COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

April 26, 2012

Ms. Anne Chiang
Health Insurance Specialist
Center for Medicare and Medicaid Services
Center for Medicaid, CHIP, and Survey & Certifications
Children & Adults Health Programs Group, Division of State Demonstration & Waivers
7500 Security Boulevard
Mail Stop S2-01-16
Baltimore, Maryland 21244

Dear Ms. Chiang:

Enclosed please find the Commonwealth of Pennsylvania's (commonwealth) renewal application of the Section 1115 Family Planning Demonstration Waiver. The commonwealth is requesting renewal of the waiver for the period of June 1, 2012 through December 31, 2013. With your approval, the Department of Public Welfare will be able to continue to contain Pennsylvania's Medical Assistance (MA) costs by reducing the expenditures for MA paid births and assisting women with spacing the time between births. Further, renewal of the waiver enable the commonwealth to continue to provide a means for counteracting the health risks associated with a poorly timed pregnancy among women in the target population.

I would like to thank you in advance for your consideration of this renewal application of the commonwealth's Section 1115 Family Planning Demonstration Waiver. If you have any questions or need additional information, please contact Mr. Dan DeLellis at (717) 772-6341.

Sincerely,

[redacted]
Gary D. Alexander
Secretary

c: Mr. Vincent Gordon, Deputy Secretary, Office of Medical Assistance Programs
Mr. Dan DeLellis, Bureau of Policy, Analysis and Planning, Office of Medical Assistance Programs

The Pennsylvania Section 1115 Family Planning Demonstration Waiver Renewal Application

Submitted to:

The Centers for Medicare and Medicaid Services

Submitted by:

Pennsylvania Department of Public Welfare

April 26, 2012

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EXECUTIVE SUMMARY

Purpose

The renewal of the Section 1115 Family Planning Waiver will allow the Commonwealth of Pennsylvania to continue providing family planning services to women who do not meet traditional Medical Assistance Program eligibility requirements in order to reduce the number of pregnancies and births paid for by the Pennsylvania Medical Assistance Program. Pennsylvania's current Section 1115 Family Planning Waiver, approved by the Centers for Medicare and Medicaid Services (CMS) on May 11, 2007, has proven to be effective in reducing the number of pregnancies and births that would have been paid for by the Medical Assistance Program.

Objectives

Renewal of the Section 1115 Family Planning Waiver will allow Pennsylvania to continue to:

- improve access to and use of family planning services among women in the target population
- decrease the number of Medical Assistance-paid deliveries, which will reduce annual Federal and State Medicaid expenditures for prenatal, delivery, and newborn care
- improve birth outcomes and the health of women by increasing the child spacing interval (also referred to as the interbirth or inter-pregnancy interval) among women in the target population

Background

The general fertility rate in Pennsylvania showed a general upward trend from 2003 to 2007 and a decline in both 2008 and 2009. The percentage of Medical Assistance -paid births as a percentage of total births in Pennsylvania, referred to as the Medical Assistance fertility rate, has continued to decline. Pennsylvania anticipates that continued access to family planning services for low-income women not otherwise eligible for Medical Assistance will result in the further decline of the Medical Assistance fertility rate, as well as the percentage of Medical Assistance -paid births, if this waiver renewal is approved.

Proposal

Pennsylvania seeks to renew its Family Planning Waiver under Section 1115 of the Social Security Act (42 U.S.C.A. § 1315) for the period beginning June 1, 2012, through December 31, 2013. Specifically, with this renewal the Department will continue to cover selected family planning services to women who:

- are between the ages of 18 and 44
- are residents of Pennsylvania
- are U.S. citizens or have satisfactory immigration status
- have no, or limited, family planning insurance coverage
- are not otherwise eligible for Medical Assistance
- are not pregnant or sterilized
- have income at or below 185% of the Federal Poverty Level (FPL)

Additionally, the Department will continue to provide pharmaceutical coverage for family planning drugs and supplies with the renewal of this waiver. This coverage includes Federal Drug Administration (FDA)-approved contraceptives as well as antibiotics for family planning related conditions such as genito-urinary infections and Sexually Transmitted Diseases (STDs).

The target population will be covered under Medical Assistance under this waiver only for family planning services and will obtain those services on a fee-for-service basis from any qualified provider of such services recognized by the Pennsylvania Medical Assistance Program.

Benefits and Costs

Pennsylvania expects this waiver to be cost effective by virtue of reductions in future Medical Assistance prenatal care, delivery and newborn care expenditures. The estimated projections to determine the cost effectiveness are detailed in Appendix C.

I.

INTRODUCTION

This chapter presents the context for the request to renew Pennsylvania's Section 1115 Family Planning Waiver and includes the purpose and objectives of the waiver, and background that supports the need for continuance of the waiver.

1.1 Purpose

The renewal of the Section 1115 Family Planning Waiver will allow the Commonwealth of Pennsylvania to continue providing family planning services to women who do not meet traditional Medical Assistance Program eligibility requirements in order to reduce the number of pregnancies and births paid for by the Pennsylvania Medical Assistance Program. Reducing pregnancies and births will lead to a reduction in Federal and State Medical Assistance Program spending.

1.2 Objectives

With the renewal of this Section 1115 Family Planning Waiver, Pennsylvania will continue to:

- improve access to and use of family planning services among women in the target population;

- decrease the number of Medicaid-paid deliveries, which will reduce annual Federal and State Medicaid expenditures for prenatal, delivery, newborn, and infant care; and

- improve birth outcomes and the health of women by increasing the child spacing interval (also referred to as the interbirth or inter-pregnancy interval) among women in the target population

1.3 Background

On May 11, 2007, Pennsylvania received approval from the Centers of Medicare and Medicaid Services (CMS) for its Section 1115 Family Planning Demonstration Waiver, known as SelectPlan for Women, from June 1, 2007, through May 31, 2012. On February 1, 2008, Pennsylvania's Department of Public Welfare (Department) issued Medical Assistance Bulletin 01-08-02, "Implementation of SelectPlan for Women", announcing implementation of the program. The Family Planning Waiver provides coverage of selected family planning services, pharmaceuticals and supplies for women who are not otherwise eligible for Medical Assistance and are at or below 185 percent of the Federal Poverty Level (FPL). A request to amend the waiver was submitted to CMS on January 28, 2008, to add Current Procedural Terminology (CPT) codes for Implanon, urine pregnancy testing and a test for the Human Papilloma Virus

(HPV) to the list of available procedures and to remove the contraceptive drug Norplant that was no longer manufactured. The amendment was approved by CMS in April 2008.

Prior to implementation of the waiver, there was an increasing trend of Medical Assistance paid births while the live births and general fertility rates in Pennsylvania, trended downward. The general fertility rate is the number of total live births per 1,000 females of childbearing age (ages 15-44). According to the Pennsylvania Department of Health, the general fertility rate in Pennsylvania was 63.6 in 1990. In 1995, the fertility rate was 57.9; 57.0 in 2000; and 57.8 in 2003. However, the percentage for Medical Assistance paid births grew from 33.2% to 34.1%, between 2000 and 2003. Pennsylvania's Medical Assistance covers pregnant women and infants with monthly incomes at or below 185 percent of the Federal poverty level. Prior to implementation of the waiver, pregnant Medical Assistance recipients would lose eligibility 60 days postpartum or post loss of pregnancy, if the recipients were not within the financial guidelines for Medical Assistance. If the recipients lost eligibility, they lost coverage for all Medical Assistance benefits, including family planning. The loss of Medical Assistance benefits, and specifically, family planning services, may have contributed to the increase in Medical Assistance fertility rates and Medical Assistance paid births.

The Department evaluated the effectiveness of the waiver and found an overall decrease in the rate of births under the Medical Assistance Program since the Family Planning Waiver was implemented, indicating an increase in the effective use of birth control. Since implementation, approximately 119,000 women have received services under the waiver. From 2008 through 2010, the most recent years for which complete claims data is available, 64,885 women received services at a cost of approximately $23.7 million. The Department estimates that, as a result of the waiver, there were 7,061 pregnancies prevented that, without the waiver would have resulted in Medical Assistance expenditures of $113.8 million for maternity, newborn, and infant service payments.

The Department also surveyed waiver participants and found for each waiver year, an increase in the use of abstinence and more effective methods of birth control. In 2008/2009 and 2009/2010 demonstration years, the use of abstinence and more effective methods of birth control increased by approximately 15 percent. For the 2010/20122 demonstration year, the use of these methods increased by 18 percent.

Women who conceive a pregnancy within 18 months of a live birth are considered to have a short interbirth interval. Studies show that women with a short interbirth interval increase the odds for premature births and are more likely to have a low birthweight baby. Although Pennsylvania has seen an overall reduction in the percentage of low birthweight births since implementation of the waiver, there is not sufficient data to evaluate the effectiveness of the waiver in reducing the number of short birth intervals for women in the target population. The Department anticipates that further analysis with the renewal of the Family Planning Waiver.

The overall results of the State's evaluation suggests the waiver was effective in decreasing the number of Medical Assistance paid deliveries, which in turn reduced annual Federal and State Medicaid expenditures for prenatal, delivery, newborn and infant care, by improving access to and the use of family planning services among women who were not eligible for Medical

Assistance. Therefore, the Department requests approval from CMS to renew Pennsylvania's Section 1115 Family Planning Demonstration Waiver.

II.

ADMINISTRATION

2.1 Administering Agency

The Pennsylvania Department of Public Welfare (Department) administers the Medical Assistance Program. The Office of Medical Assistance Programs (OMAP) is responsible for the statewide administration of Pennsylvania's Medical Assistance Program. The Medical Assistance Program purchases medical and health care services on behalf of Medical Assistance recipients in an efficient, economical and accountable manner. Major program areas include: managed care services purchased on a prepaid capitation basis; long-term nursing home care; inpatient care; and outpatient services purchased on a fee-for-service or cost reimbursement basis. In addition, OMAP is responsible for preventing and detecting fraud and abuse and assessing the quality of care received by recipients enrolled in both the fee-for-service and managed care delivery systems.

Medical Assistance Program operations in Pennsylvania are managed through various bureaus and offices. The Bureau of Policy, Analysis, and Planning (BPAP) has overall responsibility for the administration and management of all policy development (except long-term care), monitoring of the Medical Assistance Program budget and planning for all Medical Assistance Program initiatives for both the fee-for-service and managed care delivery systems. BPAP is also responsible for the promulgation of regulations, the maintenance of the Medicaid State Plan the development and renewal of waivers and program initiatives and program development in response to Federal and State statutory, Federal regulatory, and judicial decisions.

The Bureau of Fee-for-Service Programs (BFFSP) is responsible for a variety of functions related to the delivery of services to consumers who are not enrolled in a managed care plan but receive services through the fee-for-service (FFS) delivery system. The activities performed by this bureau include:

- Rate-setting and cost reporting for all hospitals and physical health provider types with the exception of nursing homes;
- Processing of special payments to hospitals including disproportionate share and medical education;
- Oversight of the ACCESS Plus primary care case management program;
- Provider enrollment;
- Prior authorization for pharmaceuticals and services as required;
- Review of 1150 Waiver requests (requests for payment of services/items not on the Medical Assistance fee schedule);
- Medical review of all hospital admissions and physical health continued stay requests under the fee-for-service delivery system;
- Intensive medical case management;
- Administration of Targeted Case Management, Healthy Beginnings Plus and the Special Pharmaceutical Benefits Program;

- Serve as liaison with various provider organizations; and
- Oversight of the Fee-for-Service Subcommittee of the Medical Assistance Advisory Committee.

The Bureau of Data and Claims Management (BDCM) is responsible for activities related to Medical Assistance invoice processing and payments to providers. All claims processing issues that involve the claims processing contractor, the Bureau of Information Systems, other OMAP bureaus, and other Department of Public Welfare organizations are coordinated and approved by this bureau.

BDCM is responsible for activities related to operation of the Provider Reimbursement and Management Information System (PROMISe™), including the implementation of new projects and initiatives and revisions to the PROMISe™ system. BDCM oversees all operations of the claims processing contractor and authorizes payment of the contractor's invoices. BDCM serves as the primary contact with the Centers for Medicare and Medicaid Services related to Medicaid Management Information Systems (MMIS) operations, system performance reviews, and preparation of all advance planning documents requesting enhanced federal funding related to modifications enhancements to the claims processing system.

BDCM is responsible for all data collection and data maintenance activities. BDCM is responsible for the operational support of the Managed Care Program. These functions include Managed Care Organization (MCO) eligibility and enrollment and MCO systems payment support.

The Bureau of Managed Care Operations is responsible for the administration and oversight of both the mandatory and voluntary managed care programs that provide Medical Assistance benefits to recipients in Pennsylvania.

The Office of Clinical Quality Improvement (OCQI), formerly the Office of the Medical Director, is responsible for the development and implementation of a centralized clinical quality improvement program for services delivered primarily by OMAP's BFFSP and BMCO. OCQI assists in the planning, direction, coordination, and evaluation of the clinical quality improvement goals and objectives defined by OMAP. OCQI works collaboratively with all four OMAP Bureaus to monitor and evaluate OMAP's comprehensive quality improvement strategies and assure compliance with federal and state requirements for performance evaluation in access, quality and appropriateness of clinical service delivery.

The OCQI is comprised of a wide variety of staff including the Chief Medical Officer, a Director, the Chief Dental Officer, Registered Nurses, Medical Economists, a Human Service Program Specialist, a Senior Health Care Analyst and the Health Information Technology (HIT) staff. The staff of the OCQI helps to identify:

- barriers to care;
- ways to improve access to care for Medical Assistance consumers; and
- ways to engage providers in the Medical Assistance Program.

The staff is focusing on improving access to technology for providers to enhance the delivery of quality care and improve efficiency.

The Bureau of Program Integrity (BPI) is responsible for ensuring that:

- The Medical Assistance Program is protected from provider fraud, abuse, and waste;
- Medical Assistance recipients receive quality medical services;
- Medical Assistance recipients do not abuse their use of medical services; and
- Feedback is provided to the Department to enhance program performance.

BPI is comprised primarily of medical professionals responsible for preventing, detecting, deterring, and correcting fraud, abuse, and wasteful practices by providers of medical assistance services, including managed care organizations, applying administrative sanctions, and referring cases of potential fraud to the appropriate enforcement agency. This responsibility includes evaluating services rendered by medical providers and managed care organization provider networks, monitoring recipient overuse and abuse, and maintaining ongoing working relationships with federal and state enforcement agencies involved in monitoring potential health care fraud and abuse.

The Office of Income Maintenance's (OIM) Bureau of Operations is responsible for the overall planning, organization, direction, and control of determining eligibility for public assistance programs, including Medical Assistance, delivered through the county assistance offices (CAOs) and their district offices. Responsibilities include planning and implementing new initiatives, policies, procedures, processes, programs and automation supports, and establishing goals and standards to ensure public assistance program requirements and goals are being met.

2.2 Program Oversight

Program oversight for Pennsylvania's Family Planning Waiver will be included in the functions and activities currently undertaken by the Pennsylvania Medical Assistance Program. These functions and activities include:

- BPAP will be responsible for the planning, budgeting and analysis under this waiver including preparing waiver-related reports and monitoring cost effectiveness.

- BFFSP will perform rate-setting under this waiver for all provider types, with the exception of pharmacy, and will handle all operations including provider enrollment, inquiry, and training.

- BDCM will pay Fee-for-Service claims under this waiver.

- OCQI will support the quality-related aspects of this waiver.

- BPI will be responsible for protecting this waiver from fraud, abuse, and waste.
- OIM will determine recipient eligibility and maintain caseload records.

III.

PROJECT DESIGN

This chapter presents the design for this Family Planning Waiver for the Commonwealth of Pennsylvania and includes the following sections:

- 3.1 Target Population
- 3.2 Eligibility and Duration
- 3.3 Family Planning Services
- 3.4 Service Delivery
- 3.5 Provider Network
- 3.6 Primary care Services
- 3.7 Outreach/Public Awareness
- 3.8 Provider Education
- 3.9 Confidentiality

3.1 Target Population

The Family Planning Waiver, known as SelectPlan for Women, will extend Medical Assistance coverage for family planning services to all women in Pennsylvania who would not otherwise be eligible for Medical Assistance who:

- are between the ages of 18 and 44
- are residents of Pennsylvania
- are U.S. citizens or have satisfactory immigration status
- have no, or limited, family planning insurance coverage
- are not otherwise eligible for Medical Assistance
- are not pregnant or sterilized
- have income at or below 185% of the Federal Poverty Level (FPL)

This target population includes women who lost Medical Assistance eligibility 60 days postpartum or post loss of pregnancy.

3.2 Eligibility and Duration

The Office of Income Maintenance (OIM) oversees the eligibility determination for Medical Assistance recipients. When an application is received in which the applicant requests both Medical Assistance and SelectPlan for Women, the Income Maintenance Case Worker (IMCW) completes a full eligibility determination in order to find the "best" possible coverage. If the applicant is not eligible for any other category of Medical Assistance and the other criteria in Section 3.1 are met, SelectPlan for Women is authorized. If the applicant requests SelectPlan for Women only, eligibility will be determined in accordance with the eligibility factors of the Family Planning Waiver.

Pennsylvania will continue to complete full eligibility determinations for individuals who apply for SelectPlan for Women.

With the Family Planning Waiver and renewal of the waiver, those in the target population losing Medical Assistance eligibility at the end of the 60-day postpartum or post loss of pregnancy period will receive a written notice from the Department informing them of the termination of full Medical Assistance benefits. Continued eligibility for family planning services will be determined based on information already in the record. If eligible, an eligibility notice accompanied by an explanation of the family planning services covered under the Family Planning Waiver will be sent.

Individuals interested in applying for coverage of family planning services under this waiver will be able to use the following process.

Step 1 – Initiating application

Individuals interested in applying for Medical Assistance under this Family Planning Waiver can:

- Request a paper application (PA 600 or PA 600CH) from their local CAO or other community agency; or
- Access the online COMPASS application at www.compass.state.pa.us; or
- Ask a COMPASS Community Partner (CP), for example, a family planning clinic, to submit a COMPASS application on their behalf

Individuals may apply for Medical Assistance and SelectPlan for Women, Medical Assistance only, or SelectPlan only.

Step 2 – Application completion

Table 4 below shows the waiver application completion process.

Table 4

Family Planning Waiver Application Completion Process

PAPER APPLICATION	COMPASS APPLICATION	COMPASS CP APPLICATION
Individual completes application indicating selection of Family Planning Waiver benefits and signs paper application.	Individual completes COMPASS application indicating selection of Family Planning Waiver benefits and prints signature page. If no printer, signature page is mailed to them.	CP completes COMPASS application for an individual selecting Family Planning Waiver benefits and prints signature page for individual. If no printer, signature page is mailed to individual.
Individual submits completed paper application via mail, fax, or in person, to CAO for eligibility determination by IMCW.	Individual submits COMPASS application electronically to CAO for eligibility determination by IMCW.	CP submits COMPASS application electronically to CAO for eligibility determination by IMCW. *
Application is received in CAO and	COMPASS Application is instantaneously	COMPASS Application is

date/time stamped.	date/time stamped when individual clicks "submit" button.	instantaneously date/time stamped when individual clicks "submit" button.
IMCW reviews application to determine verification required.	Individual submits (mails, faxes, or delivers) signed signature page and required verification as listed on signature page	Individual submits (mails, faxes, or delivers) signed signature page and required verification as listed on signature page
IMCW contacts individual (via mail or telephone) to request required verification documents.		
Individual submits (mails, faxes, or delivers) required verification documents to CAO.		

*****An individual working with a COMPASS CP has three options when it comes time to submit the COMPASS application. The individual can:

- Submit a self-signed signature page;
- Authorize the CP to electronically sign the signature page on his/her behalf; or
- Authorize the CP to electronically sign the signature page and provide confirmation that the CP has seen the verification documents relating to income, resources, expenses, and pregnancy.

