMS approved of an extension of the waiver for an additional three-year period.

eQHealth Solutions was contracted during December 2009 to evaluate the Mississippi FPW with a two-year independent assessment (RFP#20090911) whether the following program objectives are being met:

[1] Baumrucker, E.P, "CRS Report for Congress, Medicaid and SCHIP Section 1115 Research and Demonstration Waivers", Congressional Research Service, The Library of Congress, Order Code RS 21054, September 11, 2008
[2] Edwards, j., Bronstein, J., and Adams, K., Evaluation of Medicaid Family Planning Demonstrations, The CNA Corporation, CMS Contract No. 752-2-415921, November 2003
[3] Alan Guttmacher Institute, State Policies in Brief: State Medicaid Family Planning Eligibility Expansions, Alan Guttmacher Institute, New York, New York, November 1, 2006

Mississippi Family Planning Waiver Program Objectives:

1. Increase access to and use of family planning services by the target population.
2. Improve birth outcomes and the health of women by increasing the child spacing interval among the target population.
3. Decrease the number of Medicaid-paid deliveries which will reduce the growth of annual expenditures for prenatal care, delivery, newborn and infant care.
4. Reduce teen pregnancy and repeat births among teens.
5. Reduce the number of unintended and unwanted pregnancies among those who are eligible for Medicaid-paid deliveries.
6. Increase the number of primary care referrals to improve the health of the target population.

Each objective has been measured with several metrics that provide the quantitative basis for the evaluation of the waiver impact. Given the absence of quantitative goals attached to the objectives (i.e. by how much does use of family planning need to be increased?) the determination whether these requirements have been met involves a certain degree of subjectivity. However, the selected metrics do draw a picture of the impact the Family Planning Waiver is making on low-income women in Mississippi. The following interim or benchmark report was developed to provide detailed background information to the reader on the methodology used to identify and describe our findings as part of our analysis.

Methodology

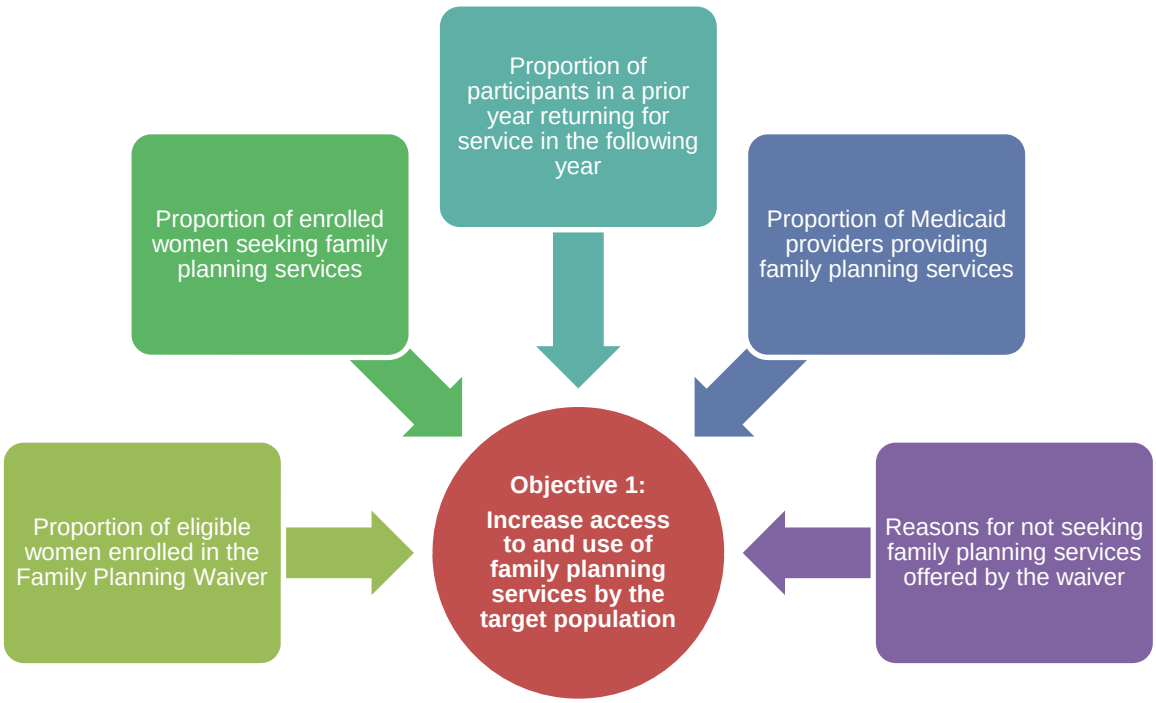
The core of the FPW analysis is made up of quantitative measures that are indicative of whether waiver objectives are being reached. These measures use data from a variety of sources such as the Medicaid Medical Management Information System (MMIS), the U.S. Census Bureau's Current Population Survey (CPS), the Pregnancy Risk Assessment Monitoring System (PRAMS), as well as the surveys and focus groups conducted by eQHealth Solutions. The following is a description of the adopted measures and their relation to the FPW objectives, the assumptions, the data and their sources and the limitations applied in this analysis. Also, additional details can be found in the Appendices A and B.

Program Objectives Measures

Objective 1: Increase access to and use of family planning services by the target population.

The FPW reaches out to women who meet financial requirements in order to become eligible for preventative & family planning counseling and birth control options. One of the goals of the FPW is to enroll all eligible women and encourage these women to use the services. Increasing the number of providers who offer family planning services to Medicaid FPW beneficiaries facilitates access to these services, in addition to enrolling those eligible for services. Knowledge of the reasons why beneficiaries do not use the services once enrolled or discontinue use of services, may be help in further understanding how to improve access to these services. Access to and use of family planning services by the target population has been evaluated with the measures listed in Figure 1.

Figure 1 - Objective 1 Measures



In order to draw conclusions with regard to this objective, eQHealth:

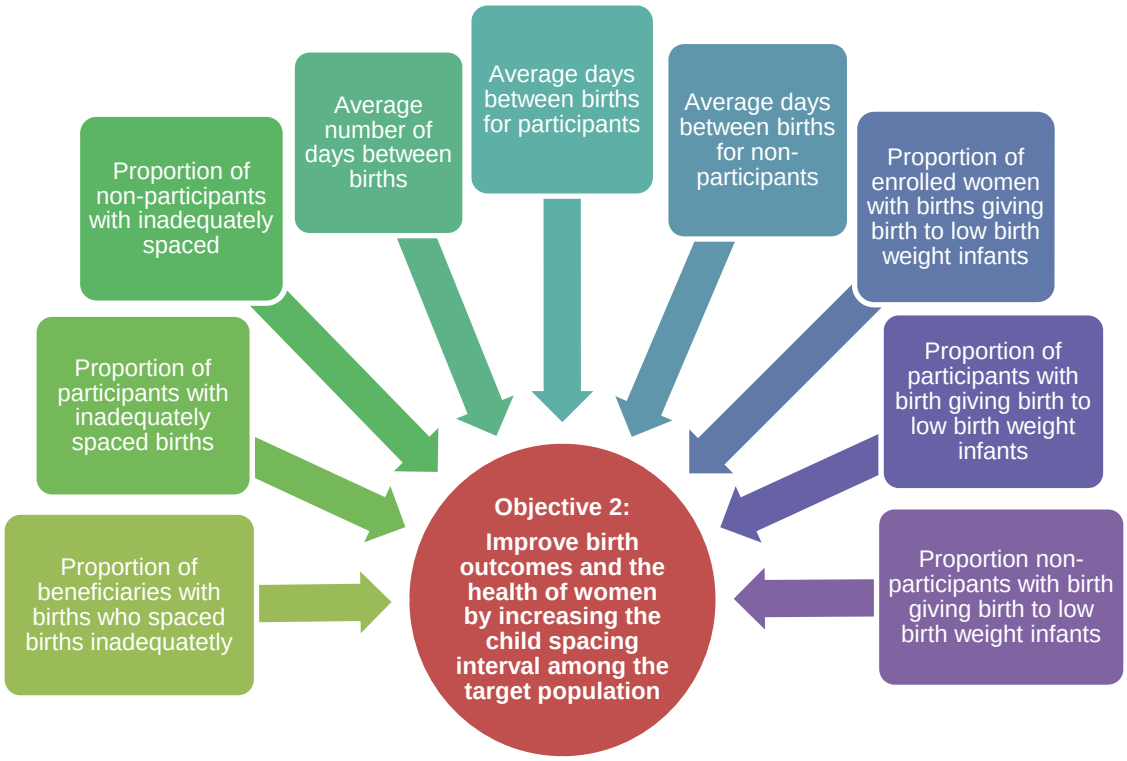
1. Calculated the proportion of eligible women enrolled in each waiver year.
2. Calculated the proportion of enrolled women seeking family planning services in each waiver year.

3. Calculated the proportion of participants in a prior year returning for service in the following year.
4. Calculated the proportion of Medicaid providers providing family planning services.
5. Collected reasons for not seeking family planning services offered by the waiver for each waiver year.

Objective 2: Improve birth outcomes and the health of women by increasing the child spacing interval among the target population.

Improving both mothers' and babies' health is an important goal of the FPW. If more women are aware that increased time between births can improve both their and their baby's health and in birth spacing increases then the FPW had a positive impact. In order to draw conclusions on the effectiveness of the FPW on birth spacing and adverse birth outcomes, the analysis compared birth spacing and low baby birth weight between women who participate in the FPW and those enrolled women who do not seek family planning services. This objective has been assessed with the following measures displayed in Figure 2.

Figure 2 - Objective 2 Measures



The analytic activities consisted of:

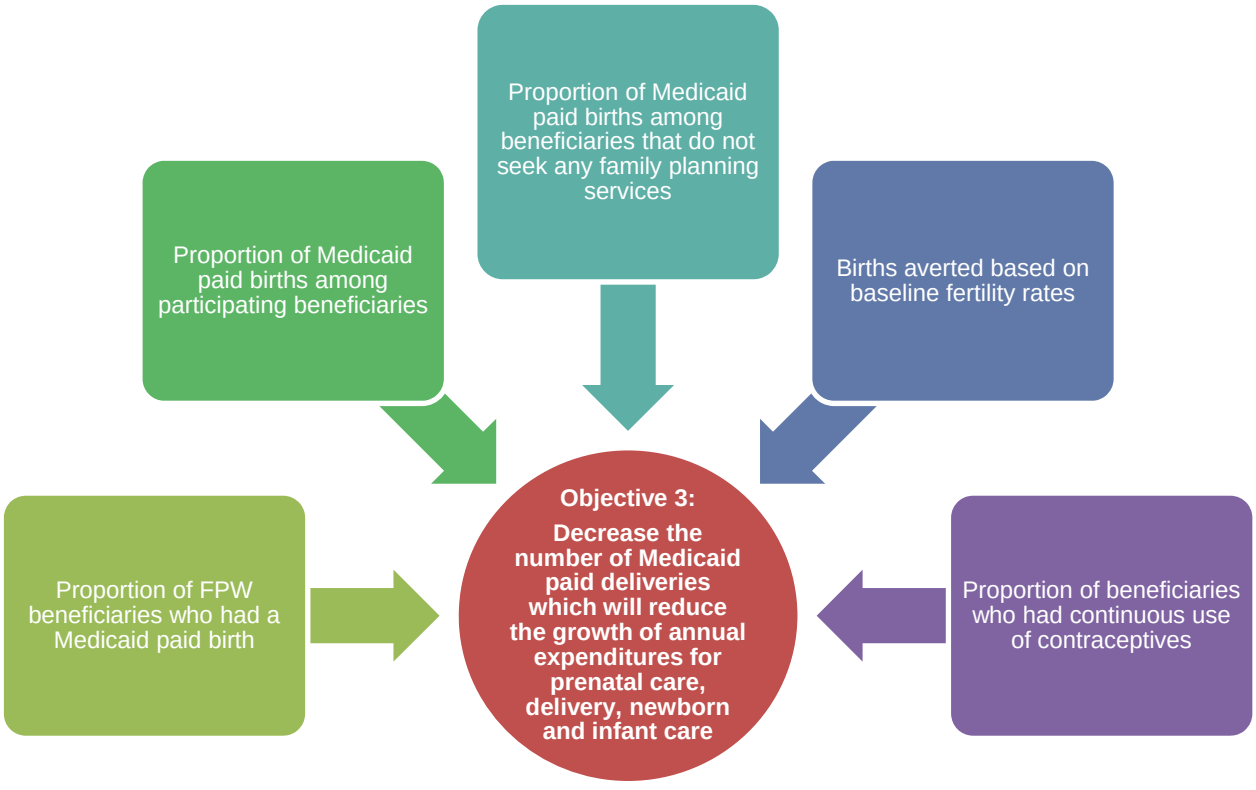
1. Calculating the proportion of women with births who spaced births inadequately.
2. Comparing the proportion of participating women with births who spaced births inadequately to those women who don't seek family planning services and have inadequately spaced births.

3. Calculating the average number of days between births for each waiver year.
4. Comparing the average days between births of women on the waiver who seek family planning services to those who don't seek family planning services.
5. Calculating the proportion of enrolled women with births giving birth to low or very low birth weight infants.
6. Comparing this proportion of women on the waiver who seek family planning services to those who don't seek family planning services.

Objective 3: Decrease the number of Medicaid paid deliveries which will reduce the growth of annual expenditures for prenatal care, delivery, newborn and infant care.

FPW beneficiaries are counseled about birth spacing and birth control by the FPW service provider. Programmatic efforts such as counseling and other information, along with and continuous use of contraceptive methods should lead to a smaller number of Medicaid paid births, Therefore lending to a lower overall cost due to a decrease births in low birth weights, high risk pregnancies and numbers of births including the possible medical costs accrued during an infant's first year of life. Ultimately, it is expected that the savings due to births averted are equal to or surpass the cost of FPW. The measures depicted in Figure 3 have been adopted to evaluate the decrease in the number of Medicaid paid deliveries.

Figure 3 - Objective 3 Measures



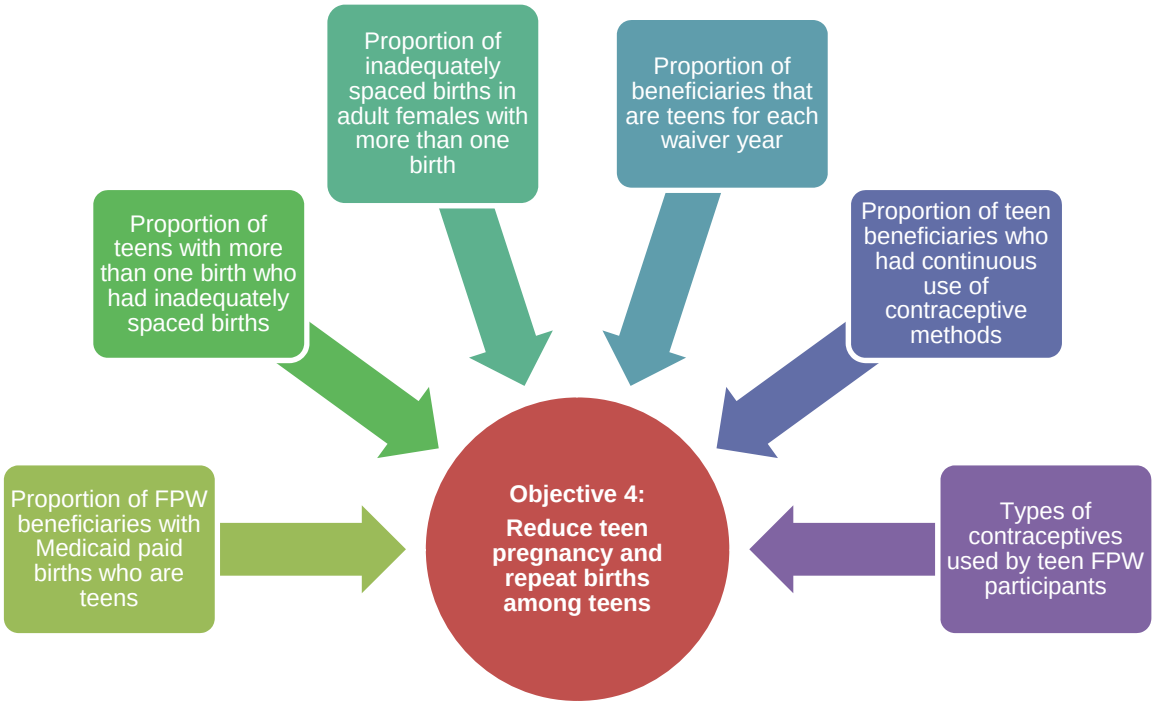
The analytic activities consisted of:

1. Calculated the proportion of FPW beneficiaries who had a Medicaid paid birth in each waiver year.
2. Compared proportion of Medicaid paid births in each waiver year among participating beneficiaries and beneficiaries that do not seek any family planning services.
3. Calculated the number of births averted based on baseline fertility rates.
4. Calculated the proportion of beneficiaries who had continuous use of contraceptive methods during the waiver year.

Objective 4: Reduce teen pregnancy and repeat births among teens.

The FPW has the important task to reduce the number of births by teenage mothers. A successful program manages to reduce the number of Medicaid paid births and reduce the number of inadequately spaced births among teens. The evaluation of this objective used the measures depicted in Figure 4.

Figure 4 - Objective 4 Measures



The analytic activities consisted of:

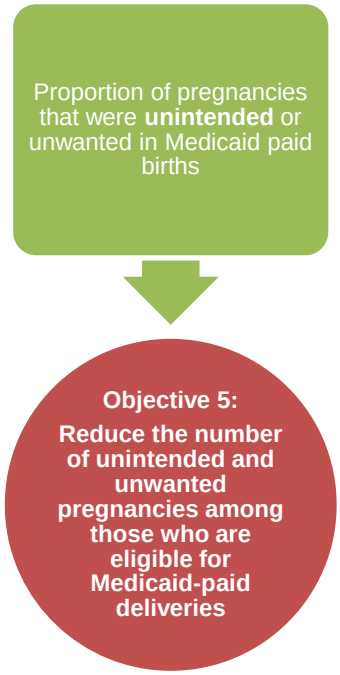
1. Calculating the proportion of FPW beneficiaries with Medicaid paid births that are teens in each waiver year.
2. Calculating the proportion of teens with inadequately spaced births.

3. Comparing the proportion of inadequately spaced births in teens to the proportion in adult females.
4. Calculating the proportion of beneficiaries that are teens for each waiver year.
5. Calculating the proportion of teen beneficiaries who had continuous use of contraceptive methods during the waiver year.
6. Identifying types of contraceptives used by teen beneficiaries over the waiver years.

Objective 5: Reduce the number of unintended and unwanted pregnancies among those who are eligible for Medicaid paid deliveries.

The FPW and other Medicaid programs providing family planning services are expected to help reduce the number of unintended or unwanted pregnancies by providing access to family planning services and contraceptive methods that may otherwise not be available. The evaluation of this objective relied on the Pregnancy Risk Assessment Monitoring System (PRAMS) data collected by the Mississippi, Department of Health.[4] This survey provided the basis for evaluating whether the FPW succeeded in reducing the number of unintended and unwanted pregnancies. The analysis for this objective presented the proportion of pregnancies that were mistimed or unwanted in Medicaid paid births in each calendar year (Figure 5).

Figure 5 - Objective 5 Measures

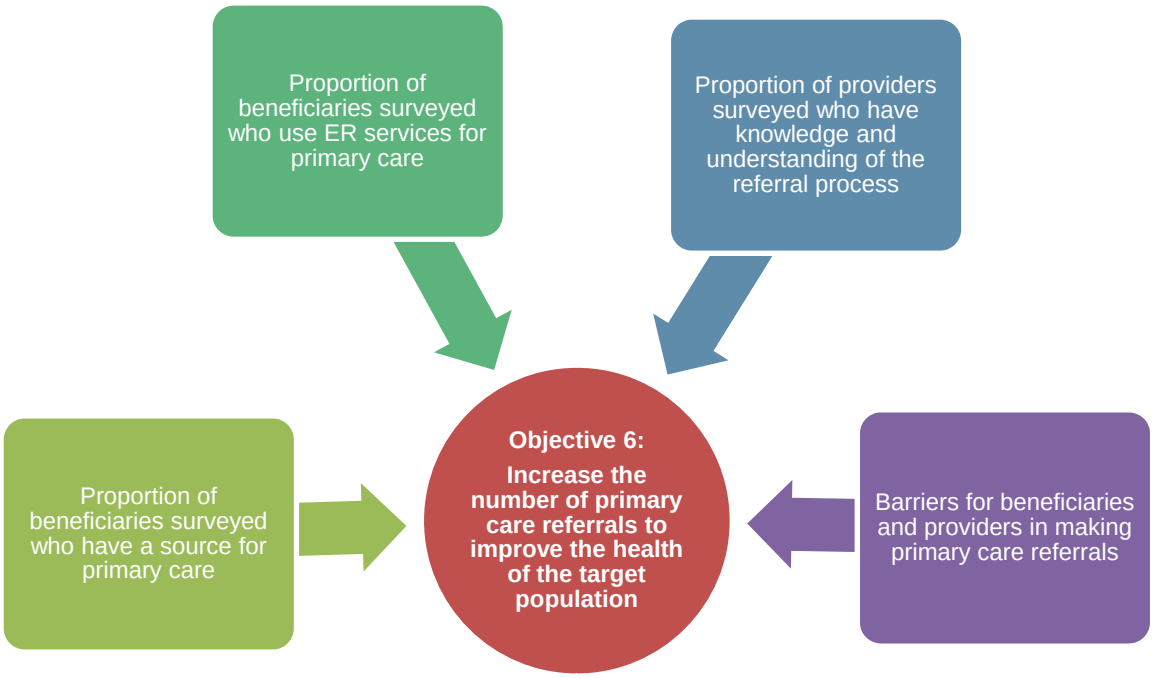


[4] Pregnancy Risk Assessment Monitoring System (PRAMS), Centers for Disease Control and Prevention (CDC) and Mississippi State Department of Health

Objective 6: Increase the number of primary care referrals to improve the health of the target population.

Waiver participants diagnosed with a non-covered medical condition during their family planning visit should be provided with appropriate referrals to primary health providers. FPW also wanted to measure women who seek primary healthcare through referrals from FPW and thus reduce the number of emergency department visits. There are no direct measurements to evaluate increases or decreases of primary care referrals so we developed tools to achieve an indirect measurement, as listed in Figure 6.

Figure 6 – Objective 6 Measures



The analysis involved:

1. Estimation of the proportion of beneficiaries surveyed who have a source for primary care.
2. Estimation of the proportion of beneficiaries surveyed who use ER services for primary care.
3. Estimation of the proportion of providers surveyed who have knowledge and understanding of the referral process.
4. Identification of the barriers for beneficiaries and providers in making primary care referrals.

Assumptions and Data

All measures are based on quantitative or qualitative data. This section defines important concepts necessary for the understanding and interpretation of analysis results. It also describes the data, such as the populations of interest (eligible women, Medicaid providers, etc.), their characteristics (FPW enrollment and participation status, age, fertility, etc.), the assessed time frame and the data sources.

Eligible Population

The women targeted by the Mississippi Division of Medicaid (DOM) as potential FPW beneficiaries are low-income women in Mississippi who do not meet the current financial requirements for the regular Medicaid program and do not have any other insurance. They constitute the eligible population that comprises the FPW population. DOM website lists the following FPW eligibility criteria:[5,6]

- Family income at or below 185% of the Federal Poverty Guidelines (FPL).
- Females 13 – 44 years of age.
- Individual is not pregnant and has not had a medical procedure that would prevent pregnancy.
- Individual is uninsured, and is not enrolled in Medicare, Medicaid, or the State Children's Health Insurance Program (SCHIP).
- Individual is a U.S. citizen or documented immigrant.
- Individual is a Mississippi resident.

The analysis used national survey data from the Current Population Survey (CPS) conducted by the U.S. Census Bureau to estimate the population in Mississippi that would be eligible for family planning waiver enrollment.[7] The Current Population Survey (CPS) is a monthly survey conducted by the Bureau of the Census for the Bureau of Labor Statistics. The Annual Social and Economic Supplements to this survey contain a variety of demographic, social and economic indicators. Age, gender, income as a percentage of FPL, and health insurance coverage status have been used to estimate the eligible population for each year of the family planning waiver program.[8] These estimates do not take into account that the individuals may be pregnant, or cannot become pregnant, or don't fulfill the residency or citizenship/legal immigrant criterion. However, they provide a reasonably representative estimate of the eligible population in Mississippi. The estimates have been adjusted to represent individuals that are uninsured at any point during a year. [9]

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[5] http://www.medicaid.ms.gov/MaternalChildHealth.aspx#FamilyPlanning

[6] http://www.medicaid.ms.gov/ProviderManualSection.aspx?Section%2072%20-%20Family%20Planning%20Waiver

[7] U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2003-2010

[8] http://www.census.gov/hhes/www/cpstc/cps_table_creator.html

[9] Jennifer J. Frost, Adam Sonfield, and Rachel Benson Gold, Estimating the Impact of Expanding

Beneficiaries

FPW beneficiaries, or enrollees, are a subset of the Medicaid population of eligible women. They are eligible women who have filled out the FPW enrollment form or have been automatically enrolled (i.e. women between ages 13 through 44 who have been eligible for the Medicaid pregnancy program (IS-88) and have reached the end of their 60 day postpartum period). Women who have been certified as eligible family planning services need re-certification every year and are not eligible for all Medicaid services. FPM enrollees only receive the preventative counseling of the program.

The Medicaid Medical Management Information System (MMIS) is used to identify subjects enrolled in the Family Planning Waiver. The MMIS eligibility file lists all Medicaid beneficiaries and the Medicaid programs they have been eligible, with begin and end dates of eligibility for each program (eligibility span). The Medicaid Category of Eligibility (COE) identifies the program the beneficiary is eligible for or in which is enrolled. The code for enrollment in the Family Planning Waiver program is '029'. A women enrolled in this program is supposed to fit the enrollment criteria. In particular, she is not supposed to be eligible for another program. Beneficiaries lose FPW eligibility when the criteria are no longer satisfied (age, income, pregnancy, other Medicaid eligibility or insurance, etc).

The number of beneficiaries enrolled with COE equal to '029' with eligibility span in a waiver year has been used to calculate measurements for Objectives 1 through 4.

Participants

The women who are enrolled in the FPW are only eligible for Medicaid coverage of family planning services.[10] Family planning waiver services are provided, with limitations, for physician visits, contraceptive drugs, contraceptive devices, voluntary sterilization and laboratory procedures. The detailed diagnosis and procedure codes, including CPT© codes, accepted as an insured valid claim paid by FPW funds are published on the DOM website[11]. The list has been added to Appendix B.

For the purpose of calculating the number of participants used in the metrics for Objectives 1 through 4, a participant is defined as a woman who uses a FPW service *at least once a year* while enrolled.[12] In the Medicaid Medical Management Information System (MMIS), this requirement is identified through claims data.

Medicaid Eligibility for Family Planning Services, Occasional Report No. 28, Guttmacher Institute, August 2006

[10]MS DOM Provider Policy Manual http://www.medicaid.ms.gov/ProviderManualSection.aspx?Section%2072%20-%20Family%20Planning%20Waiver

[11]http://www.medicaid.ms.gov/Documents/FAMILY%20PLANNING%20WAIVER%20PROCEDURE%20DIAGNOSIS%20CODES%2010-01-03%20THRU%209-30-08.pdf

[12] eQHealth Solutions, Family Planning Demonstration Independent Assessment, Technical Proposal, page 5-27

This means an enrolled woman who had at least one claim matching the FPW allowable list of codes during the waiver year while eligible as per MMIS eligibility span.

A participant's claims have been extracted as follows for each waiver year:

1. Valid eligibility defined by beginning and end dates for COE 029 while using the service.
2. Not being simultaneously enrolled in another program.
3. Claim with eligible principal and/or secondary diagnosis and/or procedure codes, and/or CPT© codes.

Baseline Fertility Rate

The baseline fertility rate is based on the number of Medicaid paid live births per 1,000 beneficiary women in calendar year 2001.[13] The analysis' premise is that fertility rates (live births) of the Medicaid population and the target population of low-income women are similar. In fact, the pregnancy program for low-income women (IS-88) uses the same age and income eligibility criteria as the FPW. These fertility rates have been adjusted to match the age ranges used in this assessment by assuming that the birth distribution is uniform within an age range.

Table 1: Baseline Fertility Rates

Age Category	Number of Live Births per 1,000 Women
13 - 17 Years	160.34
18 - 19 Years	257.37
20 Years	388.31
21 - 36 Years	187.34
37 - 44 Years	26.24

These baseline fertility rates have been applied to the number of beneficiaries enrolled in each waiver year in order to calculate the number of expected births, assuming fertility rates would not change over time. The number of births averted calculated to evaluate Objective 3 is the difference between actual births and the expected births. Budget neutrality of the FPW can then be assessed by comparing the cost of the program to the estimated cost of the births that have been averted.

Pregnancy and Birth

The MMIS Claims database provides pregnancy and birth related information on the women who are enrolled in the FPW for the calculation of the measurement for Objectives 2, 3 and 4.

The principal diagnosis code is used to determine whether an enrolled woman became pregnant or gave birth. The analysis algorithm determines which of the women enrolled during a given waiver year had a Medicaid paid birth between *the beginning of the waiver year plus 9 months and the end of the waiver year plus 9 months*.

[13] CMS methodology; preliminary estimates have been provided by DOM on October 21, 2008, MS FP Renew Budget Neutrality Worksheets_Oct17.xlsx

The data at hand does not allow determination of the length of pregnancy and the attribution of a birth to a given waiver year is not precise.

Table 2: Births Attributed to Family Planning Waiver Year

Births from:	Births to:	FPW Year
7/01/2004	6/30/2005	Year 1 (10/1/2003 – 9/30/2004)
7/01/2005	6/30/2006	Year 2 (10/1/2004 – 9/30/2005)
7/01/2006	6/30/2007	Year 3 (10/1/2005 – 9/30/2006)
7/01/2007	6/30/2008	Year 4 (10/1/2006 – 9/30/2007)
7/01/2008	6/29/2009	Year 5 (10/1/2007 – 9/30/2008)
7/01/2009	6/30/2010	Year 6 (10/1/2008 – 9/30/2009)
7/01/2010	6/30/2011	Year 7 (10/1/2009 – 9/30/2010)
7/01/2011	6/30/2012	Year 8 (10/1/2010 – 9/30/2011)

It is also clear from Table 2 that the interim report will not include births attributed to FPW Year 7 because the MMIS Claims database may lag up to 6 months.

The ICD-9-CM diagnostic codes that have been used to identify pregnancies and deliveries (including stillbirths) are listed in Appendix B. The first three digits of these codes determine pregnancy. The 5th digit determines whether a baby has been delivered. The latter has been used for the calculations of births averted.

Babies

Babies born into the Medicaid program have been linked to their FPW enrolled mothers with help of the case number[14], corresponding eligibility spans, and matching date of birth from the MMIS eligibility file. The retrieved baby information has been linked to MMIS claims accrued by the baby and has been used to determine low birth weight (Objective 2). MMIS claims will be used to calculate costs to Medicaid during the first year of the baby (Objective 3) for the final report.

Low Birth Weight

The MMIS claims data provides information on the birth weight of infants who are premature or light-for-dates born to beneficiaries. Low birth weight is indicated by the 5th digit assigned to 764, 765.0 and 765.1 ICD-9-CM diagnosis codes, and by CPT© codes 99298, 99299, 99478 and 99479. The ranges for very low birth weight are 1,499 grams and less and for low birth weight between 1,500 and 2,499 grams. Low birth weight infants were identified with help of principal and secondary diagnostic codes and CPT© line item procedure codes. The list and description of these codes and description can be consulted in Appendix B.

[14] Beginning in 2010, the eQHealth Analytic team was able to access and link FPW enrolled mothers with babies on Medicaid by help of case number.

Birth-to-Conception Interval

A birth-to-conception interval of less than 18 months is considered inadequate.[15] With the data sources at hand (MMIS claims), it is not possible to calculate the birth-to-conception interval. A birth-to-birth interval of 26 months or less is used to define inadequately spaced pregnancies in order to evaluate Objectives 2 and 4. To do so, the analysis used the birth dates of babies from beneficiaries who have been enrolled in the FPW when they became pregnant and determined whether they had a previous birth paid by Medicaid. If the previous birth took place 26 months or less before the current birth, the birth-spacing interval was deemed inadequate.

Unintended Pregnancies

The Pregnancy Risk Assessment Monitoring System (PRAMS) is a comprehensive data collection effort led by the Centers for Disease Control and Prevention (CDC) in collaboration with state health departments. It describes maternal experiences before, during, and after pregnancy among women who deliver live-born infants. The evaluation of Objective 5 uses the historic survey estimates provided by the Center of Disease Control (CDC) and the Mississippi Department of Health with available data for calendar years 2003, 2004, 2006, and 2008.[16,17]

Contraceptive Use

The MMIS Pharmacy Point of Sale (POS) claims database has been used to calculate contraceptive use by FPW participants. Category of Service Code equal to '34' (family planning) identifies contraceptives. The database also contains information on the number of days that the contraceptive has been supplied, thus allowing the estimation of the duration of use for Objectives 3 and 4. The MMIS Claims file provides the information on other contraceptive methods such as sterilization and the use of contraceptive devices (ICD-9-CM and CPT© codes) and was used to determine the type of contraceptives used by teenage participants (Objective 4).

Family Planning Waiver Providers

The analysis limits itself to Medicaid providers who are located in Mississippi. Provider information from the MMIS provider eligibility files has been linked to the MMIS Claims data to determine which of these providers offer family planning waiver services from the list of diagnosis and procedure codes in Appendix B. The MMIS Claims data have also been used to determine the number of Medicaid providers who provide these services to FPW participants.

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[15] Technical proposal and Region IV Common Definitions, Birth-to-Conception Interval (High Risk): A birth-to-conception interval of less than 18 months is considered high risk. (5/8/06 conference call and 1/15/08 e-mail
from Jeff Roth)

[16] Office of Health Data and Research, Mississippi State Department of Health. Mississippi PRAMS Surveillance Report, Year 2006 Births, Jackson, MS: Mississippi Department of Health, 2006.