Step 3 – Verifying the application

Upon receipt of the application, the CAO will:

- Review the application and those documents that are necessary to verify eligibility for Medical Assistance to determine that all the information provided is complete. The CAO will notify the applicant immediately if information is incomplete or additional information is required.

- Review the application to ensure the applicant meets the following eligibility criteria:

    - are between the ages of 18 and 44
    - are residents of Pennsylvania
    - are U.S. citizens or have satisfactory immigration status
    - have no, or limited, family planning insurance coverage
    - are not otherwise eligible for Medical Assistance
    - are not pregnant or sterilized
    - have income at or below 185% of the Federal Poverty Level (FPL)

For purposes of determining whether the applicant has income at or below 185% of the FPL, the countable income includes income of the applicant, spouse, and children. There will be no resource limit under this Family Planning Waiver.

All conditions of eligibility, including citizenship and income, will be verified using the same validity checks and Quality Control reviews used as part the standard Medical Assistance application/redetermination process. Pennsylvania will use the income verification system to validate the income information the individual provides. Similarly, Pennsylvania will use an

automated exchange for SSN validation and the Systematic Alien Verification for Entitlements (SAVE) to verify immigration status.

An individual's health insurance information will be processed for third party liability coverage (TPL) as currently done. Services covered under the waiver will be billed to the TPL and if not paid for, the service will be paid by the Medical Assistance Program. The individual has the responsibility to tell the Department about any TPL and whether it covers family planning services.

Additionally, potential waiver applicants will be asked if they are pregnant or if they have undergone sterilization. If so, they will be determined ineligible for the waiver.

Step 4 – Authorizing eligibility

If all conditions of eligibility are met, the CAO will authorize eligibility for the Family Planning Waiver within 30 days from the date of application. The effective date of eligibility for coverage under the Family Planning Waiver begins:

- The first day of the calendar month the application was submitted through COMPASS or
- The first day of the calendar month in which the Family Planning Waiver application is submitted by a Community Partner; or
- The first day of the calendar month in which the Family Planning Waiver application is received by the CAO submitted by an individual and not through a Community Partner; or
- The first day of the calendar month following the 60-day postpartum period for women ages 18-44 unless they qualify for full coverage Medical Assistance.

While there is no interface with Pennsylvania Insurance Department's (PID) Children's Health Insurance Program (CHIP) Processing System (CAPS) prior to Medical Assistance benefits being authorized in the Client Information System (CIS), a cross match is performed prior to the authorization of medical benefits in CAPS for CHIP. The basics are that:

1. On a daily basis there is an interface from CAPS to CIS for all individual who are potentially eligible for CHIP. Based on a straight Social Security Number (SSN) match, CIS provides the Program Status Codes of the individuals that are receiving Cash or Medical Assistance benefits along with eligibility periods and some other details.
2. Matching individuals who are receiving Cash or Medical Assistance are then denied enrollment.

The above process above occurs at the time of reapplication for CHIP which takes place once a year. Individuals who are receiving Cash or Medical Assistance benefits have their enrollment terminated by PID.

Step 5 – Notifying the applicant

The CAO will send an eligibility notice to applicant of their eligibility for MA and the applicant will receive a Medical Assistance identification card specific to the Family Planning Waiver. A copy of the Healthcare Benefit Package describing the services available through the waiver will be included.

Step 6 – Redetermination

Eligibility under this Family Planning Waiver will be re-determined every twelve months, in keeping with existing Medical Assistance policy. The CAO will mail a form to each person eligible under this Family Planning Waiver to initiate the re-determination. Recipients seeking to remain eligible for services under the waiver must complete the form, sign it, and either bring it, mail it, or fax it to the CAO for processing, or the redetermination can be made through COMPASS.

3.3 Family Planning Services

Under its Medicaid State Plan, the Pennsylvania Medical Assistance Program covers family planning services. Family planning includes medically necessary services and supplies related to birth control, pregnancy prevention, and preventive services. Family planning services include contraceptive management for a variety of methods, recipient education, counseling, and referral as needed to other health care providers and social services.

Women enrolled in the Pennsylvania Family Planning Waiver will continue to receive the family planning services covered under the Pennsylvania Medical Assistance Program shown in Appendix A, relating to Family Planning Services, Pharmaceuticals and Supplies. If family planning services are added or removed from the scope of services available through the Family Planning Waiver during the course of this waiver, Appendix A will be updated accordingly.

Family planning services under this waiver will be paid for on a fee-for-service basis. Any limitations on family planning services under the Pennsylvania Medical Assistance Program will also apply under this waiver and are identified in Appendix A. With the renewal, the waiver will continue to cover selected family planning services, pharmaceuticals and supplies eligible for reimbursement through the Medical Assistance Program, including all FDA-approved contraceptives and antibiotics for family planning related conditions such as genito-urinary infections and sexually transmitted diseases (STD), and supplies. A claim for antibiotics prescribed for STDs or for vaginal infections, or for diagnostic labs and/or pharmaceuticals, must include the Family Planning (FP) modifier to show it is related to the Family Planning Waiver. For those waiver participants who use an RHC/FQHC for their family planning services, the RHC/FQHC will bill the Department of Public Welfare at its encounter rate. Claims submitted by an RHC/FQHC will be required to have an FP modifier on the claim to show it is related to the Family Planning Waiver.

3.4 Service Delivery

Women eligible under this Family Planning Waiver will have freedom of choice to select any provider of family planning service who is a Medical Assistance enrolled provider and who is enrolled in Medical Assistance Program to provide family planning services.

3.5 Provider Network

Family planning providers recognized by the Pennsylvania Medical Assistance Program include family planning clinics, hospital outpatient clinics, physicians, certified registered nurse practitioners, certified nurse midwives, city and county health departments, federally qualified health centers (FQHC), and rural health clinics (RHC), laboratories, pharmacies, medical suppliers, and independent medical/surgical clinics. The regulations for Medical Assistance-funded family planning clinics are included as Appendix B. It should be noted that some family planning providers in border States (i.e., Maryland and New York) are enrolled in the Pennsylvania Medical Assistance Program and will be eligible providers under this waiver.

3.6 Primary Care Services

Women covered under the Family Planning Waiver will be referred to Pennsylvania's FQHCs and RHCs for primary care services. Family planning providers, if they fulfill the role of a COMPASS Community Partner in the eligibility determination process described in Section 3.2 above, will provide an explanation of how to access primary care services at the time of initial application and at subsequent visits to the family planning clinics. CAOs will also provide this information at the initial application, if the applicant applies directly through the CAOs. Eligibility notices from the CAOs will also contain a separate listing of the names, locations, and telephone numbers of the primary care providers in Pennsylvania.

3.7 Public Input

As with any initiative in the MA Program, OMAP seeks the input and advice of those who have a direct interest in the initiative. In the case of the Family Planning Waiver, OMAP has sought input from providers, advocates, and consumers. The purpose, scope and general overview of the proposed waiver renewal was presented to the Medical Assistance Advisory Committee (MAAC) at the October, 2011, January and March 2012 meetings. This committee, which is required by federal Medicaid regulations, is comprised of representatives from provider associations, practitioners, advocacy groups, and recipients or their representatives. After the presentations to the MAAC, the membership was afforded the opportunity to provide their comments and suggestions for this waiver renewal.

A Public Notice will be published in the Pennsylvania Bulletin and will provide for a 30-day comment period. OMAP will analyze all comments to determine the general themes or concerns of the public.

3.8 Outreach/Public Awareness

Pennsylvania will continue to maintain the Family Planning Waiver's SelectPlan for Women website which can be accessed at: http://www.selectplanforwomen.com.

Brochures about SelectPlan for Women will continue to be available at CAOs, city and county health departments, hospitals, Federally qualified health centers, rural health clinics, Women Infant and Children (WIC) program offices, and other maternal and child health and provider locations. The brochure will also be posted on the OMAP Website.

Department call center staff will be trained on the waiver so that consumers can access information about the waiver by telephone toll-free at:

- 1-800-1-800-537-8862, option #2 (Non-English Speaking individuals may also access through this line)
- TDD/TTY-PA Relay 711 – by giving the operator the Recipient Call Center # 1-800-657-7925 (Hearing Impaired)

New Provider call line staff will be trained on the waiver.

3.9 Provider Education

Pennsylvania offered four orientation and training sessions throughout Pennsylvania on the waiver for family planning providers prior to the February 2008 waiver implementation. The orientation and training sessions addressed the following topics:

- Eligible groups
- Duration of eligibility
- How to apply for coverage under the waiver
- Covered services
- Billing
- Confidentiality

Training related to SelectPlan for Women is available for providers on an individual basis. Pennsylvania issues provider bulletins related to the waiver to provide updates as necessary throughout the waiver period. These bulletins are posted on the Department of Public Welfare's website. Providers who cannot access them on the internet are mailed paper copies.

3.10 Confidentiality

Confidentiality is of critical importance to the provision of quality family planning services. Family planning services in Pennsylvania are provided in a strict, confidential manner to all Medical Assistance recipients in Pennsylvania. The Family Planning Waiver is subject to all current Medical Assistance Program confidentiality rules.

IV.

CASELOAD AND FINANCING

This chapter presents caseload and financing information for this Family Planning Waiver renewal application.

4.1 Caseload Projections

Pennsylvania estimates that it will have the following caseloads during the period of the waiver:

- Waiver Year One – 137,282 waiver eligibles
- Waiver Year Two – 142,773 waiver eligibles

4.2 Savings

Pennsylvania expects this waiver to be cost-effective, efficient, and in keeping with the objectives of the Pennsylvania Medical Assistance Program by virtue of reductions in future Medical Assistance prenatal care, delivery, and newborn and infant care expenditures.

4.3 Program Costs

The projected costs will be calculated using a per-member-per-month (PMPM). The methodology for calculating the PMPM rate will be developed by CMS upon submission of the waiver renewal request using the annual member month figures for the life of the waiver and the projected member month calculations for the term of the waiver renewal.

- Waiver Year One – 1,068,770 Annual Member Months
- Waiver Year Two – 1,111,521 Annual Member Months

Details to support these figures are provided in Appendix C.

4.4 State Matching Funds

Pennsylvania will provide its share of the matching funds to support this waiver at the rate of ten percent for direct family planning services.

V.

WAIVERS

The Commonwealth of Pennsylvania seeks waivers of the following sections of the Social Security Act for this Section 1115 family planning waiver project:

- **Eligibility** – Section 1902(e)(5) and (6) of the Social Security Act (the Act) limit eligibility of poverty level postpartum of post loss of pregnancy women to sixty days following the pregnancy. Waiver of these sections of the Act is requested to extend family planning benefits following the 60-day post-pregnancy period. Pennsylvania also requests that family planning benefits for non-pregnant women be available through this waiver for all women aged 18 to 44 who are not categorically eligible for Medical Assistance whose income does not exceed 185 percent of the FPL.

- **Income Limitations** – Sections 1902(1) and 1903 (f) of the Act prohibit payment under Medical Assistance to States that implement eligibility standards in excess of the maximum allowed by Federal regulations. Pennsylvania requests a waiver of these sections of the Act to expand eligibility for family planning services to women up to 185 percent of the FPL. Income levels for all other Medical Assistance eligibility categories will remain as stated in the Medicaid State Plan.

- **Resource Limitations** – Sections 1902(a)(10)(A)(ii)(II) and 1902(a)(17) of the Act require States to take into account income or resources of individuals who are not receiving assistance under Temporary Assistance to Needy Families (TANF) who might otherwise become eligible for assistance under TANF. Pennsylvania requests waiver of these sections of the Act so that the target population under this waiver will not be subject to an asset test.

- **Amount, Duration, and Scope of Services** – Section 1902(a)(10)(B) of the Act requires that the amount, duration, and scope of services be available equally to all recipients within a Medical Assistance eligibility category and be available equally to categorically eligible and Medically Needy recipients. Pennsylvania requests a waiver of this section of the Act so that those women eligible for this waiver will only be eligible for those family planning services specified in Appendix A.

- **Retroactive Eligibility** – Section 1902(a)(34) of the Act requires the States to retroactively provide Medical Assistance for three months prior to the date of the application for such assistance. Pennsylvania requests a waiver of this section of the Act so that it will not apply to women eligible for this waiver.

- **Other Restrictions** – Pennsylvania requests that Department of Health and Human Services (DHHS) grant any other waiver deemed necessary to provide the family planning services to women who meet the eligibility requirements described in this waiver renewal application.

VI.

EVALUATION PLAN

Evaluation of the Original Waiver

Since the implementation date of February 1, 2008, SelectPlan for Women has extended family planning services to women in Pennsylvania between the ages of 18 and 44 with an income at or below 185 percent of the Federal Poverty Level (FPL) with no insurance coverage for family planning services and otherwise not eligible for MA services. There are three primary objectives of the program. The first objective is to improve access to and use of family planning services among women in the target population. Second, the program should decrease the number of Medicaid-paid deliveries, which will reduce annual Federal and State Medicaid expenditures for prenatal, delivery, newborn, and infant care. The third objective of the program is to improve birth outcomes and the health of women by increasing the child spacing interval (also referred to as the interbirth or inter-pregnancy interval) among women in the target population.

In an effort to achieve the above stated objectives, seven hypotheses were created and examined using data from the annual recipient survey and from claims. The hypotheses are as follows:

- **Hypothesis #1**: The demonstration will result in an increase in appropriate use of effective forms of birth control among recipients aged 18 to 44.
- **Hypothesis #2**: The demonstration will result in a decrease in the annual rate of Medical Assistance-paid deliveries for women aged 18 to 44.
- **Hypothesis #3**: The demonstration will result in a decrease in the proportion of women, ages 18 to 44, with a Medical Assistance-paid delivery within 18 months of a previous Medical Assistance-paid delivery.
- **Hypothesis #4**: Over the five- year period of the waiver, the demonstration will produce net annual savings in Federal and State expenditures for birth-related services.
- **Hypothesis #5**: Waiver recipients will likely be satisfied with the services they receive under the demonstration.
- **Hypothesis #6**: The demonstration waiver will result in an increase in referrals to Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) for primary care services for recipients.
- **Hypothesis #7**: Referrals made as part of the demonstration waiver will result in an increase in primary care services provided to waiver recipients by Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs).

Evidence of Achieved Objectives

After a thorough review, we concluded that the data supported several of the hypotheses. The data suggested an increase in the use of effective methods of birth control showing support for Hypothesis 1. Overall, the rate of births decreased as the SelectPlan for Women program was

implemented suggesting support for Hypothesis 2 regarding the demonstration resulting in a decrease in annual rate of Medical Assistance-paid deliveries for women in the eligible age range. Over the period of the waiver, the demonstration produced net annual savings. This data supports Hypothesis 4. Based on the 10 indicators for participant satisfaction, eight showed positive perceptions of the program. These responses lend support to Hypothesis 5 which indicated that program participants would be satisfied with services.

Evaluation of the Renewal Waiver

Areas for Improvement

While the data from the original waiver supported four of the hypotheses, three hypotheses failed to be supported. There was not enough data to properly test Hypothesis 3. Renewing the waiver would provide sufficient data for thorough analysis of birth spacing phenomenon. The data from the second and third annual surveys also suggested consistent issues in the referral of recipients to Federally Qualified Health Centers (FQHC) or Rural Health Centers (RHC) and the subsequent attainment of services. As such, a clear position of support for Hypothesis 6 and Hypothesis 7 cannot be made. The data also emphasized areas for program improvement in the area of participant satisfaction or Hypothesis 5. The two indicators that did not clearly suggest support for Hypothesis 5 were "I know who to call if I have questions" and "I know what services SelectPlan will pay for". These two indicators highlight specific areas that need attention and improvement from a program implementation perspective.

Suggested Changes

The following information highlights proposed adjustments to the program as well as listed evaluation hypotheses for the renewal waiver.

Old Hypothesis	New Hypothesis	Wording
#3	**#1**	*Old*: "The demonstration will result in a decrease in the proportion of women, ages 18 to 44, with a Medical Assistance-paid delivery within 18 months of a previous Medical Assistance-paid delivery" *New*: "The demonstration will result in a decrease in the proportion of SelectPlan for Women program recipients, with a Medical Assistance-paid delivery within 18 months of a previous Medical Assistance-paid delivery." This change in wording clarifies the focal population of the analysis and provides a more accurate description of how to assess the effectiveness of the SelectPlan for Women program.
Process of Evaluation: The measurement to test new Hypothesis 1 will be the proportion of SelectPlan for Women recipients aged 18 to 44 with two or more Medical Assistance-paid deliveries within 18 months of each other. The delivery data will be extracted from the Pennsylvania MMIS system (PROMISe), as identified as the Fee-for-Service (FFS) paid inpatient claims with a delivery-related DRG and the maternity capitation payment records paid to the Medical Assistance managed care organizations. These claims and capitation payment data identified instances of deliveries, and the instances of SelectPlan for Women recipients aged 18 to 44 who have had a subsequent Medical Assistance-paid delivery within 18 months.		

Old Hypothesis	New Hypothesis	Wording
#5	**#2**	*Old*: "Waiver recipients will likely be satisfied with the services they receive under the demonstration." *New*: (same)

Process of Evaluation:
The annual survey will be used to evaluate new Hypothesis 2. The survey instrument includes ten indicators of satisfaction. These ten indicators included information on ease of application, satisfaction with the application process, ease of information, knowing who to call, knowing what services are covered, ease of access to family planning services, intention to renew, belief that more women should be told about the program, recommending the program to others, and overall happiness with the program. The percentages of respondents who indicated satisfaction with these items were calculated and compared for three years.

The two indicators in the original waiver that failed to support Hypothesis 5 about recipient satisfaction will be left in their current state. It is assumed that the wording for these two questions was clear and easy to understand thereby identifying an area for program improvement and not a problem with the measurement instrument. The renewal waiver will reassess this hypothesis to mark improvement in the two specific areas of need namely that participants understand who to call with questions and understand what services are covered under SelectPlan for Women.

Old Hypothesis	New Hypothesis	Wording
#6	**#3**	*Old*: "The demonstration waiver will result in an increase in referrals to Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) for primary care services for recipients." *New*: (same)

Process of Evaluation:
The annual surveys will be used to test new Hypothesis 3. The recipients will be asked whether or not they received referrals for primary care from a family planning service provider. The results of the responses to the question will be compared for each year to determine if the rate of primary care referrals provided by family planning service providers increases over the duration of the extended waiver.

Responses to the questions regarding referrals will be analyzed by sign-up location. This change is motivated by the consideration that multi-faceted health centers might have failed to refer recipients to other health facilities based on their own ability to offer general services. This additional level of analysis will permit the exploration of this prospect and provide a better understanding of the referral patterns of different types of health provider facilities.

Old Hypothesis	New Hypothesis	Wording
#7	**#4**	*Old*: "Referrals made as part of the demonstration waiver will result in an increase in primary care services provided to waiver recipients by Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)." *New*: (same)
Process of Evaluation: The new Hypothesis 4 will be examined in conjunction with new Hypothesis #3, using data obtained from the annual surveys, which will include a question regarding whether or not the participants actually go to receive primary care services being referred by family planning service providers.		

In summary, the renewal waiver will address the following hypotheses:

1. The demonstration waiver will result in a decrease in the proportion of SelectPlan for Women program recipients, with a Medical Assistance-paid delivery within 18 months of a previous Medical Assistance-paid delivery.
2. Waiver recipients will likely be satisfied with the services they receive under the demonstration.
3. The demonstration waiver will result in an increase in referrals to Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) for primary care services for recipients.
4. Referrals made as part of the demonstration waiver will result in an increase in primary care services provided to waiver recipients by Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs).

Projections for Renewal Waiver

	Current Waiver			Renewed Waiver	
	Year 1	**Year 2**	**Year 3***	**Year 1**	**Year 2**
	2008/2009	2009/2010	2010/2011	2012/2013	2013/2014
Enrolled Recipients	74,397	107,403	132,002	137,282	142,773
Annual Member Days	15,650,395	24,881,016	31,240,965	32,490,604	33,790,228
Annual Member months				1,068,770	1,111,521

*The third year of the current waiver was used as the base year due to incomplete data for the fourth year (2011/2012).