[17] Retrieved December 1, 2010 from http://www.cdc.gov/PRAMS/index.htm and http://apps.nccd.cdc.gov/cPONDER/default.aspx?page=main

Timeframe

The original Mississippi Family Planning Demonstration Waiver took place during five years from October 1, 2003 through September 29, 2008. An additional three-year extension has been added that started on October 1, 2008 and will end on September 30, 2011. This interim assessment evaluates the objectives for seven years of the program, using the latest available data.[18] Family planning waiver years are based on the federal fiscal year definition as listed in Table 3:

Table 3: Timeframe

FPW Year	Demonstration	Start	End
Year 1	Original	10/01/2003	09/30/2004
Year 2	Original	10/01/2004	09/30/2005
Year 3	Original	10/01/2005	09/30/2006
Year 4	Original	10/01/2006	09/30/2007
Year 5	Original	10/01/2007	09/29/2008
Year 6	Extension	10/01/2008	09/30/2009
Year 7	Extension	10/01/2009	09/30/2010
Year 8	Extension	10/01/2010	09/30/2011

Age Groups

Findings have been calculated and are presented for these age categories in addition to the aggregated results: [19]

- 13 - 17 years old
- 18 - 19 years old
- 20 years old
- 21 - 36 years old
- 37 - 44 years old

Based on the information provided by the MMIS eligibility file the age of a FPW beneficiary at the end of a waiver year has been calculated and used for attribution to age group. It is possible that for the chosen cutoff date some beneficiaries are slightly younger than 13 or older than 44. They have been added to the closest age group.

[18] The information in the claims database is non-static and may lag behind for up to 6 months. The analysis is based on data retrieved between Nov.1 and Nov.12, 2010.
[19] as per decision at DOM/HSM meeting on February 9, 2010

Beneficiary Survey

The beneficiary survey[20] providing information for Objectives 1 and 6 was conducted via telephone by the Mississippi State University Social Science Research Center in April 2010. The population targeted for the beneficiary survey was the women enrolled in the FPW program at some point during 2009. The final sample of 400 beneficiaries who completed this computer-assisted telephone survey guaranteed a margin of error no larger than ± 5% at a 95% confidence level. The survey asked for reasons why beneficiaries did not participate in the FPW and for information on primary healthcare referral and location.

Provider Survey

The provider survey[21] providing information for Objective 6 was conducted by eQHealth Solutions via internet and phone from March – June 2010. The 193 providers surveyed assured an overall bound on the margin of error of 7%, with a confidence coefficient 95%. However, because the population from which the sample was taken included providers who currently do not provide FPW services, the subset of 55 FPW providers who completed this web-based survey in its entirety was not sufficiently large and only guaranteed a margin of error of ± 13% at a 95% confidence level (or ± 11% at a 90% confidence level) for questions to be answered by Family Planning Waiver service providers.

Focus Groups

The focus group agendas were developed, and the meetings were conducted by, eQHealth and the Mississippi State University Health Policy Research Center. The beneficiary focus group was held in Jackson, Mississippi on May 25, 2010, and the provider focus group was held in Canton, Mississippi on May 19, 2010. The focus group discussions provided extra information on barriers to accessing services.

Limitations

The interpretation of this study's findings needs to take into account that the assumptions and data imposed limitations. Most of the data was extracted from the Medicaid Medical Management Information System (MMIS) Claims Database. The data was reviewed to assure their usefulness in measuring achievement of the objectives, but the following challenges needed to be addressed:

- Year 6 of the FPW was also the start of the demonstration extension. There were several changes in eligibility and the application process that occurred that year. As a result of these changes the program data was impacted by:
  - 26,000 women were removed from the program.

[20] eQHealth Solutions, Mississippi Medicaid Family Planning Waiver Program: 2010 – Year One Beneficiary and Provider Survey and Focus Group Reports, September 2010
[21] eQHealth Solutions, Mississippi Medicaid Family Planning Waiver Program: 2010 – Year One Beneficiary and Provider Survey and Focus Group Reports, September 2010

  - Enrollment period was changed from biannual to annual.
  - Proof of income became a requirement of the application process.
- Analysis results have been calculated for the first seven years of the Family Planning Waiver. Results for Year 7 (Oct. 2009 – Sept. 2010) may be based on incomplete data, and are only indicative. For some measures, such as the number of births, or contraceptive use, even Year 6 data may be incomplete and the results need to be interpreted with caution.
- The MMIS eligibility file lists all Medicaid eligible persons along with the Medicaid program they are eligible for, and begin and end date of eligibility to these programs (i.e. eligibility span). Because the FPW does not allow concurrent enrollment in other programs overlapping eligibility spans between FPW and other programs needed to be corrected by using the begin date of a following overlapping eligibility span as the end date of the prior eligibility span (minus one day). This eliminated some of the overlapping eligibility spans, but the estimates presented in the results sections may include counts of women that are actually enrolled and have participated in other programs.
- The MMIS eligibility spans for the FPW (i.e. COE=029) define the basic building tools for this study: eligibility (enrollment) status in FPW and participation status. If the begin and end dates for FPW eligibility are wrongly entered in the database, enrollment and participation may not be clearly attributed. Both enrollment and participation numbers may be potentially inflated for this reason. For the same reasons, differences between participating and non-participating beneficiaries may be understated.
- Missing county information in the beneficiary and provider eligibility files needed to be complemented by a commercially available zip code database.[22]
- Missing case numbers for some beneficiaries giving birth did not allow matching to babies.[23]
- A participant is defined as an enrolled beneficiary who has at least one claim matching the list of FPW allowable ICD-9-CM diagnosis codes, procedure codes or CPT© codes. This definition was used to eliminate non-FPW claims that occurred during the FPW eligibility span because of incorrect eligibility spans provided by the MMIS claims and eligibility files. Theoretically, any claim that occurred during a “correct” FPW eligibility span should be a family planning related claim. However, this was not found to always be true.
- Some of these ICD-9-CM diagnosis codes, procedure codes or CPT© codes are very general and are used by a wide number of providers for non-family planning related claims. If there is an issue with the eligibility span, the use of FPW codes does not filter out all non-family planning related claims. The number of participants may be somewhat overstated.
- Age groups used by different sources did not always match the age groups chosen for this study. Data relevant to age groups have been adjusted proportionally.
- Some age groups, such as the 13 -17 and 37 - 44 year old beneficiaries have small numbers of births making estimates regarding birthing behavior of these age groups less stable.
- Federal fiscal year population numbers have been calculated proportionally to the population number in each of the calendar years that intersect with the federal fiscal year.

[22] www.zipinfo.com
[23] 499 (1.8%) of the 27,809 mothers could not be matched to their babies

- The birth-to-conception interval had to be replaced by the proxy birth-to-birth interval to estimate inadequate birth spacing.
- Births have been associated to a given FPW year by adding 9 months to the beginning and the end of the waiver year. Any birth occurring during this time span would be attributed to the particular waiver year. In this manner, preemies would be attributed to a previous waiver year.
- A beneficiary who uses contraceptives 80% of the enrollment span in a given waiver year is defined as having a continuous use of contraceptives. This definition is somewhat arbitrary, but was thought to be at least indicative of continued use of contraceptive.
- Using baseline fertility rate[24] to calculate births averted due to FPW participation assumes that there is no natural birth trend or other programs that may influence birth rates.
- The estimate for the baseline fertility rate is based on the number of Medicaid paid live births per 1,000 Medicaid beneficiary women in the calendar year 2001. [25] This estimate may be biased because the FPW population is different. These estimates are preliminary until confirmed by DOM.

The findings should also be viewed in the context of the above stated limitations and "external factors" such as economic cycles or demographic trends. Environmental factors, such as the catastrophe left by Hurricane Katrina in August 2005, had undoubtedly a social and economic impact for many women and caused large population shifts in the region.

Finally, although objectives have been announced, no quantitative goals have been set. For example, a participation rate of 10% enrolled beneficiaries is certainly higher than zero participation; however, it should not be considered adequate.

[24] Live birth rate; CMS methodology outlined in "Monitoring Budget Neutrality" section of the CMS Special Terms and Conditions, E-mail communication from Ashlyn Booker, 10/19/2010
[25] Preliminary estimates have been provided by DOM on October 21, 2008, MS FP Renew Budget Neutrality Worksheets_Oct17.xlsx

Findings

Findings are first presented and explained for each objective measure separately. They will then be summarized for each objective. Differences between proportions will be expressed in terms of absolute differences (i.e. “percentage points”). For example, the difference between a participation rate of 33% and 23% is 10 percentage points. Occasionally, a difference will be presented as a relative difference such as a rate of change, especially when comparing proportions across the waiver years. For example, a participation rate may have increased from 23% to 33%. The rate of change would be 43.5% with respect to 23%.

Objective 1: Increase access to and use of family planning services by the target population.

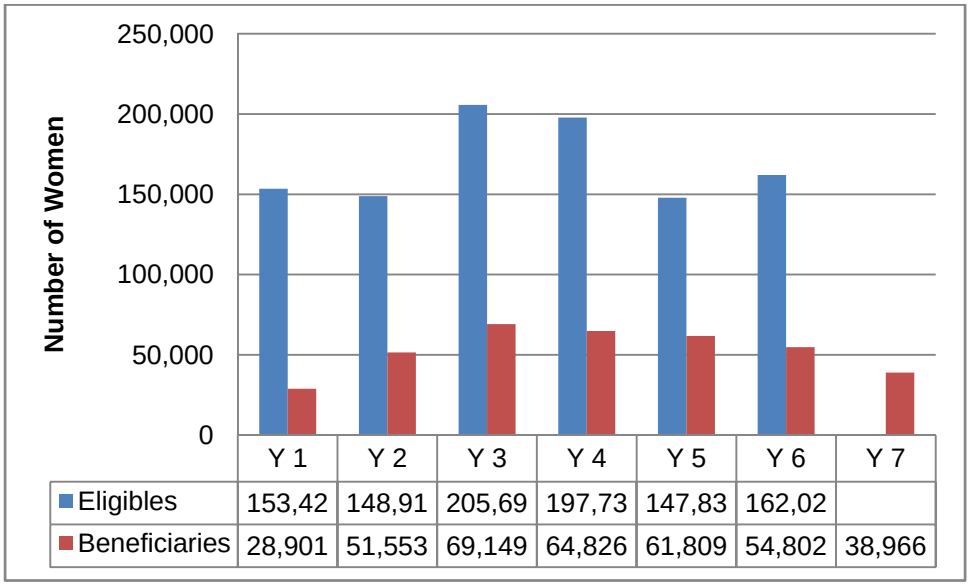
The FPW reaches out to women who otherwise might not be able to afford or use family planning services as a result of being economically disadvantaged. The program may be considered successful in increasing access to and use of family planning service by low-income women if the following are met:

1. A considerable proportion of eligible women enroll in the FPW.
2. The FPW manages to maintain or even increase this proportion during the duration of the program.
3. A sizeable proportion of enrolled women use the family planning services offered by FPW.
4. This proportion is maintained or even increases during the duration of the program.
5. The proportion of women who return for family planning services the following year remains stable or increases.
6. The proportion of providers who offer family planning services to Medicaid beneficiaries increases over the duration of the program.
7. The reasons why beneficiaries do not use the services offered should not be related to limited access or programmatic obstacles.

Measure 1.1 – Proportion of Eligible Women Enrolled in Each Waiver Year

The eligible population, i.e. women who are between 13 and 44 years of age, whose income is at or below 185% of the FPL and who are uninsured, has spiked during the period of the third and fourth waiver year (Oct.1, 2005 - Sept. 2006 and Oct 1, 2006 - Sept. 2007, respectively) as shown in Figure 7. This period coincides with the aftermath of Hurricane Katrina that displaced entire populations and left them with fewer resources. The increase of the number of eligible women in the sixth year of the waiver may be linked to beginning of the recession – prognostic to be confirmed with the 2009-2010 counts which have not yet been published.

Figure 7: Numbers of FPW Eligible Women and Beneficiaries



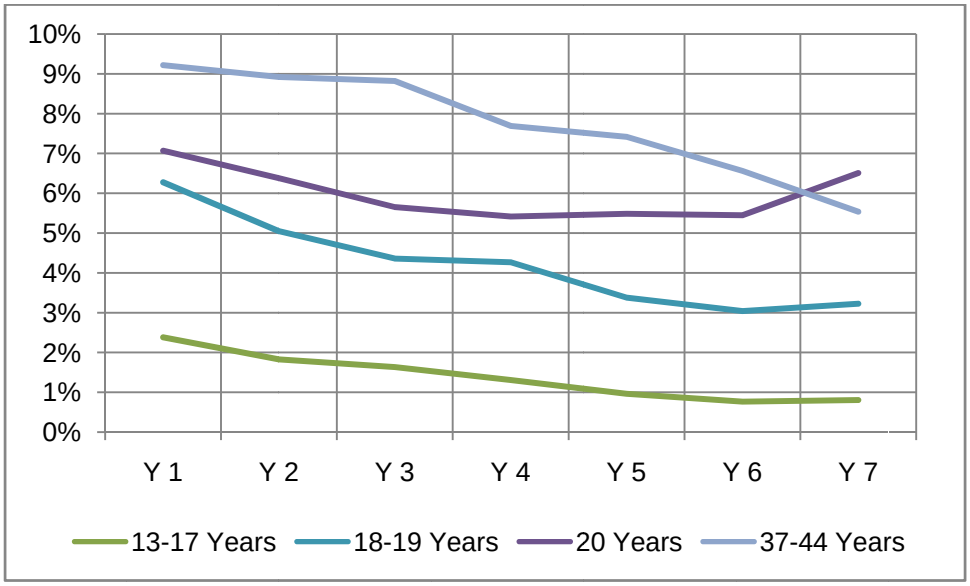
Similarly, the number of women who enrolled in the FPW increased continuously to a high of 69,317 in Year 3 (2005/2006), as shown in Table 4. The number of enrolled beneficiaries has decreased ever since to 38,966 beneficiaries in Year 7 of the waiver. However, as Table 4 also shows, the percentage of women who were enrolled in the Medicaid FPW increased substantially after the first waiver year and stayed relatively stable, with a high in the fifth year (2007/2008). The first year of the waiver extension (Year 6) has seen a decrease in this proportion as the number of beneficiaries decreased while the number of eligible women increased. The proportion of enrolled women for Year 6 (33.8%) is similar to that of Years 2 (34.6%) and 4 (32.8%). Year 5 may have been exceptional because it reflects the "back to before Hurricane Katrina" levels of the eligible population. In Year 6, there was also a disenrollment process of approximately 26,000 women as a result of program eligibility changes which excluded women who had other health insurance coverage.

Table 4: Number and Percentage of FPW Beneficiaries

	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Year 6**	**Year 7**
Eligible Women	153,427	148,910	205,694	197,738	147,839	162,024	n/a
FPW Beneficiaries	28,901	51,553	69,149	64,826	61,809	54,802	38,966
Percent Enrolled	**18.8%**	**34.6%**	**33.6%**	**32.8%**	**41.8%**	**33.8%**	**n/a**

The age composition of FPW beneficiaries changed over time as illustrated by Figure 8. In particular the 37 – 44 year old beneficiaries decreased by 3.7 percentage points (or almost 40%) with respect to Year 1 of the Waiver.

Figure 8: Age Composition of Beneficiaries



The proportion of 21 – 36 year old beneficiaries not depicted in the graph because a much larger scale (their proportion is about 80%) would not allow highlighting the other age groups' tendency , increased by 8.9 percentage points (or 11.8%) from 75.1% in Year 1 to 83.9% in Year 7 (Table 34 in Appendix C).

Measure 1.1 – Proportion of Eligible Women Enrolled in Each Waiver Year

- The proportion of eligible women enrolled has stayed stable on average at 32.6%, with a low of 18.8% in the first year and a high (41.8%) in Year 5 of the Waiver.
- The age composition changed over the year with the 21-36 year old beneficiaries increasing to 83.9% in Year 7, up from 75.1% in Year 1.

Measure 1.2 – Proportion of enrolled women seeking family planning services

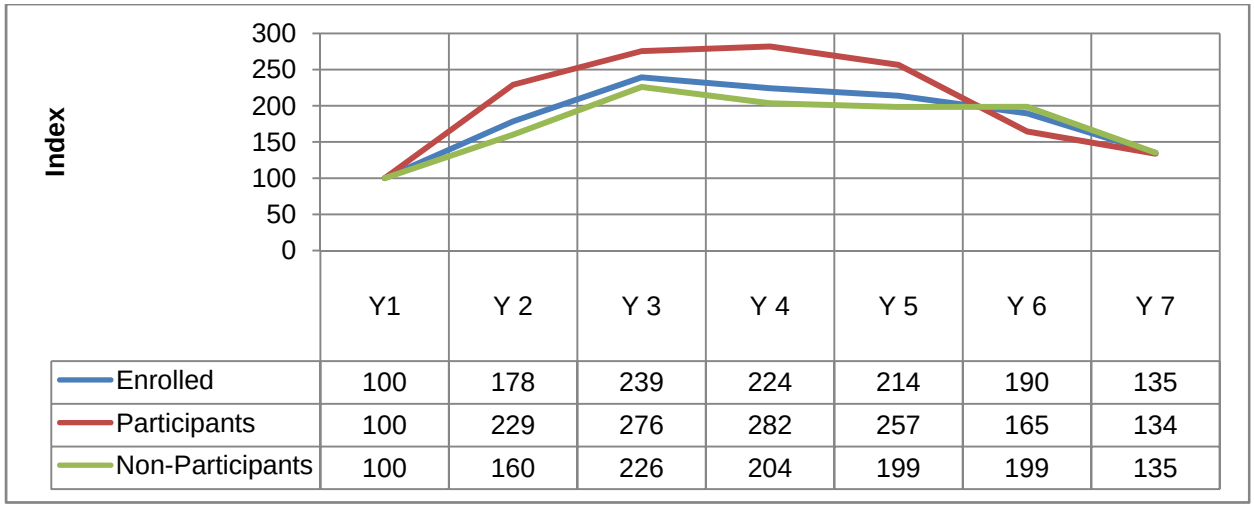
Over all seven years under analysis, a total of 64,261 distinct FPW beneficiaries have participated in FPW, which is 48.6% of all or a total of 132,234 enrolled beneficiaries. The number of beneficiaries who had at least one claim during a given FPW year has steadily increased from 7,641 women in the first year to 21,552 women in Year 4 and then decreased to 12,573 in the first extension year, as indicated in Table 5.

Table 5: Number of Participants

Year	Non-Participants	Participants
Y 1	21,260	7,641
Y 2	34,044	17,509
Y 3	48,081	21,068
Y 4	43,274	21,552
Y 5	42,202	19,607
Y 6	42,229	12,573
Y 7[26]	28,732	10,234

Figure 9 compares trends of the different populations (i.e. FPW beneficiaries, participants and non-participants) with respect to their values in the first year of the Waiver. A value of '100' means that the population number is the same as in the first year. A value of '129' means that the population number is 29% higher than in the first year. The data indicates participation increased much faster than any of the other populations for the first four years possibly due to recruiting efforts and increased awareness; however, participation has dropped steeply in the first year of the waiver extension (Overall Year 7).

Figure 9: Index of Beneficiary Growth (100=Year1)

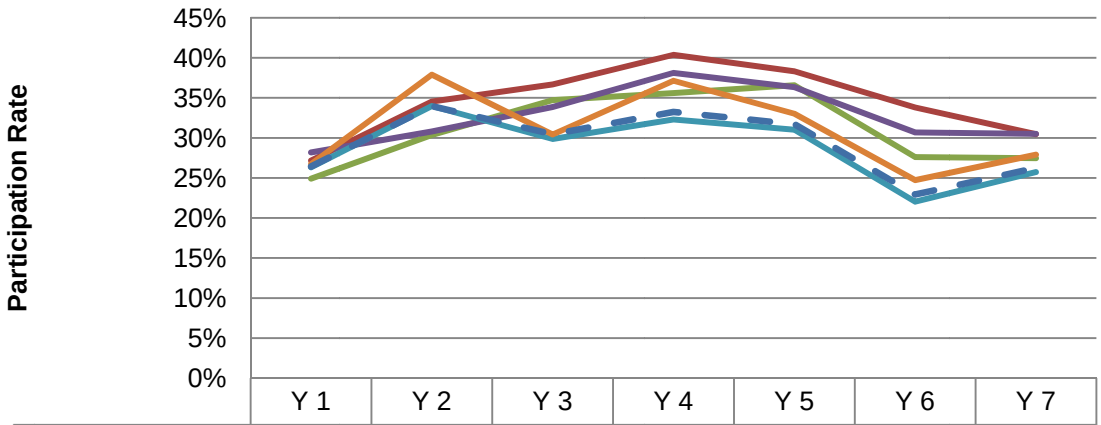


[26] MMIS Claims, as of Nov. 1, 2010. This number is preliminary the data base is non-static and may lag up to 6 month.

Table 35 in Appendix C can be consulted for detailed participation counts for age ranges and years.

Figure 10 indicates the participation rate among beneficiaries of all ages is lower in the waiver extension phase (Year 7); however, the rate shows signs of recovery. The graph also shows how the participation rate for the 21 to 36 year old beneficiaries (the largest enrolled group) has been consistently lower than that of other age ranges since Year 2.

Figure 10: Participation Rate by Age



	Y 1	Y 2	Y 3	Y 4	Y 5	Y 6	Y 7
13-17 Years	27.2%	34.5%	36.7%	40.4%	38.3%	33.8%	30.5%
18-19 Years	24.9%	30.4%	34.7%	35.6%	36.6%	27.6%	27.5%
20 Years	28.2%	30.8%	33.9%	38.1%	36.3%	30.7%	30.5%
21-36 Years	26.3%	34.0%	29.9%	32.3%	31.0%	22.0%	25.7%
37-44 Years	26.7%	37.9%	30.4%	37.1%	33.0%	24.7%	27.9%
All	26.4%	34.0%	30.5%	33.2%	31.7%	22.9%	26.3%

Measure 1.2 – Proportion of enrolled women seeking family planning services

- A total of 64,261 distinct FPW beneficiaries have participated over the seven years, which is 48.6% of all of 132,234 enrolled beneficiaries.
- The weighted average across all years is 29.8% of enrolled women sought family planning services.
- This proportion reached a maximum of 34% in Year 2 before declining by 14.1 percentage points, to a minimum of 22.9% in Year 6.
- The Year 7 participation rate increased again and is close to Year 1 levels.
- The weighted average participation rate for 21-36 year old beneficiaries is 29.1%. This number significantly decreases the average of the entire population.
- The other age groups (21-36, 37-44 years) are the beneficiary groups with a participation rate that dropped below Year 1 levels.

Measure 1.3 – Proportion of participants in a prior year returning for service in the following year

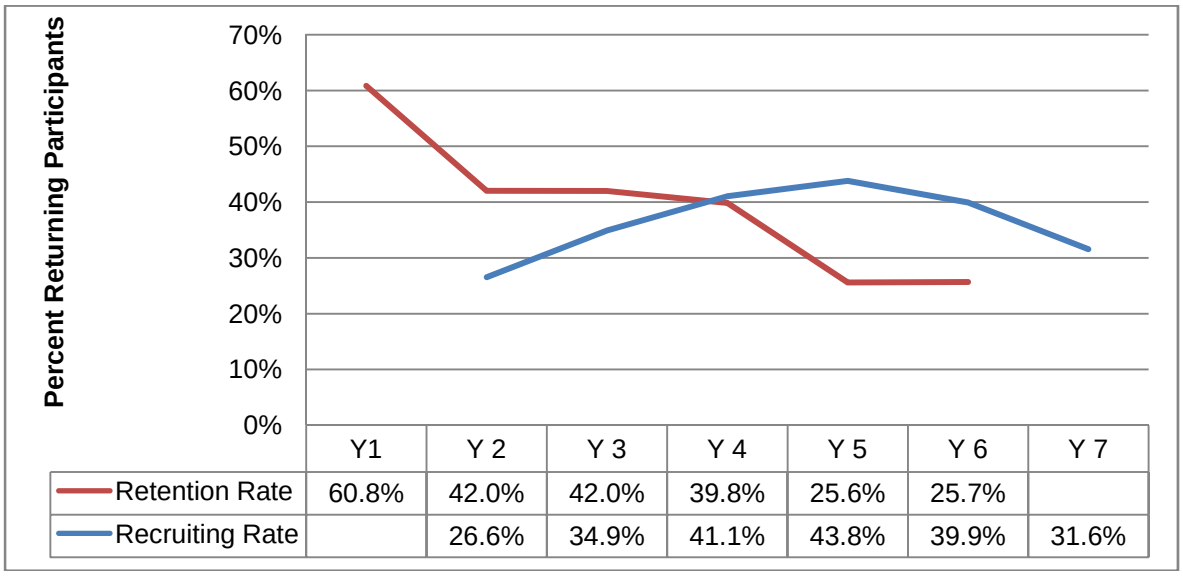
The proportion of participants in a prior year returning for family planning waiver services the following year has been calculated in two ways:

a. The number of participants that participated again the following year expressed as a percentage of the current year's participants may be understood as a "retention" rate. A high rate shows that participants are satisfied and continue using the services. For example, if there were 100 participants in a year, and 100 of the 1,000 participants came back next year, the "retention" rate would be 100%.
b. The number of returning participants from the prior year expressed as a percentage of the current year tells how many "experienced" beneficiaries take part in a year's cohort. It can be thought of as the "recruiting rate": it gives an idea of how many "new" participants could be recruited. For example, in the current year there are 1,000 participants. 100 of these have participated the previous year (10%); 900 of these women are new recruits (90%).

These interpretations are only indicative because they need to be put in context with the fluctuations of the total number of beneficiaries and participants throughout the years.

Figure 11 illustrates how both measures evolved over the study period. 60.8% of participants who used family planning services in the first waiver year returned in the second year for services. These returning participants represented 26.6% of the second year participants. 42% of Year 2 participants returned in Year 3 where they made up 34.9% of the Year 3 participants and so on. The "retention" rate stays around 40% even as enrollment and participation increased. The rate dropped by 14.2 percentage points from 39.8% to 25.6% in Year 5 with a drop in enrollment and participation as the target population number decreased significantly.

Figure 11: Percent Returning Participants



	Y1	Y 2	Y 3	Y 4	Y 5	Y 6	Y 7
Retention Rate	60.8%	42.0%	42.0%	39.8%	25.6%	25.7%	
Recruiting Rate		26.6%	34.9%	41.1%	43.8%	39.9%	31.6%

In each of Years 4 to 6 of the Family Planning Waiver, about 40% of the participants were beneficiaries who had already participated in the previous year. This means that approximately 60% of participants are "recruited" into participation after a break, or they are new participants. The drop to 31.6% in Year 7 does not represent a definite number and is expected to rise because MMIS Claims data lag exist at the time of this measure.

Table 6 and Table 7 present returning participation rates by age.[27] Table 37 in Appendix C also presents the number of returning participants detailed by age and year for reference.

Table 6: Percentage of Present Year's Participants Who Participated Again in the Following Year by Age Group

Age Group	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7
13-17 Years	71.1%	44.6%	43.6%	40.9%	24.6%	23.9%	n/a
18 - 19 Years	57.3%	40.0%	41.2%	40.7%	25.8%	23.9%	n/a
20 Years	59.5%	47.1%	46.9%	44.9%	28.4%	29.7%	n/a
21 - 36 Years	60.3%	41.8%	41.1%	39.3%	25.2%	25.0%	n/a
37 - 44 Years	65.4%	41.5%	46.9%	41.0%	27.7%	30.6%	n/a
All	**60.8%**	**42.0%**	**42.0%**	**39.8%**	**25.6%**	**25.7%**	n/a

60.8 % of first waiver year participants would return for family planning services the following year. This overall number is grounded in the behavior of the 21 – 36 year olds who represent the main contingent in this study. Only 13 – 17 year olds and 37 – 44 year olds have a higher retention rate in the first year. The age group differences become much less pronounced in the following years to end up around 25.6% (Year 5) and 25.7% (Year 6) with 20 year olds and 37 – 44 year olds at approximately 30%.

Table 7: Percentage of Present Year Participants Who Participated in the Previous Year by Age Group

Age Group	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7
13-17 Years	n/a	21.5%	14.5%	23.1%	23.2%	18.3%	12.5%
18 - 19 Years	n/a	18.5%	19.3%	27.4%	30.8%	22.0%	16.8%
20 Years	n/a	17.4%	15.0%	19.7%	20.5%	13.8%	9.6%
21 - 36 Years	n/a	27.3%	36.7%	42.2%	45.2%	41.7%	33.0%
37 - 44 Years	n/a	31.0%	47.1%	56.4%	58.1%	58.9%	51.7%
All	**n/a**	**26.6%**	**34.9%**	**41.1%**	**43.8%**	**39.9%**	**31.6%**

[27] Age groups based on reference year used in denominator

As the proportion of present year participants who participated in the previous year increased throughout the first five years of the FPW, so did the rate of the different age groups with the exception of 13 – 17 year olds and 20 year olds. A substantial proportion of present year participants in the 21 – 36 year old beneficiaries (maximum 45.2% in Year 5), and even more so in the 37 – 44 year old beneficiaries (maximum of 58.9% in Year 6) have already participated the year before. The proportion of present year participants who participated in the previous year remains considerably higher for these age groups throughout the waiver years.

Measure 1.3 – Proportion of participants in a prior year returning for service in the following year

- Participant retention was high in the first year. 60.8% of first year participants returned the second year of the Waiver.
- The proportion of participants who re-enrolled the following year is stable at approximately 40% during the first waiver years (2-4), then dropped to 25.6% during Year 5 and have stayed at that level.
- During the first five years, the proportion of participants that have previously participated rose continuously from 26.6% in Year 2 to 43.8% in Year 5.
- The proportion of 21 – 36 and 37 – 44 year old participating beneficiaries who have previously participated remains above average throughout the first 7 years of the program.

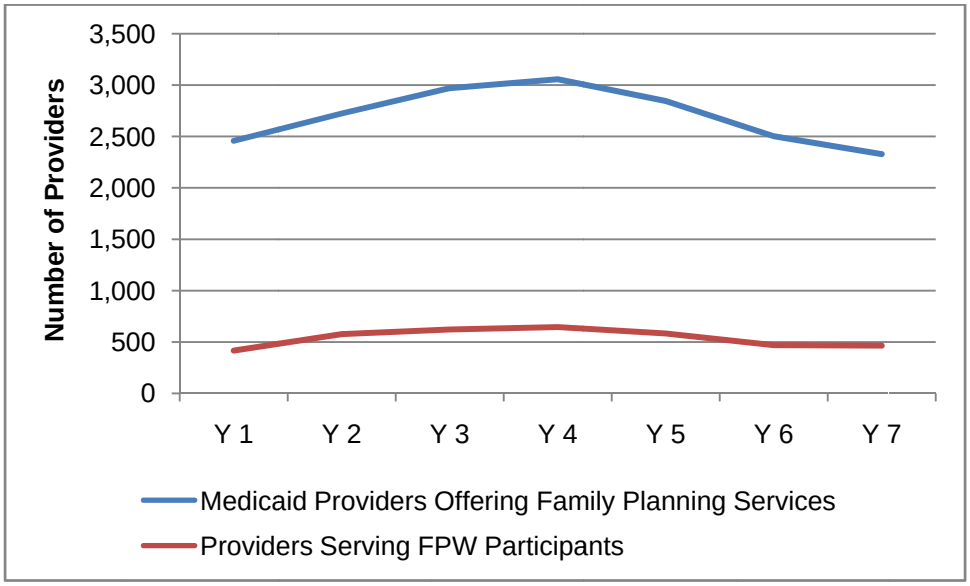
Measure 1.4 – Proportion of Medicaid providers providing family planning services

Increasing the number of providers who offer family planning services to Medicaid beneficiaries is expected to facilitate access to these services by the target population. The number of providers who make any claim with the FPW allowable diagnosis and procedure codes[28,29] has increased steadily over the first four years of the program as shown in Figure 12 and Table 8. This development parallels the increase in the eligible population during those years. This number has been declining to levels below the ones at the start of the program. The number of Medicaid providers who serve FPW participants has also declined, but is still above the number of FPW providers in the first year. The related proportion remained stable around 20%, with the exception of the first waiver year.

[28] http://www.medicaid.ms.gov/Documents/FAMILY%20PLANNING%20WAIVER%20PROCEDURE%20DIAGNOSIS%20CODES%2010-01-03%20THRU%209-30-08.pdf

[29] see also Table 26 and following in Appendix B

Figure 12: Number of Medicaid Providers Offering Family Services



The decline in the number of Medicaid providers offering family planning services is surpassed by the decrease in the number of the participants, as indicated by the lower average number of participants per provider presented in Table 8.

Table 8: Number of Medicaid Providers Offering Family Planning Services

FPW Year	Medicaid Providers Offering Family Planning Services	Medicaid Providers Serving FPW Participants	Percent Providers Serving FPW	Average Number of Participants per Provider
Y 1	2,458	416	16.9%	18
Y 2	2,724	576	21.1%	30
Y 3	2,970	621	20.9%	34
Y 4	3,057	645	21.1%	33
Y 5	2,845	582	20.5%	34
Y 6	2,502	469	18.7%	27
Y 7	2,328	464	19.9%	22

Measure 1.4 – Proportion of Medicaid providers providing family planning services

- Up to 3,057 Medicaid providers (Year 4) offer family planning services.
- Up to 645 (21.1%) provided family planning services to FPW beneficiaries.

Measure 1.5 –Reasons for not seeking family planning services offered by the waiver for each waiver year

A survey[30] administered to a sample of 400 women enrolled in FPW during the calendar year of 2009 (covering most of FPW Year 6) revealed the reasons for non-participation. The survey results are discussed in detail in "Mississippi Medicaid Family Planning Waiver Program: 2010 – Year One Beneficiary and Provider Survey and Focus Group Reports".[31] The following provides a brief summary of reasons for non-participation as expressed by survey participants.

Reasons related to the lack of information or to misinformation: Not knowing what was covered by the Medicaid Family Planning Waiver (51.0%), and not knowing being eligible to get family planning services (42.5%) are among the top three reasons why beneficiaries did not participate. Further, 26.2% did not know where to get services. Three of those reasons account for large percentages of why women did not use the services but also indicate that increased information would be beneficial for reaching the goals of the FPW program. This could be achieved by including in the mailing of beneficiary card a single page list of website links for updated list and a partial list of providers. Simple yellow signs could be offered to providers that are yellow and indicate the provider accepts the FPW card or is a FPW provider.

Reasons related to not receiving the yellow card: 5.1% of the non-participating beneficiaries said that they did not receive the yellow card or it came too late. 2.8% forgot to renew it or let it expire.

Reasons related to "not needing" the services: 45.2% of surveyed non-participating beneficiaries said that they were automatically enrolled into the Medicaid Family Planning Waiver without wanting to be enrolled. 29.1 % of non-participating beneficiaries said they did not need the services. 24.6% did not participate because they became pregnant. 13.9% of non-participating beneficiaries are abstinent, 8.9% said that either they or their partners are sterilized. 15.2% said that they did not want to use FPW services, or that their partner did not want them to use the services (2.2%). 2.5% indicated that they had another insurance. Auto-enrollment occurs following a qualifying pregnancy and subsequent end to the pregnancy. These women qualify financially for FPW but not for continued full Medicaid benefits. Consumers of healthcare always have the right to choose services or refuse, it is unclear if the lack of use for FPW is a direct result of auto-enrollment versus this is a group of women who are resistant to using birth control options to prevent pregnancy or assist in birth spacing. This sub group may warrant further research.

Practical reasons related to "not being able" to get services: Non-participating beneficiaries that may have potentially participated are those that did not have transportation (7.6%), no childcare (6.2%), and those that did not have time (9.4%).

[30] Question A4 of beneficiary survey by eQHealth Solutions, Mississippi Medicaid Family Planning Waiver Program: 2010 – Year One Beneficiary and Provider Survey and Focus Group Reports, September 2010
[31] eQHealth Solutions, September 2010

Reasons related to the unavailability of providers: 10.7% of non-participating beneficiaries said that they were not able to find a provider who offered family planning services. Another reason for non-participation was that the beneficiary could not find providers they were comfortable with (9.4%).

Measure 1.5 –Reasons for not seeking family planning services offered by the waiver for each waiver year

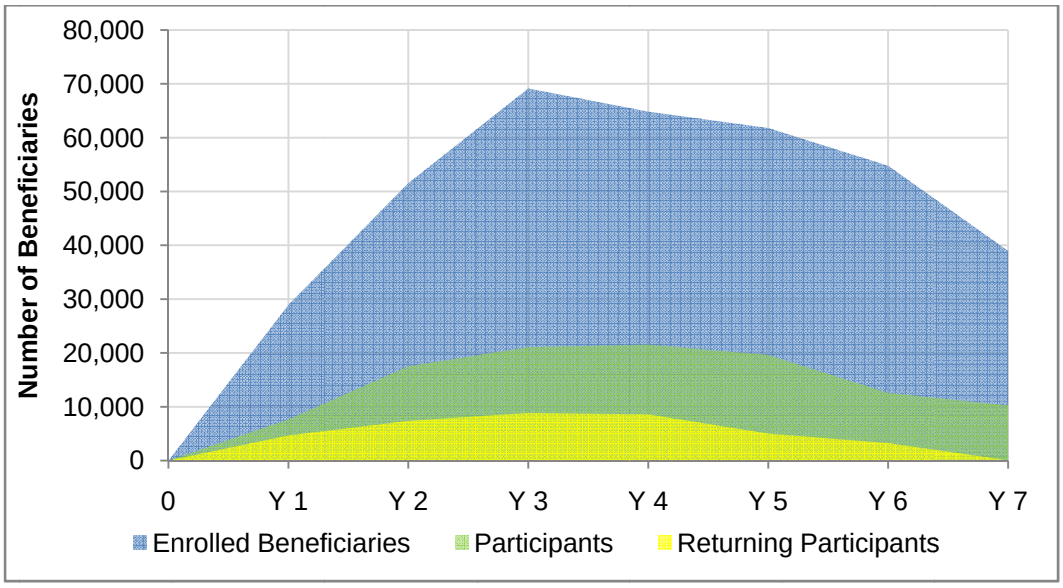
- The top reasons for not participating in FPW are related to the lack of information; 51% of non-participants did not know they were covered, and 42.5% said the did not know that they were eligible
- 45.2 % of non-participants said they were automatically enrolled without wanting to be enrolled.

Objective 1 Summary

The Family Planning Waiver has helped women who may have otherwise not received family planning services to gain access to these free services. A total of 64,261 distinct FPW beneficiaries have participated over the 7 years, which is 48.6% of all of 132,234 enrolled beneficiaries.

As Figure 13 illustrates, each year participating beneficiaries represent 29.8% of the yearly-enrolled beneficiaries and therefore only a fraction of the yearly eligible population. Total yearly participation numbers have declined along with the reduction of eligible and enrolled women brought about by the recovery from Hurricane Katrina (Year 4 and after). However, the yearly participation rate diminished as well.

Figure 13: Numbers of Enrolled Beneficiaries and Participants



This may be partly due to a lower proportion of participants that would come back the following year (25.6%, down from a 39.8% in Year 4, or 60.8% in Year 1). Reduced access to services does not seem to be an obstacle as the number of served beneficiaries per FPW provider decreased over the last couple of years. Still, 10.7% of non-participants mentioned that they were not able to find a provider who offered family planning services. About half of surveyed beneficiaries who did not participate in 2009 (who did give a reason for not doing so) indicated that they did not know what was covered under the Waiver, and 42.5% said that they did not know they were eligible. This indicates a need for change in how women are notified when eligible, what services are covered, and where they can access services.

Objective 2 – Improve birth outcomes and the health of women by increasing the child spacing interval among the target population.

The time between births can improve a woman's and her babies' health. Reducing the number of inadequately spaced pregnancies should lead to reductions in the number of adverse pregnancy outcomes such as low birth weight. The objective of improving birth outcomes, and thus the health of mother and baby, may be considered reached if the following items are met:

1. The proportion of beneficiaries with (previous) births whose birth spacing is inadequate decreases.
2. The proportion of participants with (previous) births whose birth spacing is inadequate is lower than that of non-participants with births.
3. The average number of days between births increases over time.
4. The average number of days between births is higher for participating beneficiaries than that for non-participating beneficiaries.
5. The proportion of enrolled women with births giving birth to low or very low birth weight infants decreases.
6. The proportion of participating women giving birth to low or very low birth weight infants is lower than that of non-participating women.

Measure 2.1 – Proportion of enrolled women with two Medicaid paid births whose spacing is inadequate for each waiver year

The number of beneficiaries with inadequately spaced births increased during the first five years of the Waiver as the number of FPW beneficiaries and the number of beneficiaries with a previous birth increased. In Year 6, the first extension year, the number of inadequately spaced births by beneficiaries dropped from 840 to 696 by 17% with respect to the previous year (See Table 9). The number of adequately spaced births also increased because the number of beneficiaries who have more than one Medicaid paid birth increases as more women are enrolled in the program and more women give birth. In Year 3, the number of beneficiaries who had an inadequately spaced birth was up to 15 times higher than the number of adequately spaced births. As the program matured, this ratio decreased to 1.4 times higher (Year 6).

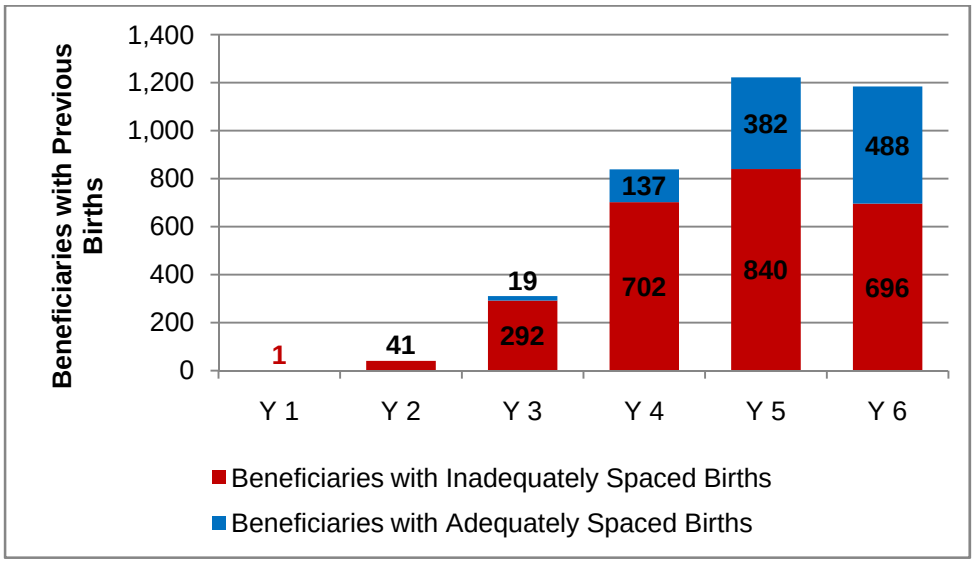
The proportion of *beneficiaries with births* who spaced consecutive births inadequately also increases throughout the first five years of the Waiver, but reduced to 12.9% in Year 6.

Table 9: Proportion of Beneficiaries with Births Who Had Inadequately Spaced Births

	Y 1	Y 2	Y 3	Y 4	Y 5	Y 6
Beneficiaries with Birth	1048	3967	7041	6848	6404	5381
Beneficiaries with Previous Births	1	41	311	839	1,222	1,184
Beneficiaries with Adequately Spaced Births	0	0	19	137	382	488
% of Beneficiaries with Births	0%	0%	0.3%	2.0%	6.0%	9.1%
% of Beneficiaries with Previous Births	0%	0%	6.1%	16.3%	31.3%	41.2%
Beneficiaries with Inadequately Spaced Births	1	41	292	702	840	696
% of Beneficiaries with Births	0.1%	1.0%	4.1%	10.3%	13.1%	12.9%
% of Beneficiaries with Previous Births	100%	100%	93.9%	83.7%	68.7%	58.8%

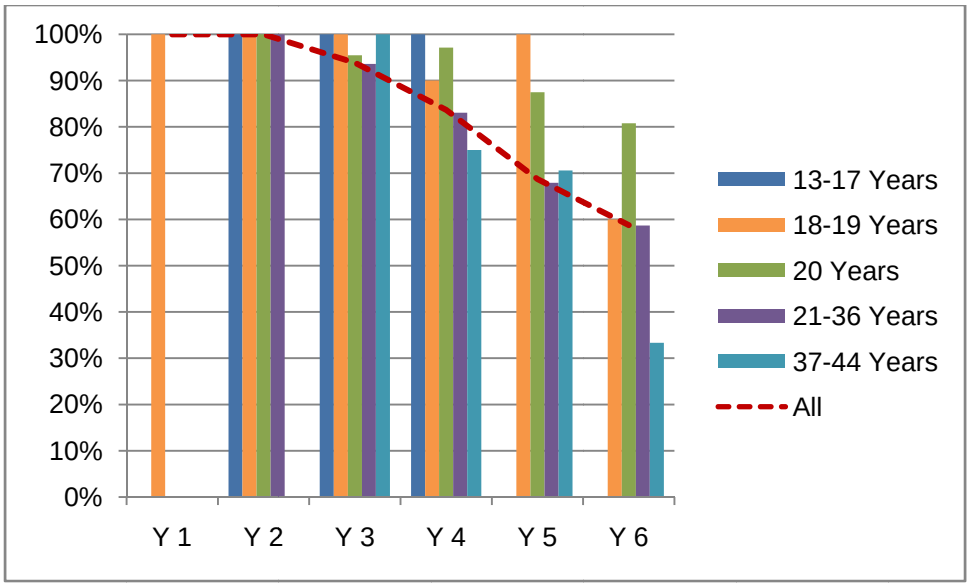
When the number of women with inadequately spaced births is expressed in terms of *beneficiaries who had a previous birth,* the proportion of inadequately spaced births dropped from 100% in Years 1 and 2 (all women with previous births, spaced births inadequately) to 58.8% in Year 6. This may be indicative of a change in behavior of women who had previous births. Figure 14 below illustrates how the number of beneficiaries with previous births increased during the first five years of the program as beneficiary numbers increased considerably, and how the proportion of beneficiaries with inadequately spaced births decreased except in Years 1 and 2.

Figure 14: Beneficiaries with Inadequately Spaced Births



Because most beneficiaries are women aged 21 – 36, the typical childbearing age, this age group accounts for most of the births and has more births per beneficiary than other age groups. The rate of 21 – 36 year old beneficiaries with previous births increased throughout the study period to 23.7% in Year 6 (See Table 42 in Appendix C). These beneficiaries contribute most of the inadequately spaced births. However, when expressed as the proportion of *beneficiaries with previous births* as in Figure 15, women aged 21 – 36 years are less likely to have an inadequately spaced birth than younger women. Almost all of the births for the younger than 20 year old beneficiaries with previous births were inadequately spaced, with the exception of Year 6, the first extension year.

Figure 15: Proportion of Beneficiaries with Previous Births Who have Inadequately Spaced Births by Age Group



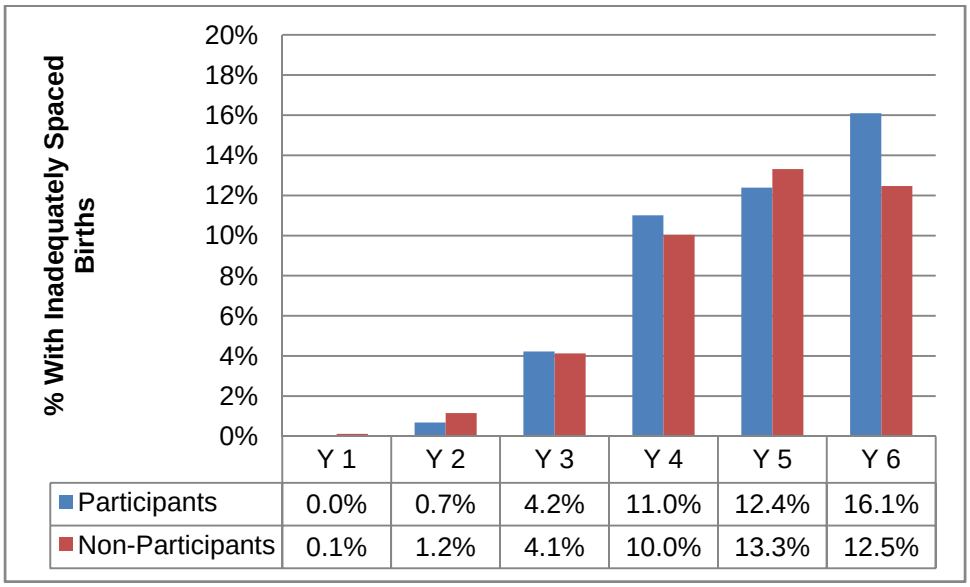
Measure 2.1 – Proportion of enrolled women with two Medicaid paid births whose spacing is inadequate for each waiver year

- The proportion of beneficiaries with births who had an inadequately spaced birth increased during the first five year of the Waiver by 13 percentage points from 0.1% in Year 1 to 13.1% in Year 5.
- This proportion remained at 12.9% in Year 6.
- The proportion of women *with a previous Medicaid paid birth* who had an inadequately spaced birth dropped from 100% in Years 1 and 2 to 58.8% in Year 6.
- Beneficiaries aged 21 – 36 years are likely to have more than one birth. But the proportion of these with inadequately spaced births decreased.

Measure 2.2 – Comparing the proportion of FPW women with inadequately spaced births among those who seek family planning services and those who don't seek family planning services

The proportion of both participating and non-participating beneficiaries with births who had inadequately spaced births increases over the six years of the program under study. Figure 16 shows a slightly higher proportion of participating beneficiaries with births who would space their births inadequately for most years. This difference became pronounced in Year 6 when the proportion of inadequately spaced births by participants increased by 3.7 percentage points with respect to the previous year.

Figure 16: Beneficiaries with Births Who Spaced Inadequately

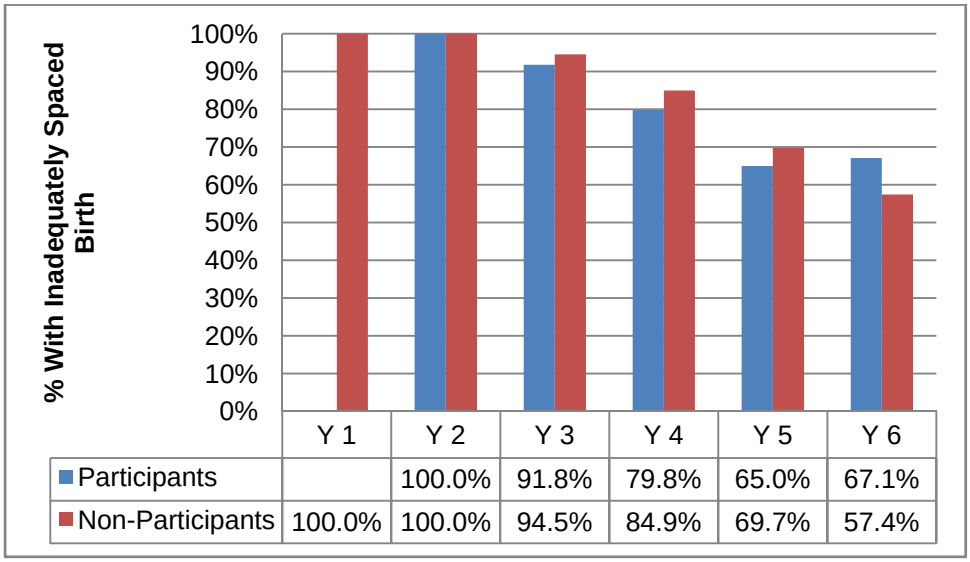


	Y 1	Y 2	Y 3	Y 4	Y 5	Y 6
Participants	0.0%	0.7%	4.2%	11.0%	12.4%	16.1%
Non-Participants	0.1%	1.2%	4.1%	10.0%	13.3%	12.5%

This unexpected finding may be traced to the fact that in Year 6 the number of births by participants (696 births) decreased to almost half of the number of participant births in Year 5, (1,332 births). In the same period, the number of births from non-participants decreased only slightly (from 5,072 to 4,685). During the same time, the number of participants who spaced their birth inadequately decreased by 32%, from 165 to112, where as non-participants decreased them only by 13%, from 675 to 584.

Only when looking at FPW beneficiaries who had previous Medicaid paid births the benefit of participating in the FPW is demonstrated. That is, if women had previous births they are more likely to space them adequately if they participate. However, in Year 6 the proportion of participants with inadequately spaced births is higher than that of non-participants. In Year 6, the number of non-participants with previous births increased by 5%, from 968 to 1,017 whereas that of participants decreased by 34%, from 243 to 167 – a larger decrease than that of inadequately spaced births by this group.

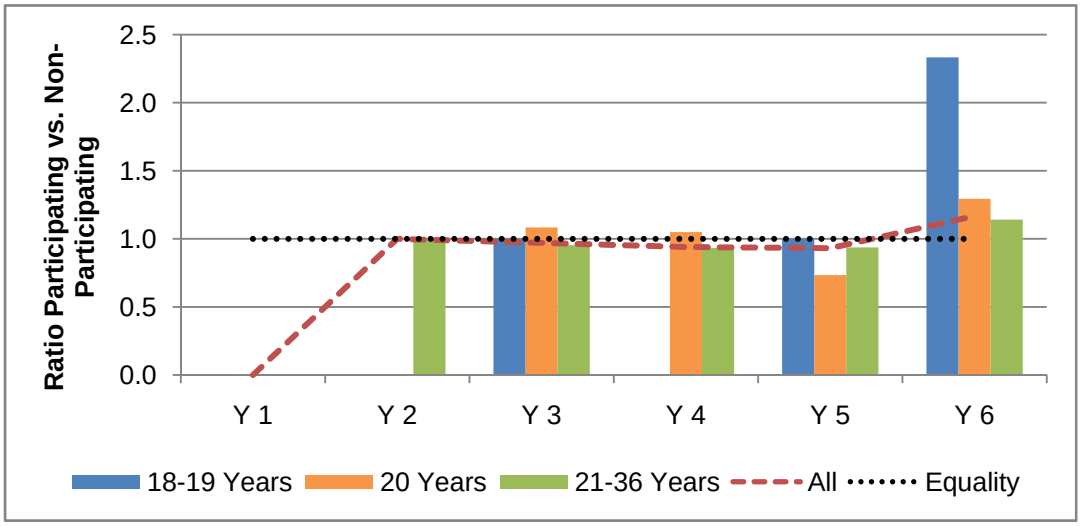
Figure 17: Beneficiaries with Previous Births Who Spaced Inadequately



	Y 1	Y 2	Y 3	Y 4	Y 5	Y 6
Participants		100.0%	91.8%	79.8%	65.0%	67.1%
Non-Participants	100.0%	100.0%	94.5%	84.9%	69.7%	57.4%

For each age group the ratio of the proportion of participating versus the proportion of non-participating beneficiaries with inadequately spaced births has been calculated in order to evaluate age related behavior. The ratio is below 1 if the participating beneficiaries are less likely to have an inadequately spaced birth. Figure 18 shows that no important differences exist between participants and non-participants within an age group, with the exception of Year 6. In that year the driving 21 – 36 year old participants' proportion becomes higher than that of the non-participants, also of note in Year 6, the 18 – 19 year old participants with previous births were more than twice as likely to have an inadequately spaced birth in that year. For 13 – 17 and 37 – 44 year old beneficiaries the ratio was either zero (no participants with inadequately spaced births) or could not be determined because of a zero denominator (i.e. no non-participants with inadequately spaced births).

Figure 18: Inadequately Spaced Births – Ratio Participating vs. Non-Participating Beneficiaries



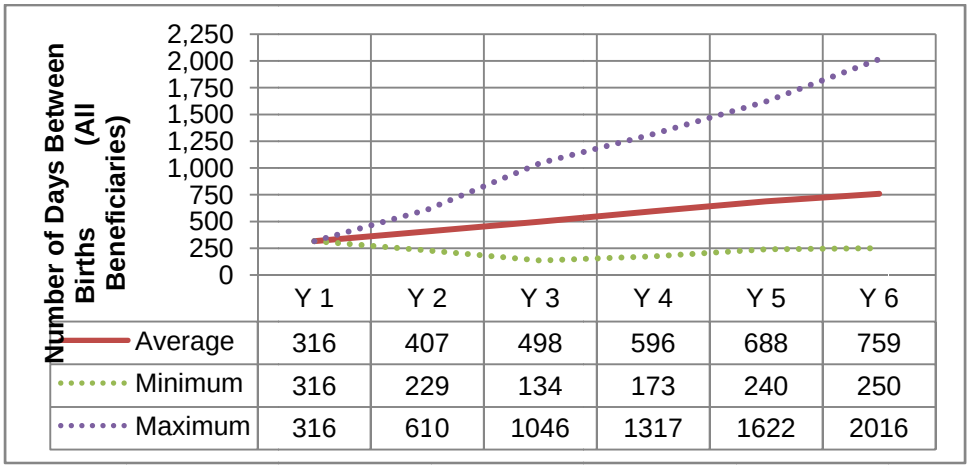
Measure 2.2 – Comparing the proportion of FPW women with inadequately spaced births on the waiver among those who seek family planning services and those who don't seek family planning services

- The proportion of both participants and non-participating beneficiaries with births who had an inadequately spaced birth increased over the study period.
- Participants with births had a slighlty higher proportion of inadequately space births.
- However, participants with more than one birth are more likely to space these births adequately than non-participants in Years 3 – 5. Their proportion of inadequately spaced births was between 2.8 and 5.1 percentage points lower.
- In Year 6 participants with more than one birth are less likely to space their births adequately than non-participants (67.1% vs. 57.4%, respectively).

Measure 2.3 – Average number of days between births for each waiver year

A birth-to-conception interval of fewer than 18 months is considered high risk.[32] Because it is difficult to estimate this interval the study considered 26 months or less between two consecutive births as inadequate. The average number of days between two consecutive Medicaid paid births increased throughout the duration of the Waiver. The minimum number of days hovered around 225 days (approximately 7 months). The maximum number of days has steadily increased over the years to reach 2016 days (66 months). Figure 19 illustrates these trends.

Figure 19: Numbers of Days between Births



	Y 1	Y 2	Y 3	Y 4	Y 5	Y 6
Average	316	407	498	596	688	759
Minimum	316	229	134	173	240	250
Maximum	316	610	1046	1317	1622	2016

[32] Technical proposal and Region IV Common Definitions, Birth-to-Conception Interval (High Risk): A birth-to-conception interval of less than 18 months is considered high risk. (5/8/06 conference call and 1/15/08 e-mail from Jeff Roth)

Table 10 shows average number of days between births by age group. On average, the 21 – 36 year old and the 37 – 44 year old beneficiaries observed 610 and 761, days between births. This is higher than the 20 and 18 – 19 year olds with 501 and 510 days. The average number of days approached or passed the threshold of 791 days (approx. 26 months) for the 21 and over age groups. This observation represents successful behavior change in the 21 – 36 and 37 – 44 year old groups. The number of beneficiaries with two births in each age group has been added to Table 10 to point out the relevance of these averages.

Table 10: Average Number of Days between Births

Age Group of Beneficiaries with Previous Births	Year 1	Y ear 2	Y ear 3	Year 4	Year 5	Year 6
13-17 Years	**na**	**339**	**338**	**387**	**na**	**na**
N		1	1	1		
18 - 19 Years	**316**	**568**	**484**	**477**	**541**	**673**
N	1	1	5	10	11	10
20 Years	**na**	**326**	**466**	**458**	**585**	**557**
N		2	22	35	32	26
21 - 36 Years	**na**	**409**	**500**	**603**	**691**	**761**
N		37	282	785	1,162	1,130
37 - 44 Years	**na**	**na**	**760**	**690**	**708**	**967**
N			1	8	17	18
All Ages	**316**[33]	**407**	**498**	**596**	**688**	**759**
N	1	41	311	839	1,222	1,184

Measure 2.3 – Average number of days between births for each waiver year

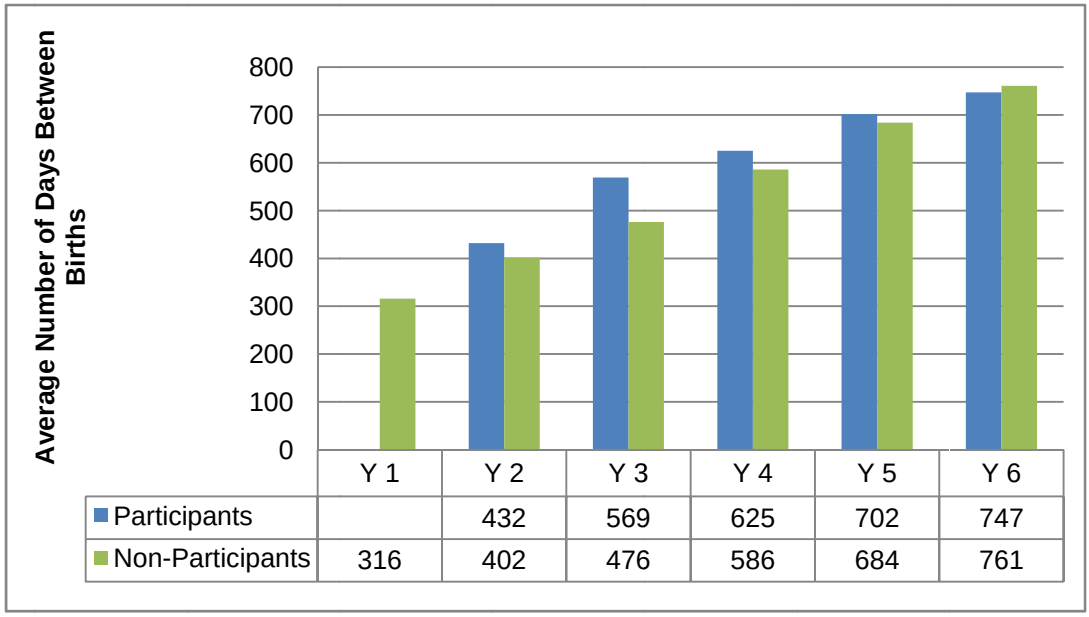
- The average number of days between births has risen from 407 days in Year 2, to 759 days in Year 6.
- This corresponds to a rate of change of 86.5% between Year 2 and Year 6
- This change is driven by the 21-36 year old women whose average number of days increased from 409 days to 761 days (Year 2 -6).

[33] One person aged 18 - 19 had two births in this year.

Measure 2.4 – Comparing the average number of days between births of women on the waiver who seek family planning services to those who don't seek family planning services

On average participants wait longer between births than non-participants as Figure 20 illustrates. This confirms the finding in Measure 2.2. However, Year 6 of the waiver shows a reversal. While the average number of days still increases for participants (747), it is lower than for non-participants (761). However, in Year 6 the observation in Measure 2.2 regarding participating beneficiaries with previous births indicates they are more likely to space births inadequately. This may also be indicative of other family planning educational forces in the community and shows the need for further education as part of Waiver services. It should be noted that these averages are close to adequate. Once the numbers for Year 7 and partial Year 8 are available, this current observation may change.

Figure 20: Average Number of Days between Births (Participants vs. Non-Participants)



	Y 1	Y 2	Y 3	Y 4	Y 5	Y 6
Participants		432	569	625	702	747
Non-Participants	316	402	476	586	684	761

Measure 2.4 – Comparing the average days between births of women on the waiver who seek family planning services to those who don't seek family planning services

- Participating beneficiaries space their births on average 33 days longer than non-participants.
- However, in Year 6 of the waiver, non-participants have a longer interval between births.

Measure 2.5 – Proportion of enrolled women with births, giving birth to low or very low birth weight infants

The proportion of enrolled women with births giving birth to low or very low weight infants does not change much over the seven years. On average, the proportion is about 7%, highest at 7.9% in Year 1 and lowest at 6.5% in Year 5.

For the different age groups these proportions can be quite different. The youngest group succeeds with a decrease from 14% in Year 2 to 0% in Year 5. The 18 – 19 year old beneficiaries start lower at 5.5% and ended up at 8.2%, higher than the overall average proportion for all years. 21 – 36 year old beneficiaries held the level around 6.7% after decreasing from 8.5% in Y1. 37 – 44 old beneficiaries showed big variations with a high of 11.4% and a low of 2.5%.

Table 11: Proportion of Beneficiaries with Low or Very Low Birth Weight

Age Group	Y ear 1	Year 2	Year 3	Year 4	Year 5	Year 6
13-17 Years	8.3%	14.0%	6.8%	4.2%	0%	0%
18 - 19 Years	5.3%	7.7%	8.4%	6.6%	7.5%	8.2%
20 Years	4.8%	8.2%	7.7%	6.3%	7.7%	8.0%
21 - 36 Years	8.5%	6.7%	6.8%	6.8%	6.4%	6.8%
37 - 44 Years	8.7%	2.5%	11.4%	10.6%	8.1%	5.2%
All Ages	**7.9%**	**6.9%**	**7.0%**	**6.8%**	**6.5%**	**6.9%**

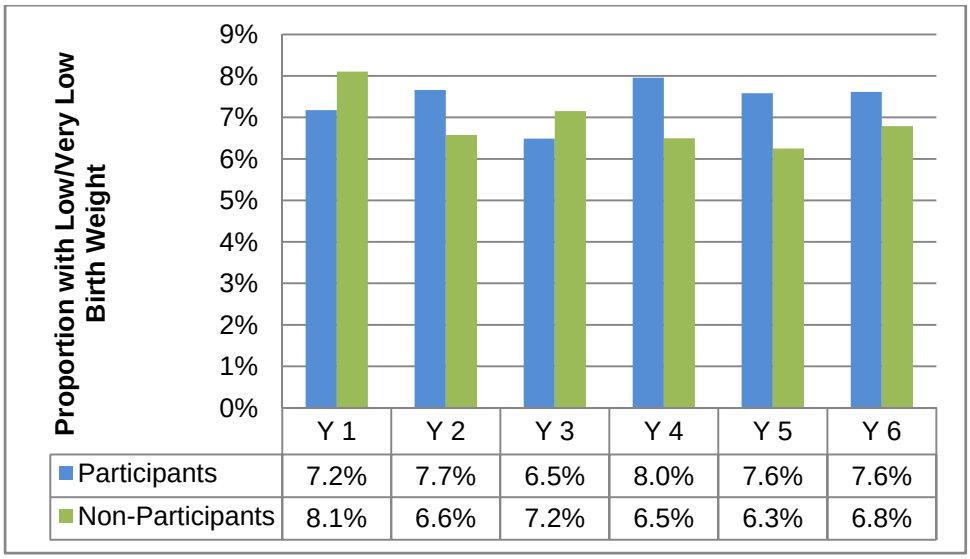
Measure 2.5 – Proportion of enrolled women with births giving birth to low or very low birth weight infants

- The proportion of beneficiaries giving birth to low or very low weight infants remains stable at an average of 6.9% across the FPW years.
- 13 – 17 year old and 37 – 44 year old beneficiaries show strong improvement by the end of the interim evaluation period.

Measure 2.6 – Comparing this proportion of women on the waiver who seek family planning services to those who don't seek family planning services

The comparison of these proportions between participants and non-participants reveals that participating women have a slightly higher proportion of births with low/very low weight babies than non-participating women for Years 2, 4, 5 and 6, as Figure 21 puts into evidence.

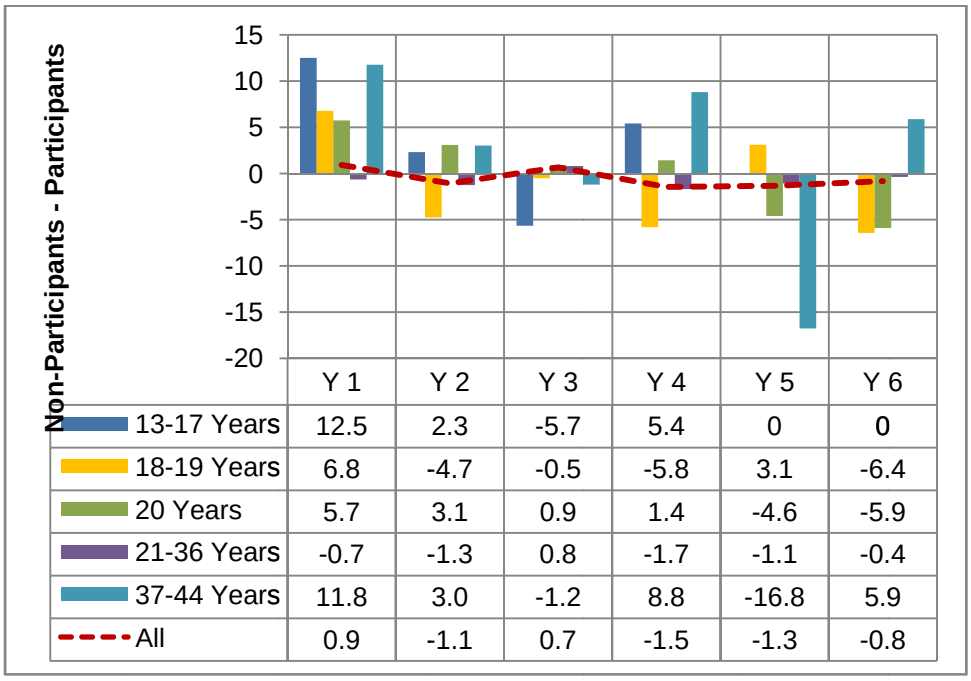
Figure 21: Proportions of Beneficiaries with Low/Very Low Birth Weight Babies



	Y 1	Y 2	Y 3	Y 4	Y 5	Y 6
Participants	7.2%	7.7%	6.5%	8.0%	7.6%	7.6%
Non-Participants	8.1%	6.6%	7.2%	6.5%	6.3%	6.8%

Figure 22 shows the comparison between participants and non-participants for the different age groups. The graph displays the absolute difference between the percentage of non-participating women and participating women who gave birth to low/very low weight babies. Positive differences indicate that participants are doing better: for example in Year 2 of the Waiver, 9% of non-participating 20-year-old women had low/very low weight babies. 5.9% of participating 20-year-old women had low/very low weight babies. The positive absolute difference of 3.1 percentage points indicates that 20-year-old participating beneficiaries have fewer low/very low weight births. Negative differences indicate that non-participants are doing better, i.e. have fewer low/very low weight births in that age group. The difference in the proportion of women who gave birth to low/very low weight babies between non-participants and participants of all ages seems to be caused by 21 – 36 old women who represent most of beneficiaries giving birth. The tendency may be exacerbated by the numbers from other age groups, such as 37 – 44 year old participants in Year 5 (whose proportion for other years is actually much lower than that of non-participants). Details can be found in Table 47 and Table 48 in Appendix C.