Assumptions:

4% Growth of Enrollment

APPENDIX A
PENNSYLVANIA FAMILY PLANNING WAIVER SERVICES, PHARMACEUTICALS AND SUPPLIES

State	Procedure Code	Procedure Code Description	90% FFP	90% FFP with V25 or FP	FMAP
PA	11975	Insertion , implantable contraceptive capsules	X		
PA	11976	Removal, implantable Contraceptive Capsules	X		
PA	11977	Removal with reinsertion, implantable contraceptive capsules	X		
PA	58300	Insertion of Intrauterine device (IUD)	X		
PA	58301	Removal of Intrauterine device (IUD)	X		
PA	81000	Urinalysis by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy		X	
PA	81001	Urinalysis by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, with microscopy		X	
PA	81025	Urine pregnancy test, by visual color comparison methods		X	
PA	83001	Gonadotropin; follicle stimulating hormone (FSH)		X	
PA	83898	Molecular Diagnostics; amplification, target, each nucleic acid sequence		X	
PA	84138	Pregnanetriol		X	
PA	84144	Progesterone		X	
PA	84146	Prolactin		X	
PA	84702	Gonadotropin, chorionic (hCG); quantitative		X	
PA	84703	Gonadotropin, chorionic (hCG); qualitative		X	
PA	85014	Blood count; hematocrit (Hct)		X	
PA	85018	Blood count; hemoglobin (Hgb)		X	
PA	85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count		X	
PA	85660	Sickling of RBC, reduction		X	
PA	86255	Fluorescent noninfectious agent antibody; screen, each antibody		X	
PA	86317	Immunoassay for infectious agent antibody; quantitative, not otherwise specified		X	
PA	86592	Syphilis test, qualitative (eg, VDRL, RPR, ART)		X	
PA	86701	Antibody; HIV-1		X	
PA	86702	Antibody; HIV-2		X	
PA	86762	Antibody; rubella		X	
PA	86780	Antibody; Treponema pallidum, confirmatory test (eg, FTA-abs)		X	
PA	87070	Culture, bacterial; any other source except urine, blood or stool, aerobic, with isolation and presumptive identification of isolates		X	

PA	87075	Culture, bacterial; any source, except blood, anaerobic with isolation and presumptive identification of isolates		X	
PA	87076	Culture, bacterial; anaerobic isolate, additional methods required for definitive identification, each isolate		X	
PA	87086	Culture, bacterial; quantitative colony count, urine		X	
PA	87110	Culture, chlamydia, any source		X	
PA	87166	Dark field examination, any source (eg, penile, vaginal, oral, skin); without collection		X	
PA	87205	Smear, primary source with interpretation; Gram or Giemsa stain for bacteria, fungi, or cell types		X	
PA	87207	Smear primary source with interpretation; special stain for inclusion bodies or parasites (eg, malaria, coccidian, microsporidia, trypanosomes, herpes viruses)		X	
PA	87210	Smear primary source with interpretation; wet mount for infectious agents (eg, saline, India ink, KOH preps)		X	
PA	87491	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia Trachomatis, amplified probe technique		X	
PA	87536	Infectious agent detection by nucleic acid (DNA or RNA), HIV-1, quantification		X	
PA	87591	Infectious agent detection by nucleic acid (DNA or RNA), Neisseria gonorrhoeae, amplified probe technique		X	
PA	87621	Infectious agent detection by nucleic acid (DNA or RNA), papillomavirus, human, amplified probe technique		X	
PA	87797	Infectious agent detection by nucleic acid (DNA or RNA); not otherwise specified, direct probe technique, each organism		X	
PA	87798	Infectious agent detection by nucleic acid (DNA or RNA); not otherwise specified, amplified probe technique, each organism		X	
PA	88141	Cytopathology, cervical or vaginal (any reporting system), requiring interpretation by physician		X	
PA	88142	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision		X	
PA	88161	Cytopathology, smears, any other source; preparation, screening and interpretation		X	
PA	88164	Cytopathology, slides, cervical or vaginal (the Bethesda System); manual screening under physician supervision		X	
PA	88175	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with screening by automated system and manual rescreening or review, under physician supervision		X	
PA	99201	New patient office or other outpatient visit (with Problem) = 10 minutes		X	
PA	99202	New patient office or other outpatient visit (with Problem) = 20 minutes		X	
PA	99203	New patient office or other outpatient visit (with Problem) = 30 minutes		X	
PA	99211	Established patient office or other outpatient visit (with Problem) = 5 minutes		X	
PA	99212	Established patient office or other outpatient visit (with Problem) = 10 minutes		X	
PA	99213	Established patient office or other outpatient visit (with Problem) = 15 minutes		X	
PA	99214	Established patient office or other outpatient visit (with Problem) = 25 minutes		X	
PA	99385	Initial comprehensive preventive medicine evaluation and management (Age 18 through 39 years)		X	
PA	99386	Initial comprehensive preventive medicine reevaluation and management (Age 40 through 64 years)		X	
PA	99395	Periodic comprehensive preventive medicine (Age 18 through 39 years)		X	

PA	99396	Periodic comprehensive preventive medicine (Age 40 through 64 years)		X	
PA	99401	Preventive medicine counseling and/or risk factor reduction intervention = 15 minutes		X	
PA	T1015	Clinic visit/encounter, all-inclusive		X	
PA	A4267	Contraceptive supply, condom, male, each	X		
PA	A4268	Contraceptive supply, condom, female, each	X		
	Pharmaceuticals and Supplies				
PA	Appropriate National Drug Code	Antibiotics			X
PA	Appropriate National Drug Code	Contraceptive Ring	X		
PA	Appropriate National Drug Code	Contraceptive Cream or Jelly	X		
PA	Appropriate National Drug Code	Contraceptive Foam	X		
PA	Appropriate National Drug Code	Depo-Provera	X		
PA	Appropriate National Drug Code	Diaphragm	X		
PA	Appropriate National Drug Code	Emergency Contraceptive	X		
PA	Appropriate National Drug Code	Implanon	X		
PA	Appropriate National Drug Code	Nexplanon	X		
PA	Appropriate National Drug Code	Lunelle	X		
PA	Appropriate National Drug Code	Medication for Vaginal Infection			X
PA	Appropriate National Drug Code	Mirena, Intrauterine Device (IUD)	X		

PA	Appropriate National Drug Code	Oral Contraceptives	X		
PA	Appropriate National Drug Code	Ortho Evra (Patch)	X		
PA	Appropriate National Drug Code	ParaGuard	X		

APPENDIX B

FAMILY PLANNING REGULAIONS

GENERAL PROVISIONS

§ 1225.1. Policy.

The MA Program provides payment for family planning services provided to eligible recipients by hospital outpatient family planning clinics and independent family planning clinics enrolled as providers under the program. Payment for family planning clinic services is subject to this chapter and Chapters 1101 and 1150 (relating to general provisions; and MA Program payment policies) and the MA Program fee schedule.

Source

The provisions of this § 1225.1 adopted December 5, 1980, effective December 1, 1980, 10 Pa.B. 4607; amended December 23, 1983, effective January 1, 1983, 13 Pa.B. 3932; amended September 30, 1988, effective October 1, 1988, 18 Pa.B. 4418. Immediately preceding text appears at serial page (117482).

§ 1225.2. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

CRNP—Certified registered nurse practitioner—An individual currently certified by the State Board of Medicine and the State Board of Nursing as a CRNP within the scope of the Medical Practice Act of 1974 (63 P. S. § § 421.1—421.18) (Repealed).

FPIS—Family planning invoicing system—A computerized billing system whereby the Family Planning Council or family planning clinic receives payment for several levels of family planning examinations, specific laboratory tests performed at the clinic site and for dispensing specific family planning drugs and devices at the clinic site.

Family planning services—Diagnosis, treatment, drugs, supplies and related counseling which are provided to individuals of child bearing age to enable the individuals to determine freely the number and spacing of their children.

Hospital outpatient family planning clinic—A hospital affiliated facility that provides family planning services on an outpatient basis.

Independent family planning clinic—A free-standing facility operated by a public or private

organization which provides family planning services on an outpatient basis.

Physician—An individual currently licensed by the State Board of Medicine or the State Board of Osteopathic Medicine to practice medicine and surgery under section 10 of the Medical Practice Act of 1974 (63 P. S. § 421.10) (Repealed) or the Osteopathic Medical Practice Act (63 P. S. § § 271.1—271.18).

Physician assistant—An individual currently certified by the State Board of Medicine or the State Board of Osteopathic Medicine as a physician assistant within the scope of the Medical Practice Act of 1974 (63 P. S. § § 421.1—421.18) (Repealed) or the Osteopathic Medical Practice Act (63 P. S. § § 271.1—271.18).

Registered nurse—An individual currently licensed in this Commonwealth by the State Board of Nursing to practice professional nursing within the scope of the Professional Nursing Law (63 P. S. § § 211—225).

Source

The provisions of this § 1225.2 adopted December 5, 1980, effective December 1, 1980, 10 Pa.B. 4607.

SCOPE OF BENEFITS

§ 1225.21. Scope of benefits for the categorically needy.

Categorically needy recipients are eligible for the family planning services listed in MA Program fee schedule.

Source

The provisions of this § 1225.21 adopted December 5, 1980, effective December 1, 1980, 10 Pa.B. 4607; amended December 23, 1983, effective January 1, 1983, 13 Pa.B. 3932; amended September 30, 1988, effective October 1, 1988, 18 Pa.B. 4418. Immediately preceding text appears at serial page (117483).

§ 1225.22. Scope of benefits for the medically needy.

Medically needy recipients are eligible for the family planning services listed in the MA Program fee schedule.

Source

The provisions of this § 1225.22 adopted December 5, 1980, effective December 1, 1980, 10 Pa.B. 4607; amended December 23, 1983, effective January 1, 1983, 13 Pa.B. 3932; amended September 30, 1988, effective October 1, 1988, 18 Pa.B. 4418. Immediately preceding text appears at serial page (117483).

§ 1225.23. Scope of benefits for State Blind Pension recipients.

State Blind Pension recipients are eligible for the family planning services listed in the MA Program fee schedule.

Source

The provisions of this § 1225.23 adopted December 5, 1980, effective December 1, 1980, 10 Pa.B. 4607; amended December 23, 1983, effective January 1, 1983, 13 Pa.B. 3932; amended September 30, 1988, effective October 1, 1988, 18 Pa.B. 4418. Immediately preceding text appears at serial pages (117483) to (117484).

§ 1225.24. Scope of benefits for General Assistance recipients.

General Assistance recipients, age 21 to 65, whose MA benefits are funded solely by State funds, are eligible for medically necessary basic health care benefits as defined in Chapter 1101 (relating to general provisions). See § 1101.31(e) (relating to scope).

Source

The provisions of this § 1225.24 adopted December 11, 1992, effective January 1, 1993, 22 Pa.B. 59

PROVIDER PARTICIPATION

§ 1225.41. General participation requirements.

In addition to the participation requirements established in Chapter 1101 (relating to general provisions) and the applicable participation requirements listed in § § 1225.42, 1225.43 and 1225.45 (relating additional requirements for hospital outpatient family planning clinics; additional requirements for independent family planning clinics; and ongoing responsibilities of providers) hospital outpatient family planning clinics and independent family planning clinics shall meet the following participation requirements:

(1) Have a patient referral system that ensures follow-up treatment by other physicians or appropriate specialists.

(2) Be certified as a family planning clinic by the Office of Social Programs, Family Planning Division.

Cross References

This section cited in 55 Pa. Code § 1225.42 (relating to additional requirements for hospital outpatient family planning clinics); and 55 Pa. Code § 1225.43 (relating to additional requirements for independent family planning clinics).

1225.42. Additional requirements for hospital outpatient family planning clinics.

(a) In addition to the participation requirements listed in § 1225.41 (relating to general participation requirements) hospital outpatient family planning clinics shall meet the following participation requirements:

(1) Be part of an institution formally licensed as a hospital by the Department of Health.

(2) Be organizationally integrated with inpatient services and have the authority to independently admit patients to the hospital.

(b) If the hospital outpatient family planning clinic is operated indirectly through contract between the hospital and other organizations or individuals, all participation requirements of this section and § 1225.41 shall be met.

Source

The provisions of this § 1225.42 adopted December 5, 1980, effective December 1, 1980, 10 Pa.B. 4607.

Cross References

This section cited in 55 Pa. Code § 1225.41 (relating to general participation requirements).

§ 1225.43. Additional requirements for independent family planning clinics.

In addition to the participation requirements listed in § 1225.41 (relating to general participation requirements) independent family planning clinics shall meet the following participation requirements:

(1) Provide services either directly by a physician or under the supervision of a physician. This means that one or more physicians shall be on staff to either provide directly or supervise the provision of service. If a physician does not provide services directly, then:

(i) The services shall be provided by a certified registered nurse practitioner, a physician assistant or a registered nurse, as appropriate, on the basis of a predetermined plan of diagnosis and treatment that has been approved by a physician.

(ii) A physician shall be immediately available through direct communication or by radio, telephone or telecommunications.

(2) Not limit the number of patients served by virtue of the payment source.

(3) Through formal agreements, provide access to health care for emergencies related to the family planning services provided, both during and after the regularly scheduled hours of the clinic.

Source

The provisions of this § 1225.43 adopted December 5, 1980, effective December 1, 1980, 10 Pa.B. 4607.

Cross References

This section cited in 55 Pa. Code § 1225.41 (relating to general participation requirements).

§ 1225.44. Participation requirements for out-of-State family planning clinics.

Out-of-State family planning clinics shall meet the requirements set forth in § 1101.42(b) (relating to prerequisites for participation).

Source

The provisions of this § 1225.44 adopted December 5, 1980, effective December 1, 1980, 10 Pa.B. 4607.

§ 1225.45. Ongoing responsibilities of providers.

Ongoing responsibilities of providers are established in Chapter 1101 (relating to general provisions).

Source

The provisions of this § 1225.45 adopted December 5, 1980, effective December 1, 1980, 10 Pa.B. 4607.

Cross References

This section cited in 55 Pa. Code § 1225.41 (relating to general participation requirements).

PAYMENT FOR FAMILY PLANNING CLINIC SERVICES

§ 1225.51. General payment policy.

Payment is made for services provided by or under the supervision of a physician in a hospital outpatient family planning clinic, or independent family planning clinic, subject to the conditions and limitations set forth in this chapter and Chapters 1101 and 1150 (relating to general provisions; and MA Program payment policies) and the MA Program fee schedule.

Source

The provisions of this § 1225.51 adopted December 5, 1980, effective December 1, 1980, 10 Pa.B. 4607; amended December 23, 1983, effective January 1, 1983, 13 Pa.B. 3932; amended September 30, 1988, effective October 1, 1988, 18 Pa.B. 4418. Immediately preceding text appears at serial page (117486).

§ 1225.52. Conditions of payment.

(a) Family planning services shall be provided either by, or under the supervision of a physician.

(b) Family planning services shall be provided at the clinic site.

Source

The provisions of this § 1225.52 adopted December 5, 1980, effective December 1, 1980, 10 Pa.B. 4607

§ 1225.54. Noncompensable family planning services.

Payment will not be made to a family planning clinic for the following services regardless of where or to whom they are provided:

(1) Services and procedures that are available through other public agencies, private insurance plans, and State or Federal Programs, except Titles V, X, XX, and the Indochinese Refugee Assistance Act.

(2) Procedures not listed in the MA Program fee schedule or the fee schedule promulgated by the Family Planning Division of the Department.

Source

The provisions of this § 1225.54 adopted December 5, 1980, effective December 1, 1980, 10 Pa.B. 4607; amended December 23, 1983, effective January 1, 1983, 13 Pa.B. 3932; amended September 30, 1988, effective October 1, 1988, 18 Pa.B. 4418. Immediately preceding text appears at serial pages (117486) to (117487).

UTILIZATION CONTROL

§ 1225.71. Scope of claims review procedures.

Claims submitted for payment under the MA Program are subject to the utilization review procedures established in Chapter 1101 (relating to general provisions).

Source

The provisions of this § 1225.71 adopted December 5, 1980, effective December 1, 1980, 10 Pa.B. 4607.

ADMINISTRATIVE SANCTIONS

§ 1225.81. Provider misutilization.

Providers determined to have billed for services inconsistent with MA Program regulations, to have provided services outside the scope of customary standards of medical practice or to have otherwise violated the standards set forth in the provider agreement, are subject to the sanctions described in Chapter 1101 (relating to general provisions).

Source

The provisions of this § 1225.81 adopted December 5, 1980, effective December 1, 1980, 10 Pa.B. 4607.

APPENDIX C

Waiver Member Projections

Projections for Renewal Waiver

	Current Waiver			Renewed Waiver	
	Year 1	**Year 2**	**Year 3***	**Year 1**	**Year 2**
	2008/2009	2009/2010	2010/2011	2012/2013	2013/2014
Enrolled Recipients	74,397	107,403	132,002	137,282	142,773
Annual Member Days	15,650,395	24,881,016	31,240,965	32,490,604	33,790,228
Annual Member months				1,068,770	1,111,521

*The third year of the current waiver was used as the base year due to incomplete data for the fourth year (2011/2012).

Assumptions:

4% Growth of Enrollment

The Pennsylvania Family Planning Waiver

SelectPlan for Women

Final Evaluation Report for 2007-2012

Pennsylvania Department of Public Welfare
Office of Medical Assistance Programs
Bureau of Policy, Analysis & Planning
Division of Evaluation and Data Analysis

April 2012

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EXECUTIVE SUMMARY

- Over the life of the waiver, 119,269 women received professional or outpatient services such as annual gynecological exams or pharmacy services such as contraceptives.

- Since 2008, the demonstration created a savings of $150,552,984 for Pennsylvania indicating budget neutrality of the waiver (Supporting Hypothesis 4, p. 18).

- Between the years of 2008 and 2010, the total number of births averted was 7,061. This accounted for a total averted cost of $137,572,983.00. After factoring in the program costs of the waiver, there was a net total savings of $113,862,221.00 (Supporting Hypothesis 4, p. 19).

- For each waiver year, the results of the recipient survey indicated an increase in the use of Abstinence and More Effective methods of birth control. For the 2008/2009 and 2009/2010 demonstration years, the use of Abstinence and More Effective methods of birth control increased by approximately 15% per year. For the 2010/2011 demonstration year, the use of these methods increased by 18%. (Supporting Hypothesis 1, p. 10).

- Although there was a slight increase between the first and second waiver years, in subsequent waiver years the overall Medical Assistance-paid birth rate steadily decreased across all age groups ending at a rate of 126 per 1,000. (Supporting Hypothesis 2, p. 13).

- There was not enough data to evaluate Hypothesis 3 which examined the proportion of women ages 18 to 44 having a Medical Assistance-paid delivery within 18 months of a previous Medical Assistance-paid delivery. Renewing the waiver will make this possible by providing additional years of data to analyze.

- Eight of ten indicators on the recipient survey highlighted support for overall satisfaction with the program. (Supporting Hypothesis 5, p. 21)
    - ✓ Approximately 90% of respondents each year indicated that the application process was somewhat or very easy.
    - ✓ Between 85% and 89% of respondents each year indicated that they were very or somewhat satisfied with the application process.
    - ✓ For the final two years of the survey, over 92% of respondents indicated being happy overall with SelectPlan.

- The data from the recipient surveys suggested inconsistent data surrounding the referral of recipients to Federally Qualified Health Centers (FQHC) or Rural Health Centers (RHC) and subsequent attendance at appointments. (Failing to lend support for Hypotheses 6 and 7, p. 26).

INFORMATION ABOUT THE DEMONSTRATION

Name and Dates

This is the report for the Medicaid Section 1115 Demonstration Waiver Project for Pennsylvania's Family Planning Services, which is referred to as SelectPlan for Women. The project number is 11-W-00233/3. Pennsylvania received approval of the Waiver Program from the Centers for Medicare and Medicaid Services (CMS) on May 11, 2007, effective June 1, 2007 for a five year period. The implementation date was February 1, 2008, and the end date is May 31, 2012.

Purposes

SelectPlan for Women program extends family planning services such as pharmaceuticals and devices to uninsured women ages 18 through 44 at or below 185% of the Federal Poverty Level who are not otherwise eligible for services under Medical Assistance Programs (MA). Among the purposes of the Waiver are to provide family planning services to a specific population of Pennsylvania women with the goal of reducing the number of pregnancies and births paid for by MA, which is Pennsylvania's Medicaid program. Reducing pregnancies and births should lead to net Federal and State MA Program Savings.

Program Objectives

The objectives of the program are to:

- Improve access to and encourage the use of family planning services among women in the target population;
- Decrease the number of Medicaid-paid deliveries, which will reduce annual Federal and State Medicaid expenditures for prenatal, delivery, newborn, and infant care; and
- Improve birth outcomes and the health of women by increasing the child spacing interval (also referred to as the interbirth or inter-pregnancy interval) among women in the target population.

Background

According to the Pennsylvania Department of Health, the general fertility rate in Pennsylvania, which is the number of total live births per 1,000 females of childbearing age (between age 15 and 44), was 63.6 in 1990. In 1995, this rate was 57.9; in 2000, the rate was 57.0; and 2003, the rate was 57.8. While the live births and general fertility rates in Pennsylvania trended downward since 1990, the MA fertility rate continued to grow. At the same time, the percentage of MA paid births as a percentage of total births in Pennsylvania continued to increase. Between 2000 and 2003, the percentage grew from 33.2% to 34.1%, 35.3% and to 36.8%, respectively.

Pennsylvania MA Programs cover pregnant women and infants with monthly income at or below 185% of the Federal Poverty Level. However, pregnant MA recipients lose eligibility 60 days postpartum or 60 days after the loss of pregnancy, if these recipients are not within the financial guidelines for MA eligibility. When these recipients lost eligibility, they lost coverage for all

MA benefits including family planning. The consequence of losing MA benefits may have inadvertently contributed to the increasing trend in MA fertility rate and MA paid births. This waiver program attempted to increase the interbirth interval. Women who conceive a pregnancy within 18 months of a live birth are considered to have a short interbirth interval. Women with a short interbirth interval are at an increases risk for premature deliveries and are more likely to have low birth weight babies. In Pennsylvania in 2003, 8.1% of the births were low birth weight births (i.e., under 2,500 grams) and 1.3% were very low birth weight births (i.e., under 1,500 grams). MA recipients are disproportionately represented among both low and very low birth weight babies compared to women who have commercial insurance. These births have important health outcome and financial implications, many of which result in costly neonatal intensive care. Improved access to family planning services in Pennsylvania for low-income women not otherwise eligible for MA through SelectPlan for Women mitigated these trends.

Brief History

The 1115 demonstration waiver application was submitted to the Centers for Medicare and Medicaid Services (CMS) by the Pennsylvania Department of Public Welfare (the Department) on December 30, 2005 and approved by CMS in May 2007 for a five year period ending May 31, 2012. The Department implemented the program on February 1, 2008. A request to amend the program was made on January 28, 2008 to add two additional services to the list of available procedures offered through the Program (urine pregnancy testing and a test for the Human Papilloma Virus, or HPV) and to remove the contraceptive drug Norplant which was no longer manufactured. The amendment was approved by CMS in April 2008.

Population Groups Impacted

The Program's target population includes women who:

- are between the ages of 18 and 44;
- are a resident of Pennsylvania;
- are a U.S. citizen or has satisfactory immigration status for MA;
- have income at or below 185 percent of the Federal Poverty Level (FPL);
- are not otherwise eligible for MA;
- have no other insurance coverage for family planning services; and
- are not pregnant or sterilized.

Scope of Covered Services

SelectPlan for Women covers family planning services for eligible recipients identified according to the conditions provided under Population Groups Impacted. Family planning includes medically necessary services, drugs, and supplies related to birth control, pregnancy prevention, and preventive services. Family planning services include contraceptive management for a variety of methods, recipient education, counseling, and referral as needed to other health care providers and social services. The services covered under the waiver program are listed in Appendix E.

Program Administration

The Office of Medical Assistance Programs (OMAP) within the Pennsylvania Department of Public Welfare (DPW) administers the SelectPlan for Women Program. The program is solely administered under the Fee-for-Service (FFS) delivery system. The bureaus within OMAP are responsible for the following specific functions to implement the program:

- Bureau for Fee-for-Service Program – performs rate-setting under the waiver and handles all operations including provider enrollment, inquiry, and training.
- Bureau of Data and Claims Management – coordinates FFS claims under the waiver.
- Bureau of Policy, Analysis and Planning – responsible for planning and budgeting under this waiver including preparing waiver-related reports and monitoring budget neutrality.
- Bureau of Program Integrity – responsible for protecting this waiver project from fraud, abuse and waste.
- Office of Income Maintenance (OIM) – administers eligibility for the waiver program.
- Office of the Medical Director – supports the quality-related aspects of this waiver project.

Requirements for the Evaluation in the Special Terms and Conditions

Under the Special Terms and Conditions of the approval of the program, CMS requires submission of an evaluation report of the Program at the end of the demonstration period. The evaluation must assess the impact of providing referrals for primary care services, the program's budget neutrality, and the hypotheses that were developed in the evaluation plan to evaluate the effects of the program.

Hypotheses Tested to Determine the Outcomes of the Demonstration

For the program evaluation purposes, seven hypotheses were developed, which the program is expected to have impact on.

Hypothesis #1: *The demonstration will result in an increase in appropriate use of effective forms of birth control among recipients aged 18 to 44.*

Hypothesis #2: *The demonstration will result in a decrease in the annual rate of Medical Assistance-paid deliveries for women aged 18 to 44.*

Hypothesis #3: *The demonstration will result in a decrease in the proportion of women, ages 18 to 44, with a Medical Assistance-paid delivery within 18 months of a previous Medical Assistance-paid delivery.*

Hypothesis #4: *Over the five- year period of the waiver, the demonstration will produce net annual savings in Federal and State expenditures for birth-related services.*

Hypothesis #5: *Waiver recipients will likely be satisfied with the services they receive under the demonstration.*

Hypothesis #6: *The demonstration waiver will result in an increase in referrals to Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) for primary care services for recipients.*

Hypothesis #7: *Referrals made as part of the demonstration waiver will result in an increase in primary care services provided to waiver recipients by Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs).*

EVALUATION DESIGN

Organization Conducting the Evaluation

In order for the Department to monitor the ongoing and overall effectiveness of the program, the Evaluation and Analysis Section in the Bureau of Policy, Analysis and Planning of the Office of Medical Assistance Programs conducted the evaluation. The section provided support for program evaluation, budget neutrality monitoring, and other data support during the waiver period. The section had no direct program management responsibilities.

Evaluation Target

To evaluate the program's effectiveness, the target population included only those who enrolled in the program and were in the Category and Program Status Code of PSF/00 during the life of the waiver between February 1, 2008 and May 31, 2012[1]. These recipients were female aged between 18 and 44 at the time of enrollment. The data of female recipients in other MA eligible categories aged between 18 and 44 were collected for comparison analysis.

Methods of Data Collection

The following two sources of data were used for the purposes of evaluating the waiver demonstration:

- *Annual Recipient Survey*
  To collect recipient data for program evaluation, three annual recipient surveys were conducted approximately 45 days after the end of each demonstration year of 2009, 2010 and 2011 (Appendix A, Appendix B, and Appendix C). Specifically, the survey provides information for four of the seven hypotheses established in the evaluation plan. These four hypotheses are related to the use of effective forms of contraceptives by the recipients participating in the program, recipient's satisfaction with the program, and the degree to which women in the program are referred for and receive primary care services when necessary. The survey instrument was mailed to 5,000 randomly sampled recipients in 2009, 15,000 in 2010, and 20,000 in 2011. These recipients were enrolled in the program for more than 60 days during the corresponding year. Responses were recorded in a database and an annual report on each survey was released.

- *Pennsylvania Medicaid Management Information Systems (MMIS) Data*
  Data made available from the Pennsylvania's MMIS, which is referred to as Provider Reimbursement and Operations Management Information System (PROMISe), include MA eligibility data, waiver enrollment data, the FFS waiver claim data, and MA-paid delivery data. These sets of data were utilized in answering questions to evaluate the program's effectiveness.

[1] Though the evaluation covers the life of the waiver through May 31, 2012, due to availability of data the analysis was based on data through March 2012.

EVALUATION OF HYPOTHESES

The evaluation tested the following seven hypotheses to determine the degree to which the program accomplished its objectives.

- ***Hypothesis #1:*** *The demonstration will result in an increase in appropriate use of effective forms of birth control among recipients aged 18 to 44.*

Process of Evaluation:

This hypothesis is based on the assumption that the program will result in an increase in the number of women, aged 18 to 44, who received Medical Assistance-paid family planning services and who used effective forms of birth control. An increase in effective use of birth control will result in decreased Medical Assistance-paid deliveries, which will translate to State and Federal savings.

The measurement to test the hypothesis is the rate of recipients aged 18 to 44 who appropriately used effective forms of birth control. In order to obtain the measurement, the number of recipients who used an effective form of birth control prior to and after receiving the program services will be compared. The number will be based on the responses provided on the annual recipient surveys.

Three annual Recipient Surveys were conducted after the end of each demonstration year. The survey asked respondents to report the main birth control method they used for the week before the application for the program, the birth control method provided by the program, and the main birth control method they used at the time of response. The numbers of responses by the type of birth control method were collected for the pre and post program enrollment.

For the purpose of evaluation, the responses were grouped into the following five types:

1. Abstinence
2. More Effective – Rates of unintended pregnancy less than 1% when used properly[2]: This includes the following types of methods: pills, shots, implant, patch, IUD, Nuva Ring®, tubal ligation, hysterectomy, and vasectomy of the recipient's partner.
3. Less Effective – Rates of unintended pregnancy is 1% or higher when used properly[2]: This includes the following types of methods: condoms, withdrawals, diaphragm and spermicide.
4. No Method
5. No Answer

[2] World Health Organization Department of Reproductive Health and Research (WHO/RHR) and Johns Hopkins Bloomberg School of Public Health/ Center for Communication Programs (CCP), INFO Project. Family Planning: A Global Handbook for Providers. Baltimore and Geneva: CCP and WHO, 2007. Also used in Washington State Department of Social and Health Services, Take Charge, Final Evaluation First Five Years: July 2001 – June 2006, 2006

Findings and Analysis:

The following table provides information on the type of birth control used before enrollment in SelectPlan for Women and after enrollment in the program for years. The type of birth control method was divided into five categories based on effectiveness as suggested above. For each survey year, the proportion of respondents using each type of birth control method prior to and after program enrollment was calculated.

Table 1: Responses by Type of Birth Control Method before and After Enrollment

Survey Year	Type of Birth Control Method*	Before	Before %	After	After %
1st Year – 2009 (N=991)	Abstinence	62	6.26%	57	5.75%
	More Effective	489	49.34%	648	65.39%
	Less Effective	193	19.48%	101	10.19%
	No Method	161	16.25%	126	12.71%
	No Answer	86	8.68%	59	5.95%
	TOTAL	**991**	**100.00%**	**991**	**100.00%**
2nd Year – 2010 (N=3,022)	Abstinence	157	5.20%	139	4.60%
	More Effective	1,648	54.50%	2,118	70.10%
	Less Effective	710	23.50%	360	11.90%
	No Method	471	15.60%	363	12.00%
	No Answer	36	1.20%	42	1.40%
	TOTAL	**3,022**	**100.00%**	**3,022**	**100.00%**
3rd Year – 2011 (N=2,280)	Abstinence	174	7.63%	146	6.40%
	More Effective	1,054	46.23%	1,494	65.53%
	Less Effective	544	23.86%	240	10.53%
	No Method	473	20.75%	375	16.45%
	No Answer	35	1.54%	25	1.10%
	TOTAL	**2,280**	**100.00%**	**2,280**	**100.00%**

* The More Effective types include pills, shot, implant, patch, IUD, Nuva Ring®, tubal ligation, hysterectomy and vasectomy. The Less Effective types include condoms, withdrawals, diaphragm, spermicide and "Natural Method".

1st Year – 2009:

- The 991 responses on birth control usage before and after program enrollment from the first survey year are presented in Table 1:

  - ✓ Nearly 50% (489) of the respondents indicated that they used a More Effective birth control method before enrollment.
  - ✓ Approximately 65% (648) of the respondents indicated they were using a More Effective type of birth control method after program enrollment.
  - ✓ Similarly, the number of respondents that used a Less Effective or No Method of birth control decreased from 354 (36%) before enrollment to 227 (23%) after the program.

2nd Year – 2010:

- The 3,022 responses on birth control usage before and after program enrollment from the second survey year are presented in Table 1:

  - ✓ Nearly 55% (1,648) of the respondents indicated that they used a More Effective birth control method before enrollment.
  - ✓ Approximately 70% (2,118) of the respondents indicated they were using a More Effective type of birth control method after program enrollment.
  - ✓ Similarly, the number of respondents that used a Less Effective or No Method of birth control decreased from 1,181 (39%) before enrollment to 723 (24%) after the program.

3rd Year – 2011:

- The 2,280 responses on birth control usage before and after program enrollment from the third survey year are presented in Table 1:

  - ✓ Nearly 46% (1,054) of the respondents indicated that they used a More Effective birth control method before enrollment.
  - ✓ Approximately 66% (1,494) of the respondents indicated they were using a More Effective type of birth control method after program enrollment.
  - ✓ Similarly, the number of respondents that used a Less Effective or No Method of birth control decreased from 1,017 (45%) before enrollment to 615 (27%) after the program.

Three Year Comparison:

Comparatively, the percentage of women using both Abstinence and More Effective Methods of birth control increased 15% in demonstration waiver years 2008/2009 and 2009/2010 from before to after program enrollment. The percentage of women using both Abstinence and More Effective Methods of birth control increased 18% in demonstration year 2010/2011 from before to after program enrollment. These trends support our hypothesis that the program would increase the use of effective forms of birth control.

The number of women using Less Effective or No Methods of birth control from before to after program enrollment decreased 13% in the first year, 15% in the second year and 18% in the third year. The recipient responses surrounding birth control usage indicate a decrease in the use of methods understood to be less effective in preventing pregnancy. This also supports Hypothesis 1.

***Hypothesis #2**: The demonstration will result in a decrease in the annual rate of Medical Assistance-paid deliveries for women aged 18 to 44.*

Process of Evaluation:

This hypothesis was evaluated to determine if the annual rate of Medical Assistance-paid deliveries for the target population decreased after the implementation of the Waiver. It was expected that the expansion of family planning services provided by the Waiver would decrease the rate of paid deliveries due to improved access to the family planning services, thereby preventing unplanned and/or unintended pregnancies.

The measurement to test the hypothesis is the rate of Medical Assistance –paid deliveries for women aged 18 and 44. In order to obtain the measurement, the number of Medical Assistance-paid deliveries for women aged 18 to 44 during the waiver period and the numbers of Medical Assistance-paid deliveries during the three year period prior to the demonstration will be used. The data was aggregated by quarter and age group. Age groups are defined as ages: 18-20, 21-24, 25-29, 30-34, and 35-44.

The delivery data were extracted from the Pennsylvania MMIS system (PROMISe), as identified as the Fee-for-Service (FFS) paid inpatient claims with a delivery-related DRG and the maternity capitation payment records paid to the Medical Assistance managed care organizations. The numbers of Medical Assistance eligible recipients were obtained from the Client Information System (CIS) to calculate the rates.

Findings and Analysis:

The following table provides information on birth rate for eligible female recipients. The rates were determined by dividing the number of deliveries by the number of eligible recipients, and then multiplying by 1,000 to get the delivery rate per 1,000 Medical Assistance eligible recipients aged 18 to 44.

The table includes data for 2008, or the year of program implementation, through the end of the fourth quarter 2010.

Table 2: Medical Assistance Paid Deliveries per 1,000 Eligible Female Recipients by Age Group, Services between 6/1/2008 and 11/30/2010*

	Age 18-20			Age 21-24			Age 25-29			Age 30-34			Age 35-44			All Age		
	Eligible Recipients	Recipients with Deliveries	Rate per 1,000	Eligible Recipients	Recipients with Deliveries	Rate per 1,000	Eligible Recipients	Recipients with Deliveries	Rate per 1,000	Eligible Recipients	Recipients with Deliveries	Rate per 1,000	Eligible Recipients	Recipients with Deliveries	Rate per 1,000	Eligible Recipients	Recipients with Deliveries	Rate per 1,000
2008																		
Q1	66,479	3,139	47.2	64,559	4,558	70.6	73,896	3,875	52.4	56,693	1,753	30.9	97,240	924	9.5	358,867	14,249	39.7
Q2	67,531	3,072	45.5	65,143	4,510	69.2	74,409	3,566	47.9	57,806	1,755	30.4	97,401	880	9.0	362,290	13,783	38.0
Q3	69,082	3,060	44.3	65,963	4,359	66.1	74,515	3,666	49.2	58,290	1,697	29.1	97,387	901	9.3	365,237	13,683	37.5
Q4	70,864	3,102	43.8	67,012	4,325	64.5	75,186	3,717	49.4	59,045	1,750	29.6	97,609	916	9.4	369,716	13,810	37.4
TOTAL	**81,892**	**12,373**	**151.1**	**81,096**	**17,752**	**218.9**	**90,280**	**14,824**	**164.2**	**69,451**	**6,955**	**100.1**	**114,619**	**3,621**	**31.6**	437,338	55,525	**127.0**
2009																		
Q1	72,693	3,074	42.3	67,352	4,689	69.6	75,449	3,900	51.7	59,467	1,861	31.3	97,455	1,003	10.3	372,416	14,527	39.0
Q2	74,057	3,090	41.7	67,780	4,546	67.1	75,856	3,751	49.4	60,367	1,881	31.2	97,511	938	9.6	375,571	14,206	37.8
Q3	75,088	3,050	40.6	68,120	4,451	65.3	75,487	3,691	48.9	60,390	1,889	31.3	96,599	967	10.0	375,684	14,048	37.4
Q4	76,742	2,891	37.7	69,825	4,384	62.8	76,603	3,828	50.0	61,967	1,868	30.1	97,937	992	10.1	383,074	13,963	36.4
TOTAL	**87,502**	**12,105**	**138.3**	84,144	**18,070**	**214.8**	91,792	**15,170**	**165.3**	72,590	**7,499**	**103.3**	114,265	**3,900**	**34.1**	450,293	56,744	**126.0**
2010																		
Q1	77,414	2,926	37.8	70,291	4,588	65.3	77,868	4,056	52.1	63,586	2,065	32.5	99,404	1,006	10.1	388,563	14,641	37.7
Q2	77,329	2,900	37.5	70,430	4,536	64.4	78,392	3,917	50.0	64,586	2,100	32.5	100,063	966	9.7	390,800	14,419	36.9
Q3	77,691	2,754	35.4	70,866	4,489	63.3	78,900	3,842	48.7	65,465	1,929	29.5	100,823	1,010	10.0	393,745	14,024	35.6
Q4	77,765	2,610	33.6	71,823	4,194	58.4	80,024	3,845	48.0	66,706	2,039	30.6	102,084	999	9.8	398,402	13,687	34.4
TOTAL	**89,941**	**11,190**	**124.4**	**87,400**	**17,807**	**203.7**	**95,020**	**15,660**	**164.8**	**78,087**	**8,133**	**104.2**	**118,041**	**3,981**	**33.7**	**468,489**	**56,771**	**121.2**

*Each year starts on June 1 and ends on May 31 based on the Waiver effective date on June 1, 2007. The age was determined on the date of the delivery.
** The total eligible recipient count per year does not add up to the sum of each quarter based on duplications.