Figure 22: PParticipants vs. Non-Participants with Low/Very Low Birth Weight



	Y 1	Y 2	Y 3	Y 4	Y 5	Y 6
13-17 Years	12.5	2.3	-5.7	5.4	0	0
18-19 Years	6.8	-4.7	-0.5	-5.8	3.1	-6.4
20 Years	5.7	3.1	0.9	1.4	-4.6	-5.9
21-36 Years	-0.7	-1.3	0.8	-1.7	-1.1	-0.4
37-44 Years	11.8	3.0	-1.2	8.8	-16.8	5.9
All	0.9	-1.1	0.7	-1.5	-1.3	-0.8

This development may be partially explained by the observation that participants are likely to have fewer births than non-participants. The proportion of participants with births is smaller than that of non-participants (See Table 40 in Appendix C).

Measure 2.6 – Comparing this proportion of women on the waiver who seek family planning services to those who don't seek family planning services

- On average participants' proportion of women with low birth weight births is 0.5 percentage points lower than that of non-participants in the first six years of the FPW.
- The differences in the proportion may be considerable depending on the age.

Objective 2 Summary

The proportion of beneficiaries with births who had an inadequately spaced birth increased over the study period as did the proportion of women with births who had a previous birth (See Tables 42 and 44 in Appendix C). This may be partially because women in the eligible population who give birth are automatically enrolled into the FPW, possibly more than twice. However, when expressed as a percentage of beneficiaries with *previous* births the proportion of beneficiaries who had an inadequately spaced birth decreased considerably from 100% in Year 2 to 58.8% in Year 6 (68.7% in Year 5).

When considering the proportion of beneficiaries with a previous birth, participation in the FPW results in lower proportions of inadequately spaced births. On these equal terms, participating beneficiaries with previous births are less likely to have an inadequately spaced birth than do non-participants.[34]

The FPW has succeeded in increasing the average number of days between consecutive births. This is shown for all beneficiaries and in particular for participating beneficiaries. An exception to these trends seems to be Year 6 of the Waiver, the last year with available birth data[35]. This year, the first extension year, coincides with a considerable lower number of participants, participants with birth and participants with previous births.

Enrollment in the FPW does not seem to influence the proportion of women giving birth to low or very low weight infants. However, the proportion remains stable at an average of about 7% across the FPW years. The findings also indicate that participation in the FPW does not seem to make a difference in the proportion of women with low and very low birth weight babies. On the contrary, in some years a slightly higher proportion of participating women had low/very low weight births.

Objective 3 – Decrease the number of Medicaid paid deliveries which will reduce the growth of annual expenditures for prenatal delivery, newborn and infant care.

FPW beneficiaries are counseled by providers about birth spacing and birth control. It is expected that the programmatic efforts and continuous use of contraceptive methods lead to a smaller number of Medicaid paid births and hence lower overall cost due to births. The savings due to births averted should be equal or surpass the cost of the FPW. This objective will be met if the following hypotheses are verified:

1. The proportion of beneficiaries who had a Medicaid paid birth decreases.
2. The proportion of Medicaid paid births is lower for participating beneficiaries than that for beneficiaries that do not seek any family planning services.
3. The number of births averted based on baseline fertility rates is positive.
4. The number of births averted based on baseline fertility rates increases.
5. The savings due to births averted is equal or surpass the cost of the FPW (not included in this report.)
6. Proportion of beneficiaries who had continuous use of contraceptive methods during the waiver year increases.

[34] Except in Year 6
[35] Year 6 birth claims (7/1/2009 – 6/30/2010) downloaded from MMIS on Nov.1, 2010.

Measure 3.1 – Proportion of beneficiaries who had a Medicaid paid birth in each waiver year

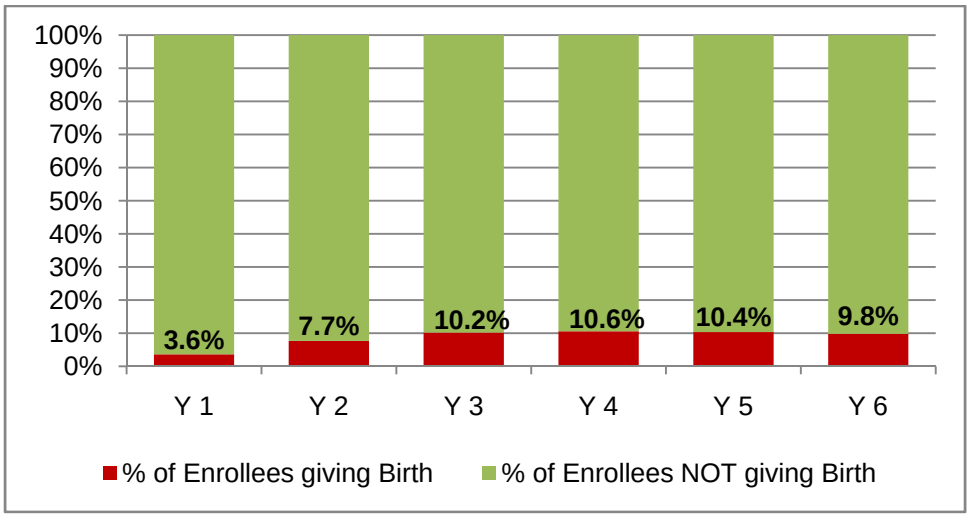
The number of beneficiaries increased considerably during the first three years of the program from an initial 28,901 to a high of 69,149 in the third year. The number of births to beneficiaries reached a high of 7,041 in FPW Year 3. Table 12 displays the number of births to beneficiaries who have been enrolled in a given year. The table also shows the number of births to beneficiaries in each age group, exposing a similar pattern.

Table 12: Number of Births to FPW Beneficiaries by Age

Beneficiaries Births						
Age Group	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
13-17 Years	12	43	73	48	31	18
18 - 19 Years	75	220	358	361	239	147
20 Years	104	319	522	446	415	323
21 - 36 Years	834	3,304	5,948	5,880	5,595	4,778
37 - 44 Years	23	81	140	113	124	115
All	**1,048**	**3,967**	**7,041**	**6,848**	**6,404**	**5,381**

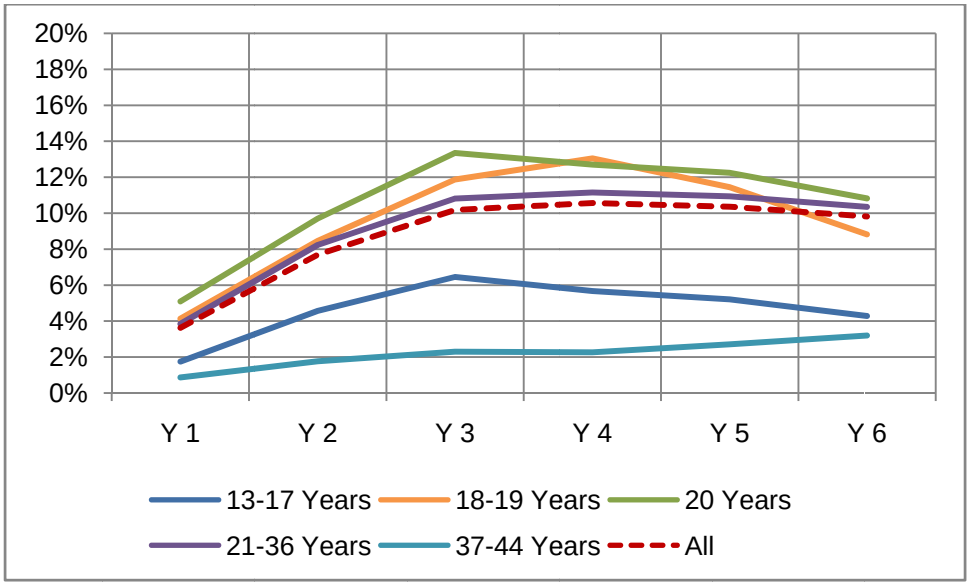
Year 3 (Oct.1, 2005 – Sept. 30, 2006) saw a 34% increase in beneficiaries over the previous year due to the economic and social consequences of Hurricane Katrina (See Table 4). The number of births by beneficiaries however increased more than twice that much (77.5%) from Year 2 to Year 3. This is reflected in an increasing proportion of beneficiaries with births. Figure 23 shows that this proportion increased to 10.6% in Year 4 when the total number of beneficiaries started to decrease, but the number of births attributed to that year was only 193 lower than in the third year. Ever since, this proportion has been decreasing, but is still above Year 2 levels.

Figure 23: Proportions of Beneficiaries Giving Birth



The proportion of beneficiaries giving birth is naturally different for different age groups. Women aged 18 – 19, 20 and 21 – 36 do have higher birth rates than women in the youngest and oldest age groups. The proportion of beneficiaries in each age group giving birth over time follows a similar pattern with the exception of the 37 – 44 year old beneficiaries where the proportion increases throughout the program years as illustrated in Figure 24.

Figure 24: Proportions of Beneficiaries Giving Birth by Age



By Year 6 the proportion of women giving birth has decreased from their highest value, which occurred for most age groups in Years 3 and 4, substantially.

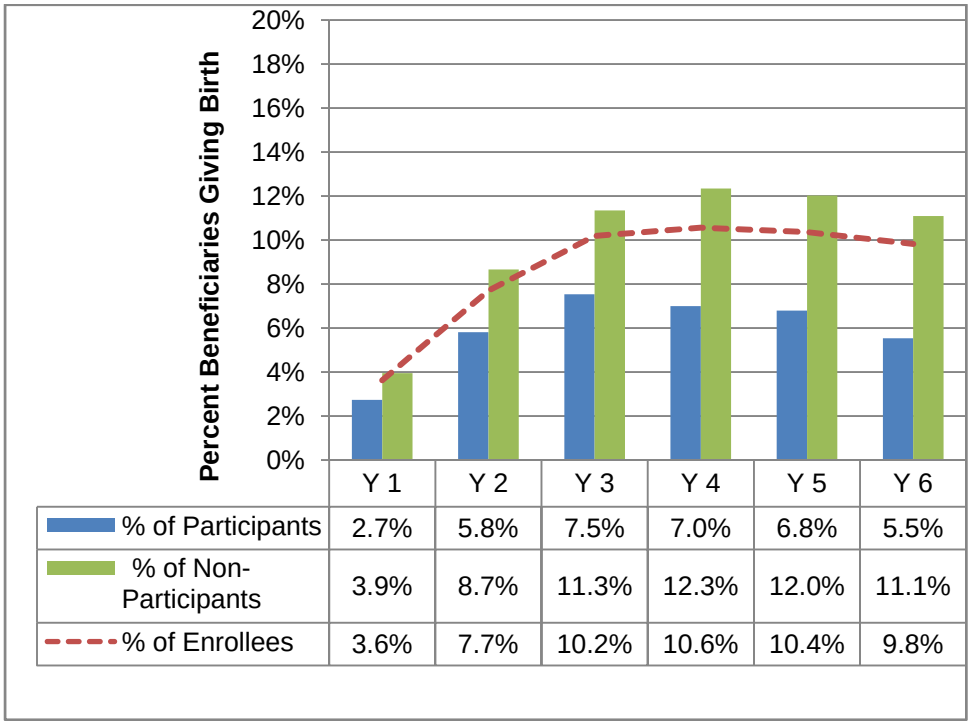
Measure 3.1 – Proportion of beneficiaries who had a Medicaid paid birth in each waiver year

- The proportion of beneficiaries who had a Medicaid paid birth increased until Year 4 from an initial 3.6% to 10.6%.
- This proportion decreased to 9.8% in Year 6, a 7% rate of change from the maximum in Year 4.
- Ages 13 – 20 years had the largest decreases.
- Ages 37 – 44 years slowly increased over time.

Measure 3.2 – Compare proportion of Medicaid paid births in each waiver year among participating beneficiaries and beneficiaries that do not seek any family planning services

The proportion of participating beneficiaries giving birth increased during the first four years of the program as did that of the non-participants. In the first year, the difference in proportion was 1.2 percentage points and increased throughout the years with available data as Figure 25 demonstrates.

Figure 25: Proportion of Beneficiaries Giving Birth (Participants vs. Non-Participants)



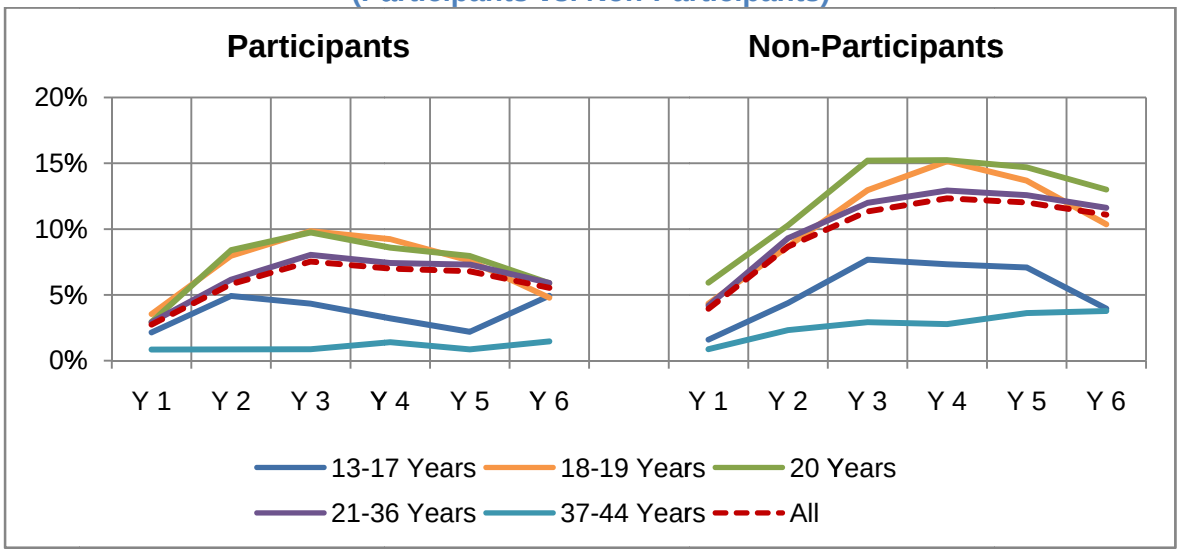
The difference grows more pronounced as FPW matures, refer below to Table 13. The proportion of 20-year-old participants registered 7.1 percentage points below that of the non-participating 20-year-old beneficiaries in Year 6. The proportions for the 18 – 19 year and 21 – 36 year old beneficiaries were 5.6 and 5.7 percentage points below that of their non-participating counterparts in Year 6.

Table 13: Difference in Proportion Giving Birth (Participants – Non-Participants)

Participants - Non-participants						
Age Group	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Year 6**
13-17 Years	0.5%	0.5%	-3.3%	-4.1%	-4.9%	1.0%
18 - 19 Years	-0.8%	-0.7%	-3.1%	-5.9%	-6.1%	-5.6%
20 Years	-3.0%	-1.9%	-5.5%	-6.6%	-6.7%	-7.1%
21 - 36 Years	-1.3%	-3.2%	-4.0%	-5.5%	-5.3%	-5.7%
37 - 44 Years	0%	-1.5%	-2.1%	-1.4%	-2.8%	-2.3%
All	**-1.2%**	**-2.8%**	**-3.8%**	**-5.3%**	**-5.2%**	**-5.6%**

Figure 26 illustrates that participating beneficiaries are much less likely to have a Medicaid paid birth. It shows how participation lowers the proportion of 18 – 19, 20 and 21 – 36 year old beneficiaries giving birth to proportions close to that of the 13 – 17 and 37 – 44 year old beneficiary groups.

Figure 26: Prooportion of Beneficiaries Giving Birth by Age (Participants vs. Non-Participants)



Measure 3.2 – Compare proportion of Medicaid paid births in each waiver year among participating beneficiaries and beneficiaries that do not seek any family planning services

- On average, over 6 years the proportion of births for particiants is 4.2 percentage points lower than that of non-participants.
- In Year 6 the proportion of participants who gave birth is 50% less than the proportion of non-participants who gave birth.
- Participation in FPW has the effect of lowering the proportion of women giving birth in the 18-19, 20, and 21-36 year old beneficiaries.

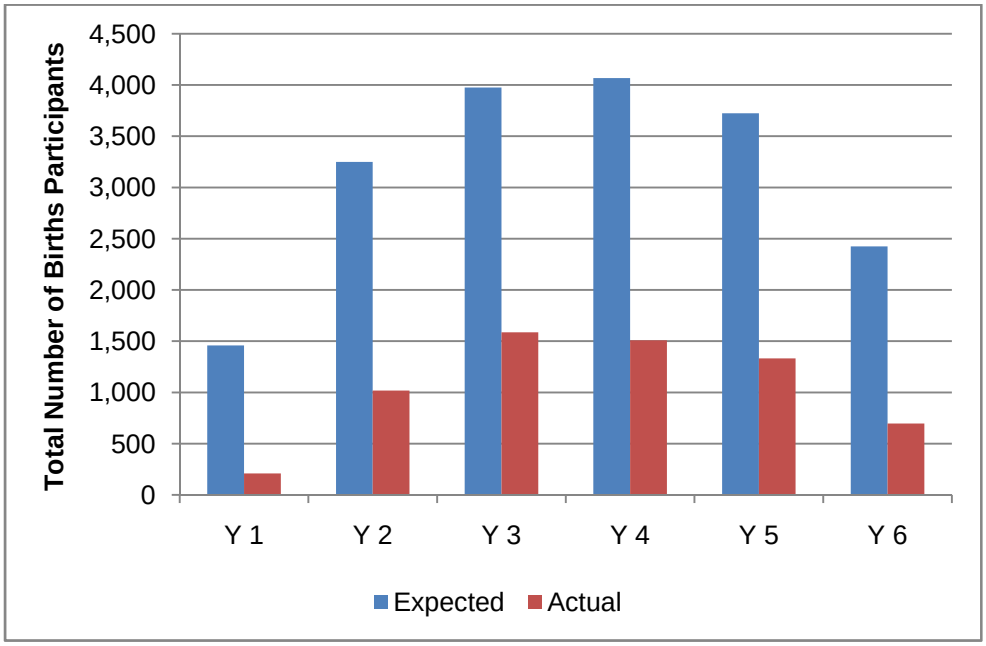
Measure 3.3 – Births averted based on baseline fertility rates

The baseline fertility rates[36] for year 2001, the year prior to the start of the program, have been used to calculate the expected births for each waiver year by applying the rate to the number of participating beneficiaries of that year. This approach assumes that the target population fertility rates would remain stable throughout the assessment period.[37] The estimate for the baseline fertility rate may be biased (see discussion in assumptions and limitations), but it provides a fixed reference that can be used to compare "expected" births to actual births over time.

[36] Preliminary estimates have been provided by DOM on October 21, 2008, MS FP Renew Budget Neutrality Worksheets_Oct17.xlsx
[37] CMS methodology

Figure 27 shows that there are more expected births than actual births for participating beneficiaries, based on these fertility rates. The number of births averted is the difference between expected and actual births by FPW participants.

Figure 27: Total Numbers of Expected and Actual Births by Participants



Over the first six years of the FPW, a total of 12,552 births due to participation have been averted, if the baseline fertility rates represent the true target population fertility rates.

Table 14 details the number of births averted by participants' age group.

Table 14: Number of Participant Births Averted

Number of Births Averted							
Age Group	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Year 6**	**All Years**
13-17 Years	26	36	49	44	32	16	202
18 - 19 Years	100	140	166	163	139	96	805
20 Years	207	308	385	405	380	302	1,986
21 - 36 Years	904	1,716	1,756	1,927	1,815	1,305	9,423
37 - 44 Years	13	31	33	23	27	10	136
All Participants	**1,250**	**2,232**	**2,389**	**2,560**	**2,392**	**1,729**	**12,552**

A total of 31,751 births have been averted over the first six years of the program; however, a large number of the averted births (19,199) are attributed to non-participating beneficiaries. This result may be due to the high baseline fertility rate estimates used in this calculation that may not be appropriate for this population (See limitations). But it also seems to support data from the 2010 Beneficiary Survey which indicated that 78% used contraceptives to prevent

pregnancy but only 61% used FPW services. Closing the gap among participating and non-participating beneficiaries will greatly enhance the overall impact of the program.

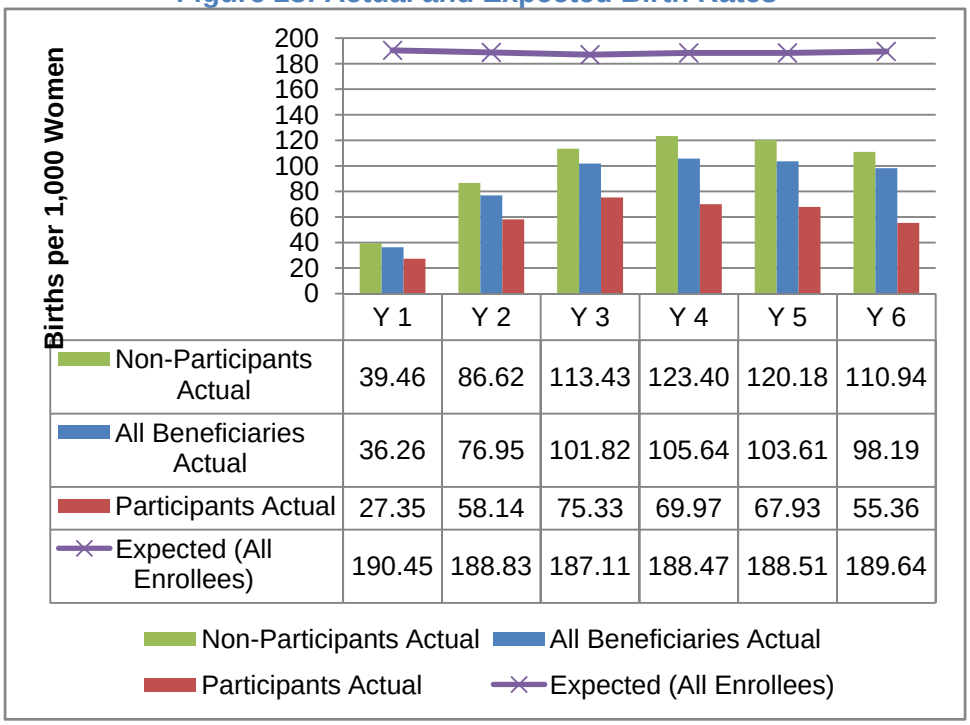
Evaluation of FPW's budget neutrality (not included in this report) *based on all beneficiaries* would then involve comparing the cost to the program for all beneficiaries and compare them to the "savings" due to births averted among all beneficiaries, regardless of whether they participated or not. The number of births averted from all beneficiaries would be as presented in Table 15.

Table 15: Number of Births Averted (All Beneficiaries)

Number of Births Averted							
Age Group	**Y 1**	**Y 2**	**Y 3**	**Y 4**	**Y 5**	**Y 6**	**All Years**
13-17 Years	98	108	108	88	64	49	516
18 - 19 Years	392	449	418	351	298	282	2,190
20 Years	689	958	996	917	901	836	5,296
21 - 36 Years	3,230	4,213	4,355	3,997	3,988	3,865	23,648
37 - 44 Years	47	40	20	18	-4	-21[38]	100
All Beneficiaries	**4,456**	**5,768**	**5,897**	**5,370**	**5,248**	**5,012**	**31,751**

It is interesting to see how the actual birth rate of non-participants compares to the baseline rates. Actual birthrates for non-participants are well below the adopted baseline fertility rates, as indicated in Figure 28.

Figure 28: Actual and Expected Birth Rates



[38] These numbers (-4, -21) means there were more actual births than expected births based on baseline fertility rates.

It seems that the natural fertility rate of FPW beneficiaries is lower than the assumed baseline, even when they do not participate. The general fertility rate for Mississippi of women aged 15 – 44 was 67.2 births per 1,000 women in 2001 and increased to 74.3 births per 1,000 women in 2008 after reaching a high of 76.6 in 2007.[39] FPW participants' rate was close to, and at times below the State average as Figure 28 indicates. One possible explanation may be that automatic enrollment into the FPW of the target population (previously enrolled, and non-enrolled) after giving birth (IS – 88 program) may contribute to the lower birth rates given lower fertility after birth.

Measure 3.3 – Births averted based on baseline fertility rates

- The number of births averted by participants increased during the first four years of the Waiver, then decreased along with overall enrollee numbers and number of births.
- Participants number of births averted increased by an average rate of change of 11.7% with respect to a previous year. The biggest increase occured in the 2nd year (+78.5%).
- A total of 12,552 births have been averted over 6 years of participation in FPW.
- Participants birth rate increased during the first three years to a maximum of 75.33 births per 1,000 participants. It decreased to 55.6 births per 1,000 participants in Year 6.
- A total of 31,751 births have been averted over 6 years of enrollement in FPW.
- Beneficiaries birth rate increased during the first four years to a maximum of 105.64 births per 1,000 beneficiaries. It decreased to 98.19 births per 1,000 beneficiaries in Year 6.

Measure 3.4 – Use births averted to calculate Medicaid birth costs averted and hence cost savings to assess budget neutrality

This measure has not been calculated for this interim report. Overall, cost savings and program budget neutrality will be assessed for the final report, when more data is available.

Measure 3.5 – Proportion of beneficiaries who had continuous use of contraceptive methods during the waiver year

The analysis measured "continuous use of contraceptive" in various ways using the MMIS pharmacy database (MMIS POS[40]). All of these metrics show interesting perspectives of contraceptive use of beneficiaries.

[39] Pew Research Center, U.S. Birth Rate Decline Linked to Recession, A Social & Demographic Trends Report, April 6, 2010
[40] Year 6 data may not be complete

Average time on a contraceptive per Year

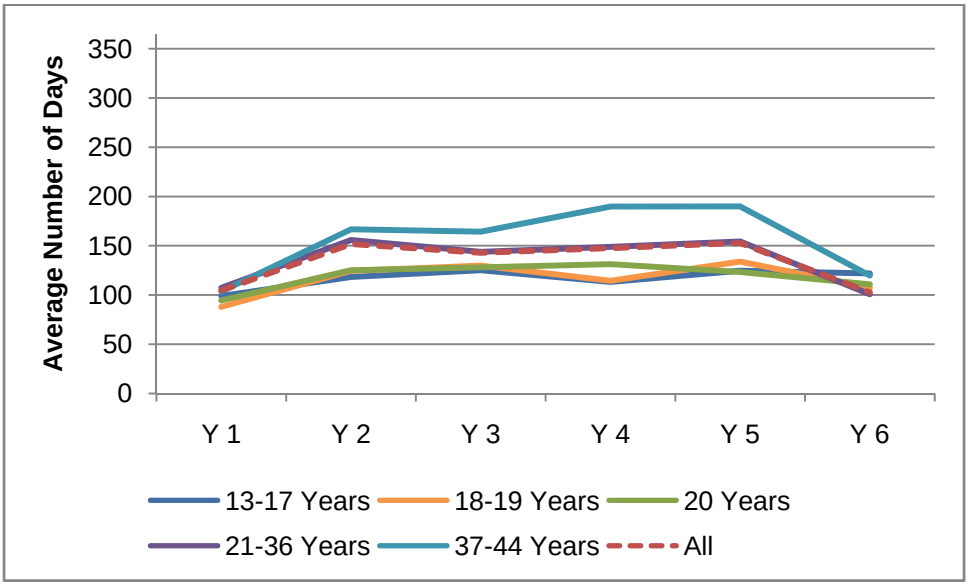
The average time on a contraceptive did not vary much over the years. The longest average time on a contraceptive was 153 days in Year 5 (See Table 16).

Table 16: Average Number of Days on a Contraceptive

	Number of Beneficiaries	Average Days
Year 1	2,605	104
Year 2	7,082	152
Year 3	7,710	143
Year 4	6,862	147
Year 5	6,698	153
Year 6	6,328	103

Figure 29 below shows that there were no large differences in the average number of days a beneficiary used contraceptives between age groups. The only exception indentified was the 37 – 44 year old participants who reached 190 days in Years 4 and 5.

Figure 29: Average Number of Days on Contraceptive[41]

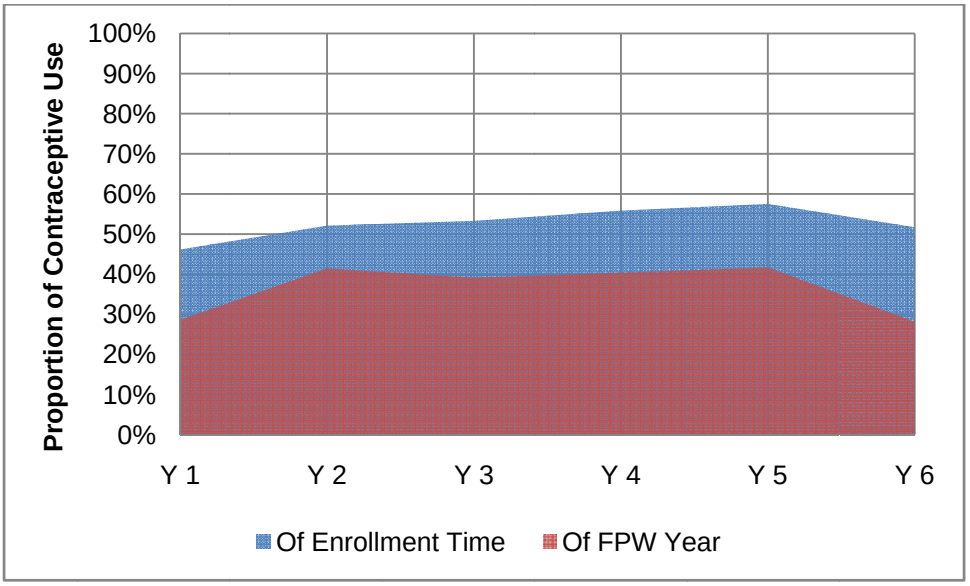


[41] Estimate for Year 6 is preliminary because of incomplete POS data

Proportion of Enrollment Time/Proportion of Year Covered by Contraceptive Use

When the average number of days is related to the total enrollment time in a given waiver year the resulting measure "proportion of enrollment time covered by a contraceptive" indicates how much of a beneficiary's enrollment time is "covered" by contraceptive use. The ideal situation would see 100% of the enrollment time covered by contraceptive use. The highest average of enrollment time covered by contraceptive use was 41.7% reached in Year 5; this indicates that on average beneficiaries used contraceptives during 41.7% of the enrollment time. However, this measure does not take into account the length of enrollment during a waiver year. It is possible that a beneficiary was enrolled for one-week only and used contraceptives during that whole week. Her coverage would be 100%. Therefore, the average number of days using a contraceptive has also been used to calculate the proportion of the waiver year that was covered by contraceptive use. The goal would be 100% enrollment and 100% contraceptive use. These two measures behaved similarly over the years (See Figure 30) with a gap of 11 to 24 percentage points indicating part time enrollment.[42]

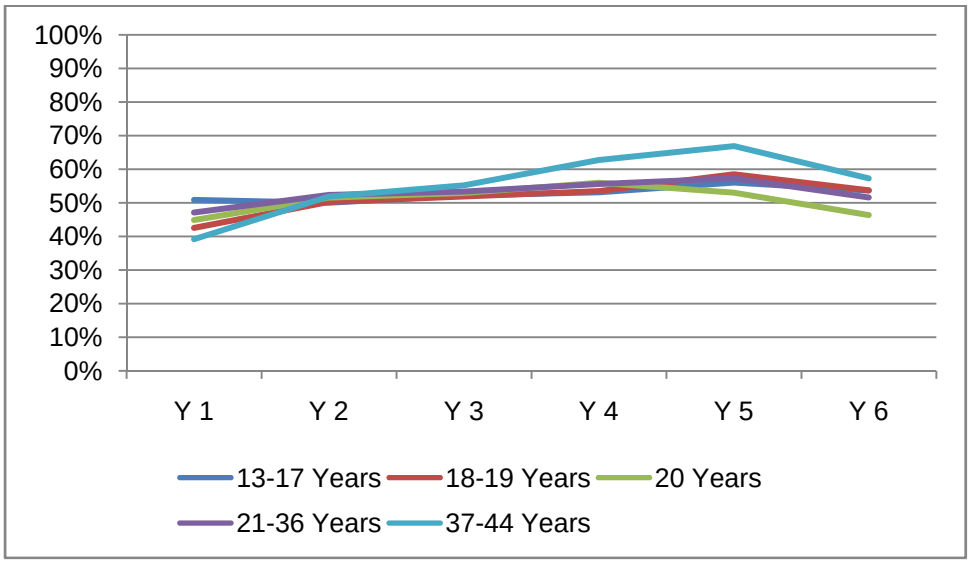
Figure 30: Proportion of Time Covered by Contraceptive Use



There are no big age differences in the average proportion of enrollment time covered with the exception of the oldest women (37 – 44 years) who used contraceptives during most of their enrollment time as demonstrated in Figure 31 (next page) shows.[43]

[42] Estimate for Year 6 is preliminary because of incomplete POS data
[43] Estimate for Year 6 is preliminary because of incomplete POS data

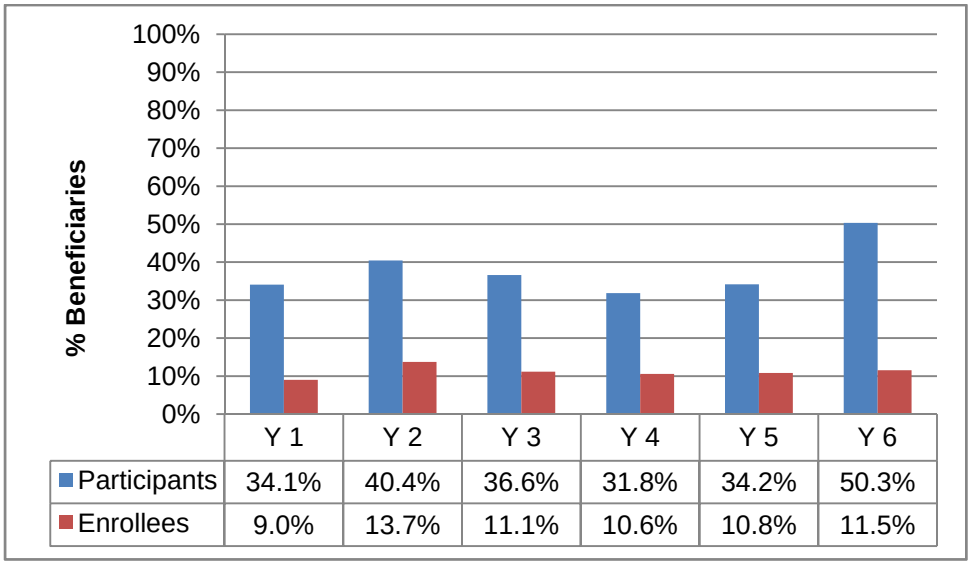
Figure 31: Proportion of Enrollment Time Covered by Contraceptive by Age



Proportion of Beneficiaries Who Use Contraceptives at Least Once in the Year

The number of beneficiaries who use contraceptives at least once during the waiver year varied between 9% and 13.7% of enrolled beneficiaries, with the latter occurring in the second waiver year. However, in terms of participation the largest number of beneficiaries who used contraceptives at least once during that year was reached in Year 6, with 50.3% (See Figure 32).