- The rate of births per 1,000 MA eligible women for all age groups steadily decreased to from 127.0 in 2008 to 121.2 in 2010.

- The birth rate per 1,000 MA eligible women decreased for those in the age group of 18-20 from 151.1 per 1,000 in 2008 to 124.4 per 1,000 in 2010. This age group represented the largest rate decrease in births per 1,000.

- The birth rate per 1,000 MA eligible women steadily declined for those in the age group 21-24 from 218.9 in 2008 to 203.7 per 1,000 in 2010. This age group represented the second largest rate decrease in births per 1,000.

- The birth rate per 1,000 MA eligible women for those in the age group 25-29 increased slightly from164.2 per 1,000 in 2008 to 165.3 per 1,000 in 2009. Then, the rate for this age group decreased to 164.8 births per 1,000 representing an overall

increase in rate per 1,000. Though the birth rate for those in the 25-29 age group showed a slight overall increase, the number stayed approximately the same fluctuating by only one point over the 3 years.

- The birth rate per 1,000 MA eligible women slightly increased for those women in the 30-34 and 35-44 age groups. For example, for those in the age group 30-34 the birth rate per 1,000 women increased from 100.1 per 1,000 in 2008 to 104.2 per 1,000 in 2010. For those in the age group 35-44 the birth rate per 1,000 women increased from 31.6 per 1,000 in 2008 to 33.7 in 2010.

The two oldest age groups posted small increases in the birth rate per 1,000 MA eligible women from 2008 to 2010, but the overall birth rate decreased over the life of the waiver. This data suggests support for the hypothesis regarding the demonstration resulting in a decrease in annual rate of Medical Assistance-paid deliveries for women in the eligible age range.

Hypothesis #3: *The demonstration will result in a decrease in the proportion of women, ages 18 to 44, with a Medical Assistance-paid delivery within 18 months of a previous Medical Assistance-paid delivery.*

Process of Evaluation:

One of the objectives of SelectPlan for Women is to improve birth outcomes and the health of women by increasing the child spacing interval (also referred to as the interbirth or inter-pregnancy interval) among women in the target population. Women who conceive a pregnancy within 18 months of a live birth are considered to have a short interbirth interval. Research has shown that women with a short interbirth interval increase the odds for prematurity and they are more likely to have a low birth weight baby. Low birth weight newborns have a greater chance of requiring neonatal intensive care.

The SelectPlan for Women program offers women access to contraceptives and other family planning services so they can take the steps to avoid unintended pregnancies within the 18 month period. This hypothesis was tested to determine if the program achieved this objective.

The measurement to test the hypothesis is the proportion of women aged 18 to 44 with two Medical Assistance-paid deliveries within 18 months of one another. The delivery data were extracted from the Pennsylvania MMIS system (PROMISe), as identified as the Fee-for-Service (FFS) paid inpatient claims with a delivery-related DRG and the maternity capitation payment records paid to the Medical Assistance managed care organizations. These claims and capitation payment data identified instances of deliveries, and the instances of women aged 18 to 44 who have had a subsequent Medical Assistance-paid delivery within 18 months.

Findings and Analysis:

The following table provides information on births to waiver participants. These birth records occurred between August 1, 2008 (six months after the implementation of the waiver program) and March 26, 2012.

Table 3: Summary of SelectPlan Recipients having Birth Records after Receiving SelectPlan Services

Deliveries per Recipient	Recipients	Count of Deliveries
1 Delivery	9,155	9,155
2 Deliveries	14	28
Total	**9,169**	**9,183**

- Between August 1, 2008, and January 10, 2012 (which is the most recent date of delivery available in the data extraction from March 2012), there were 9,169 distinct SelectPlan recipients that had a birth event after receiving SelectPlan services. This suggests that 8%, or a birth rate of 78.7 per 1,000 recipients, of the women who received SelectPlan services over the life of the waiver later became pregnant.

- These 9,169 SelectPlan recipients accounted for 9,183 deliveries.

- Of those SelectPlan recipients with recorded birth events, 14 had multiple births events. However, for each of these 14 women with multiple birth events only one birth events occurred while enrolled in SelectPlan.

There is currently not enough data to appropriately assess Hypothesis 3. As previously stated, the number of women with multiple births events was 14. Of those women, none are eligible for analysis based on the birth spacing occurring less than 18 months apart as only one of the two birth events occurred while enrolled in SelectPlan. There are no observations in the three year dataset to determine if the program decreased the number of deliveries within an 18 month period of a previous delivery.

This limitation in the data provides support for the renewal of the SelectPlan waiver as to enable analysis with additional years of data. Renewing the waiver would provide additional time and data for analysis of this hypothesis.

***Hypothesis #4**: Over the five- year period of the waiver, the demonstration will produce net annual savings in Federal and State expenditures for birth-related services.*

Process of Evaluation:

This hypothesis was tested to determine if the Medical Assistance coverage of the population group impacted and the scope of services covered produced savings in expenditures for birth-related services after the implementation of the Waiver in February 2008 and, if so, how much. The hypothesis was tested through the budget neutrality calculation process, outlined by CMS in the Terms and Conditions document. The number of averted births was calculated by taking the difference between the actual Medical Assistance-paid births and the initial projected number of births, and then multiplying the difference by the average expenditure per birth. The formula expressing the estimated savings is listed below:

(Births Averted X Average Delivery Cost) – Program Cost = Net Savings

Findings and Analysis:

Table 4 presents information on births averted. Using the average cost of a Medical Assistance-paid delivery, which includes all paid Medical Assistance FFS claims covering nine months prior to and two months after the delivery in the FFS delivery system, and the cost of managed care maternity care payments that compensated for five months prenatal and two months postpartum in the managed care delivery system, the total cost of deliveries averted was calculated by multiplying the average cost by the estimated number of averted births.

Table 4: Analysis of Births Averted in 2008/2009 and 2009/2010 based on Maternal Delivery and Infant Costs

Year	Projected Births	Actual Births	Difference	Average Expenditure	Cost Averted	Annual Waiver Cost	Total Savings
2008/2009	58,495	55,525	2,970	$17,969.00	$53,367,930.00	$10,038,350.00	**$43,329,580.00**
2009/2010	60,835	56,744	4,091	$20,583.00	$84,205,053.00	$13,672,412.00	**$70,532,641.00**
Total	**119,330**	**112,269**	**7,061**	**n/a**	**$137,572,983.00**	**$23,710,762.00**	**$113,862,221.00**

- During the 2008/2009 demonstration year, 2,970 fewer births occurred than were previously projected. This difference was estimated to be about $53,367,930.00 in averted costs. When factoring in the waiver cost, the total savings for 2008/2009 was $43,329,580.00.

- During the 2009/2010 demonstration year, 4,091 fewer births occurred than were previously projected. This difference was about $84,205,053.00 in averted costs. When factoring in the waiver cost, the total savings for 2009/2010 was $70,532,641.00.

- Over the course of the two years, a total of 7,061 births were averted based on the initial projections. The difference was about $137,572,983.00 in averted costs. After factoring in the waiver cost over the two years, the total savings was $113,862,221.00.

Table 5 compares costs of deliveries under MA and first year infant costs under MA with and without the demonstration. The numbers for the base year with demonstration were based on projections asserted in the original waiver application.

Table 5: Budget Neutrality Information

		Base Year	Implementation Years			
		2006/2007	2007/2008	2008/2009	2009/2010	TOTAL
WITHOUT DEMONSTRATION						
FAMILY PLANNING SERVICES UNDER MEDICAID STATE PLAN -- All current Medicaid eligibles/participants	Persons	96,628	100,493	104,513	108,694	
	Cost per Person	$ 200.00	$ 209.00	$ 218.00	$ 227.00	
	Total	$ 19,325,600.00	$ 21,003,037	$ 22,783,834	$ 24,673,538	$ 87,786,009
DELIVERIES UNDER MEDICAID STATE PLAN (include costs for prenatal care, deliveries, and 60- days postpartum)	Persons	54,082	56,245	58,495	60,835	175,575
	Cost per Person	$ 9,351.00	$ 9,734.00	$ 10,172.00	$ 10,609.00	
	Total	$ 505,720,782	$ 547,488,830	$ 595,011,140	$ 645,398,515	$ 1,787,898,485
FIRST YEAR INFANT COSTS UNDER MEDICAID STATE PLAN	Persons	54,082	56,245	58,495	60,835	175,575
	Cost per Person	$ 8,595.00	$ 8,947.00	$ 9,350.00	$ 9,752.00	
	Total	$ 464,834,790	$ 503,224,015	$ 546,928,250	$ 593,262,920	$ 1,643,415,185
TOTAL WITHOUT-WAIVER COSTS		$ 986,801,347	$ 1,068,308,787	$ 1,161,058,630	$ 1,259,397,669	$ 3,488,765,086
WITH DEMONSTRATION						
FAMILY PLANNING SERVICES UNDER MEDICAID STATE PLAN -- All current Medicaid eligibles/participants	Persons	96,628	100,493	104,513	108,694	
	Cost per Person	$ 200.00	$ 209.00	$ 218.00	$ 227.00	
	Total	$ 19,325,600	$ 21,003,037	$ 22,783,834	$ 24,673,538	$ 87,786,009
DELIVERIES UNDER MEDICAID STATE PLAN ADJUSTED FOR EFFECTS OF THE DEMONSTRATION (include costs for prenatal care, deliveries, and 60- days postpartum)	Persons	50,296	55,730	55,525	56,744	167,999
	Cost per Person	$ 9,351.00	$ 10,191.00	$ 10,494.00	$ 10,709.00	
	Total	$ 470,317,896	$ 567,944,430	$ 582,679,350	$ 607,671,496	$ 1,758,295,276
FIRST YEAR INFANT COSTS ADJUSTED FOR EFFECTS OF THE DEMONSTRATION	Persons	50,296	55,730	55,525	56,744	167,999
	Cost per Person	$ 8,595.00	$ 8,852.00	$ 7,475.00	$ 9,874.00	
	Total	$ 432,294,120	$ 493,321,960	$ 415,049,375	$ 559,893,048	$ 1,468,264,383
FAMILY PLANNING SERVICES FOR DEMONSTRATION PARTICIPANTS	Persons	112,154	19,069	46,690	56,732	122,491
	Cost per Person	$ 139.00	$ 108.00	$ 215.00	$ 241.00	
	Total	$ 15,589,350	$ 2,059,452	$ 10,038,350	$ 13,672,412	$ 25,770,214
TOTAL WITH DEMONSTRATION COSTS		$ 934,447,141	$ 1,085,636,922	$ 1,036,836,080	$ 1,215,739,100	$ 3,338,212,102
DIFFERENCE		$ 52,354,206	$ (17,328,135)	$ 124,222,550	$ 43,658,569	**$ 150,552,984**
PARAMETER ASSUMPTIONS						
FP FMAP =	90.00%	**REGULAR FMAP**		54.56%	**MCPI COST TREND**	4.30%

Table 5 shows the following information:

- In the first implementation year, or demonstration year 2007/2008, there was a lack of savings as projected in the original waiver application. This represented a deficit amount of $17,328,135.

- In the second implementation year, or demonstration year 2008/2009, there was a savings of $124,222,550.

- In the third implementation year, or demonstration year 2009/2010, there was a savings of $43,658,569.

This information suggests, including the first year deficit, the demonstration created a savings of $150,552,984. The increase in savings across the demonstration period lends support for Hypothesis 4.

***Hypothesis #5**: Waiver recipients will likely be satisfied with the services they receive under the demonstration.*

Process of Evaluation:

Women enrolled in SelectPlan receive family planning services at no cost. The program provides these recipients the freedom to choose their provider of family planning services. In consultation with the service provider, SelectPlan recipients choose the birth control method that best fits their personal situation. Freedom of choice, increased access to services, and high quality of service delivery affects the satisfaction of recipients in the program.

It was hypothesized that the more satisfied recipients are with the program, the more likely they are to adhere to the program, as indicated by showing up for appointments, following physician instructions, and consequently resulting in better health outcomes, and Federal and State savings. The hypothesis was tested to determine the rate of waiver enrollees who were satisfied with the services.

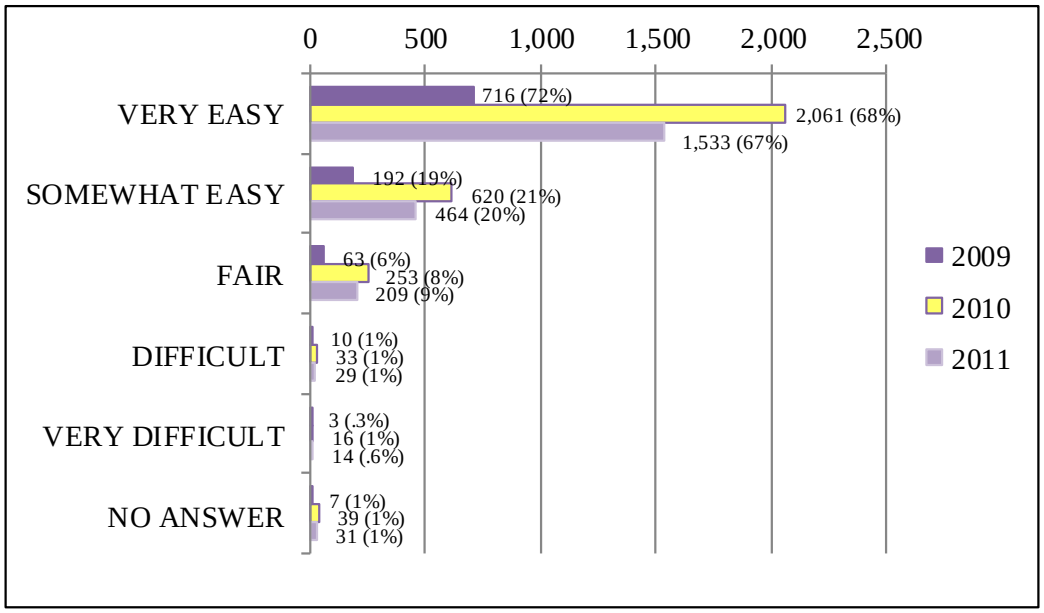
An annual survey of the program enrollees was conducted three times; at the end of each demonstration year starting in March 2009. A sample of randomly selected enrollees completed the survey, which included questions that assessed recipients' satisfaction with the program, as well as recipients' contraception behaviors and providers' primary care referrals.

The survey instrument included ten indicators of satisfaction. These ten indicators included information on ease of application, satisfaction with the application process, ease of information, knowing who to call, knowing what services are covered, ease of access to family planning services, intention to renew, belief that more women should be told about the program, recommending the program to others, and overall happiness with the program. The percentages of respondents who indicated satisfaction with these items were calculated and compared for three years.

Findings and Analysis:

The following figure presents the respondents' answers regarding the ease of application process as reported during each year's survey.

Figure 1: Perception of Ease of SelectPlan for Women Application Process, 2009, 2010 & 2011



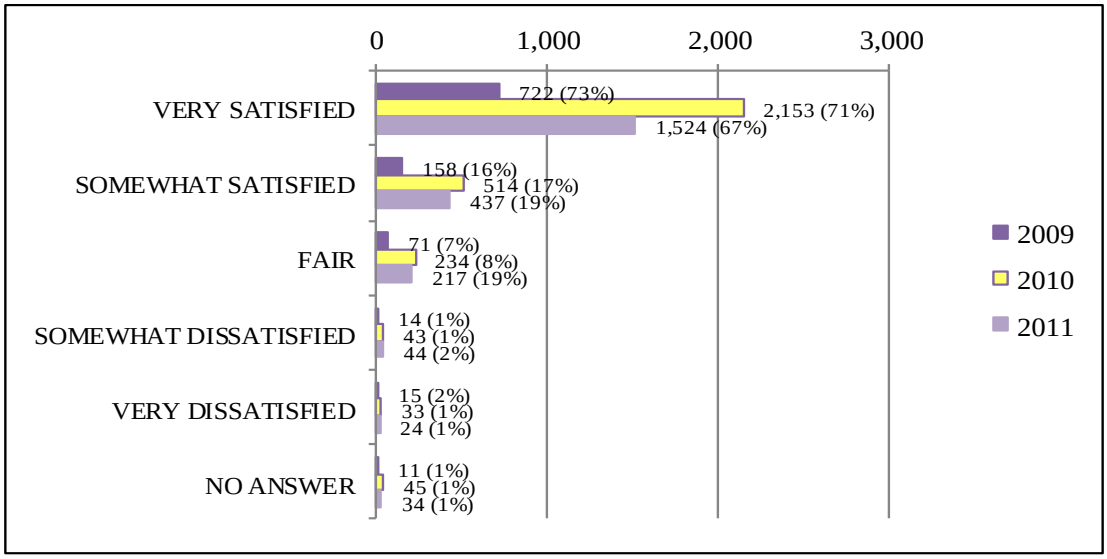
*Percentages may not equal to 100% due to rounding.

- In 2009, nearly 92% (908) of the respondents indicated that it was very easy or somewhat easy to apply for the program.
- In 2010, nearly 89% (2,681) of the respondents indicated that it was very easy or somewhat easy to apply for the program.
- In 2011, nearly 88% (1,997) of the respondents indicated that it was very easy or somewhat easy to apply for the program.
- For each year, less than one percent of the respondents indicated that it was difficult, very difficult, or failed to answer the question.

Figure 1 shows consistency across the three years in the percentages of selected responses. Each year, over 87% of the respondents indicated that the application process was somewhat or very easy. Ease of application as shown by high percentage of favorable responses is an indication of a recipient's overall satisfaction with the SelectPlan for Women program. In this case, the overwhelming response of somewhat or very easy supports our hypothesis that the program will satisfy the recipients.

Similar to the question regarding the ease of application, Figure 2 shows the level of the respondents' satisfaction with the application process as reported during each year's survey.

Figure 2: Satisfaction with SelectPlan for Women Application Process, 2009, 2010, & 2011



*Percentages might not equal 100% due to rounding.

- In 2009, nearly 89% (880) of the respondents indicated that they were very satisfied or somewhat satisfied with the application process.
- In 2010, approximately 88% (2,667) of the respondents indicated that they were very satisfied or somewhat satisfied with the application process.
- In 2011, approximately 86% (1,961) of the respondents indicated that they were very satisfied or somewhat satisfied with the application process.
- For each year, less than two percent of the respondents indicated that they were somewhat dissatisfied, very dissatisfied, or failed to provide an answer.

Figure 1 and Figure 2 show consistency of responses across the three years' surveys. Each year over 86% of the respondents indicated being satisfied with the application process. This result adds further support for Hypothesis 5.

The following table presents information on the remaining eight indicators of satisfaction across three survey years.

Table 6: Agree/Disagree Statements about SelectPlan for Women

Survey Question	2009			2010			2011		
	AGREE	DISAGREE	NO ANSWER	AGREE	DISAGREE	NO ANSWER	AGREE	DISAGREE	NO ANSWER
INFORMATION I GET ABOUT SELECTPLAN IS EASY TO READ AND UNDERSTAND	885	74	32	2,704	191	127	2,007	169	104
I KNOW WHO TO CALL IF I HAVE QUESTIONS ABOUT USING SELECTPLAN	590	367	34	1,783	1,120	119	1,308	875	97
I KNOW WHAT SERVICES SELECTPLAN WILL PAY FOR	603	351	37	1,721	1,173	128	1,315	864	101
IT IS EASIER FOR ME TO GET FAMILY PLANNING SERVICES NOW THAT I HAVE SELECTPLAN	816	119	56	2,439	382	201	1,773	342	165
I WILL RENEW MY SELECTPLAN FOR ANOTHER YEAR**	853	87	51	2,535	297	190	n/a	n/a	n/a
MORE WOMEN SHOULD BE TOLD ABOUT SELECTPLAN	939	15	37	2,831	44	147	2,103	49	128
I HAVE RECOMMENDED OTHERS TO SIGN-UP FOR SELECTPLAN	714	232	45	2,795	70	157	2,048	96	136
OVERALL, I AM HAPPY WITH SELECT PLAN*	n/a	n/a	n/a	2,686	159	177	1,966	168	146

*This question was added to the second year survey instrument. Data is unavailable for 2009.
**This question was removed from the third year instrument. Data is unavailable for 2011.

2009:

- The first year survey responses on attitudes about SelectPlan for Women are presented above in Table 6:

  - ✓ Among 959 respondents who provided a response, about 90% (885) indicated that the information about the program is easy to read and understand.
  - ✓ Among 935 respondents who provided a response, about 87% (816) indicated that it is easier to get family planning services with SelectPlan.
  - ✓ Among 954 respondents who provided a response, about 98% (939) indicated that more women should be told about SelectPlan.

2010:

- The second year survey responses on attitudes about SelectPlan for Women are presented above in Table 6:

  - ✓ Among 2,895 respondents who provided a response to the question related to information about SelectPlan for Women, about 93% (2,704) indicated that the information was easy to read and understand.
  - ✓ About 98% (2,795) of the respondents indicated that they would recommend others to sign-up for SelectPlan.
  - ✓ Among 2,845 respondents who provided a response to the question related to the overall satisfaction with the program, approximately 94% (2,686) of the respondents indicated being happy with the program overall.

2011:

- The third year survey responses on attitudes about SelectPlan for Women are presented above in Table 6:

  - ✓ Among 2,176 respondents who provided a response to the question related to information about SelectPlan for Women, about 92% (2,007) indicated that the information was easy to read and understand.
  - ✓ About 95% (2,048) of the respondents indicated that they would recommend others to sign-up for SelectPlan.
  - ✓ Among 2,134 respondents who provided a response to the question related to the overall satisfaction with the program, approximately 92% (1,966) of the respondents indicated being happy with the program overall.

Three Year Comparison:

Based on the survey's 10 indicators of satisfaction, there were eight indicators showing support for respondents' satisfaction with the program. Approximately 90% of the respondents in each year indicated that the application process for the program was somewhat or very easy. Between 85% and 89% of the respondents in each year indicated that they were very or somewhat satisfied with the application process. Over 90% of the respondents in each year suggested that the information from the plan was easy to read and understand. Ninety-eight percent of the respondents in the first year, 92% of the respondents in the second year, and 90% of the respondents in the third year agreed that more women should be told about SelectPlan. In years two and three of the program 95% and 98% of the respondents respectively recommended others to sign-up for SelectPlan. The question about overall satisfaction was added for the second and third year surveys. For each of these two years, over 92% of the respondents indicated being happy overall with SelectPlan. These responses lend support to our hypothesis that program participants would be satisfied with services.

The two indicators that did not clearly suggest support for the hypothesis were "I know who to call if I have questions" and "I know what services SelectPlan will pay for". The responses to these questions suggested a need for improvement in the program's implementation.

***Hypothesis #6**: The demonstration waiver will result in an increase in referrals to Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) for primary care services for recipients.*

Process of Evaluation:

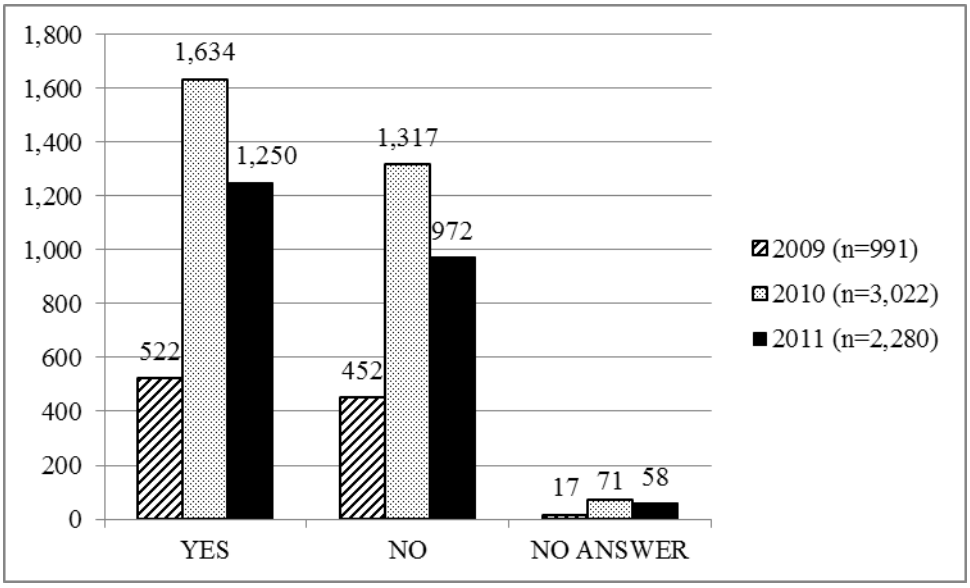
The program was designed not only to provide Family Planning Services to eligible recipients, but also to refer the waiver recipients to Pennsylvania's Federally Qualified Health Centers (FQHCs) and/or Rural Health Clinics (RHCs) for primary care services when the recipients do not have a primary care service provider. This hypothesis was tested to determine the degree to which the recipients in the program were referred for primary care services when necessary.

The three annual surveys of the samples of the program's enrollees included a question regarding whether or not they received referrals for primary care from a family planning service provider. The results of the responses to the question were compared for each year to determine if the rate of primary care referrals provided by family planning service providers increased over the duration of the waiver.

Findings and Analysis:

First, the survey asked the respondents if they had a doctor that provided general health services. If a SelectPlan recipient also had a primary care doctor the recipient would not likely require additional referral to outside providers for general health concerns. The following figure shows the responses for the question regarding whether or not the recipients had a general health practitioner at the time of enrollment in SelectPlan for Women.

Figure 3: Whether or not Respondents had a General Health Care Doctor at the Time of SelectPlan Enrollment



- In 2009, approximately 53% (522) of the respondents indicated having a doctor that provides general health services at the time they signed up for SelectPlan for Women.

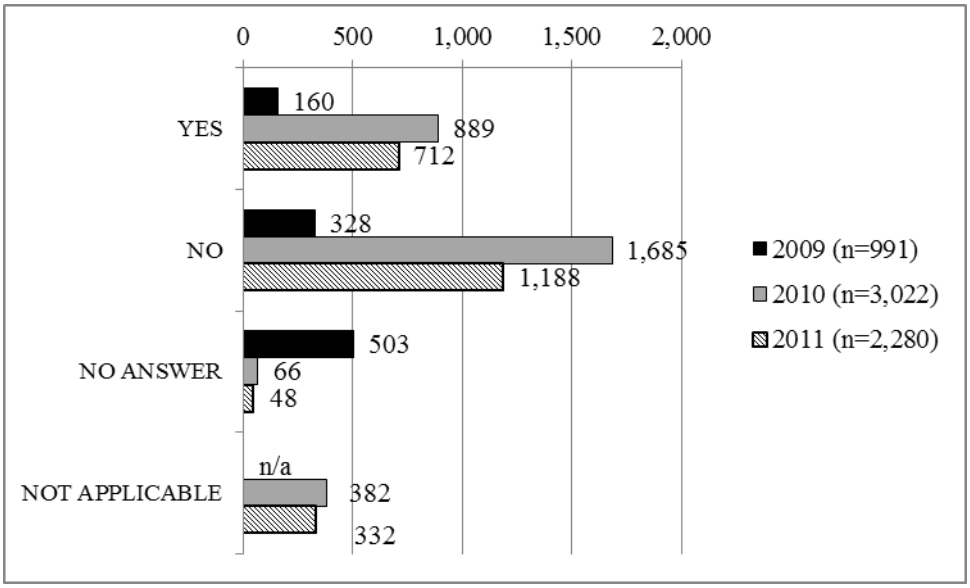
- In 2010, approximately 54% (1,634) of the respondents indicated that they had a doctor that provided general health care services at the time they signed up for SelectPlan for Women.

- In 2011, nearly 55% (1,250) of the respondents indicated that they had a doctor that provided general health care services at the time they signed up for SelectPlan for Women.

- Overall, approximately the same percentage ranging from 53% to 55% of the respondents each year had a general health doctor prior to SelectPlan enrollment.

Second, the survey instrument asked the respondents if their SelectPlan providers talked to them about their general health needs. The following figure addresses this issue.

Figure 4: Whether or not the SelectPlan Providers Talked to Recipients about Other Health Needs



- In 2009, 67% (328) of the respondents indicated that the SelectPlan service providers did not talk about other general health care services. The first year survey did not give respondents the option to select "Not Applicable".

- In 2010, nearly 63% (1,685) of the respondents to which the question was applicable indicated that SelectPlan for Women service providers did not talk to them about other health care needs beyond their family planning needs.

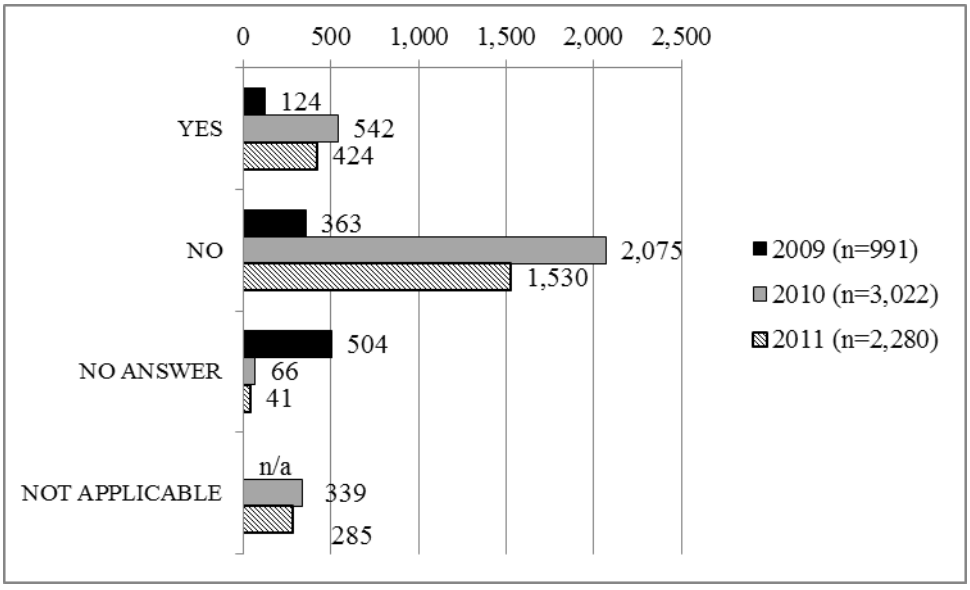
- In 2011, nearly 61% (1,188) of the respondents to which the question was applicable indicated that SelectPlan for Women service providers did not talk to them about other health care needs beyond their family planning needs.

- Each year, over 60% of the respondents indicated that the SelectPlan provider did not talk to them about general healthcare needs.

The review of the responses from the 2009 survey clearly showed that the structure of the general health care doctor question (Figure 3) influenced respondents to inappropriately supply information for the two follow-up questions that talked about healthcare needs and where to go for other health services (Figure 4 and Figure 5). Some respondents that indicated having a general health care doctor also answered the two follow-up questions. On the other hand, some respondents that indicated that they did not have a general healthcare doctor failed to supply responses to the follow-up questions. It seemed the question's instructions were unclear to the respondents. The instrument for the 2010 survey was adjusted accordingly in an effort to yield more unbiased responses. After the adjustment to the wording in the 2010 and 2011 surveys, the response data still suggested that consistent issues exist in the area of discussing other health care needs (Figure 4).

Next, the survey instrument asked the respondents if their SelectPlan providers told them where to go to receive free or low cost general health services. The following figure presents the results of this survey question.

Figure 5: Whether or not the SelectPlan Provider Told the Recipient Where to Go for Other Health Services



- In 2009, about 75% (363) of the respondents indicated that the SelectPlan service providers did not tell them where to go for services. The first year survey did not give respondents the option to select "Not Applicable".

- In 2010, approximately 77% (2,075) of the survey respondents to which the question was applicable reported that the SelectPlan for Women service providers did not talk about where they could go for low cost or free general health care services.

- In 2011, approximately 79% (1,530) of the survey respondents to which the question was applicable reported that the SelectPlan for Women service providers did not talk about where they could go for low cost or free general health care services.

- Each year, over 75% of respondents indicated that the SelectPlan provider did not tell them where to go for low cost health services.

While these questions introduced risk of recollection bias due to the wording and structure of the questionnaire, this information still suggests a need for improvement in the program implementation surrounding the discussion of other health needs and alternate locations to obtain services. As such, the data suggests that a clear position of support for Hypothesis 6 cannot be made.

***Hypothesis #7**: Referrals made as part of the demonstration waiver will result in an increase in primary care services provided to waiver recipients by Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs).*

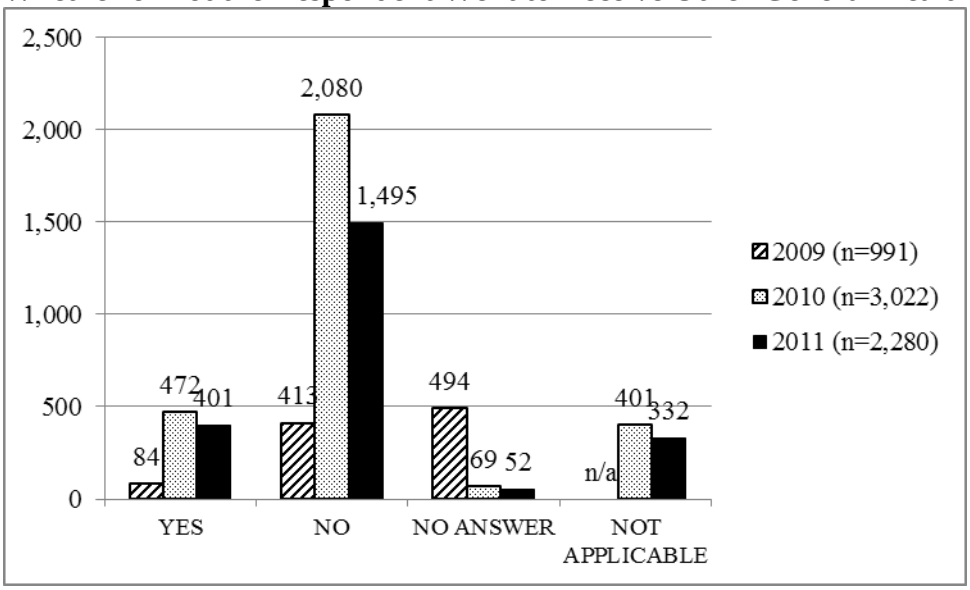
Process of Evaluation:

This hypothesis was analyzed to determine if the referrals made as defined under Hypothesis #6 actually resulted in access to primary care services from FQHCs and/or RHCs. The hypothesis also enabled the Department to assess whether the primary care referrals resulted in delivery of services to the participants. The hypothesis was examined in conjunction with Hypothesis #6, using data obtained from the annual surveys, which included a question regarding whether or not the referred recipient actually went to receive primary care services referred by family planning service providers.

Findings and Analysis:

The following figure refers to the survey question that asks the respondents if they went to receive other health services. While issues surrounding communication of other health needs as highlighted above did not lend support to Hypothesis 6, the data related to receiving other health services also lends minimal support to Hypothesis 7.

Figure 6: Whether or not the Respondent Went to Receive Other General Health Services



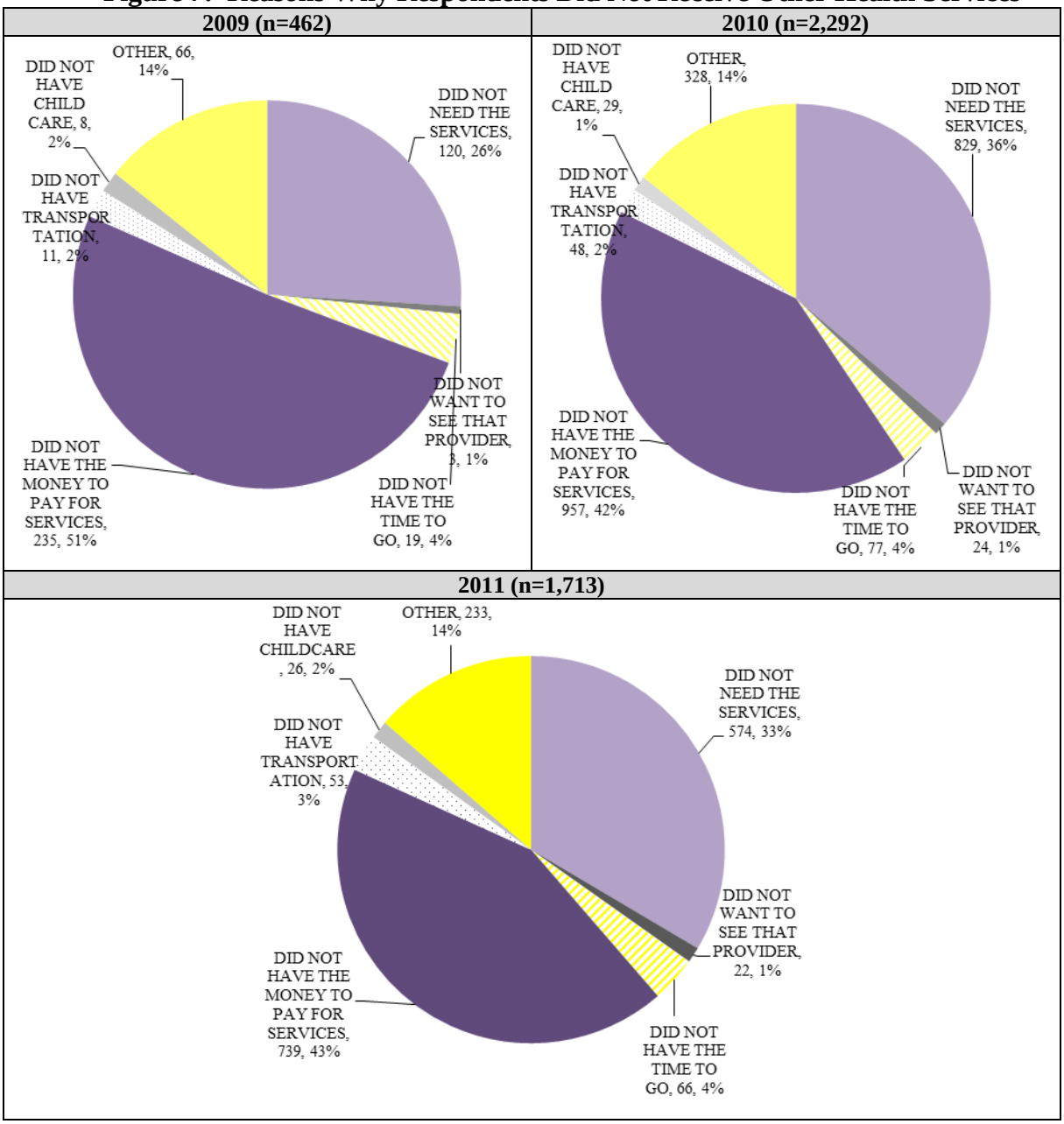
- In 2009, approximately 83% (413) of the respondents indicated that they did not go to receive other health care services. The first year survey did not give respondents the option to select "Not Applicable".

- In 2010, about 79% (2,080) of the respondents indicated that they did not go to receive other health care services.

- In 2011, approximately 77% (1,495) of the respondents indicated that they did not go to receive other health care services.

- The percentage of the respondents indicating that they did not go to receive other health services decreased over the course of the waiver from 83% in the first year to 77% in the third year.