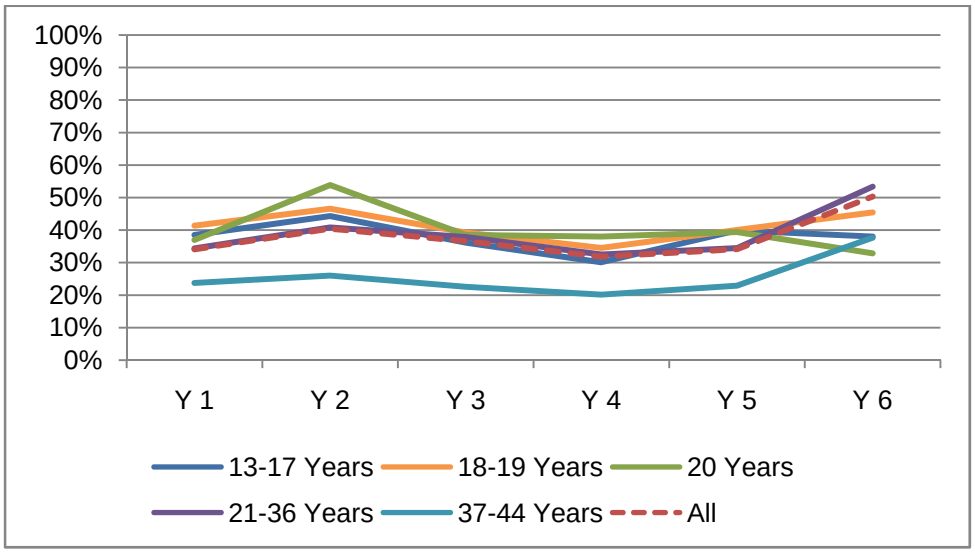
Figure 32: Proportions of Beneficiaries Who Used Contraceptive at Least Once



	Y 1	Y 2	Y 3	Y 4	Y 5	Y 6
Participants	34.1%	40.4%	36.6%	31.8%	34.2%	50.3%
Enrollees	9.0%	13.7%	11.1%	10.6%	10.8%	11.5%

As Figure 33, indicates the proportion of participating women aged 37 – 44 years who used contraceptives at least once during a waiver year is below average, but did increase in Year 6 to nearly 37.7%. The other age groups follow the average with exception of the 20 year olds whose proportion stabilized around 38% after Year 2.

Figure 33: Proportion of Participants who used Contraceptives at Least Once



Proportion of women who use a contraceptive for at least 80% of the Enrollment Time

Beneficiaries who used contraceptives for at least 80% of their enrollment time have been defined as beneficiaries who use contraceptives "continuously". Table 17 presents the number of beneficiaries who use contraceptives during at least 80% of their yearly enrollment time as related to a)the total number of beneficiaries, b) the total number of participants, and c) the total number of those who use contraceptives at least once a year.

Table 17: Proportion of Women with Continuous Contraceptive Use[44]

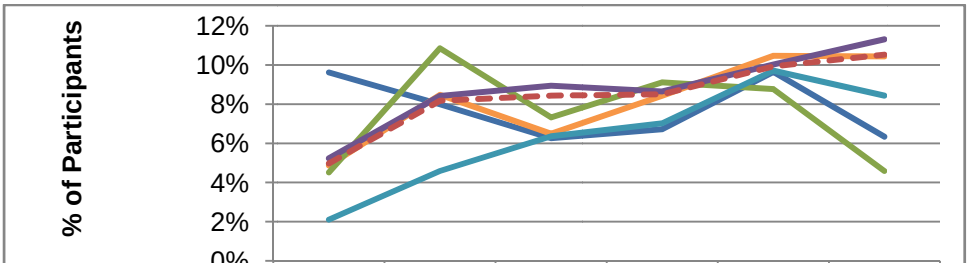
	Number of Beneficiaries with Continued Use	Percent of Beneficiaries	Percent of Participants	Percent of Those Who Used Contraceptive at Least Once
Year 1	380	1.3%	5.0%	14.6%
Year 2	1431	2.8%	8.2%	20.2%
Year 3	1778	2.6%	8.4%	23.1%
Year 4	1832	2.8%	8.5%	26.7%
Year 5	1947	3.2%	9.9%	29.1%
Year 6	1324	2.4%	10.5%	20.9%

[44] "Continuous use of contraceptive" = Contraceptive Use for at least 80% of enrollment time

The number of beneficiaries who used contraceptives continuously has increased throughout the program. The maximum was reached in Year 5 with 1,947 beneficiaries, corresponding to 29.1% of beneficiaries who used contraceptives at least once during that year. But the highest percentage of participants occurred in Year 6 with 10.5% who use contraceptives continuously. This proportion has more than doubled since the first waiver year, when it was 5%.

Figure 34 shows that the proportion of 37 – 44 year old participants with continued use of contraceptives increased strongly from 2.1% to 9.7% in Year 5, joining ranks with the other age groups. Importantly, the proportion of women aged 21 – 36 years also increased from 5.2% in Year 1 to 11.3% in Year 6.

Figure 34: Proportions of Participants with Continued Use of Contraceptives



	Y 1	Y 2	Y 3	Y 4	Y 5	Y 6
13-17 Years	9.6%	8.0%	6.3%	6.7%	9.6%	6.3%
18-19 Years	4.9%	8.5%	6.5%	8.4%	10.5%	10.4%
20 Years	4.5%	10.9%	7.3%	9.1%	8.8%	4.6%
21-36 Years	5.2%	8.4%	8.9%	8.7%	10.0%	11.3%
37-44 Years	2.1%	4.6%	6.4%	7.0%	9.7%	8.4%
All	5.0%	8.2%	8.4%	8.5%	9.9%	10.5%

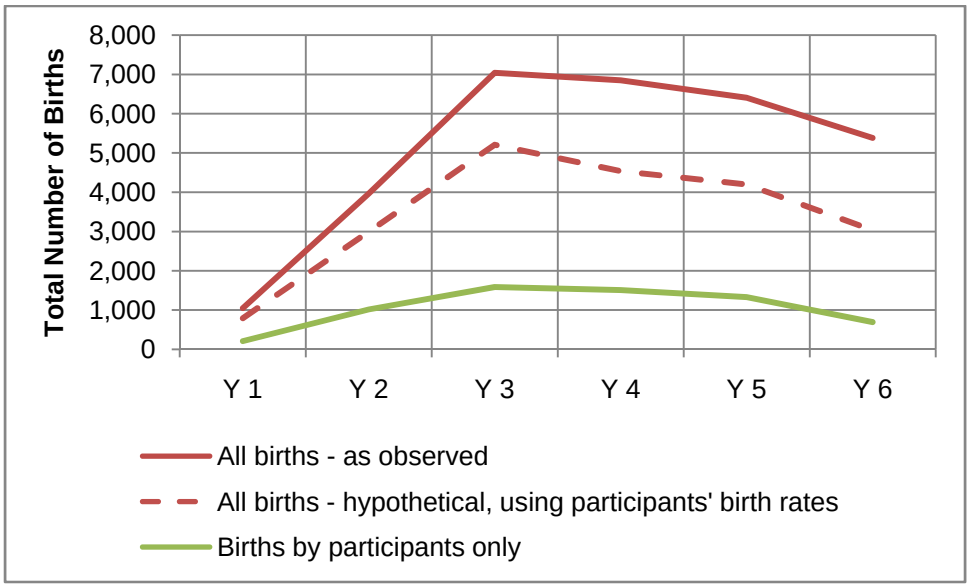
Measure 3.5 – Proportion of beneficiaries who had continuous use of contraceptive methods during the waiver year

- The proportion of *beneficiaries* who use a contraceptive at least once during a waiver year varied; it reached a maximum of 13.7% in the second waiver year.
- This proportion increased to 11.5% in Year 6 from 9% in Year 1.
- The proportion of *participants* who use a a contraceptive at least once during a waiver year varied and reached a maximum of 50.3% in Year 6, up from 34.1% in Year 1.
- The proportion of *participants* who used contraceptives continuosly doubled from 5% in Year 1 to 10.5% in Year 6.

Objective 3 Summary

Overall, the number of births by beneficiaries has increased to reach a high in Year 3 of the program. As can be seen in Figure 35 the contribution to the total number of births by participating beneficiaries (green line) is much lower than that of non-participants (difference between red and green line). There were fewer births because there were fewer participants (between 22.9% and 34%, according to Measure 1.2) but also because participants have lower birth rates. If the participants' birth rates were applied to non-participants, the total number of births would be represented by the dotted red line in Figure 35. There would have been 9,924 fewer births.

Figure 35: Total Number of Medicaid Paid Births by Beneficiaries



The proportion of births for participants is on average 4.2 percentage points lower than that of non-participants. Importantly, participation in FPW has the effect of lowering the proportion of women giving birth in the 18 – 19, 20, and 21 – 36 year old beneficiaries considerably.

Beneficiaries' birth rate increased during the first four years to a maximum of 105.64 births per 1,000 beneficiaries. It decreased to 98.19 births per 1,000 beneficiaries in Year 6. Participants' birth rate increased during the first three years to a maximum of 75.33 births per 1,000 participants. It decreased to 55.6 births per 1,000 participants in Year 6. These rates are close to the State's average general fertility rate.[45] Because the beneficiary population increased dramatically during the first few years of the Waiver, comparison to the adopted baseline fertility rates shows that the number of births averted by participants increased during the first four years of the Waiver, then decreased along with overall beneficiary numbers and number of births. A total of 12,552 births from FPW participants have been averted when compared to the baseline. The total is 31,751 if all FPW beneficiaries are taken into account.

[45] Pew Research Center, U.S. Birth Rate Decline Linked to Recession, A Social & Demographic Trends Report, April 6, 2010

The proportion of beneficiaries who use contraception at least once during a waiver year reached a maximum of 13.7% in the second waiver year. In Year 6, this proportion stands at 11.5%, as opposed to 9% in Year 1. The proportion of participants who use a contraceptive at least once during a waiver year varied, reaching a maximum of 50.3% in Year 6. This is an increase. 34.1% in Year 1 and the proportion of participants who used contraceptives continuously doubled from 5% in Year 1 to 10.5% in Year 6. Table 55 in Appendix C indicates that approximately 90% of adult women use Ortho Evra Patch, Depo-Provera or Medroxyprogesterone.

Objective 4 – Reduce teen pregnancy and repeat births among teens

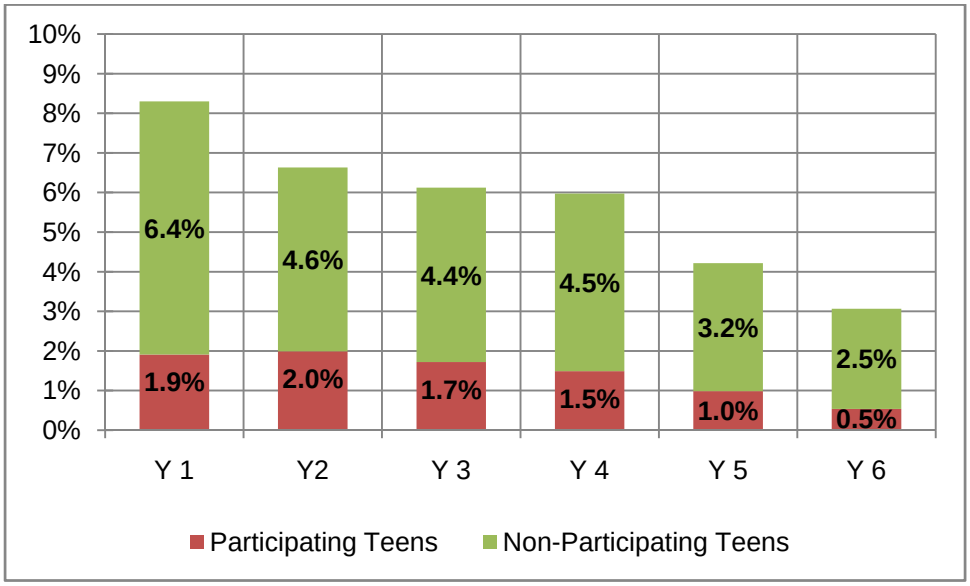
It is hypothesized that the waiver is successful in reducing the number of Medicaid paid births of teen beneficiaries and succeeds in reducing the number of inadequately spaced births and repeat births. Continuous and proper use of contraceptives by the teen population should have a measurable impact on both teen pregnancy and repeat birth rate. The analysis calculated the number of Medicaid paid deliveries for FPW beneficiaries who do seek family planning services and for those who don't. These numbers were compared to the number of expected births from these groups, given baseline fertility rates. In order to consider the FPW successful in reducing teen pregnancy and repeat births among teens the following hypotheses need to be verified:

1. The proportion of beneficiaries with Medicaid paid births who are teens in each waiver year decreases.
2. The proportion of teens with inadequately spaced births decreases.
3. The proportion of teen beneficiaries who had continuous use of contraceptive methods increases.

Measure 4.1 – Proportion of beneficiaries with Medicaid paid births who are teens in each waiver year

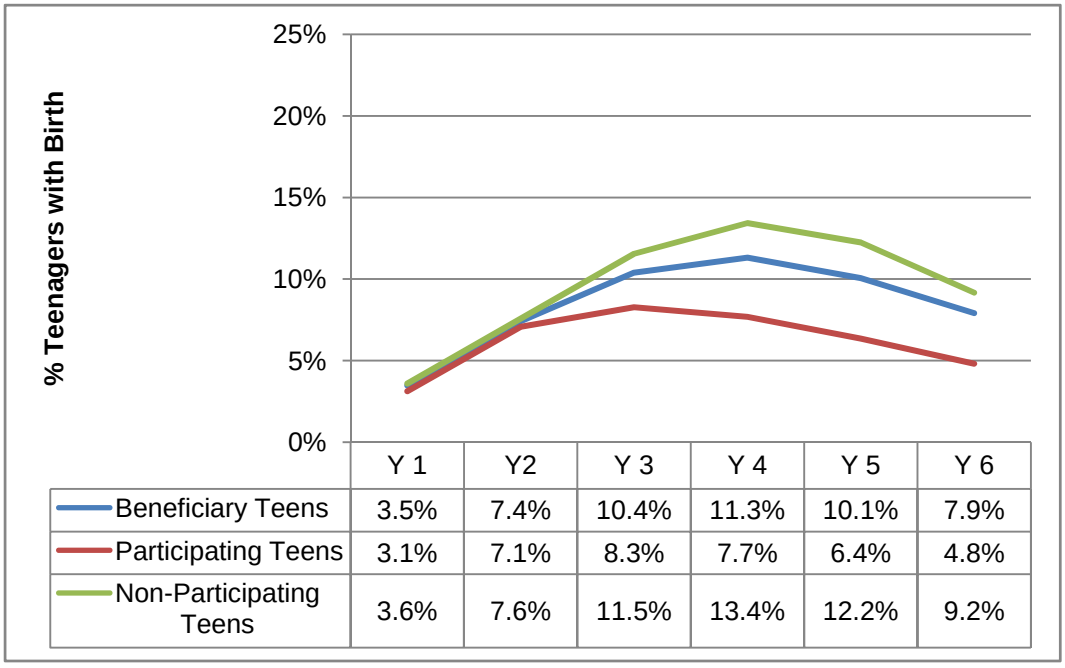
The teen contribution to total births decreased throughout the first six years of the program from 8.4% (Year 1) to 3.1% (Year 6) (See Table 52 in Appendix C). As Figure 36 illustrates the proportion of beneficiaries with births, who are participating teenagers are lower than that of non-participant teens but decreases somewhat slowly in comparison, down from 1.9% in Year 1 to 0.5% of beneficiaries with births in Year 6. The proportion of beneficiaries with births who are non-participating teens starts out at 6.4%, decreasing to 2.5% in Year 6.

Figure 36: Proportions of Teenaged Beneficiaries with Births



When looking at the population of enrolled teenagers the result is different: the proportion of enrolled teenagers who give birth increased from 3.5% (Year 1) to 11.3% (Year 4), and then decreased to 7.9% in Year 6. Figure 37 also shows the proportion of participating teenagers who give birth is always lower than that of the non-participating teenagers and that it grew slower and decreased earlier, demonstrating that access to FPW changed the behavior of teen participants.

Figure 37: Proportion of Enrolled Teens who gave birth



	Y 1	Y2	Y 3	Y 4	Y 5	Y 6
Beneficiary Teens	3.5%	7.4%	10.4%	11.3%	10.1%	7.9%
Participating Teens	3.1%	7.1%	8.3%	7.7%	6.4%	4.8%
Non-Participating Teens	3.6%	7.6%	11.5%	13.4%	12.2%	9.2%

Measure 4.1 – Proportion of beneficiaries with Medicaid paid births who are teens in each waiver year.

- The contribution from teenagers to all beneficiary births decreased by 5.2 percentage points from 8.3% in Year 1 to 3.1% in Year 6.
- The contribution from participating teenagers to all beneficiary births is approximately one third lower than that from non-participating teenagers.
- The proportion of enrolled teenagers who gave birth increased from 3.5% in Year 1 to 11.3% in Year 2, and decreased to 7.9% in Year 6.
- The proportion of participating teenagers who gave birth was up to 5.9 percentage points (Year 5) lower than that for non-participating teens.

Measure 4.2 – Proportion of teens with inadequately spaced births

The total of numbers of teens with repeat births over the span of the program is 41 out of 1,625 FPW enrolled teens (See Table 18, columns 5 and 6). This is a relatively small number compared to enrolled teens (2.5% on average) but the proportion increases each year (except Year 2). As a reminder, Year 6 data is incomplete and may change the information in Table 18. It is of interest that the number of FPW enrolled teens giving birth has dropped dramatically since the Year 3 high of 431, almost as dramatic is the drop in the number of enrolled teens from the Year 3 high of 4,146.

The proportion of teens with births that spaced their births inadequately increased during the first five years of the waiver by 3.7 percentage points from 1.1% to 4.1%, with exception of Year 2 (See Table 18, column 8). Year 6 birth data sees a slightly lower proportion of teens whose birth was inadequately spaced (3.6%). As Table 18 demonstrates, this development happens as the proportion of enrolled teens with births increased. Over all six years, the total number of teens with inadequately spaced birth is 36 out of 1,625 teenagers with births (2.2%).

Table 18 also points out almost all teens with previous births had births that were inadequately spaced (column nine).

Table 18: Proportion of Teenagers with Inadequately Spaced Births

	Enrolled Teens	Teens Giving Birth		Teens with Previous Births		Teens with Inadequately Spaced Births	
	N	N	% of Enrolled Teens	N	As % of Teens giving Birth	N	As % of Teens Giving Birth	As % of Teens with Previous Births
Year 1	2,502	87	3.5%	1	1.1%	1	1.1%	100%
Year 2	3,542	263	7.4%	2	0.8%	2	0.8%	100%
Year 3	4,146	431	10.4%	6	1.4%	6	1.4%	100%
Year 4	3,613	409	11.3%	11	2.7%	10	2.4%	90.9%
Year 5	2,683	270	10.1%	11	4.1%	11	4.1%	100%
Year 6	2,086	165	7.9%	10	6.1%	6	3.6%	60%
All	**18,572**	**1,625**	**8.7%**	**41**	**2.5%**	**36**	**2.2%**	**87.8%**

Measure 4.2 – Proportion of teens with inadequately spaced births

- The proportion of teens *with births* whose birth spacing was inadequate increased from 1 out of 87 (1.1%) in Year 1 to its maximum of 11 out of 270 (4.1%) in Year 5.
- This proportion decreased to 6 out of 165 (3.6%), or 6 out of 2,086 (0.29%) in Year 6.
- Almost all births by teenagers *with more than one birth* were inadequately spaced.

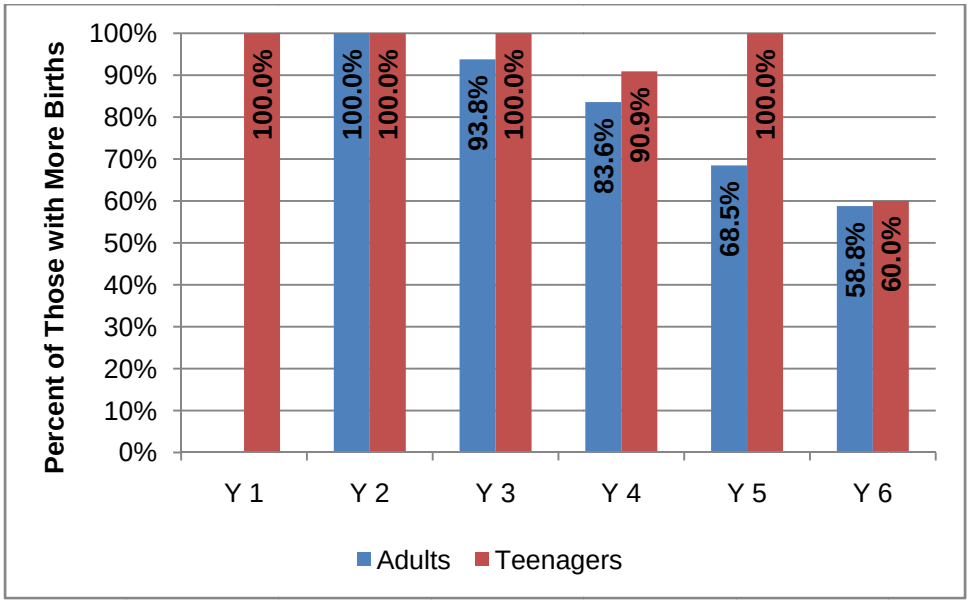
Measure 4.3 – Comparing the proportion of inadequately spaced births in teens to the proportion in adult females

As Table 18 indicates, few teenagers had a previous birth. Over the first six years of the waiver, only 41 teenagers had more than one Medicaid paid birth (i.e. previous birth). Most of these teenagers spaced their births inadequately. During the same time, 2,536 non-teenaged women did not space their births adequately. Table 53 in Appendix C provides details and percentages of interest.

The proportion of beneficiaries *with previous births* who had inadequately spaced births is always higher for teenagers than that of non-teenaged women. Although this proportion is quite high for non-teenaged women, teenagers always have a higher rate, close to 100%, except in Year 2 were all beneficiaries spaced their births inadequately (See Figure 38).

This proportion decreased to 60% in Year 6, close to the one of non-teenaged women, whose proportion had been decreasing since Year 3.

Figure 38: Proportion of Beneficiaries with Previous Births who spaced Births Inadequately (Adults vs. Teens)



Measure 4.3 – Comparing the proportion of inadequately spaced births in teens to the proportion in non-teenaged females

- Almost all *teenagers with previous births* spaced these births inadequately. This proportion is up to 1.5 times higher than that of non-teenaged women (Year 5).
- In Year 6 this proportion was almost the same for teens and for non-teenged women at approximately 60%.

Measure 4.4 – Proportion of beneficiaries that are teens for each waiver year

The number of enrolled teenagers increased into the third waiver year. The most recent years (6-7) see levels below those of the first year as displayed in Table 19. As the number of non-teenaged beneficiaries recruited into the program increased faster, the proportion of teenage beneficiaries has decreased from Year 1 (8.7% of enrolled beneficiaries) to Year 6 (3.8% of enrolled beneficiaries). Year 7 of the Waiver sees a slightly higher proportion of 4%.

Table 19: Proportion of Beneficiaries that are Teenagers

Teenage Beneficiaries							
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Year 6**	**Year 7**
13 –17 Years	688	941	1,131	847	595	420	315
18 –19 Years	1,814	2,601	3,015	2,766	2,088	1,666	1,256
All Enrolled Teens	2,502	3,542	4,146	3,613	2,683	2,086	1,571
Percent of Beneficiaries	**8.7%**	**6.9%**	**6.0%**	**5.6%**	**4.3%**	**3.8%**	**4.0%**

Measure 4.4 – Proportion of beneficiaries that are teens for each waiver year.

- The proportion of beneficiaries that are teens decreased from 8.7% in Year 1 to 3.8% in Year 6. It has slightly increased in Year 7 to 4.0%. The biggest factor is the increase in numbers of non-teenaged enrollees.
- From Year 3 to present the proportion of participating beneficiaries that are teens is between 0.4 and 1.4 percentage points higher than that of non-participating beneficiaries.
- The proportion of teenage participating beneficiaries decreased from its maximum of 8.4% (Year 1) to 4.3% (Year 7).

Measure 4.5 – Proportion of participating teen beneficiaries who had continuous use of contraceptive methods during the waiver year

The number of teens who use contraceptives at least once for some time during a waiver year more than doubled in the first three years of the program (Table 20). This number has since decreased to levels close to those in the first year of the waiver, as the number of participating teens decreased. When put into relevance to the number of participating teens, it is Years 3 and 4 of the program with the smallest proportion of participating teens who use a contraceptive at least once during an enrollment period, i.e. 38.4% and 33.4%. These are the years with the highest number of participants (i.e. 21,068 and 21,552) and participating teens (i.e. 1,462 and 1,327).

Table 20: Teenagers Who Used Contraceptive at Least Once in Waiver Year

Teenagers Who Use Contraceptive at Least Once in Waiver Year						
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Year 6**
Teens using Contraceptive	259	512	561	443	397	263
Percent of Participating Teens	40.5%	45.9%	38.4%	33.4%	40.0%	43.7%

The number of teens who used a contraceptive continuously (i.e. 80% of their enrollment time of a given year) more than doubled in the first three years of the program (Table 21). This number increased in Year 4 and leveled off in Year 5. In Year 6, the level was closer to Year 1 measures.[46]

Table 21: Teenagers Who Used Contraceptive Continuously[47]

Teenagers Who Use Contraceptive Continuously in Waiver Year						
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Year 6**
Teens using Contraceptive	40	93	94	106	102	57
Percent of Participating Teens	6.3%	8.3%	6.4%	8.0%	10.3%	9.5%

In terms of participating teens, the proportion of teenagers who used a contraceptive continuously varied between 6.3% (Year 1) and 10.3% (Year 5) without showing a clear trend. Years 5 and 6 indicate that around 10% of participating teens use a contraceptive continuously.

[46] Year 6 MMIS POS data may not be complete
[47] At least during 80% of their enrollment during a Waiver year

Measure 4.5 – Proportion of teen beneficiaries who had continuous use of contraceptive methods during the waiver year

- The proportion of participating teens using a contraceptive at least once was at a maximum in Year 2 (45.9%).
- This proportion decreased in Years 3 and 4 to a minimum of 33.4% (Year 4).
- The proportion of participating teens using a contraceptive continuously varies between 6.3% (Year 1) and 10.3% (Year 5) without a clear trend.
- This porportion is 3.2 percentage points higher in Year 6 than at the beginning of the program (6.3% in Year 1).

Measure 4.6 – Types of contraceptives used by teen beneficiaries over the waiver years

Over all the waiver years, the Ortho Evra Patch has been the most used contraceptive for teens. 43.7% of teenagers used the patch at least once. The Depo-Provera injection has also been used very often (33.5%). Oral contraceptives or pills seem to be less used in this age group as Table 22 suggests. Interestingly, the top contraceptives used by adult participating women are also very similar as Table 55 in Appendix C suggests, approximately 90% of adult women use Ortho Evra Patch, Depo-Provera or Medroxyprogesterone.

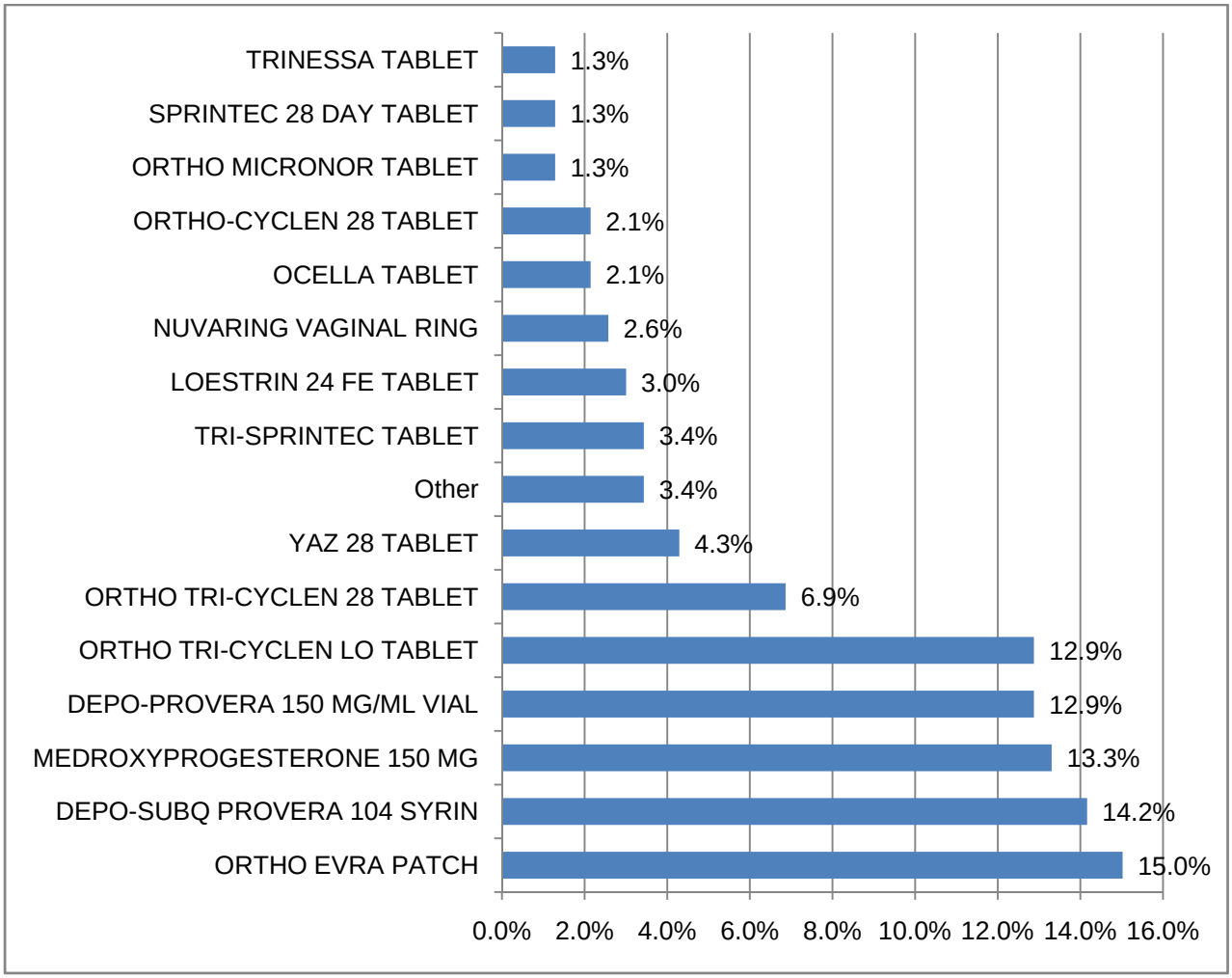
Table 22: Teens' Most Used Contraceptives

Drug Name	Number of Teenagers	Percent of Teens with Contraceptive
ORTHO EVRA PATCH	841	43.7%
DEPO-PROVERA 150 MG/ML VIAL	643	33.4%
MEDROXYPROGESTERONE 150 MG/	252	13.1%
DEPO-SUBQ PROVERA 104 SYRIN	41	2.1%
DEPO-PROVERA 150 MG/ML SYRN	36	1.9%
ORTHO TRI-CYCLEN LO TABLET	31	1.6%
ORTHO TRI-CYCLEN 28 TABLET	20	1.0%
YAZ 28 TABLET	10	0.5%
Other*	51	2.6%

The popularity of these contraceptives has changed over the years of the Family Planning Waiver. The proportion of the Ortho Evra Patch decreased as the number of teens with contraceptive injections increased and a larger variety of contraceptives became available. In the first year, the top two contraceptives were Depo-Provera (61.9% of teenagers) and Ortho Evra Patch (31.7%). The variety of contraceptives used by teens became particularly wide in Year 6 of the Waiver. Figure 39 illustrates these proportions.[48]

[48] Other category includes: Aviane-28 Tablet, Balziva 28 Tablet, Enpress-28 Tablet, Errin Tablet, Femcon FE Tablet, Jolvette Tablet, Necon 1-35-28 Tablet, Nortrel 0.5-35 Tablet

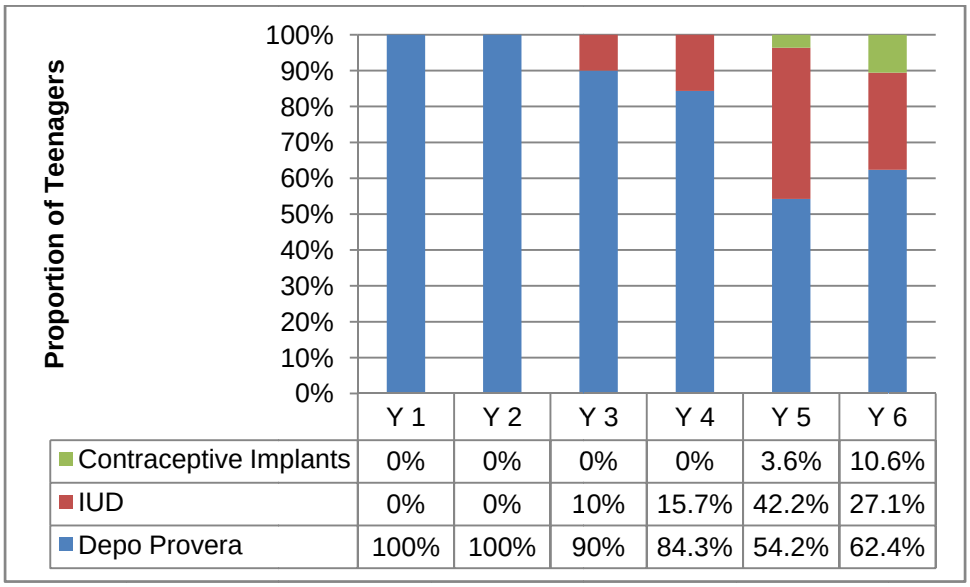
Figure 39: Year 6 Types of Contraceptives Used by Teenagers (MMIS POS)



In addition to the MMIS pharmacy data, the MMIS Claims data provide extra information on the types of contraceptive methods used by teenagers. Figure 40 shows the diminishing importance of Depo Provera and the increased use of contraceptive implants in teenagers using contraceptives at least once during the waiver year[49]. According to the claims data all teenagers using a contraceptive at least once during the year used Depo Provera in the first FPW year. In the sixth year, this proportion went down to 62.4%, in favor of contraceptive implants (10.6% of teens using contraceptive at least once) and IUDs (27.1%).