Figure 7: Reasons Why Respondents Did Not Receive Other Health Services



- The most frequently selected response as to the reason for not going to receive other health care services was "I did not have the money to pay for services" as selected by 235

respondents in 2009, 957 respondents in 2010, and 739 respondents in 2011. This suggests a need for improvement in the program that will include a change of respondents' perception about the cost of other health services provided by FQHCs and RHCs.

- The second most frequently selected reason for not going to receive other health services, listed by 120 respondents in 2009, 829 respondents in 2010, and 574 respondents in 2011, was "I did not need the services".

DISCUSSION

Supported Hypotheses:

Based on the results of the Annual Surveys and claims data, we concluded that several of the hypotheses were supported. Analysis of Hypothesis 1 was based on data collected in the annual recipients' survey. This data suggested an increase in the use of effective methods of birth control lending support to Hypothesis 1. The analysis of Hypothesis 2 was based on the data extracted from the Pennsylvania MMIS system (PROMISe). Overall, the rate of births decreased after the SelectPlan for Women program was implemented suggesting support for Hypothesis 2 which postulated that the waiver demonstration would result in a decrease in the annual rate of Medical Assistance-paid deliveries for women in the eligible age ranges. Hypothesis 4 is based on budget neutrality calculations determined by the original waiver application. Over the period of the waiver, the demonstration produced net annual savings, supporting Hypothesis 4.

Hypothesis 5 was also tested using data from the annual survey. Based on the 10 indicators for participants' satisfaction, eight showed positive results for the program. These responses lend support to Hypothesis 5 which indicated that program participants would be satisfied with the family planning services. In addition to the eight indicators lending support for recipients' satisfaction surrounding the program, several respondents wrote comments about the surveys. The comments from SelectPlan for Women recipients included positive feedback such as:

- "I don't know what I would do without SelectPlan! Thank you."
- "Thank you for offering this plan. I don't receive insurance through an employer and it greatly eases monthly/yearly financial strain."
- "You provide a very vital service to young women who cannot afford care. Thank you."
- "This is a great program; I referred my friend to SelectPlan also."
- "Thank you so much! I am grateful for the services you have provided for me and so many other women. SelectPlan is truly unbiased and available! It is helping so many."
- "I would not have any insurance or help with birth control without this plan. Thank you for helping me and others."
- "I think it is a great program. I was on unemployment and I did not have insurance and it helped me. I now have a job and insurance. More people should know about this program."

As suggested by the written comments on the responses, it is clear that SelectPlan has provided a valuable service to women enrolled in the program. The comments corroborate the overall levels of satisfaction captured in the survey instrument.

Unsupported Hypotheses:

Three hypotheses failed to be fully supported. There was not enough data to assess Hypothesis 3 which stated the program would result in a decrease in percent of women ages 18 to 44 having a Medical Assistance-paid delivery within 18 months of a previous Medical Assistance-paid delivery during each year and across program years. The available data included 14 recipients with multiple deliveries of which only one of the birth events occurred while enrolled in the program.

The data from the second and third annual surveys suggested consistent issues in the referral of recipients to Federally Qualified Health Centers (FQHC) or Rural Health Centers (RHC). As such, a clear position of support for Hypothesis 6 cannot be made. Similarly, the data about receiving services at FQHCs or RHCs also lends minimal support to Hypothesis 7.

Both data points were assessed in the annual recipients' survey. In addition to the questions asked on the recipient survey, several respondents provided written feedback about the issue of referrals and general health services. The following are a few comments provided by the respondents:

- "I would like the option to know where to go for other low cost or free general health care services. Need information."
- "Used SelectPlan for birth control pick up and annual visits. Provider did not talk to me about where I can go for other low cost/free health care services but I am interested."
- "I wasn't told of 'other health services'"

These samples of comments provided by the respondents highlight a communication disconnect regarding the referral of SelectPlan recipients to other general health providers. These problems could have been related to recall bias, where the respondent does not accurately recall the nature of the exchange with the SelectPlan provider, confusion based on ambiguous wording of the survey question, or it could point to a need for program improvement in the communication between SelectPlan providers and program participants.

Areas for Improvement:

The data also suggested a need for program improvement in the area of participants' satisfaction. The two indicators that did not clearly suggest support for Hypothesis 5 were "I know who to call if I have questions" and "I know what services SelectPlan will pay for". This concern also emerged from the written comments included in the responses. The following responses were provided by SelectPlan recipients on the annual surveys in regards to this issue:

- "Still don't know about the plan's providers or services. It would be nice if someone would send me something."
- "I did not use SelectPlan sooner because I didn't know where/which providers would accept it."
- "Please send a list of physicians who will accept SelectPlan."
- "I never used SelectPlan because it didn't cover my check-up."

- "Was told mammogram was included at clinic when it was not."

These two indicators highlight specific areas that need attention and improvement from a program implementation perspective. These areas of concern will be addressed during the period of the renewed waiver.

RECOMMENDATIONS

The data failed to fully support Hypotheses 5, 6, and 7. As such, we recommend that the waiver be continued as to provide the opportunity to better address these hypotheses. Additionally, we recommend several corrective actions in regards to the three hypotheses that failed to achieve support.

First, there was not enough data to properly test Hypothesis 3. We suggest that the wording of Hypothesis 3 be changed from its current state,

- "The demonstration will result in a decrease in the proportion of women, ages 18 to 44, with a Medical Assistance-paid delivery within 18 months of a previous Medical Assistance-paid delivery,"

to the following:

- "The demonstration will result in a decrease in the proportion of SelectPlan program recipients, with a Medical Assistance-paid delivery within 18 months of a previous Medical Assistance-paid delivery."

The new wording clarifies the focal population of the analysis and provides a better description of how to assess the effectiveness of the SelectPlan for Women program.

Second, the questions corresponding to Hypotheses 6 and 7 will be reworded on the recipient satisfaction survey to enhance clarity. In addition, responses to these questions will be analyzed by sign-up location. It was considered that multi-faceted health centers might fail to refer SelectPlan recipients to other health facilities based on their own ability to offer general services. This additional level of analysis will permit the exploration of this prospect and provide a better understanding of the referral patterns of different types of health provider facilities.

Finally, the two indicator questions on the survey instrument that failed to support Hypothesis 5 about recipient satisfaction will be left in their current state. It is assumed that the wording for these two questions was clear and easy to understand thereby identifying an area of program improvement and not a problem with the measurement instrument. As such, we recommend that SelectPlan providers be notified of the results of these two questions to improve future outcomes.

CONCLUSIONS

The overall results of the evaluation suggest that the waiver was effective in the achievement of the predetermined goals and was perceived positively by recipients. Though it is uncertain as to whether or not the program achieved increases in referrals or appointments at Federally Qualified Health Centers and Rural Health Centers or decreased births within an 18 month spacing interval, the other four hypotheses were clearly supported by the data. The program achieved the original goals as recipients increased their appropriate use of effective forms of birth control, the rate of births decreased across the life of the waiver, and the state achieved budget neutrality for the program. Additionally, the data suggested that program recipients were highly satisfied with SelectPlan and the included services as indicated in the survey and written comments included on the responses. The demonstration waiver led to a noticeable decline in the annual birth rate when the use of the effective methods of birth control increased, while the recipients were satisfied with the program and the state achieved budget neutrality.

Appendix A – 2009 SELECTPLAN FOR WOMEN RECIPIENT SURVEY

PARTICIPANT SURVEY

1. In what month did you sign-up for SelectPlan for Women services? Month: _____

2. How did you first hear about SelectPlan for Women?
   - ☐ County Assistance Office
   - ☐ Family Planning Clinic
   - ☐ Health Care Office (Doctor's Office)
   - ☐ Community Health Clinic
   - ☐ Hospital
   - ☐ Family Member
   - ☐ Friend
   - ☐ Media Information
   - ☐ Other:_____

3. Where did you sign-up for SelectPlan for Women?
   - ☐ County Assistance Office
   - ☐ Family Planning Clinic
   - ☐ Health Care Office (Doctor's Office)
   - ☐ Community Health Clinic
   - ☐ Hospital
   - ☐ Other:_____

4. How easy was it to apply for the SelectPlan for Women?
   - ☐ Very easy
   - ☐ Somewhat easy
   - ☐ Fair
   - ☐ Difficult
   - ☐ Very difficult

5. How satisfied were you with the application process?
   - ☐ Very satisfied
   - ☐ Somewhat satisfied
   - ☐ Fair
   - ☐ Somewhat dissatisfied
   - ☐ Very dissatisfied

6. How many times have you used SelectPlan for Women to cover the cost of family planning services?
   - ☐ The day I signed up
   - ☐ 2-3 times
   - ☐ 4-5 times
   - ☐ 6 or more times
   - ☐ I never used SelectPlan

7. Before you signed up for SelectPlan did you ever receive any family planning services?
   - ☐ Yes
   - ☐ No

8. **The week before you applied for SelectPlan for Women**, what was your main method of birth control? (Please choose only ONE)
   - ☐ None
   - ☐ Abstinence or not sexually active
   - ☐ Withdrawal or "pulling out"
   - ☐ Condoms
   - ☐ Foam or gel
   - ☐ Pills
   - ☐ The Shot (such as Depo)
   - ☐ An Implant (such as Implanon)
   - ☐ The Patch (such as Evra)
   - ☐ IUD (such as Mirena or Paraguard)
   - ☐ Other: _____

9. If you have used SelectPlan already, what method of birth control did you get?
   - ☐ I never used SelectPlan
   - ☐ None
   - ☐ Abstinence or not sexually active
   - ☐ Withdrawal or "pulling out"
   - ☐ Condoms
   - ☐ Foam or gel
   - ☐ Pills
   - ☐ The Shot (such as Depo)
   - ☐ An Implant (such as Implanon)
   - ☐ The Patch (such as Evra)
   - ☐ IUD (such as Mirena or Paraguard)
   - ☐ Other: _____

10. What is your main method of birth control now? (Please choose only ONE)
    - ☐ None
    - ☐ Abstinence or not sexually active
    - ☐ Withdrawal or "pulling out"
    - ☐ Condoms
    - ☐ Foam or gel
    - ☐ Pills
    - ☐ The Shot (such as Depo)
    - ☐ An Implant (such as Implanon)
    - ☐ The Patch (such as Evra)
    - ☐ IUD (such as Mirena or Paraguard)
    - ☐ Other: _____

11. When was the last time you were pregnant?
- ☐ Never pregnant
- ☐ Currently pregnant
- ☐ Pregnant within the last year
- ☐ Pregnant more than a year ago

12. Are you planning on getting pregnant in the next 2 years?
- ☐ Yes
- ☐ No

13. Check if you AGREE or DISAGREE with each of these statements about the family planning care you receive when using SelectPlan for Women to pay for your care.

Agree	Disagree	
☐	☐	Information I get about SelectPlan is easy to read and understand
☐	☐	I know who to call if I have questions about using SelectPlan
☐	☐	I know what services SelectPlan will pay for
☐	☐	It is easier for me to get family planning services now that I have SelectPlan
☐	☐	I will renew my SelectPlan for another year
☐	☐	More women should be told about SelectPlan
☐	☐	I have recommended others to sign-up for SelectPlan

14. If you have not used SelectPlan for Women to get birth control or family planning check-ups, please tell us why.
- ☐ I have already used SelectPlan
- ☐ I don't know where to go to get birth control or family planning check-ups
- ☐ I don't have transportation to get birth control or family planning check-ups
- ☐ I can't find a place I like to get birth control or family planning check-ups
- ☐ I did not get around to using SelectPlan yet

15. At the time you signed up for SelectPlan, did you have a doctor that provided you with general health care services?
- ☐ Yes (Skip questions 16, 17, 18 and 19)
- ☐ No

16. Did your SelectPlan provider talk with you about your other health care needs?
- ☐ Yes
- ☐ No

17. Did your SelectPlan provider talk with you about where you can go to for other health care services?
- ☐ Yes
- ☐ No

18. Did you go to receive other health services?
- ☐ Yes (Skip question 19)
- ☐ No

19. If you did not receive other health services, please tell us why.
- ☐ I did not need the services
- ☐ I did not want to see that provider
- ☐ I did not have the time to go
- ☐ I did not have the money to pay for services
- ☐ I did not have transportation
- ☐ I did not have childcare
- ☐ Other: _____

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116 East Azalea Drive
Harrisburg, PA 17110-3594

Thank you for completing this survey and mailing it back to us.

In which county do you live? _____

What is your zip code? _____

Which of these best describes you?
- ☐ African American/Black
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Caucasian /White
- ☐ Native Hawaiian/Pacific Islander
- ☐ Other

Are you Hispanic or Latina?
- ☐ Yes
- ☐ No

Age:
- ☐ 18-20
- ☐ 21-24
- ☐ 25-29
- ☐ 30-34
- ☐ 35-44
- ☐ 45+

Appendix B – 2010 SELECTPLAN FOR WOMEN RECIPIENT SURVEY

PARTICIPANT SURVEY

1. How did you first hear about SelectPlan for Women?
   - ☐ County Assistance Office
   - ☐ Family Planning Clinic
   - ☐ Health Care Office (Doctor's Office)
   - ☐ Community Health Clinic
   - ☐ Hospital
   - ☐ Family Member
   - ☐ Friend
   - ☐ Media Information
   - ☐ Other:_____

2. Where did you sign-up for SelectPlan for Women?
   - ☐ County Assistance Office
   - ☐ Family Planning Clinic
   - ☐ Health Care Office (Doctor's Office)
   - ☐ Community Health Clinic
   - ☐ Hospital
   - ☐ Other:_____

3. How easy was it to apply for the SelectPlan for Women?
   - ☐ Very easy
   - ☐ Somewhat easy
   - ☐ Fair
   - ☐ Difficult
   - ☐ Very difficult

4. How satisfied were you with the application process?
   - ☐ Very satisfied
   - ☐ Somewhat satisfied
   - ☐ Fair
   - ☐ Somewhat dissatisfied
   - ☐ Very dissatisfied

5. How many times have you used SelectPlan for Women to cover the cost of family planning services?
   - ☐ One time
   - ☐ 2-3 times
   - ☐ 4-5 times
   - ☐ 6 or more times
   - ☐ I never used SelectPlan

   5a. If you have not used SelectPlan for Women to get birth control or family planning check-ups, please tell us why.
   - ☐ I have already used SelectPlan.
   - ☐ I don't know where to go to get birth control or family planning check-ups.
   - ☐ I don't have transportation to get birth control or family planning check-ups.
   - ☐ I can't find a place I like to get birth control or family planning check-ups.
   - ☐ I did not get around to using SelectPlan yet.

6. Before you signed up for SelectPlan, did you ever receive any family planning services?
   - ☐ Yes
   - ☐ No

7. The week **before** you applied for SelectPlan for Women, what was your <u>main</u> method of birth control?
   - ☐ None
   - ☐ Abstinence or not sexually active
   - ☐ Withdrawal or "pulling out"
   - ☐ Condoms
   - ☐ Nuva Ring
   - ☐ Pills
   - ☐ The Shot (such as Depo)
   - ☐ An Implant (such as Implanon)
   - ☐ The Patch (such as Evra)
   - ☐ IUD (such as Mirena or Paraguard)
   - ☐ Partner had Vasectomy
   - ☐ Other: _____

8. If you have used SelectPlan already, what method of birth control did you get?
   - ☐ I used SelectPlan for a check-up/office visit, but NOT for birth control.
   - ☐ None
   - ☐ Abstinence or not sexually active
   - ☐ Withdrawal or "pulling out"
   - ☐ Condoms
   - ☐ Nuva Ring
   - ☐ Pills
   - ☐ The Shot (such as Depo)
   - ☐ An Implant (such as Implanon)
   - ☐ The Patch (such as Evra)
   - ☐ IUD (such as Mirena or Paraguard)
   - ☐ Tubal Ligation
   - ☐ Partner had Vasectomy
   - ☐ Other: _____

9. What is your <u>main</u> method of birth control **now**?
   - ☐ None
   - ☐ Abstinence or not sexually active
   - ☐ Withdrawal or "pulling out"
   - ☐ Condoms
   - ☐ Nuva Ring
   - ☐ Pills
   - ☐ The Shot (such as Depo)
   - ☐ An Implant (such as Implanon)
   - ☐ The Patch (such as Evra)
   - ☐ IUD (such as Mirena or Paraguard)
   - ☐ Tubal Ligation
   - ☐ Partner had Vasectomy
   - ☐ Other: _____

10. When was the last time you were pregnant?
    - ☐ Never pregnant
    - ☐ Currently pregnant
    - ☐ Pregnant within the last year
    - ☐ Pregnant more than a year ago

11. Are you planning on getting pregnant in the next 2 years?
    - ☐ Yes
    - ☐ No
    - ☐ Not Sure

12. Check if you AGREE or DISAGREE with each of these statements about the family planning care you receive when using SelectPlan for Women to pay for your care.

Agree	Disagree	
☐	☐	Information I get about SelectPlan is easy to read and understand.
☐	☐	I know who to call if I have questions about using SelectPlan.
☐	☐	I know what services SelectPlan will pay for.
☐	☐	It is easier for me to get family planning services now that I have SelectPlan.
☐	☐	I will renew my SelectPlan for another year.
☐	☐	More women should know about SelectPlan.
☐	☐	I would recommend others to sign-up for SelectPlan.
☐	☐	Overall, I am happy with SelectPlan.

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13. At the time you signed up for SelectPlan, did you have a doctor that provided you with general health care services?
    - ☐ Yes
    - ☐ No

14. Although SelectPlan only covers family planning services like birth control and pap smears, did your SelectPlan provider talk with you about your other health care needs?
    - ☐ Yes
    - ☐ No
    - ☐ Not Applicable

15. Did your SelectPlan provider talk with you about where you can go to for other low cost or free general health care services?
    - ☐ Yes
    - ☐ No
    - ☐ Not Applicable

16. Did you go to receive other health services?
    - ☐ Yes
    - ☐ No
    - ☐ Not Applicable

    16a. If you did not go to receive other health services, please tell us why.
    - ☐ I did go to receive the services.
    - ☐ I did not need the services.
    - ☐ I did not want to see that provider.
    - ☐ I did not have the time to go.
    - ☐ I did not have the money to pay for services.
    - ☐ I did not have transportation.
    - ☐ I did not have childcare.
    - ☐ Other: _____

Thank you for completing this survey and mailing it back to us.

Which county in Pennsylvania do you live? (Example: Bucks, Allegheny, Chester...)
_____

Which of these best describes you?
- ☐ African American/Black
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Caucasian /White
- ☐ Native Hawaiian/Pacific Islander
- ☐ Other

Are you Hispanic or Latina?
- ☐ Yes
- ☐ No

Age:
- ☐ 18-20
- ☐ 21-24
- ☐ 25-29
- ☐ 30-34
- ☐ 35-44
- ☐ 45+

Appendix C – 2011 SELECTPLAN FOR WOMEN RECIPIENT SURVEY

PARTICIPANT SURVEY

1. How did you hear about SelectPlan for Women?
   - ☐ County Assistance Office
   - ☐ Family Planning Clinic
   - ☐ Website
   - ☐ Health Care Office (Doctor's Office)
   - ☐ Community Health Clinic
   - ☐ Hospital
   - ☐ Family Member
   - ☐ Friend
   - ☐ Media Information
   - ☐ Other:_____

2. Where did you sign-up for SelectPlan for Women?
   - ☐ County Assistance Office
   - ☐ Family Planning Clinic
   - ☐ COMPASS/Online
   - ☐ Health Care Office (Doctor's Office)
   - ☐ Community Health Clinic
   - ☐ Hospital
   - ☐ Other:_____

3. How easy was it to apply for SelectPlan for Women?
   - ☐ Very easy
   - ☐ Somewhat easy
   - ☐ Fair
   - ☐ Difficult
   - ☐ Very difficult

4. How satisfied were you with the application process?
   - ☐ Very satisfied
   - ☐ Somewhat satisfied
   - ☐ Fair
   - ☐ Somewhat dissatisfied
   - ☐ Very dissatisfied

5. How many times have you used SelectPlan for Women to cover the cost of family planning services?
   - ☐ One time
   - ☐ 2-3 times
   - ☐ 4-5 times
   - ☐ 6 or more times
   - ☐ I never used SelectPlan

   5a. If you have not used SelectPlan for Women to get birth control or family planning check-ups, please tell us why.
   - ☐ I have already used SelectPlan.
   - ☐ I don't know where to go to get birth control or family planning check-ups.
   - ☐ I don't have transportation to get birth control or family planning check-ups.
   - ☐ I can't find a place I like to get birth control or family planning check-ups.
   - ☐ I did not get around to using SelectPlan yet.