[49] Based on MMIS claims data, not MMIS POS

Figure 40: Contraceptive Types - Proportion of Teenagers using Contraceptive (MMIS Claims)



	Y 1	Y 2	Y 3	Y 4	Y 5	Y 6
Contraceptive Implants	0%	0%	0%	0%	3.6%	10.6%
IUD	0%	0%	10%	15.7%	42.2%	27.1%
Depo Provera	100%	100%	90%	84.3%	54.2%	62.4%

Measure 4.6 – Types of contraceptives used by teen beneficiaries over the waiver years

- Overall, the Ortho Evra Patch has been the most used contraceptive for teens. 43.7% of teenagers used the patch at least once, followed by Depo-Provera injection (33.5%).
- The variety of contraceptives used by teens increased over the study period.
- In the first year the top two contraceptives were Depo-Provera (61.9% of teenagers) and Ortho Evra Patch (31.7%).
- In Year 6 Ortho Evra Patch and Depo-Provera are still popular, but have decreased in use due to other choices. Depo-Provera (14.2% of teenagers) and Ortho Evra Patch (15%).

Objective 4 Summary

The contribution from teenagers to all beneficiary births decreased by 5.2 percentage points from 8.3% in Year 1 to 3.1% in Year 6. However, when expressed the number of births by teenagers as a proportion of teen beneficiaries, the proportion of enrolled teenagers who gave births increased from 3.5% in Year 1 to 11.3% in Year 2, and decreased to 7.9% in Year 6, similar to the trend in overall birth rates. Participation in FPW makes a difference as shown by the consistently higher proportion of non-participating teenagers who gave birth.

The proportion of beneficiary teenagers whose births were inadequately spaced increased each year, except from Year 5 (0.41%) to Year 6 (0.29%). Given that the number of inadequately spaced births by teens is low (a total of 36 in 6 year) this observation should not be alarming.

However, the fact that almost all births by teenagers *with previous births* were inadequately spaced is of utmost importance and reflects that FPW did little to decrease the number of repeat births among teens. As there are only few teen births that were not adequately spaced, the likelihood of an enrolled teenager to have an inadequately spaced birth is lower than that of non-teenaged women. Over all six years, 2.2% of *teenagers giving birth* had an inadequately spaced birth, compared to 9.1% of non-teenaged women.

The proportion of participating teens using a contraceptive *at least once* was at a maximum in Year 2 (45.9%), but it decreased to a minimum of 33.4% (Year 4). In Year 6, this proportion rose to 43.7%, according to available data. The proportion of teens using a contraceptive *continuously* varies between 6.3% (Year 1) and 10.3% (Year 5) without a clear trend.

Objective 5 – Reduce the number of unintended pregnancies among those who are eligible for Medicaid paid deliveries.

The FPW and other Medicaid programs providing family planning services are expected to help reduce the number of unintended pregnancies by providing access to family planning services and contraceptive methods that may otherwise not be available. The objective of reducing the number of unintended pregnancies can be considered reached if the proportion of mistimed or unwanted pregnancies decreases over the duration of the program.

Measure 5.1 – Proportion of pregnancies that were mistimed or unwanted in Medicaid paid births in each calendar year

The information on pregnancies that were unintended is provided by the Pregnancy Risk Assessment Monitoring System (PRAMS) survey.[50] These statistics are accepted by the analysis as indicative of the trend in unintended pregnancies.

Table 23 displays the proportion of women giving birth in a particular year who answered Question 10 of this survey “Thinking back to just before you got pregnant with your new baby, how did you feel about becoming pregnant?“ with answers:

a) “I wanted to be pregnant later” (i.e. mistimed) or
b) “I didn’t want to be pregnant then or at any time in the future” (i.e. unwanted).

Table 23: Unintended Pregnancies by Age

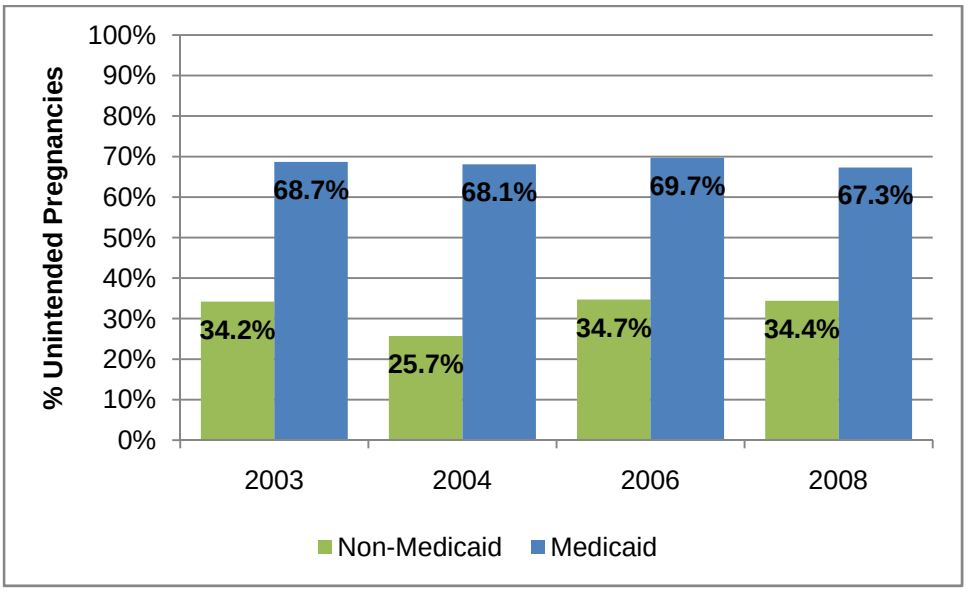
Unintended Pregnancies (%)				
Age Group	**2003**	**2004**	**2006[51]**	**2008**
<20 yrs	79.4%	78.9%	83.5%	78.1%
20 – 24 yrs	67.2%	65.0%	66.7%	67.4%
25 – 34 yrs	43.1%	40.5%	48.2%	47.4%
35+ yrs	33.6%	39.1%	40.0%	37.0%
Unintended	**57.8%**	**55.4%**	**59.5%**	**58.3%**
Medicaid Paid[52]	**68.7%**	**68.1%**	**69.7%**	**67.3%**

[50] Pregnancy Risk Assessment Monitoring System (PRAMS) - Surveillance project of the Centers for Disease Control and Prevention (CDC) and state health departments
[51] Data for 2006 represents Mississippi births from February 2006 to September 2006

The proportion of unintended pregnancies by women with babies born in 2003 was 57.8%. The FPW started on October 1, 2003 this could be taken as a baseline to which consecutive proportions may be compared. As Table 23 shows, this proportion decreased by 2.4 percentage points during 2004, but increased by 1.7 percentage points to a new high with respect to 2003. The latest available data indicate that the proportion of unintended pregnancies is again decreasing.

The corresponding proportion of women who had a Medicaid birth[53] was approximately two times higher than that of women without Medicaid. This difference narrowed in 2008 as the proportion of Medicaid related unintended pregnancies decreased below 2003 levels. Figure 41 puts these proportions in perspective.

Figure 41: Unintended Pregnancies by Insurance[54]



An unintended pregnancy is defined as either a *mistimed* pregnancy or an *unwanted* pregnancy at the time of conception. Figure 42 shows that the proportion of women who answered that their pregnancy was mistimed was much larger than the proportion of women who did not want a pregnancy at all. The decrease in 2004 of unintended pregnancies was caused mostly by a decrease in mistimed pregnancies. The proportion of women with unwanted Medicaid paid births increased from 18.6% in year 2003 to 21.2% in year 2008, whereas the proportion of mistimed Medicaid pregnancies decreased by 3.9 percentage points from 50% to 46.1%.

[52] Medicaid paid for prenatal care and/or birth
[53] Medicaid paid for prenatal care and/or birth
[54] Percentages are weighted to population characteristics

Figure 42: Proportion of Mistimed or Unwanted Pregnancies

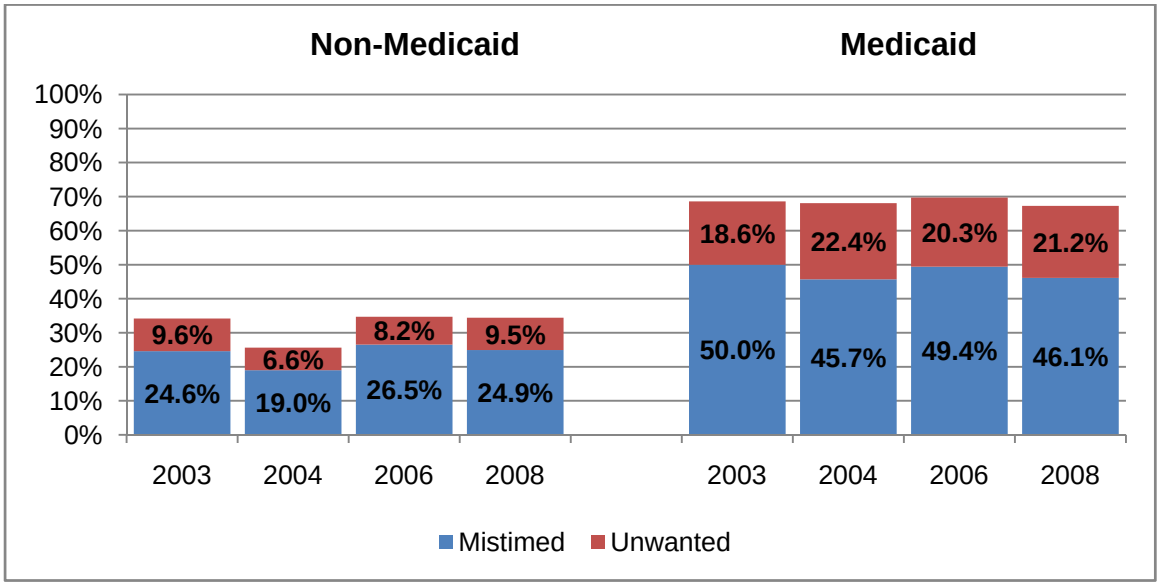


Table 24 and Table 25 show the breakdown of mistimed and unwanted pregnancies by age regardless of Medicaid status. The proportion of mistimed births in the younger than 20-year-old group was at times more than 20 percentage points above the average (See Table 24). Typically, the 25 – 34 year old group' proportions were approximately between 10 and 14 percentage points below the average. In 2008, the less than 20 year old and the 20 – 24 year old groups saw a decrease in the proportion of mistimed pregnancies as compared to 2003. The proportion for the 25 – 34 year olds increased slightly and the 35 – 44 year olds stayed about the same.

Table 24: Mistimed Pregnancies by Age

Unintended Pregnancies - Mistimed (%)				
Age Group	**2003**	**2004**	**2006**	**2008**
<20 yrs	64.7%	58.4%	66.0%	58.9%
20 – 24 yrs	50.9%	50.9%	51.9%	49.8%
25 – 34 yrs	28.6%	23.8%	32.3%	30.8%
35+ yrs	10.2%	6.5%	10.6%	10.6%
All	**42.0%**	**37.7%**	**42.7%**	**40.4%**
Medicaid	50.0%	45.7%	49.4%	46.1%
Non-Medicaid	24.6%	19.0%	26.5%	24.9%

The proportion of unwanted pregnancies is dominated by the 35 – 44 year olds when compared to baseline data from 2003, (See Table 25). Actually all age groups, with the exception of the 20 – 24 year olds in 2004 and 2006, showed a higher proportion of unwanted pregnancies when compared to 2003 baseline data.

Table 25: Unwanted Pregnancies by Age

Unintended Pregnancies – Unwanted (%)				
Age Group	**2003**	**2004**	**2006**	**2008**
<20 yrs	14.7%	20.4%	17.6%	19.2%
20 – 24 yrs	16.3%	14.1%	14.8%	17.6%
25 – 34 yrs	14.5%	16.7%	15.9%	16.6%
35+ yrs	23.4%	32.6%	29.4%	26.4%
All	**15.8%**	**17.7%**	**16.8%**	**18.0%**
Medicaid	18.6%	22.4%	20.3%	21.2%
Non-Medicaid	9.6%	6.6%	8.2%	9.5%

Measure 5.1 – Proportion of pregnancies that were mistimed or unwanted in Medicaid paid births in each calendar year

- The proportion of *unintended* pregnancies did not vary much over the years.
- This proportion was at its lowest in 2004 with 55.4% of women saying that they did not plan or intend to become pregnant. It was at its highest in 2006 with 59.5% (i.e mostly Year 3 of the FPW).
- This proportion was above average for the younger than 20 and 20 – 24 year old women (between 78.1% and 83.5%, and 65% and 67.4%).
- This proportion was below average for the 25 – 34 and 35 to 44.
- The proportion of unintended pregnanices was between 2 to 2.5 times higher for women who had a Medicaid paid birth. Little change has occured during the course of the FPW (between 67.3% and 69.7%).
- The proportion of *mistimed* pregnanies varied between 37.7% and 42.7%. The proportion was similar for Medicaid paid births.
- The proportion of *unwanted* pregnancies increased from 2003 (15.8%) to 2008 (18%).
- This proportion was higher for women who had a Medicaid paid birth.

Objective 5 Summary

No clear trend could be established in the proportion of women who did not intend their pregnancy. Thus between 55.4% and 59.5% of women interviewed did not plan their pregnancy. More than two thirds of Medicaid paid births was non-intended, almost half of Medicaid paid births was mistimed, and approximately 20% of women who had a Medicaid paid birth said that they actually did not want the pregnancy. The number of Medicaid paid births includes births from various programs, and the proportion of women who were enrolled and participated in FPW may not have the critical mass to make a difference in the PRAMS statistics.

Objective 6 – Increase the number of primary care referrals to improve the health of the target population.

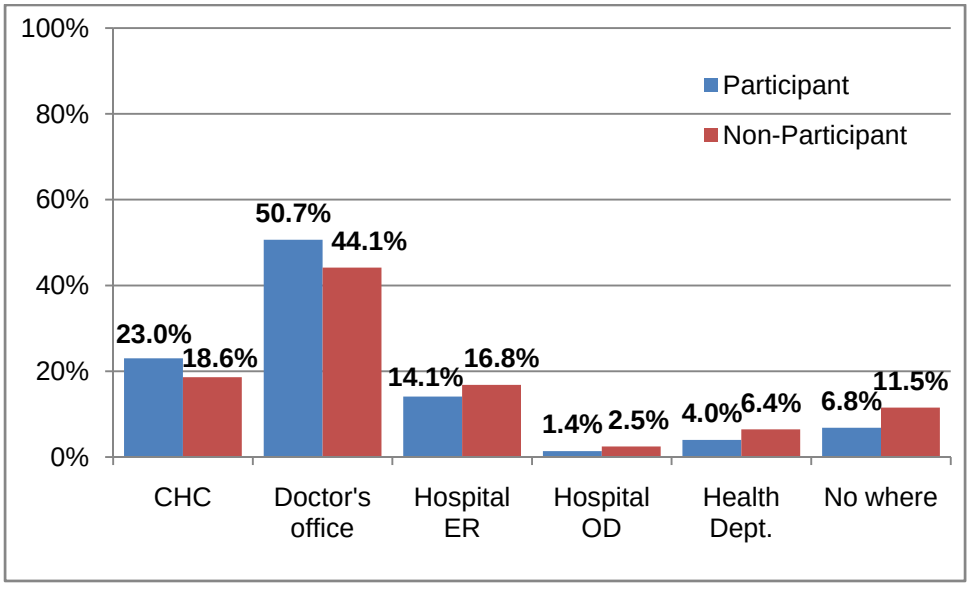
It is important for waiver participants diagnosed with a non-covered medical condition during their family planning visit to be provided with appropriate referrals to primary health providers. It expected that women receiving FPW care also impacts and encourages women to seek primary healthcare through referrals, therefore reducing the number of emergency department visits and assist in better health and wellness.

The measurement of this objective has been approached through beneficiary and provider surveys and focus groups conducted in the spring of 2010. The detailed results from these surveys have been analyzed in "Mississippi Medicaid Family Planning Waiver Program 2010 – Year One Beneficiary and Provider Survey and Focus Group Reports", September 2010. The following sections summarize the relevant findings.

Proportion of beneficiaries surveyed who have a source for primary care[55]

In 2009 almost half (48%) of all beneficiaries went to a doctor's office when they are sick, while 21.2% went to a Community Health Center for medical care. This percentage is closely followed by the percentage of women who went to the hospital emergency room (15.1%). 4.9% of women consulted the health department, and 1.8% saw someone at a hospital outpatient department. 8.6% of beneficiaries did not have a source for primary care and did not get treatment. Figure 43 shows that participating beneficiaries were more likely to go to the doctor's office or a Community Health Center (CHC) than non-participants. Non-participants were more likely to use the ER, a hospital outpatient department (OD), or the Health Department. They were also more likely to not get any follow up primary care (11.5% versus 6.8% for participants).

Figure 43 Primary Care Sources of Surveyed Beneficiaries (2009)



[55] Question D1 of the Beneficiary Survey: "Where do you usually go for medical care when you are sick?"

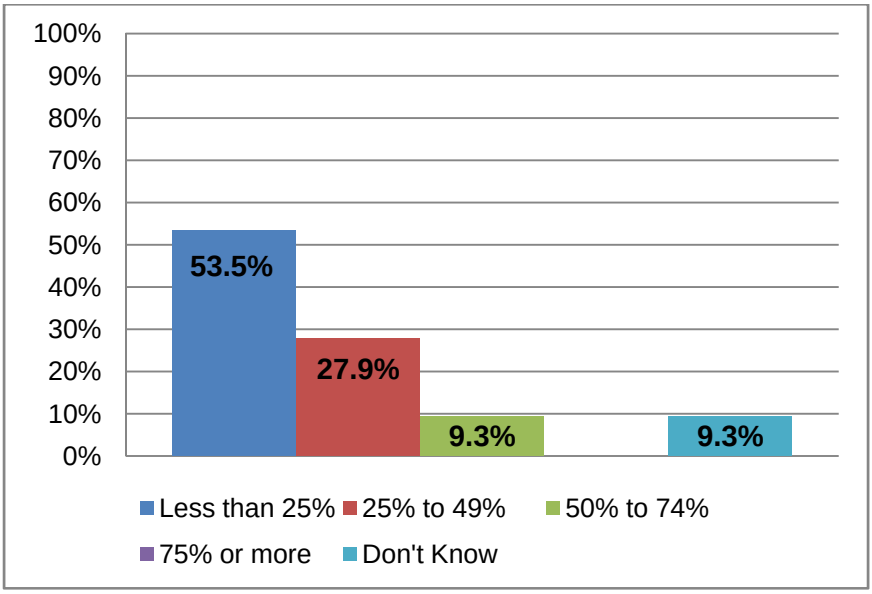
Proportion of beneficiaries surveyed who use ER services for primary care

The proportion of beneficiaries who used emergency room (ER) services for primary care was 15.1%. FPW participants were less likely than non-participants to use the hospital ER as illustrated in Figure 43 by a margin of 2.7 percentage points. If all beneficiaries participated in FPW one might see an average of 1,000 fewer beneficiaries per year who would use the ER as a primary healthcare service source.[56]

Proportion of providers surveyed who have knowledge and understanding of the referral process

The beneficiary survey[57] indicated that 17.5% of participating women were told of other medical problems that required follow-up with another medical professional. More than half of the participating providers (53.5%) said that fewer than 25% of their FPW patients did need a referral, whereas 27.9% answered that between 25% and 50% of these patients needed a referral.[58] These percentages are depicted in Figure 44.

Figure 44 Proportions of Providers Giving Referral



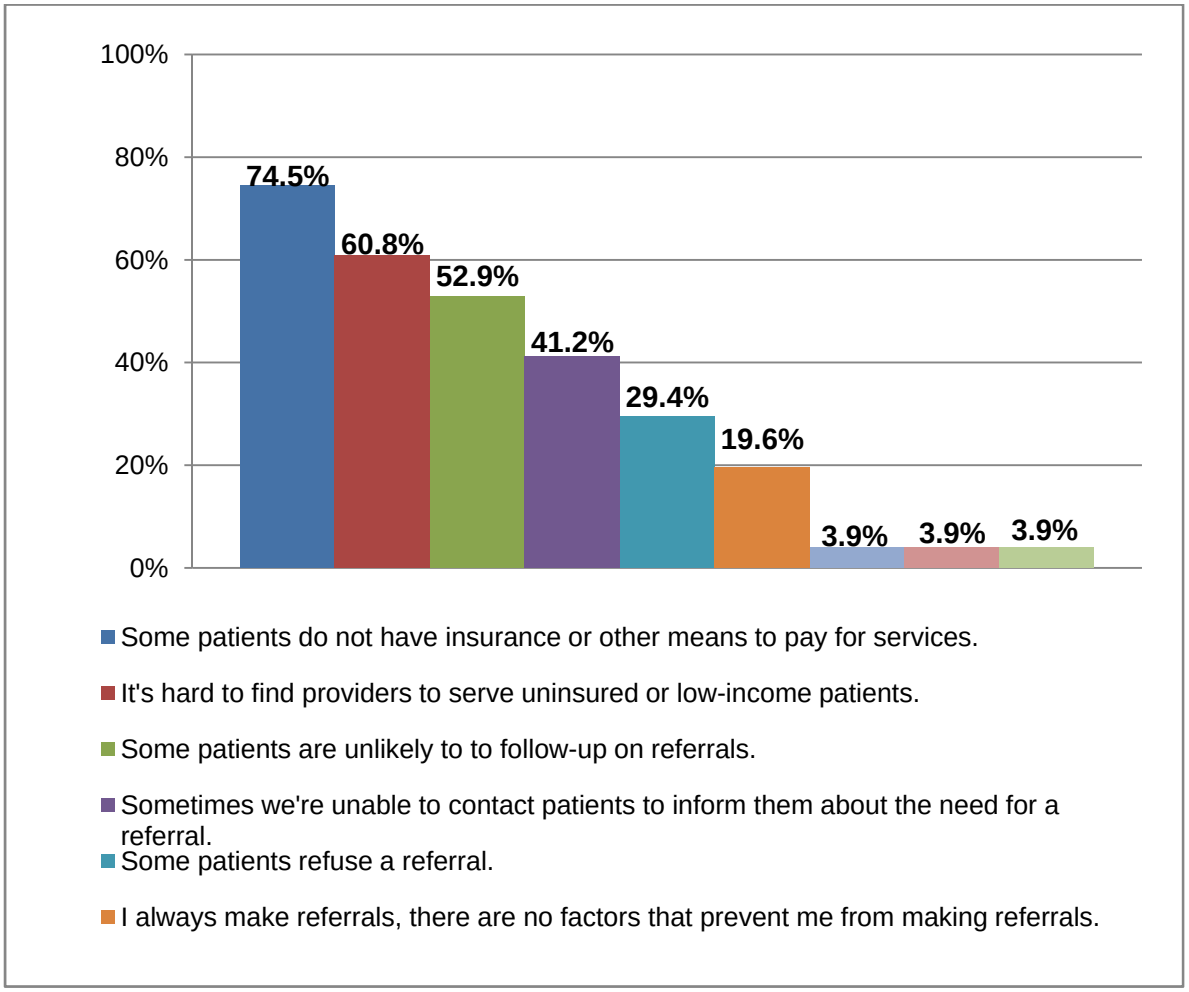
When asked, less than half of providers indicated they did any follow-up of referrals by verifying whether appointments have been held or checking on the outcomes of these appointments. Such follow-up verifications may encourage beneficiaries to follow up on their part – within the limits of their financial possibilities and personal circumstances.

[56] Participants ER rate applied to non-participants results in a total of 7,015 beneficiaries over 7 years (Oct.2003 to Sept. 2010)
[57] Question C1 of the beneficiary survey: "At any of your family planning waiver visits did the doctor or nurse tell you that you had other medical problems that should be taken care of?"
[58] Question 12 of the provider survey: "Approximately what percentage of Family Planning Waiver women receive a referral from your clinic for other medical services not covered by the waiver?"

Barriers for beneficiaries and providers in making primary care referrals[59]

Providers of FPW waiver services inconsistently provide referrals to other professionals when other health concerns are identified during a FPW office visit. Reasons why referrals are not being made are depicted in Figure 45 as reported by providers. The main reasons given for not referring patients confirm that those without means do not get needed healthcare. It also tells us that best practices by healthcare providers are not consistent and the stigma of noninsured patients exists. Only 19.6% of participating providers always make referrals, saying that there are no factors that prevent them from doing so.

Figure 45: Reasons for Not Making Referrals



[59] Question 16 of the provider survey: "Are there factors that sometimes keep your clinic from making referrals for Family Planning Waiver patients who have a health concern or medical condition that is not covered by the Waiver?"

Objective 6 – Increase the number of primary care referrals to improve the health of the target population

- ➢8.6% of beneficiaries did not have a source for primary care. Non-participating beneficiaries were 1.7 times more likely to not have a primary care source (11.5% vs. 6.8% of participants).
- 14.1% of participants used the hospital ER as a primary care source. 16.8% of non-participants used the ER as a primary care source.
- 44.7% of participating providers did usually follow up to see if the patient kept the referral appointment. 8.5% of providers indicated that they usually do not follow up.
- 48.9% providers said that they usually follow up on the outcome of the referral treatment. 12.8% never follow up on the outcomes.
- The top three reasons for not making referrals are:
  1. Some patients do not have insurance or other means to pay for services. (74.5% of participating providers)
  2. It is hard to find providers to serve uninsured or low-income patients. (60.8% of participating providers)
  3. Some patients are unlikely to follow-up on referrals. (52.9% of participating providers)

Objective 6 Summary

91.4% of surveyed beneficiaries have a primary healthcare source. Most report going to a doctor's office (48%). However, 15% of beneficiaries stated that they used the hospital ER for this purpose. FPW participants are somewhat less likely to use the ER (14.1% vs. 16.8% of non-participants). If all beneficiaries participated in FPW services one might see an average of 1,000 fewer beneficiaries per year who would use the ER as a primary healthcare source. Hypothetically, if the average cost of an ER encounter is $500, by decreasing inappropriate ER visits, overall healthcare costs will decrease too.

When providers are asked about referrals of beneficiaries requiring health care for a condition not covered by FPW, many state they give a referral, but only about half do any type of follow-up. Providers indicated the primary reason for not referring patients is has no means to pay for services. Education by DOM regarding expectations of providers can easily address this issue.

Conclusions and Recommendations

This interim report covers the first seven years (October 2003 to September 2010) of the Family Planning Waiver.[60] The waiver is still underway and will conclude in September 2011. The following discussion should be viewed in this context and is broken down into Successes and Needs Improvement.

Family Planning Waiver Successes

During the years under study, the Family Planning Waiver made headway towards the goal of increasing reproductive health services and reducing the number of unplanned births to the targeted population.

Definitely, the Waiver made available and increased the access to family planning services to a considerable portion of eligible women. A total of 132,234 beneficiaries have been enrolled and 64,261 of them made use of family planning services available through the Waiver. Participation increased faster than the eligible population, or the non-participants, to reach 34% of enrolled beneficiaries. Up to 42% of participants in a given year would return the following year. The number of providers serving FPW participants has followed the trend prescribed by the number of participants, with a maximum of 645 providers in Year 4 of the Waiver.

Participation, along with enrollment of beneficiaries has declined since Hurricane Katrina disturbed the regional demographic and socio-economic fabric in 2005. Although the proportion of beneficiaries with births increased initially it has stabilized around 10%.

The true contribution of the program becomes evident when comparing birth rates of participating beneficiaries to those of non-participating beneficiaries – the “comparison” group. Participants’ birth rates are almost half the rate of non-participants. These birth rates have been decreasing since the third year of the Waiver and are down to 5.5% in Year 6. If non-participants had shown the same behavior there would have been 9,924 fewer births over the same time period. Using baseline fertility rates as a point of reference 31,751 births (all beneficiaries) were averted. 12,552 births were averted if only participants are considered.

The proportion of enrolled teens has decreased since the first year of the waiver. Their contribution to all beneficiary births has also decreased. The proportion of teens that had a birth has increased in the first years of the waiver - as did that for adults. However, the proportion is decreasing, especially strongly for the 18 – 19 year old women. FPW participation makes a difference: not only are the birth rates half of those for non-participating teens, but also birth rates grew slowly and decreased faster.

Participation in FPW also makes a difference in the proportion of inadequately spaced births. The proportion of inadequately spaced births of beneficiaries with previous births decreased in the past four years from 93.9% in waiver Year 3 to 58.8% in waiver year 6.

[60] Statistical sources used for the quantitative evaluation of the program objectives may not have been up to date by the beginning of November 2010, when the analysis data was pulled

FPW has succeeded in increasing the child spacing interval between consecutive births, more so for participants than for non-participants. This change in behavior however did not seem to make a difference in the proportion of beneficiaries giving birth to low or very low weight infants.

Family Planning Waiver – Needs Improvement

Based on the current measurement of FPW objectives we are confident in concluding that there are strong findings to support effective impact on Objectives 1, 2 and 3. However, there continues to be room for improvement with improved provider and beneficiary educational outreach and establishing quantitative objective goals for waiver objectives.

The eQHealth FPW team is disappointed to report that little positive findings related to Objectives 4, 5 and 6 as a result of the FPW have been found. For example, Objective 4, while the specific number of repeat births among FPW teens decreased so has the number of beneficiaries. As a result, the proportion increases each year.

Objectives for FPW were written nearly ten years ago, and some of the FPW objectives have been modified overtime. However, the targeted population in which FPW is trying to impact with positive change and how they receive information and provide information have changed. Complex external factors competing against FPW's Objective 4 that need to be kept in mind include powerful messages that enter teens and their family's lives every day through technology. For example, advances in the use of technology in the classroom to the home including communication via text messaging enter teen's lives every single day. Teenagers' social lives are also complex and impacted by peer pressure and messages provided to them through the media. Popular culture such as the music industry provides information set to music such as artist Lil' Wayne's lyrics in which he sends messages to women and men on sexual behavior. The messages often times from various artists are more powerful than those even coming from within the home environment, but rarely mention or support the various interventions FPW is providing. Even family values and religious teachings often times compete against Objective 4 measures as it stands today, by either not discussing or providing information to teens about sexual behavior. Including birth control options mentioned above the competition is fierce and the outcome measurement for Objective 4 is once again poor. As a result of this measures continued poor performance over seven years, eQHealth is recommending DOM consider modifying or retiring this objective. Available data indicates that other strategies in addition to the FPW must be done together to begin to impact or decrease teen pregnancy and repeat births among teens. By making these comprehensive changes, behaviors can hypothetically change earlier during earlier the developmental years of women and have the potential to improve other FPW measures across all age groups.

Objective 5 – Over half of all women interviewed did not plan their pregnancy. Most Medicaid paid births are for an unintended pregnancy and nearly half of all Medicaid paid births are for mistimed pregnancies. 20% of women with a Medicaid paid birth said they did not want the pregnancy.

An opportunity exists by providing earlier education such as types of birth control options, what to do if birth control fails or is forgotten and access to family planning services. Over time, a shift in behavior and attitude in the population would reflect as a change in this measurement.

Currently, the limitations of the FPW scope (i.e. interventions) would not be able to achieve this on its own. Much like Objective 4, changes in attitudes, accurate information and dissemination of such has to reach into the home, school, churches and the whole "village" which shapes and educates young girls from infancy through the life cycle.

Objective 6 – Of the three objectives in which there is little to no visible positive and direct impact from FPW that can be measured, Objective 6 seems the most simplistic to resolve. Clear education to providers regarding expectations that must be covered with beneficiaries and patients is the only way to impact this measure.

The assumption that providers know what to do because they are professionals, nurses, doctors, social workers, etc., is not accurate. There are no educational tracks on best practices covered in the curriculum of medical or other professional schools, and internships do not necessarily teach or enforce best practices. The development of a simple tool such as the top 5 topics to discuss with a FPW beneficiary or Medicaid beneficiary should be made available to all providers.

Ideas and Opportunities with Providers

- Communicate Medicaid program goals.
- Share results of findings from this report with both beneficiaries and providers.
- Consult with your Quality Improvement Organization (QIO) to develop a universal tool and distribute it to all providers.
- Recognize providers who demonstrate best practices.
- Send a thank you letter to all Medicaid providers for meeting objectives consistently.
- Issuing report cards to providers.

Ideas and Opportunities with Beneficiaries

- FPW has reached a large portion of the eligible women through automatic enrollment and other recruitment efforts. If the non-participating women could be convinced to participate, the results would be very encouraging for the program. Specific recommendation to improve beneficiary education and communications were submitted in the Year One, Beneficiary Survey and Focus Group reports (September 2010).
- Given that it is difficult to determine quantitative goals that are realistic, one could select the historic maximum value reached of an objective measure as a goal that may be reached again or even surpassed. For example, the maximum participation rate of 33% reached in Year 4 may be used as a goal to be reached again.
- 21 – 36 year old women in the typical child bearing ages have driven these results. Outreach efforts may want to target this section of the population in different ways than they address teenagers.

- Given that 17.5% of participating women were told they had other medical problems that should be taken care of[61], referrals to a primary healthcare source and follow-up on these referral are important. This population seems to have a regular primary healthcare source. However, 14.1% of participants stated that a hospital ER would be that source. Access to primary healthcare is related to economic circumstances and education. This will need to be addressed by a concerted effort on a larger scale.

Closing Comments

Overall, Objectives 1, 2 and 3 show evidence related to FPW that it is impacting behavior in women of childbearing age as it relates to frequency of pregnancies and births. However, eQHealth is recommending DOM consider retiring or modifying Objective 4.

Objectives 5 and 6 are dependent on aggressive educational interventions at the beneficiary and provider level. Without education, i.e. the tools on how to use FPW services effectively, Objectives 5 and 6 have little opportunity to show any change or support as it relates to FPW. Therefore, the maximum potential will not be achieved by the current efforts that are in place.

[61] eQHealth Solutions, Mississippi Medicaid Family Planning Waiver Program: 2010 – Year One Beneficiary and Provider Survey and Focus Group Reports, September 2010

APPENDIX A – Detailed Method

Objective 1: Increase access to and use of family planning services by the target population.

The analysis included calculating the proportion of eligible women who become Family Planning Waiver beneficiaries and calculating the proportion of enrolled beneficiaries who participate. It also involved calculating the proportion of Medicaid providers that provide FPW services. These ratios have been compared across age groups, fiscal years (i.e. FPW years), and between participating and non-participating beneficiaries in order to determine if there is increased access to and use of family planning services.

Measure 1.1 – Proportion of eligible women enrolled in each waiver year

Numerator	Number of eligible women	U.S. Census, Current Population Survey, Annual Social and Economic Supplements, 2003-2010
Denominator	Number of beneficiaries enrolled in FPW	MMIS eligibility data: the number of women enrolled in the Family Planning Waiver (FPW), i.e. COE equal to '029' with valid eligibility span

Measure 1.2 – Proportion of enrolled women seeking family planning services in each waiver year

Numerator	Number of participating women: women who have at least one MMIS claim during COE=029 eligibility span	MMIS eligibility and Claims Data, all header and line item files (diag, ICD-9-CM, line items)
Denominator	Number of beneficiaries enrolled in FPW	

Measure 1.3 – Proportion of participants in a prior year returning for service in the following year

Numerator	Number of women participating in a prior year and return the following year	MMIS Eligibility and Claims Data
Denominator 1	Number of women who participated the prior year	
Denominator 2	Number of women who participated the following year	

Measure 1.4 – Proportion of Medicaid providers providing family planning services

Numerator	Number of Medicaid providers who provide family planning services to FPW participants	MMIS Eligibility and Claims Data

Denominator	Number of Medicaid providers who provide family planning services (as per FPW diagnostic and procedure codes)	

Measure 1.5 –Reasons for not seeking family planning services offered by the waiver for each waiver year

Question A4	"I'm going to read a list of possible reasons why you did NOT use the Medicaid Family Planning Waiver services. Please answer yes to all that apply to you: […]"	Mississippi Medicaid Family Planning Waiver Program: 2010 – Year One Beneficiary and Provider Survey and Focus Group Reports, eQHealth Solutions, September 2010

Objective 2: Improve birth outcomes and the health of women by increasing the child spacing interval among the target population

In order to draw conclusions on the effectiveness of the FPW on birth spacing and adverse birth outcomes the analysis calculated the interval between two consecutive births, determined whether it was adequate or inadequate, calculated the average number of days between two consecutive births, and determined which beneficiaries gave birth to infants with low or very low birth weight. For all these measures, the analysis made comparisons between participants and non-participants, age groups, and FPW years.

Measure 2.1 – Proportion of enrolled women with two Medicaid paid births whose spacing is inadequate for each waiver year

Birth spacing	For a given birth in a given waiver year, determine whether there was a previous birth, determine the number of days between the two consecutive births, and determine whether the number of days is adequate or inadequate	
Numerator	Number of beneficiaries who had an inadequately spaced birth	MMIS Eligibility and Claims Data
Denominator 1	Number of beneficiaries with births	
Denominator 2	Number of beneficiaries with previous births	

Measure 2.2 –Comparing the proportion of FPW women with inadequately spaced births among those who seek family planning services and those who don't seek family planning services

Numerator: Participants	Number of participants who had an inadequately spaced birth	MMIS Eligibility and Claims Data
Denominator 1: Participants	Number of participants with births	
Denominator 2: Participants	Number of participants with previous births	
Numerator: Non-participants	Number of non-participants who had an inadequately spaced birth	
Denominator 1: Non-participants	Number of non-participants with births	
Denominator 2: Non-participants	Number of non-participants with previous births	

Measure 2.3 – Average number of days between births for each waiver year

Birth spacing interval	For a given birth in a given waiver year, determine the number of days between the two consecutive births	MMIS Eligibility and Claims Data

Measure 2.4 – Comparing the average days between births of women on the waiver who seek family planning services to those who don't seek family planning services

Birth spacing interval participants	For a given birth in a given waiver year, determine the number of days between the two consecutive births by participants	MMIS Eligibility and Claims Data
Birth spacing interval non-participants	For a given birth in a given waiver year, determine the number of days between the two consecutive births by non-participants	

Measure 2.5 – Proportion of enrolled women with births giving birth to low or very low birth weight infants

Numerator	Number of women with births giving birth to low or very low birth weight infants	MMIS Eligibility and Claims Data
Denominator	Number of women with births	

Measure 2.6 – Comparing this proportion of women on the waiver who seek family planning services to those who don't seek family planning services

Numerator - participants	Number of participants with births giving birth to low or very low birth weight infants	MMIS Eligibility and Claims Data
Denominator - participants	Number of participants with births	
Numerator – non-participants	Number of non-participants with births giving birth to low or very low birth weight infants	
Denominator – non-participants	Number of non-participants with births	

Objective 3: Decrease the number of Medicaid paid deliveries which will reduce the growth of annual expenditures for prenatal care, delivery, newborn and infant care

In order to evaluate the decrease in the number of Medicaid paid deliveries, the analysis involved calculating the number of women enrolled during a given waiver year who had a Medicaid paid birth between the beginning of the waiver year plus 9 months and the end of the waiver year plus 9 months. The number of expected births was calculated based on the baseline fertility rate adopted for this study (i.e. calendar year 2001). The number of births averted was calculated by taking the difference between number of births expected and number of actual births. Finally, the number of beneficiaries who had continued use of contraceptives was calculated.

Measure 3.1 – Proportion of enrollees who had a Medicaid paid birth in each waiver year

Numerator	Number of beneficiaries who gave birth	MMIS Eligibility and Claims Data
Denominator	Number of beneficiaries enrolled in FPW	

Measure 3.2 – Compare proportion of Medicaid paid births in each waiver year among participating enrollees and enrollees that do not seek any family planning services

Numerator Participants	Number of participants who gave birth	MMIS Eligibility and Claims Data
Denominator Participants	Number of participants enrolled in FPW	
Numerator Participants	Number of non-participants who gave birth	
Denominator Participants	Number of non-participants enrolled in FPW	

Measure 3.3 – Births averted based on baseline fertility rates

Actual births	Number of births by beneficiaries	MMIS Eligibility and Claims Data
Expected births	Number of beneficiaries times baseline fertility rates	
Averted births	Number of expected births minus number of births by beneficiaries	
Actual births for participants	Number of births by participants	
Expected births for participants	Number of participants times baseline fertility rates	
Averted births for participants	Number of expected births minus number of births by participants	
Actual births for non-participants	Number of births by non-participants	
Expected births for non-participants	Number of non-participants times baseline fertility rates	
Averted births for non-participants	Number of expected births minus number of births by non-participants	

Measure 3.4 –Use births averted to calculate Medicaid birth costs averted and hence cost savings to assess budget neutrality

NA	NA	NA

Measure 3.5 –Proportion of enrollees who had continuous use of contraceptive methods during the waiver years

Average time on contraceptive	Number of days supply plus 30 days margin	MMIS POS Pharmacy Data
Proportion of enrollment time covered by contraceptive use	Numerator: number of days of supply	MMIS POS Pharmacy Data
	Denominator: number of days enrolled (i.e. eligible)	MMIS Eligibility and Claims Data
Proportion of fiscal year (FPW year) time covered by contraceptive use	Numerator: number of days of supply	MMIS POS Pharmacy Data
	Denominator: number of days in fiscal year	
Proportion of beneficiaries who use contraceptive at least once	Numerator: number of beneficiaries who use contraceptive at least once	MMIS POS Pharmacy Data
	Denominator 1: number of beneficiaries	MMIS Eligibility and Claims Data
	Denominator 2: number of participants	
Proportion of beneficiaries who use a contraceptive for at least 80% of the enrollment time	Numerator: number of beneficiaries who use for at least 80% of the enrollment time	MMIS POS Pharmacy Data
		MMIS Eligibility and Claims Data
	Denominator 1: number of beneficiaries	
	Denominator 2: number of participants	
	Denominator 3: number of those who used contraceptive at least once	

Objective 4: Reduce teen pregnancy and repeat births among teens

The evaluation of this objective involved the calculation of the number of beneficiaries, who were teenagers, the determination of the proportion of beneficiaries with births who were teenagers. It also calculated the proportion of beneficiary teenagers who gave birth, and the proportion of teens that used contraceptive methods continuously. The latter was done in various ways.

Measure 4.1 – Proportion of enrollees with Medicaid paid births who are teens in each waiver year

Numerator 1	Number of beneficiaries with Medicaid paid births who are teens	MMIS Eligibility and Claims Data
Denominator 1	Number of beneficiaries with Medicaid paid births	
Numerator 2	Number of teenage beneficiaries who had Medicaid paid births	
Denominator 2	Number of teenage beneficiaries	

Measure 4.2 – Proportion of teens with inadequately spaced births

Numerator 1 - teenagers	Number of beneficiary teenagers who have an inadequately spaced birth	MMIS Eligibility and Claims Data
Denominator 1 - teenagers	Number of beneficiary teenagers with births	
Denominator 2 - teenagers	Number of beneficiary teenagers with previous births	

Measure 4.3 – Comparing the proportion of inadequately spaced births in teens to the proportion in adult females

Numerator 1 - adults	Number of beneficiary adults who have an inadequately spaced birth	MMIS Eligibility and Claims Data
Denominator 1 - adults	Number of beneficiary adults with births	
Denominator 2 - adults	Number of beneficiary adults with previous births	

Measure 4.4 – Proportion of enrollees that are teens for each waiver year

Numerator	Number of beneficiaries who are teenagers	MMIS Eligibility and Claims Data
Denominator	Number of beneficiaries	

Measure 4.5 – Proportion of teen participants who had continuous use of contraceptive methods during the waiver year

Average time on contraceptive for teenagers	Number of days supply plus 30 days margin	MMIS POS Pharmacy Data
Proportion of enrollment time covered by contraceptive use for teenagers	Numerator: number of days of supply	MMIS POS Pharmacy Data
	Denominator: number of days enrolled (i.e. eligible)	MMIS Eligibility and Claims Data
Proportion of fiscal year (FPW year) time covered by contraceptive use for teenagers	Numerator: number of days of supply	MMIS POS Pharmacy Data
	Denominator: number of days in fiscal year	
Proportion of teenage beneficiaries who use contraceptive at least once	Numerator: number of teen beneficiaries who use contraceptive at least once	MMIS POS Pharmacy Data
	Denominator 1: number of beneficiary teens	MMIS Eligibility and Claims Data
	Denominator 2: number of participant teens	
Proportion of teenage beneficiaries who use a contraceptive for at least 80% of the enrollment time	Numerator: number of teen beneficiaries who use for at least 80% of the enrollment time	MMIS POS Pharmacy Data
		MMIS Eligibility and Claims Data
	Denominator 1: number of beneficiary teens	
	Denominator 2: number of participant teens	
	Denominator 3: number of those teens who used contraceptive at least once	

Measure 4.6 –Types of contraceptives used by teen enrollees over the waiver years

Contraceptives used by teenagers	Names of contraceptives	MMIS POS Pharmacy Data (Category of Service Code=34, i.e. family planning)
Types of contraceptives used by teenagers	CPT© codes grouped into types	MMIS Eligibility and Claims Data

Objective 5: Reduce the number of unintended and unwanted pregnancies among those who are eligible for Medicaid paid deliveries

The FPW and other Medicaid programs providing family planning services are expected to help reduce the number of unintended pregnancies by providing access to family planning services and contraceptive methods. The evaluation of this objective relied on the Pregnancy Risk Assessment Monitoring System (PRAMS).[62] This survey provided the basis for evaluating whether the FPW succeeded in reducing the number of unintended pregnancies, i.e. the proportion of pregnancies that were mistimed or unwanted in each calendar year.

Measure 5.1 – Proportion of pregnancies that were mistimed or unwanted in Medicaid paid births in each calendar year

Proportion of women giving birth whose pregnancy was not intended Proportion of women giving birth whose pregnancy was miss-timed Proportion of women giving birth whose pregnancy was unwanted Proportion of women with Medicaid paid birth whose pregnancy was not intended Proportion of women with Medicaid paid birth whose pregnancy was miss-timed Proportion of women with Medicaid paid birth whose pregnancy was unwanted	Pregnancy Risk Assessment Monitoring System (PRAMS), Centers for Disease Control and prevention, Mississippi Department of Health

Objective 6: Increase the number of primary care referrals to improve the health of the target population

The number of primary care referrals had been measured indirectly by proxies that describe how referrals are being handled. All measures are based on the report “Mississippi Medicaid Family Planning Waiver Program: 2010 – Year One Beneficiary and Provider Survey and Focus Group Reports” by eQHealth Solutions, September 2010

Measure 6.1 – Proportion of enrollees surveyed who have a source for primary care

Question D1 (Beneficiary Survey)	Where do you usually go for medical care when you are sick?	Mississippi Medicaid Family Planning Waiver Program: 2010 – Year One Beneficiary and Provider Survey and Focus Group Reports, eQHealth Solutions, September 2010

[62] Pregnancy Risk Assessment Monitoring System (PRAMS), Centers for Disease Control and Prevention (CDC) and Mississippi State Department of Health

Measure 6.2 – Proportion of enrollees surveyed who use ER services for primary care

Question D1 (Beneficiary Survey)	Where do you usually go for medical care when you are sick?	Mississippi Medicaid Family Planning Waiver Program: 2010 – Year One Beneficiary and Provider Survey and Focus Group Reports, eQHealth Solutions, September 2010

Measure 6.3 – Proportion of providers surveyed who have knowledge and understanding of the referral process

Question 12 (Provider Survey)	Approximately what percentage of Family Planning Waiver women receive a referral from your clinic for other medical services not covered by the waiver?	Mississippi Medicaid Family Planning Waiver Program: 2010 – Year One Beneficiary and Provider Survey and Focus Group Reports, eQHealth Solutions, September 2010
Question 13 (Provider Survey)	Is someone in your office available to help the patient with Family Planning Waiver or Medicaid questions or with payment questions related to the referral?	
Question 14 (Provider Survey)	Does someone in your office follow up to see if the patient kept the referral appointment?	
Question 15 (Provider Survey)	Does someone in your office follow up to determine the outcome of services or treatments that the patient received as a result of the referral?	

Measure 6.4 – Barriers for enrollees and providers in making primary care referrals

Question 10 (Provider Survey)	Please indicate to what extent the following are potential barriers to care. For each question, please place a check in the appropriate column: […]	Mississippi Medicaid Family Planning Waiver Program: 2010 – Year One Beneficiary and Provider Survey and Focus Group Reports, eQHealth Solutions, September 2010

APPENDIX B – Input Tables

Table 26: ICD-9 CM Diagnosis Codes Used To Determine Participation

ICD-9 CM Diagnosis Codes	
Code	**Description**
V25	ENCOUNTER FOR CONTRACEPTIVE MANAGEMENT
V25.0	GENERAL COUNSEL; ADVICE FOR CONTRACEPTIVE
V25.01	PRESCRIPTION; ORAL CONTRACEPTIVE
V25.02	INITIATE CONTRACEPTIVE
V25.09	CONTRACEPTIVE MANAGEMENT
V25.1	INSERTION OF IUD
V25.2	STERILIZATION
V25.3	MENSTRUAL EXTRACTION
V25.4	SURVEILLANCE OF PRESCRIBED CONTRACEPTIVE
V25.40	CONTRACEPTIVE SURVEILLANCE NOS
V25.41	CONTRACEPTIVE PILL SURVEILLANCE
V25.42	IUD SURVEILLANCE
V25.43	SVRL IMPLANT SUBDERMAL CONTRACEPTIVE
V25.49	CONTRACEPTIVE SURVEILLANCE
V25.5	INSERT IMPLANT SUBDERMAL CONTRACEPTIVE
V25.8	CONTRACEPTIVE MANAGEMENT NEC
V25.9	CONTRACEPTIVE MANAGEMENT NOS
V26.0	TURBOPLASTY OR VASOPLASTY AFTER PREVIOUS STERILIZATION
V26.2	INVESTIGATE AND TESTING
V26.29	INVESTIGATE AND TEST
V26.4	PROCREATIVE MANAGEMENT (COUNSEL)
V26.41	PROCREATIVE COUNSELING AND ADVICE USING
V26.49	OTHER PROCREATIVE COUNSELING
V26.5	STERILIZATION STATUS
V26.51	TUBAL LIGATION STATUS
V26.8	OTHER SPECIFIED PROCREATIVE MANAGEMENT
V72.3	GYNECOLOGICAL EXAM
V72.31	ROUTINE GYNECOLOGICAL EXAM
V72.32	ENCOUNTER PAP SMEAR SCREENING
V76.2	SCREEN NEOP CERVIX

Table 27: ICD-9 CM Procedure Codes Used To Determine Participation

ICD-9 CM Procedure Codes	
Code	**Description**
66.2	BILATERAL ENDOSCOPIC DESTRUCTION
66.21	BILATERAL ENDOSCOPIC CRUSH TUBE
66.22	BILATERAL ENDOSCOPIC DIVISION TUBE
66.29	BILATERAL ENDOSCOPIC OOC TUBE NEC
66.3	OTHER BILATERAL DESTRUCTION/OCCLUSION FAL TUBE
66.31	BILATERAL TUBE CRUSHING NEC
66.32	BILATERAL TUBE DIV NEC
66.39	BILATERAL TUBE DESTRUCTION NEC
66.52	REMOVE SOLITARY FAL TUBE
66.6	OTHER SALPINGECTOMY

Table 28: CPT© Procedure Codes Used To Determine Participation

CPT© Procedure Codes	
Code	**Description**
00851	Anesthesia intraperitioneal procedures in lower abdomen including laparoscopy; tubal ligation
11975	Insertion, implantable contraceptive capsules
11976	Norplant removal
11977	Removal of reinsertion, implantable contraceptive capsules
49320	Diagnostic laparoscopy, abdomen, peritoneum, and omentum
49321	Laparoscopy, biopsy (sing or multiple)
57160	Fitting and insertion of pessary device or other intravaginal devices
57170	Diaphragm or cervical cap fitting with instruction
57410	Pelvic exam under anesthesia
57505	Endocervical curettage(not done as part of D& C)
57700	Cerclage of uterine cervix, non-obstetrical)
57720	Trachelottaphy-plastic repair of uterine cervix, vaginal approach
57800	Dilation of cervical canal instrumental (separate procedure)
58100	Endometrial cervical biopsy
58120	Dilation and Curettage, diagnostic or nonobstetrical
58140	Myomectomy, excision of fibroid tumors, abdominal approach
58145	Myomectomy, excision of fibroid tumors, Vaginal approach
58300	Insertion of Intrauterine Device (IUD)
58301	IUD Removal
58340	Cath and introduction of saline or contrast material
58345	Trancervical introduction of fallopian tube
58350	Hydrotubation of oviduct; including material
58400	Uterine suspension, with or without shortening of round ligaments and etc
58540	Hysteroplasty, repair of uterine anominaly

CPT© Procedure Codes	
Code	**Description**
58555	Hysteroscopy, diagnostic
58558	Hysteroscopy, biopsy
58559	Hysteroscopy, with lysis of adhesions
58560	Hysteroscopy, resection of intrauterine septum
58561	Hysteroscopy. Removal of myoma
58565	Hysteroscopy, surgical ; with bilateral fallopian tube cannulation to include by placement of permanent implants
58600	Ligation or transaction to fallopian tubes (s), abdominal or vaginal approach, unilateral or bilateral
58605	Tubal ligation, post partum
58611	ligate oviducts-add on at time of c-section
58615	Occlusion of fallopian tube (s) by device, vaginal or suprapubic approach
58670	Tubal ligation by laparoscopic surgery
58671	Tubal ligation by laparoscopic surgery
58672	Laparoscopy frimbia plasty
58752	Tubouterine implantable
58760	Frimbria plasty
58825	Transpositional ovaries
58920	Wedge resection of ovaries
74742	X-ray of fallopian tubes
76856	Echography of pelvis nonobstectrical
76857	Ultrasound exam, pelvis
76872	Ultrasound- trascectional
93975	Duplex scan or arterial inflow and venous outflow
93976	Duplex scan follow-up
99050	Medical services, after hours
99201	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three components; problem focused history, problem focused examination, and straightforward medical decision-making.
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three components; an expanded problem focused examination; and straightforward medical decision-making.
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three components; a detailed examination and medical decision making of low complexity
99204	Office or other outpatient visit for evaluation and management of a new patient, which requires thee three components; a comprehensive history, a comprehensive examination; and medical decision making of moderate complexity.
99205	Initial Visit
99211	Office or other outpatient visit for evaluation and management of an established patient that may not require the presence of a physician
99212	Office or other outpatient visit for evaluation and management of established patient, which requires these three components; a problem focused history; a

CPT© Procedure Codes	
Code	**Description**
	problem focused examination; and straightforward medial decision making
99213	Office visit or other outpatient visit for the evaluation and management of an established patients, which requires at least two of these three key components; an expanded problem focused history; an expanded problem focused examination and medical decision making of low complexity.
99214	Office visit or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components; an detailed history; a detailed examination ; and medical decision making of moderate complexity.
99215	Office or other outpatient visit for evaluation and a management of an established patient, which requires these three components; a comprehensive history; a comprehensive examination; and a medial decision making of high complexity.
99241	Office consultation for a new or established patient which requires these three components; a problem focused history, a problem focused examination; and straightforward medical decision-making.
99242	Office consultation for a new or established patient which requires these three components; an expanded problem focused history, an expanded problem focused examination; and straightforward medical decision-making.
99243	Office consultation for a new or established patient which requires these three components; a detailed history; a detailed examination; and medical decision making of low complexity.
99244	Office consultation for a new or established patient which requires these three components; a comprehensive history, a comprehensive examination; and medial decision making of high complexity.
99245	Office consultation for new or established patient which requires these three components; a comprehensive history; a comprehensive examination and medial decision making of high complexity.
A4260	Levonorgestral implant discontinued
A4261	Cervical cap contraceptive discontinued
J1055	Depo Provera, 150mg
J7300	Intrauterine Copper Contraceptive system, (Paragard T380) IUD
J7302	Levonorgestrel-releasing intrauterine contraceptive system 52 mg (Mirena) IUD
J7303	Vaginal Ring
J7304	Ortho Evra Patch
J7307	Etonogestrel(contraceptive) implant system, including implants and supplies
S4989	Hormonal (Progestasert) IUD including IMP

Table 29: CPT© Procedure Lab Codes Used To Determine Participation

CPT© Lab Codes	
Code	**Description**
81000	Urinalysis, by dip stick or tablet reagent
81001	Urinalysis , automated without microscopy
81002	Urinalysis ; non-automated
81003	Urinalysis; automated without microscopy
81005	Urinalysis; qualitative or semi quantitative, except immunoassays
81007	Urinalysis; bacteriuria screen, by non-culture technique, commercial kit
81015	Urinalysis microscopic only
81025	Urine Pregnancy test
82947	Glucose; quantitive
82948	Glucose
84702	HCG quantitative
84703	HCG qualitative
85007	Blood count ; manual differential WBC count(includes RBC morphology and platelet estimation)
85008	Blood count; manual blood smear examination without differential parameters
85009	Blood count; differential WBC count, buffy coat
85013	Blood count; spun micro hematocrit
85014	Blood count; other than spun hematocrit
85018	Blood count; hemoglobin
85025	Blood count; hemogram and platelet count, automated, and automated complete differential WBC count (CBC)
86255	Fluorescent antibody
86382	Neutralization Test; viral
86592	Syphilis
86593	Syphilis
86689	HTLV or HIV antibody
86694	Herpes simplex, non-specific type test
86695	Herpes simplex, type 1
86701	HIV-1
86702	Antibody HIV 2
86703	HIV 1& 2
86706	Hepatitis B surface (HbsAb)
86707	Hepatitis B antibody (HbeAb)
86762	Rubella titer
86781	Antibody; Treponema Pallidum (Syphilis Confirmatory)
86803	Hepatitis C antibody
87070	Culture, bacterial; definitive; any other source (GC)
87075	Culture; bacterial any source; anaerobic (isolation)
87077	Bacterial culture, aerobic isolate; additional methods require of definitive identification, each isolate

CPT© Lab Codes	
Code	**Description**
87081	Culture, bacterial, screening only, for single organisms
87086	Culture, bacterial urine; quantitative colony count
87110	Culture, Chlamydia
87164	Dark field examination, any source, includes specimen collection
87205	Smear, primary source, with interpretation; routine stain for bacteria, fungi, or cell types
87206	Smear, primary source, with interpretation, fluorescent and/or acid fast stain, for bacteria, fungi , or cell types
87207	Smear, primary source, with interpretation, special stain for inclusion bodies or intracellular parasites(e.g. malaria, kala azar , herpes)
87209	Smear, primary source, with interpretation, complex special stain(e.g. trichrome, iron hemotoxylin) for ova and/or parasites
87210	Smear, primary source, with interpretation, wet mount with simple stain, for bacteria, fungi, ova, and/or parasites
87220	Tissue examination for fungi
87252	Virus identification; tissue culture inoculation & observation
87340	Hepatitis B surface antigen (HbsAg)
87350	Hepatitis BE antigen (HbeAg)
87480	Candida species, direct probe technique
87481	Candida species, amplified probe technique
87482	Candida species, quantification
87490	Infectious agent detection by nucleic acid (DNA or RNA) Chlamydia Trachomatis. Direct Probe
87491	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia Trachomatis. Amplified probe technique
87510	Gardnerella vaginalis, direct probe technique
87511	Gardnerella vaginalis, amplified probe technique
87515	Hepatitis B. Virus, direct probe technique
87516	Hepatitis B. Virus. Amplified probe technique
87520	Hepatitis C Virus, direct probe technique
87521	Hepatitis C Virus Direct amplified technique
87528	Herpes simplex virus, direct probe technique
87529	Herpes simplex virus, amplified probe technique
87590	Neisseria gonorrhea, direct probe technique + C48
87591	Neisseria gonorrhea, amplified probe technique
87620	Papillomavirus, human, direct probe technique
87621	Papillomavirus, human amplified probe technique
87660	Trichomonas vaginalis, direct probe technique
88141	Cytopathology, cervical or vaginal; requiring interpretation by physician (us in conjunction with 88142-88154
88142	Cytopathology,cervical or vaginal, automated thinlayer preparation
88143	Cytopathology, manual screening & rescreening under physician supervision
88150	Cytopathology, manual screening under physician supervision

CPT© Lab Codes	
Code	**Description**
88152	Cytopathology,slides, cervical or vaginal
88153	Cytopathology, slides, manual screening & rescreening under physician supervision (use in conjunction with 88142-88154,88162-881667)
88154	Cytopathology, slides, cervical or vaginal
88155	Cytopathology , slides, cervical or vaginal
88160	Cytopathology, smears, any other source
88161	Cytopathology, any other source
88162	Cytopathology, any other source
88164	Cytopathology, slides, cervical or vaginal
88165	Cytopathology, slides, cervical or vaginal
88166	Cytopathology, slides, computer assisted rescreening
88167	Cytopathology, slides, cervical or vaginal
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.
88300	Level I Surgical Pathology, gross examination only
88302	Surgical pathology, gross and microscopic examination

Table 30: ICD-9 CM Diagnostic Codes Used To Determine Pregnancy and Birth

Principal Diagnostic Code[63] (First 3 Digits)	5TH Digit	Use	Description
630 - 639	Not used	Used to determine pregnancy	Pregnancy codes associated with ectopic & molar pregnancy or pregnancy with abortive outcomes
677	Not used	Used to determine pregnancy	Does not indicate delivery
640 – 676 678 - 679	1	Used to determine pregnancy Used to determine birth (live and still)	With delivery
640 – 676 678 - 679	2	Used to determine pregnancy Used to determine birth (live and still)	Delivery with postpartum complication; Postpartum complications that occur during the same admission as the delivery are identified with a fifth digit of “2.”

[63] ICD-9-CM Diagnostics Codes

Table 31: ICD-9-CM-CM Diagnostics Codes 5th Digit for Pregnancy and Delivery

5TH Digit	Description
0	unspecified as to episode of care
1	with delivery;
2	Delivery with postpartum complication; Postpartum complications that occur during the same admission as the delivery are identified with a fifth digit of "2."
3	Ante partum condition or complication. Not delivered yet.
4	Postpartum condition or complication; Subsequent admissions/encounters for postpartum complications should be identified with a fifth digit of "4."

Table 32: ICD-9-CM Baby's Diagnostics Codes for Low to Very Low Birth Weight (First 4 Digits)

Principal or Secondary Diagnostic Codes (First 4 Digits)	Description
764.0	Slow fetal growth and fetal malnutrition, light-for-dates infant without mention of fetal malnutrition
764.1	Slow fetal growth and fetal malnutrition, light-for-dates infant with signs of fetal malnutrition
764.2	Slow fetal growth and fetal malnutrition, fetal malnutrition without mention of light-for-dates
764.9	Slow fetal growth and fetal malnutrition, fetal growth retardation unspecified
765.0	Disorders relating to extreme immaturity of infant
765.1	Disorders relating to other preterm infants

Table 33: ICD-9-CM Baby's Diagnostics Codes for Low to Very Low Birth Weight (5th Digit)

ICD-9-CM Fifth Digit [X]	Description	Birth Weight Category
0	Unspecified weight	
1	Less than 500 grams	Very low
2	500 – 749 grams	Very low
3	750 – 999 grams	Very low
4	1,000 – 1,249 grams	Very low
5	1,250 – 1,499 grams	Very low
6	1,500 – 1,749 grams	Low
7	1,750 – 1,999 grams	Low
8	2,000 – 2,499 grams	Low
9	2,500 grams and over	

APPENDIX C – Results Tables

Table 34: Number and Proportion of Eligible Women That Become FPW Beneficiaries

		Year 1 Oct.03 – Sept.04	Year 2 Oct.04 – Sept.05	Year 3 Oct.05 – Sept.06	Year 4 Oct.06 – Sept.07	Year 5 Oct.07 – Sept.08	Year 6 Oct.08 – Sept. 09	Year 7 Oct.09 – Sept.10
Eligible Women	13-17 Years	18,042	22,376	41,100	26,497	11,006	13,667	
	18 - 19 Years	11,174	14,682	10,149	14,234	7,784	11,686	
	20 Years	3,251	4,006	6,175	12,024	5,278	12,255	
	21 - 36 Years	88,050	76,118	119,553	115,352	95,065	87,234	
	37 - 44 Years	32,911	31,728	28,716	29,631	28,707	37,182	
	All	**153,427**	**148,910**	**205,694**	**197,738**	**147,839**	**162,024**	
Beneficiaries	13-17 Years	688	941	1,131	847	595	420	315
	18 - 19 Years	1,814	2,601	3,015	2,766	2,088	1,666	1,256
	20 Years	2,043	3,288	3,909	3,510	3,388	2,984	2,536
	21 - 36 Years	21,692	40,124	54,995	52,719	51,153	46,137	32,702
	37 - 44 Years	2,664	4,599	6,099	4,984	4,585	3,595	2,157
	All	**28,901**	**51,553**	**69,149**	**64,826**	**61,809**	**54,802**	**38,966**
Beneficiaries Age Composition (%)	13-17 Years	2.4%	1.8%	1.6%	1.3%	1.0%	0.8%	0.8%
	18 - 19 Years	6.3%	5.0%	4.4%	4.3%	3.4%	3.0%	3.2%
	20 Years	7.1%	6.4%	5.7%	5.4%	5.5%	5.4%	6.5%
	21 - 36 Years	75.1%	77.8%	79.5%	81.3%	82.8%	84.2%	83.9%
	37 - 44 Years	9.2%	8.9%	8.8%	7.7%	7.4%	6.6%	5.5%
	All	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Table 35: Number and Proportion of Beneficiaries Who Participate

		Year 1 Oct.03 – Sept.04	Year 2 Oct.04 – Sept.05	Year 3 Oct.05 – Sept.06	Year 4 Oct.06 – Sept.07	Year 5 Oct.07 – Sept.08	Year 6 Oct.08 – Sept. 09	Year 7 Oct.09 – Sept.10
Beneficiaries	13-17 Years	688	941	1,131	847	595	420	315
	18 - 19 Years	1,814	2,601	3,015	2,766	2,088	1,666	1,256
	20 Years	2,043	3,288	3,909	3,510	3,388	2,984	2,536
	21 - 36 Years	21,692	40,124	54,995	52,719	51,153	46,137	32,702
	37 - 44 Years	2,664	4,599	6,099	4,984	4,585	3,595	2,157
	All	**28,901**	**51,553**	**69,149**	**64,826**	**61,809**	**54,802**	**38,966**
Participants	13-17 Years	187	325	415	342	228	142	96
	18 - 19 Years	452	790	1,047	985	764	460	345
	20 Years	576	1,013	1,324	1,338	1,231	916	774
	21 - 36 Years	5,714	13,638	16,426	17,036	15,870	10,166	8,417
	37 - 44 Years	712	1,743	1,856	1,851	1,514	889	602
	All	**7,641**	**17,509**	**21,068**	**21,552**	**19,607**	**12,573**	**10,234**
Participants (% of Beneficiaries)	13-17 Years	27.2%	34.5%	36.7%	40.4%	38.3%	33.8%	30.5%
	18 - 19 Years	24.9%	30.4%	34.7%	35.6%	36.6%	27.6%	27.5%
	20 Years	28.2%	30.8%	33.9%	38.1%	36.3%	30.7%	30.5%
	21 - 36 Years	26.3%	34.0%	29.9%	32.3%	31.0%	22.0%	25.7%
	37 - 44 Years	26.7%	37.9%	30.4%	37.1%	33.0%	24.7%	27.9%
	All	**26.4%**	**34.0%**	**30.5%**	**33.2%**	**31.7%**	**22.9%**	**26.3%**

Denominator: Beneficiaries

Table 36: Number and Proportion of Beneficiaries Who Do NOT Participate

		Year 1 Oct.03 – Sept.04	Year 2 Oct.04 – Sept.05	Year 3 Oct.05 – Sept.06	Year 4 Oct.06 – Sept.07	Year 5 Oct.07 – Sept.08	Year 6 Oct.08 – Sept. 09	Year 7 Oct.09 – Sept.10
Beneficiaries	13-17 Years	688	941	1,131	847	595	420	315
	18 - 19 Years	1,814	2,601	3,015	2,766	2,088	1,666	1,256
	20 Years	2,043	3,288	3,909	3,510	3,388	2,984	2,536
	21 - 36 Years	21,692	40,124	54,995	52,719	51,153	46,137	32,702
	37 - 44 Years	2,664	4,599	6,099	4,984	4,585	3,595	2,157
	All	**28,901**	**51,553**	**69,149**	**64,826**	**61,809**	**54,802**	**38,966**
Non-Participants	13-17 Years	501	616	716	505	367	278	219
	18 - 19 Years	1,362	1,811	1,968	1,781	1,324	1,206	911
	20 Years	1,467	2,275	2,585	2,172	2,157	2,068	1,762
	21 - 36 Years	15,978	26,486	38,569	35,683	35,283	35,971	24,285
	37 - 44 Years	1,952	2,856	4,243	3,133	3,071	2,706	1,555
	All	**21,260**	**34,044**	**48,081**	**43,274**	**42,202**	**42,229**	**28,732**
Non-Participants (% of Beneficiaries)	13-17 Years	72.8%	65.5%	63.3%	59.6%	61.7%	66.2%	69.5%
	18 - 19 Years	75.1%	69.6%	65.3%	64.4%	63.4%	72.4%	72.5%
	20 Years	71.8%	69.2%	66.1%	61.9%	63.7%	69.3%	69.5%
	21 - 36 Years	73.7%	66.0%	70.1%	67.7%	69.0%	78.0%	74.3%
	37 - 44 Years	73.3%	62.1%	69.6%	62.9%	67.0%	75.3%	72.1%
	All	**73.6%**	**66.0%**	**69.5%**	**66.8%**	**68.3%**	**77.1%**	**73.7%**

Denominator: Beneficiaries

Table 37: Proportion of Returning Participants

		Year 1 Oct.03 – Sept.04	Year 2 Oct.04 – Sept.05	Year 3 Oct.05 – Sept.06	Year 4 Oct.06 – Sept.07	Year 5 Oct.07 – Sept.08	Year 6 Oct.08 – Sept. 09	Year 7 Oct.09 – Sept.10
Returning Participants (Previous Year as Base)	13-17 Years	133	145	181	140	56	34	
	18 - 19 Years	259	316	431	401	197	110	
	20 Years	343	477	621	601	350	272	
	21 - 36 Years	3,448	5,697	6,746	6,687	3,998	2,543	
	37 - 44 Years	466	724	871	759	419	272	
	All	**4,649**	**7,359**	**8,850**	**8,588**	**5,020**	**3,231**	
Participants (% of Previous Year)	13-17 Years	71.1%	44.6%	43.6%	40.9%	24.6%	23.9%	
	18 - 19 Years	57.3%	40.0%	41.2%	40.7%	25.8%	23.9%	
	20 Years	59.5%	47.1%	46.9%	44.9%	28.4%	29.7%	
	21 - 36 Years	60.3%	41.8%	41.1%	39.3%	25.2%	25.0%	
	37 - 44 Years	65.4%	41.5%	46.9%	41.0%	27.7%	30.6%	
	All	**60.8%**	**42.0%**	**42.0%**	**39.8%**	**25.6%**	**25.7%**	
Returning Participants (Following Y ear as Base)	13-17 Years		70	60	79	53	26	12
	18 - 19 Years		146	202	270	235	101	58
	20 Years		176	199	263	252	126	74
	21 - 36 Years		3,717	6,023	7,194	7,169	4,243	2,776
	37 - 44 Years		540	875	1,044	879	524	311
	All		**4,649**	**7,359**	**8,850**	**8,588**	**5,020**	**3,231**
Participants (% of Following Year)	13-17 Years		21.5%	14.5%	23.1%	23.2%	18.3%	12.5%
	18 - 19 Years		18.5%	19.3%	27.4%	30.8%	22.0%	16.8%
	20 Years		17.4%	15.0%	19.7%	20.5%	13.8%	9.6%
	21 - 36 Years		27.3%	36.7%	42.2%	45.2%	41.7%	33.0%
	37 - 44 Years		31.0%	47.1%	56.4%	58.1%	58.9%	51.7%
	All		**26.6%**	**34.9%**	**41.1%**	**43.8%**	**39.9%**	**31.6%**

Denominator1: Participants of previous year, Denominator 2: Participants of following year

Table 38: Proportion of Medicaid Providers Who Provide Family Planning Services to FPW Participants

		Year 1 Oct.03 – Sept. 04	Year 2 Oct.04 – Sept. 05	Year 3 Oct.05 – Sept. 06	Year 4 Oct.06 – Sept. 07	Year 5 Oct.07 – Sept. 08	Year 6 Oct.08 – Sept. 09	Year 7 Oct.09 – Sept. 10
Mississippi Medicaid Providers	Medicaid Providers Offering Family Planning Services[64]	2,458	2,724	2,970	3,057	2,845	2,502	2,328
	Providers Serving FPW Participants	416	576	621	645	582	469	464
	Percent Providers Serving FPW	16.9%	21.1%	20.9%	21.1%	20.5%	18.7%	19.9%
	Average Number of Participants per Provider	18	30	34	33	34	27	22
	Medicaid Providers Offering Family Planning Services	2,458	2,724	2,970	3,057	2,845	2,502	2,328

[64] As per FPW diagnostics and procedure codes, http://www.medicaid.ms.gov/Documents/FAMILY%20PLANNING%20WAIVER%20PROCEDURE%20DIAGNOSIS%20CODES%2010-01-03%20THRU%209-30-08.pdf

Table 39: Number of FPW Beneficiaries Who Had Births

		Year 1 Oct.03 – Sept.04	Year 2 Oct.04 – Sept.05	Year 3 Oct.05 – Sept.06	Year 4 Oct.06 – Sept.07	Year 5 Oct.07 – Sept.08	Year 6 Oct.08 – Sept. 09
Beneficiaries with Births	13-17 Years	12	43	73	48	31	18
	18 - 19 Years	75	220	358	361	239	147
	20 Years	104	319	522	446	415	323
	21 - 36 Years	834	3304	5948	5880	5595	4778
	37 - 44 Years	23	81	140	113	124	115
	All	1048	3967	7041	6848	6404	5381
Participants with Birth	13-17 Years	4	16	18	11	5	7
	18 - 19 Years	16	63	103	91	58	22
	20 Years	17	85	129	115	98	54
	21 - 36 Years	166	839	1321	1265	1158	600
	37 - 44 Years	6	15	16	26	13	13
	All	209	1018	1587	1508	1332	696
Non-Participants with Birth	13-17 Years	8	27	55	37	26	11
	18 - 19 Years	59	157	255	270	181	125
	20 Years	87	234	393	331	317	269
	21 - 36 Years	668	2465	4627	4615	4437	4178
	37 - 44 Years	17	66	124	87	111	102
	All	839	2949	5454	5340	5072	4685

Table 40: Proportion of Beneficiaries Who Had Births

		Year 1 Oct.03 – Sept.04	Year 2 Oct.04 – Sept.05	Year 3 Oct.05 – Sept.06	Year 4 Oct.06 – Sept.07	Year 5 Oct.07 – Sept.08	Year 6 Oct.08 – Sept. 09
Beneficiaries with Births	13-17 Years	1.7%	4.6%	6.5%	5.7%	5.2%	4.3%
	18 - 19 Years	4.1%	8.5%	11.9%	13.1%	11.4%	8.8%
	20 Years	5.1%	9.7%	13.4%	12.7%	12.2%	10.8%
	21 - 36 Years	3.8%	8.2%	10.8%	11.2%	10.9%	10.4%
	37 - 44 Years	0.9%	1.8%	2.3%	2.3%	2.7%	3.2%
	All	**3.6%**	**7.7%**	**10.2%**	**10.6%**	**10.4%**	**9.8%**
Participants with Birth	13-17 Years	2.1%	4.9%	4.3%	3.2%	2.2%	4.9%
	18 - 19 Years	3.5%	8.0%	9.8%	9.2%	7.6%	4.8%
	20 Years	3.0%	8.4%	9.7%	8.6%	8.0%	5.9%
	21 - 36 Years	2.9%	6.2%	8.0%	7.4%	7.3%	5.9%
	37 - 44 Years	0.8%	0.9%	0.9%	1.4%	0.9%	1.5%
	All	**2.7%**	**5.8%**	**7.5%**	**7.0%**	**6.8%**	**5.5%**
Non-Participants with Birth	13-17 Years	1.6%	4.4%	7.7%	7.3%	7.1%	4.0%
	18 - 19 Years	4.3%	8.7%	13.0%	15.2%	13.7%	10.4%
	20 Years	5.9%	10.3%	15.2%	15.2%	14.7%	13.0%
	21 - 36 Years	4.2%	9.3%	12.0%	12.9%	12.6%	11.6%
	37 - 44 Years	0.9%	2.3%	2.9%	2.8%	3.6%	3.8%
	All	**3.9%**	**8.7%**	**11.3%**	**12.3%**	**12.0%**	**11.1%**

Denominator: Beneficiaries/Participating Beneficiaries/Non-Participating Beneficiaries

Table 41: Number of Beneficiaries with Previous Births

		Year 1 Oct.03 – Sept.04	Year 2 Oct.04 – Sept.05	Year 3 Oct.05 – Sept.06	Year 4 Oct.06 – Sept.07	Year 5 Oct.07 – Sept.08	Year 6 Oct.08 – Sept. 09
Beneficiaries With Previous Births	13-17 Years	0	1	1	1	0	0
	18 - 19 Years	1	1	5	10	11	10
	20 Years	0	2	22	35	32	26
	21 - 36 Years	0	37	282	785	1,162	1,130
	37 - 44 Years	0	0	1	8	17	18
	All	1	41	311	839	1,222	1,184
Participants With Previous Births	13-17 Years	0	0	0	0	0	0
	18 - 19 Years	0	0	2	1	4	3
	20 Years	0	0	9	14	10	4
	21 - 36 Years	0	7	61	193	239	160
	37 - 44 Years	0	0	1	0	1	0
	All	0	7	73	208	254	167
Non-Participants With Previous Births	13-17 Years	0	1	1	1	0	0
	18 - 19 Years	1	1	3	9	7	7
	20 Years	0	2	13	21	22	22
	21 - 36 Years	0	30	221	592	923	970
	37 - 44 Years	0	0	0	8	16	18
	All	1	34	238	631	968	1,017

Table 42: Proportion of Beneficiaries with Births Who Had Previous Births

		Year 1 Oct.03 – Sept.04	Year 2 Oct.04 – Sept.05	Year 3 Oct.05 – Sept.06	Year 4 Oct.06 – Sept.07	Year 5 Oct.07 – Sept.08	Year 6 Oct.08 – Sept. 09
Beneficiaries With Previous Births	13-17 Years	0.0%	2.3%	1.4%	2.1%	0.0%	0.0%
	18 - 19 Years	1.3%	0.5%	1.4%	2.8%	4.6%	6.8%
	20 Years	0.0%	0.6%	4.2%	7.8%	7.7%	8.0%
	21 - 36 Years	0.0%	1.1%	4.7%	13.4%	20.8%	23.7%
	37 - 44 Years	0.0%	0.0%	0.7%	7.1%	13.7%	15.7%
	All	0.1%	1.0%	4.4%	12.3%	19.1%	22.0%
Participants With Previous Births	13-17 Years	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	18 - 19 Years	0.0%	0.0%	1.9%	1.1%	6.9%	13.6%
	20 Years	0.0%	0.0%	7.0%	12.2%	10.2%	7.4%
	21 - 36 Years	0.0%	0.8%	4.6%	15.3%	20.6%	26.7%
	37 - 44 Years	0.0%	0.0%	6.3%	0.0%	7.7%	0.0%
	All	0.0%	0.7%	4.6%	13.8%	19.1%	24.0%
Non-Participants With Previous Births	13-17 Years	0.0%	3.7%	1.8%	2.7%	0.0%	0.0%
	18 - 19 Years	1.7%	0.6%	1.2%	3.3%	3.9%	5.6%
	20 Years	0.0%	0.9%	3.3%	6.3%	6.9%	8.2%
	21 - 36 Years	0.0%	1.2%	4.8%	12.8%	20.8%	23.2%
	37 - 44 Years	0.0%	0.0%	0.0%	9.2%	14.4%	17.6%
	All	0.1%	1.2%	4.4%	11.8%	19.1%	21.7%

Denominator: Beneficiaries/Participating Beneficiaries/Non-Participating Beneficiaries ***with births***

Table 43: Beneficiaries Who Had Inadequate Spacing between Two Births

		Year 1 Oct.03 – Sept.04	Year 2 Oct.04 – Sept.05	Year 3 Oct.05 – Sept.06	Year 4 Oct.06 – Sept.07	Year 5 Oct.07 – Sept.08	Year 6 Oct.08 – Sept. 09
Beneficiaries With Inadequate Spacing	13-17 Years	0	1	1	1	0	0
	18 - 19 Years	1	1	5	9	11	6
	20 Years	0	2	21	34	28	21
	21 - 36 Years	0	37	264	652	789	663
	37 - 44 Years	0	0	1	6	12	6
	All	1	41	292	702	840	696
Participants With Inadequate Spacing	13-17 Years	0	0	0	0	0	0
	18 - 19 Years	0	0	2	0	4	3
	20 Years	0	0	9	14	7	4
	21 - 36 Years	0	7	55	152	154	105
	37 - 44 Years	0	0	1	0	0	0
	All	0	7	67	166	165	112
Non-Participants With Inadequate Spacing	13-17 Years	0	1	1	1	0	0
	18 - 19 Years	1	1	3	9	7	3
	20 Years	0	2	12	20	21	17
	21 - 36 Years	0	30	209	500	635	558
	37 - 44 Years	0	0	0	6	12	6
	All	1	34	225	536	675	584

Table 44: Proportion of Beneficiaries with Births Who Had Inadequate Spacing between Two Births

		Year 1 Oct.03 – Sept.04	Year 2 Oct.04 – Sept.05	Year 3 Oct.05 – Sept.06	Year 4 Oct.06 – Sept.07	Year 5 Oct.07 – Sept.08	Year 6 Oct.08 – Sept. 09
Beneficiaries With Inadequate Spacing	13-17 Years	0.0%	2.3%	1.4%	2.1%	0.0%	0.0%
	18 - 19 Years	1.3%	0.5%	1.4%	2.5%	4.6%	4.1%
	20 Years	0.0%	0.6%	4.0%	7.6%	6.7%	6.5%
	21 - 36 Years	0.0%	1.1%	4.4%	11.1%	14.1%	13.9%
	37 - 44 Years	0.0%	0.0%	0.7%	5.3%	9.7%	5.2%
	All	0.1%	1.0%	4.1%	10.3%	13.1%	12.9%
Participants With Inadequate Spacing	13-17 Years	0%	0%	0%	0%	0%	0%
	18 - 19 Years	0%	0%	2%	0%	7%	14%
	20 Years	0%	0%	7%	12%	7%	7%
	21 - 36 Years	0%	1%	4%	12%	13%	18%
	37 - 44 Years	0%	0%	6%	0%	0%	0%
	All	0.0%	0.7%	4.2%	11.0%	12.4%	16.1%
Non-Participants With Inadequate Spacing	13-17 Years	0%	4%	2%	3%	0%	0%
	18 - 19 Years	2%	1%	1%	3%	4%	2%
	20 Years	0%	1%	3%	6%	7%	6%
	21 - 36 Years	0%	1%	5%	11%	14%	13%
	37 - 44 Years	0%	0%	0%	7%	11%	6%
	All	0.1%	1.2%	4.1%	10.0%	13.3%	12.5%

Denominator = Beneficiaries/Participating Beneficiaries/Non-Participating Beneficiaries **with births**

Table 45: Proportion of Beneficiaries with Previous Births Who Had Inadequate Spacing between Two Births

		Year 1 Oct.03 – Sept.04	Year 2 Oct.04 – Sept.05	Year 3 Oct.05 – Sept.06	Year 4 Oct.06 – Sept.07	Year 5 Oct.07 – Sept.08	Year 6 Oct.08 – Sept. 09
Beneficiaries With Inadequate Spacing	13-17 Years	na	100%	100%	100%	na	na
	18 - 19 Years	100%	100%	100%	90.0%	100%	60.0%
	20 Years	na	100%	95.5%	97.1%	87.5%	80.8%
	21 - 36 Years	na	100%	93.6%	83.1%	67.9%	58.7%
	37 - 44 Years	na	na	100%	75.0%	70.6%	33.3%
	All	100%	100%	93.9%	83.7%	68.7%	58.8%
Participants With Inadequate Spacing	13-17 Years	na	na	na	na	na	na
	18 - 19 Years	na	na	100%	0%	100%	100%
	20 Years	na	na	100%	100%	70.0%	100%
	21 - 36 Years	na	100%	90.2%	78.8%	64.4%	65.6%
	37 - 44 Years	na	na	100%	na	0%	na
	All		100%	91.8%	79.8%	65%	67.1%
Non-Participants With Inadequate Spacing	13-17 Years	na	100%	100%	100%	na	na
	18 - 19 Years	100%	100%	100%	100%	100%	42.9%
	20 Years	na	100%	92.3%	95.2%	95.5%	77.3%
	21 - 36 Years	na	100%	94.6%	84.5%	68.8%	57.5%
	37 - 44 Years	na	na	na	75.0%	75.0%	33.3%
	All	100%	100%	94.5%	84.9%	69.7%	57.4%

Denominator: Beneficiaries/ Participating Beneficiaries/Non-Participating Beneficiaries ***with previous births***

Table 46: Average Number of Days between Births

		Year 1 Oct.03 – Sept.04	Year 2 Oct.04 – Sept.05	Year 3 Oct.05 – Sept.06	Year 4 Oct.06 – Sept.07	Year 5 Oct.07 – Sept.08	Year 6 Oct.08 – Sept. 09
Beneficiaries ' Average Number of Days Between Births	13-17 Years	na	339	338	387	na	na
	18 - 19 Years	316	568	484	477	541	673
	20 Years	na	326	466	458	585	557
	21 - 36 Years	na	409	500	603	691	761
	37 - 44 Years	na	na	760	690	708	967
	All	316	407	498	596	688	759
Participants ' Average Number of Days Between Births	13-17 Years	na	na	na	na	na	na
	18 - 19 Years	na	na	637	850	540	492
	20 Years	na	na	504	428	633	478
	21 - 36 Years	na	432	573	638	707	759
	37 - 44 Years	na	na	760	na	1,022	na
	All	na	432	569	625	702	747
Non-Participants' Average Number of Days Between Births	13-17 Years	na	339	338	387	na	na
	18 - 19 Years	316	568	383	436	542	750
	20 Years	na	326	440	478	564	571
	21 - 36 Years	na	404	480	591	688	762
	37 - 44 Years	na	na	na	690	688	967
	All	316	402	476	586	684	761

Table 47: Number of Beneficiaries Who Had Low/Very Low Weight Babies

		Year 1 Oct.03 – Sept.04	Year 2 Oct.04 – Sept.05	Year 3 Oct.05 – Sept.06	Year 4 Oct.06 – Sept.07	Year 5 Oct.07 – Sept.08	Year 6 Oct.08 – Sept. 09
Beneficiaries With Low/Very Low Weight Births	13-17 Years	1	6	5	2	0	0
	18 - 19 Years	4	17	30	24	18	12
	20 Years	5	26	40	28	32	26
	21 - 36 Years	71	221	402	401	358	327
	37 - 44 Years	2	2	16	12	10	6
	All	83	272	493	467	418	371
Participants With Low/Very Low Weight Births	13-17 Years	0	2	2	0	0	0
	18 - 19 Years	0	7	9	10	3	3
	20 Years	0	5	9	6	11	7
	21 - 36 Years	15	64	81	103	84	43
	37 - 44 Years	0		2	1	3	
	All	15	78	103	120	101	53
Non-Participants With Low/Very Low Weight Births	13-17 Years	1	4	3	2	0	0
	18 - 19 Years	4	10	21	14	15	9
	20 Years	5	21	31	22	21	19
	21 - 36 Years	56	157	321	298	274	284
	37 - 44 Years	2	2	14	11	7	6
	All	68	194	390	347	317	318

Table 48: Proportion of Beneficiaries with Births Who Had Low/Very Low Weight Babies

		Year 1 Oct.03 – Sept.04	Year 2 Oct.04 – Sept.05	Year 3 Oct.05 – Sept.06	Year 4 Oct.06 – Sept.07	Year 5 Oct.07 – Sept.08	Year 6 Oct.08 – Sept. 09
Beneficiaries 'With Low/Very Low Weight Births	13-17 Years	8.3%	14.0%	6.8%	4.2%	0%	0%
	18 - 19 Years	5.3%	7.7%	8.4%	6.6%	7.5%	8.2%
	20 Years	4.8%	8.2%	7.7%	6.3%	7.7%	8.0%
	21 - 36 Years	8.5%	6.7%	6.8%	6.8%	6.4%	6.8%
	37 - 44 Years	8.7%	2.5%	11.4%	10.6%	8.1%	5.2%
	All	7.9%	6.9%	7.0%	6.8%	6.5%	6.9%
Participants With Low/Very Low Weight Births	13-17 Years	0%	12.5%	11.1%	0%	0%	0%
	18 - 19 Years	0%	11.1%	8.7%	11.0%	5.2%	13.6%
	20 Years	0%	5.9%	7.0%	5.2%	11.2%	13.0%
	21 - 36 Years	9.0%	7.6%	6.1%	8.1%	7.3%	7.2%
	37 - 44 Years	0%	0%	12.5%	3.8%	23.1%	0%
	All	7.2%	7.7%	6.5%	8.0%	7.6%	7.6%
Non-Participants With Low/Very Low Weight Births	13-17 Years	12.5%	14.8%	5.5%	5.4%	0%	0%
	18 - 19 Years	6.8%	6.4%	8.2%	5.2%	8.3%	7.2%
	20 Years	5.7%	9.0%	7.9%	6.6%	6.6%	7.1%
	21 - 36 Years	8.4%	6.4%	6.9%	6.5%	6.2%	6.8%
	37 - 44 Years	11.8%	3.0%	11.3%	12.6%	6.3%	5.9%
	All	8.1%	6.6%	7.2%	6.5%	6.3%	6.8%

Denominator: Beneficiaries/Participating Beneficiaries/Non-Participating Beneficiaries ***with births***

Table 49: Number Expected Births

		Year 1 Oct.03 – Sept.04	Year 2 Oct.04 – Sept.05	Year 3 Oct.05 – Sept.06	Year 4 Oct.06 – Sept.07	Year 5 Oct.07 – Sept.08	Year 6 Oct.08 – Sept. 09
Beneficiaries Expected Births	13-17 Years	110	151	181	136	95	67
	18 - 19 Years	467	669	776	712	537	429
	20 Years	793	1,277	1,518	1,363	1,316	1,159
	21 - 36 Years	4,064	7,517	10,303	9,877	9,583	8,643
	37 - 44 Years	70	121	160	131	120	94
	All	**5,504**	**9,735**	**12,938**	**12,218**	**11,652**	**10,393**
Participants Expected Births	13-17 Years	30	52	67	55	37	23
	18 - 19 Years	116	203	269	254	197	118
	20 Years	224	393	514	520	478	356
	21 - 36 Years	1,070	2,555	3,077	3,192	2,973	1,905
	37 - 44 Years	19	46	49	49	40	23
	All	**1,459**	**3,250**	**3,976**	**4,068**	**3,724**	**2,425**
Non-Participants Expected Births	13-17 Years	80	99	115	81	59	45
	18 - 19 Years	351	466	507	458	341	310
	20 Years	570	883	1,004	843	838	803
	21 - 36 Years	2,993	4,962	7,226	6,685	6,610	6,739
	37 - 44 Years	51	75	111	82	81	71
	All	**4,045**	**6,485**	**8,962**	**8,150**	**7,928**	**7,968**

Table 50: Number of Births Averted

		Year 1 Oct.03 – Sept.04	Year 2 Oct.04 – Sept.05	Year 3 Oct.05 – Sept.06	Year 4 Oct.06 – Sept.07	Year 5 Oct.07 – Sept.08	Year 6 Oct.08 – Sept. 09
Beneficiaries Births Averted	13-17 Years	98	108	108	88	64	49
	18 - 19 Years	392	449	418	351	298	282
	20 Years	689	958	996	917	901	836
	21 - 36 Years	3,230	4,213	4,355	3,997	3,988	3,865
	37 - 44 Years	47	40	20	18	-4	-21
	All	**4,456**	**5,768**	**5,897**	**5,370**	**5,248**	**5,012**
Participants Births Averted	13-17 Years	26	36	49	44	32	16
	18 - 19 Years	100	140	166	163	139	96
	20 Years	207	308	385	405	380	302
	21 - 36 Years	904	1,716	1,756	1,927	1,815	1,305
	37 - 44 Years	13	31	33	23	27	10
	All	**1,250**	**2,232**	**2,389**	**2,560**	**2,392**	**1,729**
Non-Participants Births Averted	13-17 Years	72	72	60	44	33	34
	18 - 19 Years	292	309	252	188	160	185
	20 Years	483	649	611	512	521	534
	21 - 36 Years	2,325	2,497	2,599	2,070	2,173	2,561
	37 - 44 Years	34	9	-13	-5	-30	-31
	All	**3,206**	**3,536**	**3,508**	**2,810**	**2,856**	**3,283**

Table 51: Contraceptive Use

		Year 1 Oct.03 – Sept.04	Year 2 Oct.04 – Sept.05	Year 3 Oct.05 – Sept.06	Year 4 Oct.06 – Sept.07	Year 5 Oct.07 – Sept.08	Year 6 Oct.08 – Sept. 09
Average Number of Days on Contraceptive	13-17 Years	99	118	125	113	125	122
	18 - 19 Years	88	124	130	114	134	107
	20 Years	94	125	128	131	123	111
	21 - 36 Years	107	156	144	149	154	101
	37 - 44 Years	104	167	164	190	190	120
	All	104	152	143	147	153	103
Used Contraceptives at Least Once (% of Participants)	13-17 Years	38.5%	44.3%	36.1%	30.1%	39.9%	38.0%
	18 - 19 Years	41.4%	46.6%	39.3%	34.5%	40.1%	45.4%
	20 Years	37.0%	53.9%	38.5%	38.0%	39.4%	32.9%
	21 - 36 Years	34.4%	40.8%	37.9%	32.5%	34.5%	53.4%
	37 - 44 Years	23.7%	26.0%	22.6%	20.2%	22.9%	37.7%
	All	34.1%	40.4%	36.6%	31.8%	34.2%	50.3%
Used Contraceptives Continuously (% of Participants)	13-17 Years	9.6%	8.0%	6.3%	6.7%	9.6%	6.3%
	18 - 19 Years	4.9%	8.5%	6.5%	8.4%	10.5%	10.4%
	20 Years	4.5%	10.9%	7.3%	9.1%	8.8%	4.6%
	21 - 36 Years	5.2%	8.4%	8.9%	8.7%	10.0%	11.3%
	37 - 44 Years	2.1%	4.6%	6.4%	7.0%	9.7%	8.4%
	All	5.0%	8.2%	8.4%	8.5%	9.9%	10.5%

Table 52: Number and Proportion of Beneficiaries with Births Who Are Teens

	Year 1 Oct.03 – Sept.04	**Year 2** Oct.04 – Sept.05	**Year 3** Oct.05 – Sept.06	**Year 4** Oct.06 – Sept.07	**Year 5** Oct.07 – Sept.08	**Year 6** Oct.08 – Sept. 09
13-17 Years	12	43	73	48	31	18
18 - 19 Years	75	220	358	361	239	147
All Teens	87	263	431	409	270	165
As Proportion of Beneficiaries with Birth	**8.3%**	**6.6%**	**6.1%**	**6.0%**	**4.2%**	**3.1%**
As Proportion of Beneficiary Teens	**3.5%**	**7.4%**	**10.4%**	**11.3%**	**10.1%**	**7.9%**
13-17 Years	4	16	18	11	5	7
18 - 19 Years	16	63	103	91	58	22
All Teens	20	79	121	102	63	29
As Proportion of Participants with Birth	**9.6%**	**7.8%**	**7.6%**	**6.8%**	**4.7%**	**4.2%**
As Proportion of Participating Teens	**3.1%**	**7.1%**	**8.3%**	**7.7%**	**6.4%**	**4.8%**
13-17 Years	8	27	55	37	26	11
18 - 19 Years	59	157	255	270	181	125
All Teens	67	184	310	307	207	136
As Proportion of Non-Participants with Birth	**8.0%**	**6.2%**	**5.7%**	**5.7%**	**4.1%**	**2.9%**
As Proportion of Non-Beneficiary Teens	**3.6%**	**7.6%**	**11.5%**	**13.4%**	**12.2%**	**9.2%**

Table 53: Number and Proportions of Teens and Adults with Births

		Year 1 Oct.03 – Sept.04	Year 2 Oct.04 – Sept.05	Year 3 Oct.05 – Sept.06	Year 4 Oct.06 – Sept.07	Year 5 Oct.07 – Sept.08	Year 6 Oct.08 – Sept. 09
Teen Beneficiaries	Number of Teens	**2,502**	**3,542**	**4,146**	**3,613**	**2,683**	**2,086**
Teens with Births	Number of Teens	**87**	**263**	**431**	**409**	**270**	**165**
	% of Teen Beneficiaries	3.5%	7.4%	10.4%	11.3%	10.1%	7.9%
Teens with Previous Births	Number of Teens	1	2	6	11	11	10
	% of Teen Beneficiaries	0.0%	0.1%	0.1%	0.3%	0.4%	0.5%
	% of Teens With Births	1.1%	0.8%	1.4%	2.7%	4.1%	6.1%
Teens with Inadequately Spaced Births	Number of Teens	**1**	**2**	**6**	**10**	**11**	**6**
	% of Teens With Births	1.1%	0.8%	1.4%	2.4%	4.1%	3.6%
	% of Teens With Previous Births	100.0%	100.0%	100.0%	90.9%	100.0%	60.0%
Adult Beneficiaries	Number of Adults	**26,399**	**48,011**	**65,003**	**61,213**	**59,126**	**52,716**
Adult with Births	Number of Adults	961	3,704	6,610	6,439	6,134	5,216
	% of Adult Beneficiaries	3.6%	7.7%	10.2%	10.5%	10.4%	9.9%
Adult with Previous Births	Number of Adults	0	39	305	828	1,211	1,174
	% of Adult Beneficiaries	0.0%	0.1%	0.5%	1.4%	2.0%	2.2%
	% of Adults With Births	0.0%	1.1%	4.6%	12.9%	19.7%	22.5%
Adult with Inadequately Spaced Births	Number of Adults	**0**	**39**	**286**	**692**	**829**	**690**
	% of Adult With Births	0.0%	1.1%	4.3%	10.7%	13.5%	13.2%
	% of Adults With Previous Births	na	100.0%	93.8%	83.6%	68.5%	58.8%

Table 54: Teenagers Who Use Contraceptives Continuously

		Year 1 Oct.03 – Sept.04	Year 2 Oct.04 – Sept.05	Year 3 Oct.05 – Sept.06	Year 4 Oct.06 – Sept.07	Year 5 Oct.07 – Sept.08	Year 6 Oct.08 – Sept. 09
Use Contraceptive at Least Once During Enrollment	13-17 Years	72	144	150	103	91	54
	18 - 19 Years	187	368	411	340	306	209
	All Teens	259	512	561	443	397	263
	Percent of Teen Beneficiaries	10.4%	14.5%	13.5%	12.3%	14.8%	12.6%
	Percent of Participating Teens	40.5%	45.9%	38.4%	33.4%	40.0%	43.7%
Use Contraceptive Continuously	13-17 Years	18	26	26	23	22	9
	18 - 19 Years	22	67	68	83	80	48
	All Teens	40	93	94	106	102	57
	Percent of Teen Beneficiaries	1.6%	2.6%	2.3%	2.9%	3.8%	2.7%
	Percent of Participating Teens	6.3%	8.3%	6.4%	8.0%	10.3%	9.5%

Table 55: Contraceptive Choice of Adult FPW Participants

Contraceptive Name	Number of Beneficiaries[65]	% of all Beneficiaries using Contraceptive
DEPO-PROVERA 150 MG/ML VIAL	8510	38%
ORTHO EVRA PATCH	7028	31%
MEDROXYPROGESTERONE 150 MG/	3281	15%
DEPO-SUBQ PROVERA 104 SYRIN	692	3%
ORTHO TRI-CYCLEN LO TABLET	469	2%
TRI-SPRINTEC TABLET	378	2%
DEPO-PROVERA 150 MG/ML SYRN	335	1%
ORTHO TRI-CYCLEN 28 TABLET	298	1%
NUVARING VAGINAL RING	181	1%
YAZ 28 TABLET	180	1%
SPRINTEC 28 DAY TABLET	117	1%
ORTHO-CYCLEN 28 TABLET	108	0.5%
LOESTRIN 24 FE TABLET	103	0.5%
TRINESSA TABLET	102	0.5%
OCELLA TABLET	63	0%
ORTHO MICRONOR TABLET	63	0%
CAMILA TABLET	58	0%
ERRIN TABLET	49	0%
JOLIVETTE TABLET	42	0%
FEMCON FE TABLET	38	0%
AVIANE-28 TABLET	32	0%
ERRIN 0.35 MG TABLET	31	0%
NECON 1-35-28 TABLET	28	0%
NORA-BE TABLET	28	0%
LOW-OGESTREL-28 TABLET	27	0%
MONONESSA 28 TABLET	26	0%
NORTREL 1-35 TABLET	25	0%
CRYSELLE-28 TABLET	23	0%
KARIVA 28 DAY TABLET	22	0%
TRI-PREVIFEM TABLET	21	0%
SEASONIQUE 0.15/0.03-0.01 T	20	0%
APRI 28 DAY TABLET	12	0%
JOLESSA 0.15 MG-0.03 MG TAB	11	0%
LUTERA-28 TABLET	11	0%
TRIVORA-28 TABLET	11	0%
ENPRESSE-28 TABLET	10	0%

[65] Not necessarily distinct beneficiaries as these may change contraceptive

Contraceptive Name	Number of Beneficiaries[65]	% of all Beneficiaries using Contraceptive
JUNEL FE 1-20 TABLET	8	0%
LEVORA-28 TABLET	8	0%
BALZIVA 28 TABLET	6	0%
ZENCHENT 0.4-35 TABLET	5	0%
NECON 1-50-28 TABLET	4	0%
OVCON-50 28 TABLET	4	0%
QUASENSE 0.15-0.03 MG TABLE	4	0%
RECLIPSEN 28 DAY TABLET	4	0%
LESSINA-28 TABLET	3	0%
NECON 7/7/7-28 TABLET	3	0%
NORTREL 1/35 TABLET	3	0%
NORTREL 7/7/7-28 TABLET	3	0%
PLAN B 0.75 MG TABLET	3	0%
PORTIA-28 TABLET	3	0%
YASMIN 28 TABLET	3	0%
LYBREL TABLET	2	0%
MICROGESTIN FE 1-20 TABLET	2	0%
OGESTREL TABLET	2	0%
ALESSE-28 TABLET	1	0%
ESTROSTEP FE-28 TABLET	1	0%
JUNEL FE 1.5-30 TABLET	1	0%
KELNOR 1-35 28 TABLET	1	0%
MICROGESTIN FE 1.5-30 TAB	1	0%
NECON 7/7/7-28 TABLET	1	0%
NOR-Q-D TABLET	1	0%
OVCON-35 28 TABLET	1	0%
PREVIFEM TABLET	1	0%
SEASONALE 0.15/0.03 MG TAB	1	0%
TILIA FE 28 TABLET	1	0%
VELIVET 28 DAY TABLET	1	0%
ZOVIA 1-35E TABLET	1	0%
ZOVIA 1-50E TABLET	1	0%
Total	**22,517**	**100%**