6. Before you signed up for SelectPlan, did you ever receive any family planning services?
   - ☐ Yes
   - ☐ No

7. The week **before** you applied for SelectPlan for Women, what was your <u>main</u> method of birth control?
   - ☐ None
   - ☐ Abstinence or not sexually active
   - ☐ Withdrawal or "pulling out"
   - ☐ Condoms
   - ☐ Nuva Ring
   - ☐ Pills
   - ☐ The Shot (such as Depo)
   - ☐ An Implant (such as Implanon)
   - ☐ The Patch (such as Evra)
   - ☐ IUD (such as Mirena or Paraguard)
   - ☐ Partner had Vasectomy
   - ☐ Other: _____

8. If you have used SelectPlan, what method of birth control did you get?
   - ☐ I used SelectPlan for a check-up/office visit, but NOT for birth control.
   - ☐ None
   - ☐ Abstinence or not sexually active
   - ☐ Withdrawal or "pulling out"
   - ☐ Condoms
   - ☐ Nuva Ring
   - ☐ Pills
   - ☐ The Shot (such as Depo)
   - ☐ An Implant (such as Implanon)
   - ☐ The Patch (such as Evra)
   - ☐ IUD (such as Mirena or Paraguard)
   - ☐ Tubal Ligation
   - ☐ Partner had Vasectomy
   - ☐ Other: _____

9. What is your <u>main</u> method of birth control **now**?
   - ☐ None
   - ☐ Abstinence or not sexually active
   - ☐ Withdrawal or "pulling out"
   - ☐ Condoms
   - ☐ Nuva Ring
   - ☐ Pills
   - ☐ The Shot (such as Depo)
   - ☐ An Implant (such as Implanon)
   - ☐ The Patch (such as Evra)
   - ☐ IUD (such as Mirena or Paraguard)
   - ☐ Tubal Ligation
   - ☐ Partner had Vasectomy
   - ☐ Other: _____

10. When was the last time you were pregnant?
    - ☐ Never pregnant
    - ☐ Currently pregnant
    - ☐ Pregnant within the last year
    - ☐ Pregnant more than a year ago

10a. Are you planning on getting pregnant in the next 2 years?
- ☐ Yes
- ☐ No
- ☐ Not Sure

11. Check if you AGREE or DISAGREE with each of these statements about the family planning care you receive when using SelectPlan for Women to pay for your care.

Agree	Disagree	
☐	☐	Information I get about SelectPlan is easy to read and understand.
☐	☐	I know who to call if I have questions about using SelectPlan.
☐	☐	I know what services SelectPlan will pay for.
☐	☐	It is easier for me to get family planning services now that I have SelectPlan.
☐	☐	More women should know about SelectPlan.
☐	☐	I would recommend others to sign-up for SelectPlan.
☐	☐	Overall, I am happy with SelectPlan.

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12. At the time you signed up for SelectPlan, did you have a doctor that provided you with general health care services?
    - ☐ Yes
    - ☐ No

13. Although SelectPlan only covers family planning services like birth control and pap smears, did your SelectPlan provider talk with you about your other health care needs?
    - ☐ Yes
    - ☐ No
    - ☐ Not Applicable

14. Did your SelectPlan provider talk with you about where you can go for other low cost or free general health care services?
    - ☐ Yes
    - ☐ No
    - ☐ Not Applicable

15. Did you go to receive other health services?
    - ☐ Yes
    - ☐ No
    - ☐ Not Applicable

15a. If you did not go to receive other health services, please tell us why.
- ☐ I did go to receive the services.
- ☐ I did not need the services.
- ☐ I did not want to see that provider.
- ☐ I did not have the time to go.
- ☐ I did not have the money to pay for services.
- ☐ I did not have transportation.
- ☐ I did not have childcare.
- ☐ Other: _____

Thank you for completing this survey and mailing it back to us.

Which county in Pennsylvania do you live? (Example: Bucks, Allegheny, Chester...)

_____

Which of these best describes you?
- ☐ African American/Black
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Caucasian /White
- ☐ Native Hawaiian/Pacific Islander
- ☐ Other

Are you Hispanic or Latina?
- ☐ Yes
- ☐ No

Age:
- ☐ 18-20
- ☐ 21-24
- ☐ 25-29
- ☐ 30-34
- ☐ 35-44
- ☐ 45+

Appendix D

SelectPlan for Women Evaluation Plan
Hypotheses

Hypothesis #1: The demonstration will result in an increase in appropriate use of effective forms of birth control among recipients aged 18 to 44.

Hypothesis #2: The demonstration will result in a decrease in the annual rate of Medical Assistance-paid deliveries for women aged 18 to 44.

Hypothesis #3: The demonstration will result in a decrease in the proportion of women, ages 18 to 44, with a Medical Assistance-paid delivery within 18 months of a previous Medical Assistance-paid delivery.

Hypothesis #4: Over the five- year period of the waiver, the demonstration will produce net annual savings in Federal and State expenditures for birth-related services.

Hypothesis #5: Waiver recipients will likely be satisfied with the services they receive under the demonstration.

Hypothesis #6: The demonstration waiver will result in an increase in referrals to Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) for primary care services for recipients.

Hypothesis #7: Referrals made as part of the demonstration waiver will result in an increase in primary care services provided to waiver recipients by Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs).

Appendix E – Covered Services

Procedure Code	Provider Type	Specialty	Place of Service	Description
11975	01	010	22	Insertion, implantable contraceptive capsules
11975	08	082	49	Insertion, implantable contraceptive capsules
11975	08	083	22, 49	Insertion, implantable contraceptive capsules
11975	31	All	11, 21, 99	Insertion, implantable contraceptive capsules
11976	01	010	22	Removal, implantable contraceptive capsules
11976	08	082	49	Removal, implantable contraceptive capsules
11976	08	083	22, 49	Removal, implantable contraceptive capsules
11976	31	All	11, 21, 99	Removal, implantable contraceptive capsules
11977	01	010	22	Removal with reinsertion, implantable contraceptive capsules
11977	08	082	49	Removal with reinsertion, implantable contraceptive capsules
11977	08	083	22, 49	Removal with reinsertion, implantable contraceptive capsules
11977	31	All	11, 21, 99	Removal with reinsertion, implantable contraceptive capsules
58300	01	010	22	Insertion of intrauterine device (IUD)
58300	08	082	49	Insertion of intrauterine device (IUD)
58300	08	083	22, 49	Insertion of intrauterine device (IUD)
58300	31	All	11, 21, 99	Insertion of intrauterine device (IUD)
58301	01	010	22	Removal of intrauterine device (IUD)
58301	01	021	24	Removal of intrauterine device (IUD)
58301	02	020	24	Removal of intrauterine device (IUD)
58301	08	082	49	Removal of intrauterine device (IUD)
58301	08	083	22, 49	Removal of intrauterine device (IUD)
58301	31	All	11, 21, 99	Removal of intrauterine device (IUD)
99201	09	093	11, 99	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.
99201	08	083	22, 49	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.
99201	33	335	11, 99	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.
99201	31	All	11, 99	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

99202	09	093	11, 99	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.
99202	08	083	22, 49	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.
99202	33	335	11, 99	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.
99202	31	All	11, 99	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.
99203	09	093	11,99	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.
99203	08	083	22, 49	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.
99203	33	335	11, 99	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.
99203	31	All	11, 99	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.
99211	08	083	22, 49	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.
99211	33	335	11, 99	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.
99211	31	All	11, 99	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.
99212	09	093	11, 99	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

99212	08	083	22, 49	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.
99212	33	335	11, 99	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.
99212	31	All	11, 99	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.
99213	09	093	11, 99	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.
99213	08	083	22, 49	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.
99213	33	335	11, 99	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.
99213	31	All	11, 99	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.
99214	09	093	11, 99	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.
99214	08	083	22, 49	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.
99214	33	335	11, 99	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.
99214	31	All	11, 99	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

99385	09	093	11	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; 18-39 years
99385	08	083	22, 49	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; 18-39 years
99385	33	335	11	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; 18-39 years
99385	31	All	11	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; 18-39 years
99386	09	093	11	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; 40-64 years
99386	08	083	22, 49	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; 40-64 years
99386	33	335	11	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; 40-64 years
99386	31	All	11	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; 40-64 years
99395	09	093	11	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; 18-39 years
99395	08	083	22, 49	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; 18-39 years
99395	33	335	11	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; 18-39 years
99395	31	All	11	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; 18-39 years
99396	09	093	11	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; 40-64 years
99396	08	083	22, 49	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; 40-64 years
99396	33	335	11	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; 40-64 years
99396	31	All	11	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; 40-64 years
T1015	01	010	22	Clinic visit/encounter, all-inclusive
T1015	01	010	22	Clinic visit/encounter, all-inclusive
T1015	01	183	22	Clinic visit/encounter, all-inclusive

T1015	01	183	22	Clinic visit/encounter, all-inclusive
T1015	08	080	50	Clinic visit/encounter, all-inclusive
T1015	08	081	72	Clinic visit/encounter, all-inclusive
T1015	08	082	49	Clinic visit/encounter, all-inclusive
A4267	24	240, 241, 242, 243, 245	11, 12	Contraceptive supply, condom, male, each
A4267	25	250	11, 12	Contraceptive supply, condom, male, each
A4267	08	083	22, 49	Contraceptive supply, condom, male, each
A4268	24	240, 241, 242, 243, 245	11, 12	Contraceptive supply, condom, female, each
A4268	25	250	11, 12	Contraceptive supply, condom, female, each
A4268	08	083	22, 49	Contraceptive supply, condom, female, each
99211	09	093	11, 99	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.
81000	01	010	22	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy
81000	08	083	22, 49	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy
81000	28	280	81	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy
81001	01	010	22	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, with microscopy
81001	08	083	22, 49	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, with microscopy
81001	28	280	81	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, with microscopy
81025	01	010	22	Urine pregnacy test, by visual color comparison methods
81025	08	083	22, 49	Urine pregnacy test, by visual color comparison methods
81025	28	280	81	Urine pregnacy test, by visual color comparison methods
83001	01	010	22	Gonadotropin; follicle stimulating hormone (FSH)
83001	08	083	22, 49	Gonadotropin; follicle stimulating hormone (FSH)
83001	28	280	81	Gonadotropin; follicle stimulating hormone (FSH)
83898	01	010	22	Molecular diagnostics; amplification, target, each nucleic acid sequence
83898	08	083	22, 49	Molecular diagnostics; amplification, target, each nucleic acid sequence
83898	28	280	81	Molecular diagnostics; amplification, target, each nucleic acid sequence
84138	01	010	22	Pregnanetriol
84138	08	083	22, 49	Pregnanetriol
84138	28	280	81	Pregnanetriol
84144	01	010	22	Progesterone
84144	08	083	22, 49	Progesterone
84144	28	280	81	Progesterone
84146	01	010	22	Prolactin
84146	08	083	22, 49	Prolactin
84146	28	280	81	Prolactin
84702	01	010	22	Gonadotropin, chorionic (hCG); quantitative
84702	08	083	22, 49	Gonadotropin, chorionic (hCG); quantitative
84702	28	280	81	Gonadotropin, chorionic (hCG); quantitative
84703	01	010	22	Gonadotropin, chorionic (hCG); qualitative
84703	08	083	22, 49	Gonadotropin, chorionic (hCG); qualitative

84703	28	280	81	Gonadotropin, chorionic (hCG); qualitative
85014	01	010	22	Blood count; hematocrit (Hct)
85014	08	083	22, 49	Blood count; hematocrit (Hct)
85014	28	280	81	Blood count; hematocrit (Hct)
85018	01	010	22	Blood count; hemoglobin (Hgb)
85018	08	082	49	Blood count; hemoglobin (Hgb)
85018	08	083	22, 49	Blood count; hemoglobin (Hgb)
85018	09	All	11	Blood count; hemoglobin (Hgb)
85018	28	280	81	Blood count; hemoglobin (Hgb)
85018	31	All	11	Blood count; hemoglobin (Hgb)
85018	33	335	11	Blood count; hemoglobin (Hgb)
85025	01	010	22	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count
85025	08	083	22, 49	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count
85025	28	280	81	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count
85660	01	010	22	Sickling of RBC, reduction
85660	08	083	22, 49	Sickling of RBC, reduction
85660	28	280	81	Sickling of RBC, reduction
86255	01	010	22	Fluorescent noninfectious agent antibody; screen, each antibody
86255	08	083	22, 49	Fluorescent noninfectious agent antibody; screen, each antibody
86255	28	280	81	Fluorescent noninfectious agent antibody; screen, each antibody
86317	01	010	22	Immunoassay for infectious agent antibody, quantitative, not otherwise specified
86317	08	083	22, 49	Immunoassay for infectious agent antibody, quantitative, not otherwise specified
86317	28	280	81	Immunoassay for infectious agent antibody, quantitative, not otherwise specified
86592	01	010	22	Syphilis test, qualitative (eg, VDRL, RPR, ART)
86592	08	083	22, 49	Syphilis test, qualitative (eg, VDRL, RPR, ART)
86592	28	280	81	Syphilis test, qualitative (eg, VDRL, RPR, ART)
86701	01	010	22	Antibody; HIV-1
86701	08	083	22, 49	Antibody; HIV-1
86701	28	280	81	Antibody; HIV-1
86702	01	010	22	Antibody; HIV-2
86702	08	083	22, 49	Antibody; HIV-2
86702	28	280	81	Antibody; HIV-2
86762	01	010	22	Antibody; rubella
86762	08	083	22, 49	Antibody; rubella
86762	28	280	81	Antibody; rubella
86781	01	010	22	Antibody; Treponema pallidum, confirmatory test (eg, FTA-abs)
86781	08	083	22, 49	Antibody; Treponema pallidum, confirmatory test (eg, FTA-abs)
86781	28	280	81	Antibody; Treponema pallidum, confirmatory test (eg, FTA-abs)
87070	01	010	22	Culture, bacterial; any other source except urine, blood or stool, aerobic, with isolation and presumptive identification of isolates
87070	08	083	22, 49	Culture, bacterial; any other source except urine, blood or stool, aerobic, with isolation and presumptive identification of isolates
87070	28	280	81	Culture, bacterial; any other source except urine, blood or stool, aerobic, with isolation and presumptive identification of isolates
87075	01	010	22	Culture, bacterial; any source, except blood, anaerobic with isolation and presumptive identification of isolates
87075	08	083	22, 49	Culture, bacterial; any source, except blood, anaerobic with isolation and presumptive identification of isolates
87075	28	280	81	Culture, bacterial; any source, except blood, anaerobic with isolation and presumptive identification of isolates

87076	01	010	22	Culture, bacterial; anaerobic isolate, additional methods required for definitive identification, each isolate
87076	08	083	22, 49	Culture, bacterial; anaerobic isolate, additional methods required for definitive identification, each isolate
87076	28	280	81	Culture, bacterial; anaerobic isolate, additional methods required for definitive identification, each isolate
87086	01	010	22	Culture, bacterial; quantitative colony count, urine
87086	08	083	22, 49	Culture, bacterial; quantitative colony count, urine
87086	28	280	81	Culture, bacterial; quantitative colony count, urine
87110	01	010	22	Culture, chlamydia, any source
87110	08	083	22, 49	Culture, chlamydia, any source
87110	28	280	81	Culture, chlamydia, any source
87166	01	010	22	Dark field examination, any source (eg, penile, vaginal, oral, skin); without collection
87166	08	083	22, 49	Dark field examination, any source (eg, penile, vaginal, oral, skin); without collection
87166	28	280	81	Dark field examination, any source (eg, penile, vaginal, oral, skin); without collection
87205	01	010	22	Smear, primary source with interpretation; Gram or Giemsa stain for bacteria, fungi, or cell types
87205	08	083	22, 49	Smear, primary source with interpretation; Gram or Giemsa stain for bacteria, fungi, or cell types
87205	28	280	81	Smear, primary source with interpretation; Gram or Giemsa stain for bacteria, fungi, or cell types
87207	01	010	22	Smear, primary source with interpretation; special stain for inclusion bodies or parasites (eg, malaria, coccidia, microsporidia, trypanosomes, herpes viruses)
87207	08	083	22, 49	Smear, primary source with interpretation; special stain for inclusion bodies or parasites (eg, malaria, coccidia, microsporidia, trypanosomes, herpes viruses)
87207	28	280	81	Smear, primary source with interpretation; special stain for inclusion bodies or parasites (eg, malaria, coccidia, microsporidia, trypanosomes, herpes viruses)
87210	01	010	22	Smear, primary source with interpretation; wet mount for infectious agents (eg, saline, India ink, KOH preps)
87210	08	083	22, 49	Smear, primary source with interpretation; wet mount for infectious agents (eg, saline, India ink, KOH preps)
87210	28	280	81	Smear, primary source with interpretation; wet mount for infectious agents (eg, saline, India ink, KOH preps)
87491	01	010	22	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia Trachomatis, amplified probe technique
87491	08	083	22, 49	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia Trachomatis, amplified probe technique
87491	28	280	81	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia Trachomatis, amplified probe technique
87536	01	010	22	Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, quantification
87536	08	083	22, 49	Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, quantification
87536	28	280	81	Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, quantification
87591	01	010	22	Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, amplified probe technique
87591	08	083	22, 49	Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, amplified probe technique
87591	28	280	81	Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, amplified probe technique
87621	01	010	22	Infectious agent detection by nucleic acid (DNA or RNA): papillomavirus, human, amplified probe technique
87621	08	083	22, 49	Infectious agent detection by nucleic acid (DNA or RNA): papillomavirus, human, amplified probe technique
87621	28	280	81	Infectious agent detection by nucleic acid (DNA or RNA): papillomavirus, human, amplified probe technique
87797	01	010	22	Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; direct probe technique, each organism
87797	08	083	22, 49	Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; direct probe technique, each organism
87797	28	280	81	Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; direct probe technique, each organism

87798	01	010	22	Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; amplified probe technique, each organism
87798	08	083	22, 49	Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; amplified probe technique, each organism
87798	28	280	81	Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; amplified probe technique, each organism
88141	01	010	22	Cytopathology, cervical or vaginal (any reporting system), requiring interpretation by physician
88141	08	083	22, 49	Cytopathology, cervical or vaginal (any reporting system), requiring interpretation by physician
88141	28	280	81	Cytopathology, cervical or vaginal (any reporting system), requiring interpretation by physician
88142	01	010	22	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision
88142	08	083	22, 49	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision
88142	28	280	81	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision
88161	01	010	22	Cytopathology, smears, any other source; preparation, screening and interpretation
88161	08	083	22, 49	Cytopathology, smears, any other source; preparation, screening and interpretation
88161	28	280	81	Cytopathology, smears, any other source; preparation, screening and interpretation
88164	01	010	22	Cytopathology, slides, cervical or vaginal (the Bethesda System); manual screening under physician supervision
88164	08	083	22, 49	Cytopathology, slides, cervical or vaginal (the Bethesda System); manual screening under physician supervision
88164	28	280	81	Cytopathology, slides, cervical or vaginal (the Bethesda System); manual screening under physician supervision
88175	01	010	22	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with screening by automated system and manual rescreening or review, under physician supervision
88175	08	083	22, 49	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with screening by automated system and manual rescreening or review, under physician supervision
88175	28	280	81	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with screening by automated system and manual rescreening or review, under physician supervision
99401	08	083	22, 49	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes