Evaluation of Alabama Medicaid's Plan First Program

Interim Evaluation Report: Evaluation Period: Waiver Period November 27, 2017-September 30, 2022

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Certification of Member Months and Attestation of Data

"I certify that I am authorized by the Alabama Medicaid Agency to submit this report and I certify and attest to the accuracy of the member months and data contained in this Interim Evaluation Report."

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Executive Summary

Demonstration Name: Family Planning Section 1115 Demonstration Waiver
Approval date: July 1, 2000; Implementation date: October 1, 2000
Period of time covered by the evaluation: DY00-DY20

In accordance with 42 CFR §431.412(c)(2)(vi), this is the Interim Evaluation Report for the Alabama Plan First Program, a required accompanying document with the 2022 extension application. It is being completed by the University of Alabama at Birmingham's (UAB) School of Public Health and is inclusive of evaluation activities and findings for the completed years of the demonstration to date (FY20) and plans for evaluation activities during the extension period. The measurable goals of the Plan First program evaluation have changed since its inception in 2000. Therefore, some of the metrics have not been gathered consistently over time. In this report of the current goals, as many demonstration years as possible have been included if the information was collected consistently over time.

Demonstration Summary

The Alabama Plan First Program was designed to improve the well-being of children and families in Alabama whose income is at or below 141% of the Federal Poverty Level (FPL) by extending Medicaid eligibility for family planning services to eligible childbearing women between the ages of 19 through 55, and males ages 21 or older for vasectomy related services only. Plan First enrollees are also eligible to receive tobacco cessation counseling and products provided by the Alabama Department of Public Health through a partnership with the Alabama Medicaid Agency. Recipients have freedom of choice in deciding to receive or reject family planning services. Acceptance of any family planning service must be voluntary without any form of duress or coercion applied to gain such acceptance. Recipients are required to give written consent prior to receiving family planning services. However, due to the current Public Health Emergency (PHE) declared in March 2020, verbal consent for services has been accepted when needed. Plan First recipients are exempt from co-payments on services and prescription drugs/supplies designated as family planning.

Principal Results

The overall program goal of Alabama's Plan First program, to reduce unintended pregnancies, has been exceeded since the beginning of the program. Consistently, the actual birth rates among clinical service users have been lower compared to non-service users and all enrollees.

Although some progress has been made related to addressing disparities, the goal of 80% enrollment among eligible women has only partially been met throughout the program demonstration period. There have been variations in these trends by age and race/ethnicity. The percent of total visits to private providers has declined over time and varies by geographic location (Goal 1). The percentage of total visits to private providers rose from 21.8% in the first year of the demonstration; through 28.0% in Demonstration Year DY 14. The percentage of total visits to private providers increased over time, until DY14 and again more recently in DY20. Note that DY 20 covers the initial six months of the Covid pandemic emergency, which resulted in a decline in use of many physician services.

Awareness of Plan First, based on surveys, has been generally consistent and high over time. Among those surveyed, awareness of the program has increased over time, reaching 100% in DY19. The percentage of those women aware of their enrollment was consistently higher among those who had heard of Plan First. (Goal 2)

In Plan First, the utilization of services among enrollees has varied over time, but the percent of service use has not exceeded the 60% program goal. However, the percent of clinical service users receiving specific services, such as care coordination and oral contraception, has increased over time. Since DY14, more than three-quarters of women less than age 35 utilized an effective method of contraception. Women aged 35+ were only slightly lower. (Goal 3)

The percent of women who reported smoking has declined over time (DY14-DY20). The proportion of women who smoked who received a referral to the Quit Line or NRT has been consistent over time but is not at the 85% goal. (Goal 4)

Since the inception of the program, the birth rate per 1000 enrollees has been about half of the number needed for budget neutrality. (Goal 5)

Since the availability of men's services in Plan First, there has been an increase in enrollment except in DY18. However, the proportion of men receiving a vasectomy has been consistently below the 75% goal. (Goal 6)

Interpretations

Over the entire demonstration there have been numerous changes in enrollment policies related to changes in federal policies. There have also been demographic changes in the state and changes in the availability of other health insurance options for low-income women. During this most recent extension period, there have been substantial changes in program structure and service delivery because of changes in Alabama Medicaid, specifically the most recent change to the Alabama Coordinated Health Networks (ACHN). Enrollment and utilization continue to vary across racial and age groups as well as geographic regions. Additionally, for the most recent years, there were enrollment policy changes related to the COVID 19 pandemic: women covered by Medicaid for maternity services remained in Medicaid throughout the public health emergency period.

Awareness of the Plan First program and knowledge of enrollment in the program, based on survey data, has increased over time and meets the target for the program. Continued focus on outreach and engagement to reach those eligible and not enrolled is key.

Because the availability of contraceptive methodologies has changed over the past 20 years, the program has evolved. Policies have changed as well, with the introduction of postpartum Long-acting reversible contraception (LARC) in more recent years. Care coordination among those enrolled has also increased over time.

Reported smoking among women engaged in Plan First has declined over time while the support of Family Planning providers to quit has increased. Continued focus on Nicotine Replacement Therapy (NRT) and other techniques is needed.

The continued budget neutrality of the program is positive, but an increased focus on case management and subsequent vasectomies for men should be continued.

Recommendations

As we begin to move beyond the challenges of COVID-19, there will be opportunities for the ACHNs to engage more fully in the promotion of and outreach for the Plan First program among eligible women and men to increase enrollment and service utilization. Identification and resolution of barriers to uptake of services should be a priority. Also, outreach to providers regarding smoking cessation is important. Finally, the landscape of the availability of Plan First providers continues to change. Careful examination of these changes is needed to assure availability of providers for this population.

General Background Information

Demonstration Name: Family Planning Section 1115 Demonstration Waiver
Approval date: July 1, 2000; Implementation date: October 1, 2000

Period of time covered by the evaluation: DY00-DY20

This is the Interim Evaluation Report for the Alabama Plan First Program and is an accompanying document with the demonstration's extension request submitted in November 2021.

Issues To Be Addressed by the Demonstration

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

The State of Alabama requested, in 1999, a Section 1115(a) Research and Demonstration Waiver to extend Medicaid eligibility for family planning services to all women of childbearing age (19-44) with incomes at or below 133% of the federal poverty level who would not otherwise qualify for Medicaid; thereby, demonstrating the impact expanded eligibility has on unintended pregnancy. At the time of submission, the State only offered family planning services to all eligible beneficiaries including SOBRA women for whom family planning services extended through the end of the month in which the 60th postpartum day falls.

Also, at the time of submission of the request, Alabama had a higher portion of uninsured individuals than the national average of 14.3%. In 1996, Alabama ranked 41st in the nation in relative healthiness among states.

The primary goals of this program were to:

- reduce pregnancy and birth rates within the low-income population of the state,
- improve access to high quality family planning services for low-income women,
- reduce Medicaid costs associated with unintended pregnancies, utilize effective outreach programs to enhance awareness and need for available family planning services, and
- utilize care coordination services to assist women with choosing a family planning method and a means for consistently using the method and to ensure that education is communicated in a meaningful and understandable way to women.

Brief History

The Alabama Medicaid Agency (Medicaid) Plan First demonstration was initially approved on July 1, 2000, and implemented on October 1, 2000. The demonstration has been consistently extended since that date. At its inception, the Alabama Plan First Program was implemented to provide family planning services to women whose Medicaid eligibility for pregnancy had ended and for those women who would not otherwise qualify for Medicaid unless pregnant, with an income at or below 141 percent of the Federal Poverty Level (FPL).

With the December 2014 extension of the demonstration, the State was approved to provide two new services: 1) removal of migrated or embedded intrauterine devices in an office setting or outpatient

surgical facility, and 2) coverage of vasectomies for males 21 years of age or older with income at or below 141 percent of the FPL.

On November 29, 2016, Alabama submitted a request to amend the demonstration to provide an enhanced family planning counseling benefit referred to as "care coordination" to males enrolled in the demonstration receiving vasectomy services. The purpose of adding care coordination services is to help qualifying Plan First males with established Medicaid eligibility, locate an appropriate doctor to perform the vasectomy procedure, and assist with making and keeping appointments for initial consultations and follow-up visits. CMS approved this amendment to the demonstration on June 28, 2017.

On June 15, 2017, Medicaid submitted a request to extend the demonstration for a five-year period with no program changes. CMS approved this extension request through September 30, 2022, as agreed upon with the State, to realign Plan First's annual demonstration cycles back to the original date of implementation. The Special Terms and Conditions (STCs), accompanying the CMS approval letter, permit section 1115 demonstration authority for the Plan First demonstration through September 30, 2022. The program's overall goal is to reduce unintended pregnancies.

Plan First enrollees must meet one of the eligibility criteria described below:

Group 1
Women 19 through 55 years of age who have Medicaid eligible children (poverty level) who become eligible for family planning without a separate eligibility determination. They must answer "yes" to the Plan First question on the Alabama Medicaid application. Income is verified at the initial application and re-verified at recertification of their children. Eligibility is re-determined every 12 months.

Group 2
Poverty level pregnant women 19 through 55 years of age whose pregnancy ends while she is on Medicaid. The Plan First Waiver system automatically determines Plan First eligibility for every female Medicaid member entitled to Plan First after a pregnancy has ended. Women automatically certified for the Plan First Program receive a computer-generated award notice by mail. If the woman does not wish to participate in the program, she can notify the caseworker to be decertified. Women who answered "no" to the Plan First question on the Alabama Medicaid application and women who do not meet the citizenship requirement do not receive automatic eligibility. Income is verified at the initial application and re-verified at recertification of their children. Eligibility is re-determined every 12 months.

Group 3
Other women ages 19 through 55 who are not pregnant, postpartum, or who are not applying for a child must apply using a simplified Plan First application (Form 357). A Modified Adjusted Gross Income (MAGI) determination will be completed using poverty level eligibility rules and standards. Recipient declaration of income will be accepted unless there is a discrepancy. Medicaid will process the information through data matches with state and federal agencies. If a discrepancy exists between the recipient's declaration and the income reported through data matches, the recipient will be required to provide documentation and resolve the discrepancy. Eligibility is re-determined every 12 months.

Group 4
Plan First men, ages 21 and older, wishing to have a vasectomy may complete a simplified, shortened Plan First application (Form 357). An eligibility determination must be completed using poverty level eligibility rules and standards. Eligibility will only be for a 12-month period; therefore, retro-eligibility and renewals are not allowed. If the individual has completed the sterilization procedure but has not completed authorized follow-up treatments by the end of the 12-month period, a supervisory override will

be allowed for the follow-up treatments. If the individual does not receive a vasectomy within the 12-month period of eligibility, then he will have to reapply for Medicaid eligibility.

Services and Supplies Provided

Individuals eligible under this demonstration will receive family planning services and supplies as described in section 1905(a)(4)(C) of the Act, which are reimbursable at the 90 percent Federal matching rate. The specific family planning services provided under this demonstration are as follows:

a) FDA-approved methods of contraception, and vasectomy services for men.
b) Laboratory tests completed during an initial family planning visit for contraception, including Pap smears, screening tests for STIs/STDs, blood counts and pregnancy tests. Additional screening tests may be performed depending on the method of contraception desired and the protocol established by the clinic, program, or provider. Additional laboratory tests may be needed to address a family planning problem or need during an inter-periodic family planning visit for contraception.
c) Drugs, supplies, or devices related to women's health services described above that are prescribed by a health care provider who meets the state's provider enrollment requirements (subject to the national drug rebate program requirements).
d) Contraceptive management, patient education, and counseling, including care coordination services that provide enhanced education on appropriate use of the chosen family planning method and further assurance of correct and continued usage to address impediments to successful family planning. These care coordination services will be provided to female enrollees identified by providers as "high risk" or "at risk" for an unintended pregnancy and male enrollees seeking vasectomy services. Care coordination services include:
    i. Assistance with arranging a family planning visit
    ii. Locating appropriate Medicaid doctor to perform sterilization procedures
    iii. Assistance with referrals, making appointments, and follow-up to ensure appointments are kept, including subsequent family planning visits
    iv. Provision of answers to general questions about family planning
    v. Family planning education utilizing the standardized educational model (PT+3) for providing information in a manner that meets the recipients' level of understanding; and,
    vi. Counseling regarding problems with the selected family planning method.

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

Individuals eligible under this demonstration are also eligible to receive smoking cessation services and products as authorized in Alabama's approved Medicaid State Plan and provided by the Alabama Department of Public Health, through partnership with the Alabama Medicaid Agency. Recipients may also receive smoking cessation services through the Alabama Tobacco Quitline. The Quitline offers online and telephone counseling services at QuitNowAlabama.com for any Alabamian who is ready to quit tobacco use. Those who begin counseling can receive, if medically eligible, a free, eight-week supply of the nicotine patch to assist in their attempt to quit. The Quitline is not a waiver service. Reference Attachment B: Covered Nicotine Products for a listing of covered smoking cessation (nicotine) products.

Recent Program Changes

During the current demonstration period 2017-2022, the following operational changes occurred:

- Care Coordination Transition

Family Planning Care Coordination was transitioned from the Alabama Department of Public Health (ADPH) to seven Alabama Coordinated Health Networks (ACHNs) organizations in October 2019.

ACHNs receive monthly assignment file reports of all Plan First/Family Planning eligible individuals (EIs). Care Coordinators utilize these reports to attempt outreach to EIs and to offer Family Planning Care Coordination services. Although the care coordination was transitioned to the ACHNs, currently all counties within the State continue to have public provider options for Plan First services.

- Public Health Emergency (PHE) Impact

As a result of the Center for Medicaid and Medicare Services (CMS) adjusting some policies for Medicaid due to the COVID-19 Public Health Emergency (PHE) beginning in March 2020, many services, particularly case management and care coordination services, were provided telephonically rather than face to face In accordance with the policy adjustments, AMA allowed a shift to telephonic service delivery instead of the required face-to-face visit(s) for both care coordination services and contraceptive visits. AMA will continue to allow the telephonic service delivery option for some of these services after the expiration of the PHE. Additionally, enrollees who would typically enter Plan First from maternity care coverage under SOBRA, retained their SOBRA coverage during the PHE.

- Dual Enrollment

Medicaid began allowing dual enrollment for care coordination services. However, family planning services can only be provided to maternity EIs during the month of delivery and after to facilitate early engagement with the family planning service options. Dual enrollment allows family planning care coordination to begin at the hospital after the birth which helps in the continuity of care as well as positively impacts enrollment.

Evaluation Design Changes

In March 2021, CMS approved Evaluation Design changes to better reflect the data now being captured for services provided by the ACHNs. This resulted in a partial DY 20 Annual Monitoring Report being submitted to CMS in June 2021.

Evaluation Questions and Hypotheses

The State's current demonstration goals and quantifiable targets for improvement are listed below.

Goal 1. Increase the portion of women eligible for Plan First who enroll and reduce racial/ethnic and geographic disparities in enrollment.
Target: The program goal is to enroll into Plan First 80% of eligible women between ages 19 and 40 across all racial/ethnic groups and geographic areas.

> *Hypotheses: We anticipate that the composition of the enrolled population will be demographically like the population of eligible participants because of programmatic features designed to reduce barriers to enrollment, such as automatic enrollment following delivery and allowing re-enrollment through Express Lane Eligibility. However, we do not expect the enrolled population to reflect the exact distribution of eligible women because enrollment in the program is voluntary. For example, based on past evaluations of Plan First, we anticipate lower enrollment rates among older women compared to younger women.*

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

> *Hypotheses: Since Plan First is a well-established program, we expect that the majority of women enrolled will have heard of it and will be aware that they are enrolled.*

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

> *Hypotheses: Based on prior evaluations of Plan First, we expect service use to be more common among younger women than among older women, since younger women tend to rely on shorter acting hormonal methods for contraception and are recommended for routine STI and cervical cancer screening, both of which require more regular contact with providers. Because Plan First offers no-cost contraception, we also expect more than half of women using services to have a claim for a moderate or highly effective contraceptive method.*

Goal 4. Increase the portion of Plan First enrollees who receive smoking cessation services or nicotine replacement products.
Smoking cessation coverage has been available in Plan First since 2012.
Target: The program goal is to have 85% of smokers receiving these services.

> *Hypothesis: Data from recent surveys of Plan First enrollees indicate that approximately 25% are smokers. We expect that the majority of enrolled smokers will report that their health care provider advised them to quit smoking and about half will report they were provided with information about smoking cessation services.*

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

Target: A rate of about 100 births per 1000 enrollees is estimated to be sufficient to achieve budget neutrality for Plan First.

> *Hypothesis: Based on prior evaluations of Plan First, we hypothesize that the birth rate among program participants will be less than the expected birth rate in the absence of the program. We also anticipate that birth rates will be lower among women who used Plan First services than those who enrolled but did not have a clinical encounter.*

Goal 6. Increase the number of income-eligible men aged 21 years who are enrolled in the Plan First program and the proportion of male enrollees undergoing vasectomy.

Target: Our goal is that the number of men enrolled in Plan First for vasectomies and vasectomy-related covered services will increase by 10% annually, 85% of male Plan First enrollees will receive care coordination services, and 75% of male enrollees will undergo the procedure within the enrollment year.

> *Hypothesis: We anticipate that men's use of vasectomy services will increase over time, and that those who receive care coordination services will be more likely to obtain a vasectomy through Plan First than those who do not receive care coordination.*

Methodology

Eight sources of data were used for the evaluation. From the Alabama Medicaid Agency information system, the following were obtained:

(1) monthly enrollment data,
(2) claims for the recipients enrolled in the Plan First program,
(3) delivery claims on a quarterly basis that were matched to Plan First participants, and
(4) the number of Plan First participants who were referred to the smoking cessation telephone counseling service (Quit Line).

Additionally, (5) the U.S Census data was used to estimate the age, race and geographic distribution of uninsured women who may be eligible for Plan First.

Finally, surveys were conducted to collect the following data:

(6) a survey of women enrolled in Plan First about their experiences in the program.
(7) a survey of women who are no longer enrolled in Plan First to assess their reasons for not re-enrolling; and
(8) a survey of men enrolled in Plan First about their experiences obtaining vasectomy services.

Goal 1 analyses utilized enrollment and claims data. We examined enrollment and service use data over time by age, race/ethnicity, and geographic region. We also looked at Plan First participation among women with recent Medicaid maternity care across geographic regions. Because private providers participate in the Plan First program, we examined the availability and visit volume among private providers by geography. We calculated descriptive statistics over time.

Goal 2 analyses utilizes the landline phone surveys through the University of Alabama at Birmingham School of Public Health Survey Research Unit (SRU). A sample of Plan First enrollees is called and asked a series of questions about their knowledge, experience, and utilization of family planning services.

Goal 3 analyses utilize both claims and survey data to examine general utilization of family planning services with Plan First coverage as well as more specific information about specific clinical services, types of contraceptives used, case management, and provider type.

Goal 4 analyses utilize both claims and survey data related to smoking cessation.

Goal 5 analyses utilize claims data to examine the estimated and actual birth rates among enrollees, service users, and non-service users. Estimated birth rates are calculated based on pre-waiver levels and adjusted by race and age.

Goal 6 analyses utilize claims data related to vasectomy services. Previous years utilized the SRU for phone surveys, but recent surveys were conducted by mailing postcards with QR codes for a link to an online survey.

Methodological Limitations

Family Planning Care Coordination was transitioned from the Alabama Department of Public Health (ADPH) to seven Alabama Coordinated Health Networks (ACHNs) organizations in October 2019. This change resulted in a slight change in the reporting of enrollment and service use within different geographic areas of the state. However, for some of the results sections for specific goals, different classifications are included for overall examination and comparison. In DY21, the survey was revised slightly to lessen the time burden on participants. Therefore, not all the questions can be examined over time.

The structure for receipt of Plan First services has changed over time. In recent years, the service provision has shifted away from the health departments to private providers and the ACHN model. Further examination of the influence of these changes is needed to understand the full impact to the program. In addition, DY20 was impacted by COVID-19 and a new shift to the ACHNs.

Strengths and weaknesses of the study design

Eight sources of data are included in this evaluation study. These include quantitative (claims) and qualitative sources (surveys). There are limitations with both types of data—-claims records are complex and survey data are self-report and can lack depth because of standardization. However, this mixed methods approach gives the contextualized insights from the qualitative data of the surveys along with the insights of quantitative data of the Medicaid claims.

Strengths and weaknesses of the data sources/collection

The U.S Census data was used to estimate the age, race and geographic distribution of uninsured women who may be eligible for Plan First. The availability and type of Census data used for the eligibility populations changed over time. Most recently, the American Community Survey (ACS) data were used.

In DY17 and DY20, surveys were not conducted because there were delays in the contract process between Alabama Medicaid and UAB. In addition, in DY20, the evaluation team was unable to conduct the surveys because of COVID-19 issues. The survey begins in the spring and given the COVID shutdown, we were unable to begin the survey in a timely manner and would not have been able to complete it before the due date of the report.

Strengths and weaknesses of the analyses

Calculation of descriptive statistics, mostly measures of frequency, are most of the analyses in this report. These types of analyses reflect the nature of the evaluation goals and hypotheses. Future reports may include exploratory or predictive analyses.

Results

Goal 1 Results: Addressing Disparities in Enrollment

Evaluation Question and Hypothesis

Increase the portion of women eligible for Plan First who enroll and reduce racial/ethnic and geographic disparities in enrollment.

Target: The program goal is to enroll into Plan First 80% of eligible women between ages 19 and 40 across all racial/ethnic groups and geographic areas.

Hypotheses: We anticipate that the composition of the enrolled population will be demographically similar to the population of eligible participants because of programmatic features designed to reduce barriers to enrollment, such as automatic enrollment following delivery and allowing re-enrollment through Express Lane Eligibility. However, we do not expect the enrolled population to reflect the exact distribution of eligible women because enrollment in the program is voluntary. For example, based on past evaluations of Plan First, we anticipate lower enrollment rates among older women compared to younger women.

Goal 1 Overview

Enrollment of income-eligible women is a key metric that documents the impact of the demonstration program on providing coverage. To assess enrollment, we compared the number of women enrolled in Plan First to estimates of the number of income-eligible women in the American Community Survey, overall and according to age, race/ethnicity and geographic sub-groups.

We also examined patterns of re-enrollment in Plan First as this is an important *process indicator* that likely contributes to the overall number of eligible women enrolled in the program. We used consecutive years of enrollment data to assess re-enrollment patterns. We computed the overall percentage of women enrolled in the prior demonstration year (e.g., DY17) who re-enrolled in Plan First in the first period (e.g., DY18), and assessed differences in re-enrollment across sub-groups using chi- squared tests (Table 1.3). We also estimate the likelihood of re-enrollment after accounting for differences in characteristics of women in the program using multivariable-adjusted logistic regression (Table 1.4).

Additionally, we conducted a telephone survey of 300 women in all years except DY17 and DY20 who have been terminated from the Plan First program to better understand women's reasons for not re-enrolling in Plan First and identify potential solutions to reduce barriers to re-enrollment. This sample size is feasible given anticipated changes in women's contact information. The survey will be stratified by age because we expect women's eligibility and reasons for not re-enrolling in the program may be different for younger as compared to older women.

Goal 1 Results

In more recent years, enrollment in Plan First has remained significantly below the goal of 80% of eligible women (Fig 1.1). There have been variations of enrollment by age groups and racial/ethnic groups over time with women ages 24-44 and women who are Black having the highest proportion of enrollment among those eligible. Figure 1.1 and Table 1.1 provide an overview of the enrollment patterns from DY14 to DY20 by age, race, and geography. The percentage of women with SOBRA births using Plan First services declined over time (Table 1.2).

Table 1.3 presents the proportion of re-enrollment across demonstration years. In DY17-DY20, the re-enrollment from one year to the next was between roughly 60-70%. Ages 25-34 had the highest proportion of re-enrollment, with little difference by race. According to survey data, more than 60% of women were not aware that they were not enrolled in Plan First. Although there was variation between

the 2 years of surveys, obtaining health insurance and having an IUD/LARC were top reasons for not re-enrolling in the program.

Table 1.4 presents the primary factors associated with re-enrollment in Plan First in DY18 and DY19. After taking women's other characteristics into account, women 25 to 34 and 35 to 44 years old were more likely to re-enroll in Plan First than women between ages 19 and 24 in DY18, but in DY19, older women were less likely to re-enroll. In DY18, Black and Hispanic women and women reporting their race as "other" were more likely to re-enroll in the program than White women. In DY19, there was no difference in likelihood of enrollment across races except for those who reported their race as "other"—this group was more likely than White women to re-enroll.

Perhaps the strongest factor associated with whether women re-enroll is their use of clinical services; women who did not use clinical services (e.g., only had a pharmacy claim), had case management only or did not have any claim for services were significantly less likely to re-enroll in Plan First than women who had a clinical encounter.

Goal 1 Discussion/Recommendations

There have been significant changes in the Plan First program over the lifetime of the program and in the current demonstration period. Based on these data, enrollment in the program over time has declined; however, the re-enrollment trends relatively high at 60-70%. Given the transition to the ACHNs and the timing of COVID, the ability to fully engage with the target population has been limited. Additionally, the Medicaid Continuous Enrollment Provision may have impacted enrollment and re-enrollment numbers. Full evaluation of the impact of these contextual factors are critical and will be included moving forward.

Goal 1 Limitations

The calculations for eligibility varied over time. The American Community Survey data are no longer available by county, making it difficult to identify the specific proportion of women eligible. Because of this change, we will be reevaluating the use of the ACS and consider alternative data. Age groups were different over time as well. Transitions related to geographic categories, from Public Health Service areas to the ACHNs, makes it somewhat challenging to fully evaluate the change in disparities by geography. Table 1.3 does not include the service use data for those re-enrolling in DY20. We will re-analyze data and include this information in the final report for the demonstration period. Finally, there were some changes to the survey questions across this period. For the final report, the survey data will be re-analyzed for consistency.

Figure 1.1. Percent of women eligible* for Plan First who enrolled, over time and by age group (DY14-DY20)

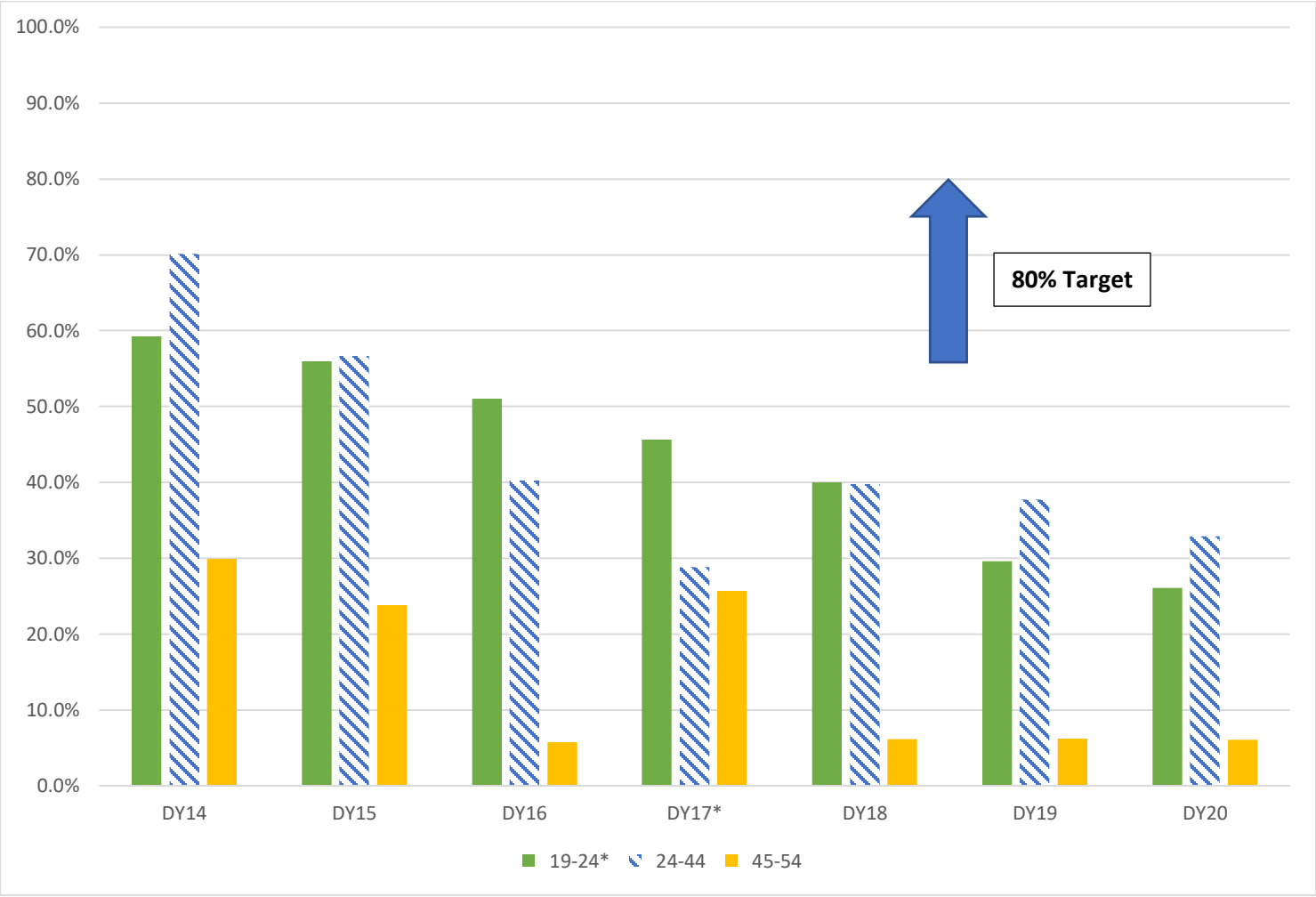

Figure 1.2. Percent of women eligible for Plan First who enrolled, over time and by race (DY14-DY20)

Table 1.1 Plan First Enrollment Over Time (Enrollment data)

	DY14	DY15	DY16	DY17	DY18	DY19	DY20	Average annual change	
								%	N
Total	**148,060**	**128,473**	**131,287**	**119,420**	**116,683**	**103,040**	**90,318**	**-7.73%**	**-9624**
Age									
19-29	102,469	86,147	86,487	75,783	69,550	55,886	47,911	-11.68%	-9093
30-39	34,982	32,566	34,524	33,612	36,189	35,622	31,337	-1.58%	-608
≥40	10,609	9,760	10,276	10,025	10,944	11,532	11,070	0.90%	77
Race									
Black	76,716	68,247	69,951	64,555	63,959	55,168	48,357	-7.21%	-4727
White	65,889	55,390	53,932	46,790	42,926	37,558	33,772	-10.44%	-5353
Hispanic	--	--	--	--	2,359	2,169	2,063	-2.16%	-148
Asian/Pacific Islander	--	--	--	--	607	470	421	-5.50%	-93
American Indian	--	--	--	--	374	317	305	-3.17%	-35
Other	5,455	4,836	7,404	8,075	6,458	7,599	7,044	6.86%	265
ACHN Regions									
Central	--	--	--	--	--	14,775	12,763	-13.62%	-2012
East	--	--	--	--	--	12,992	10,982	-15.47%	-2010
Gulf	--	--	--	--	--	19,254	16,929	-12.08%	-2325
Mid-state	--	--	--	--	--	14,943	13,459	-9.93%	-1484
Northeast	--	--	--	--	--	11,863	10,535	-11.19%	-1328
Northwest	--	--	--	--	--	14,187	12,542	-11.60%	-1645
Southeast	--	--	--	--	--	15,256	13,108	-14.08%	-2148
Public Health Area									
1	9,587	8,309	8,583	7,615	--	--	--	-7.10%	-493
2	19,530	16,845	17,149	15,343	--	--	--	-7.49%	-1047
3	9,144	8,161	8,233	7,285	--	--	--	-7.13%	-465
4	19,516	16,004	15,980	14,332	--	--	--	-9.49%	-1296
5	11,898	10,099	10,105	8,816	--	--	--	-9.27%	-771
6	11,466	10,251	10,422	9,327	--	--	--	-6.48%	-535
7	7,121	6,370	6,539	6,305	--	--	--	-3.82%	-204
8	20,959	18,312	19,173	17,511	--	--	--	-5.53%	-862
9	11,350	9,864	10,272	9,392	--	--	--	-5.84%	-490
10	10,724	9,737	10,050	9,433	--	--	--	-4.04%	-323
11	16,765	14,481	14,880	14,061	--	--	--	-5.46%	-676

Public Health District									
Northern	--	--	--	--	17,841	--	--		
Northeastern	--	--	--	--	15,007	--	--		
Jefferson	--	--	--	--	14,265	--	--		
East Central	--	--	--	--	18,737	--	--		
West Central	--	--	--	--	11,977	--	--		
Southeastern	--	--	--	--	13,334	--	--		
Southwestern	--	--	--	--	11,459	--	--		
Mobile	--	--	--	--	14,063	--	--		

*County-level population estimates of low-income women are not available for those 19-20 and 21-24,separately, due to ACS reporting.

Table 1.2. Plan First participation by women with recent Medicaid maternity care (Claims and Enrollment data)

	DY14	DY15	DY16	DY17	DY18	DY19	DY20
Women with SOBRA deliveries in the previous year and this year	49,760	38,575	36,978	34,934	32,095	34,978	30,556
Women using services in Plan First in DY	13,901	10,406	8,345	6,541	4,506	4691	1908
% Women with SOBRA births using PF services in DY	27.9%	27.0%	22.6%	18.7%	14.0%	13.4%	6.2%

Table 1.3 Percentage of Plan First participants who re-enrolled in the reporting year

	Number Enrolled in DY17	% Enrolled in DY17*		Re-enrolled in DY18†	Did not re-enroll†		Enrolled in DY18	% Enrolled in DY18*		Re-enrolled in DY19†	Did not re-enroll†		Enrolled in DY19	% Enrolled in DY19*		Re-enrolled in DY20†	Did not re-enroll†
TOTAL	119,410	100		65.1	34.9		116,553	100		59.0	41.0		103,275	100		71.9	28.1
Age, years‡																	
19-24	42,826	35.9		64.2	35.8		37,436	32.1		65.5	34.5		27,597	26.7		68.2	31.8
25-34	54,135	45.3		65.0	35.0		54,349	46.6		56.6	43.4		49,885	48.3		70.0	30.0
35-44	18,308	15.3		68.1	31.9		20,500	17.6		55.1	44.9		21,076	20.4		79.0	21.0
45-54	4,141	3.5		62.9	37.1		4,268	3.7		52.8	47.2		4,663	4.5		82.0	18.0
Race‡																	
White	46,787	39.2		61.7	38.3		42,930	36.8		57.8	42.2		37,558	36.4		70.6	29.4
Black	64,548	54.1		67.5	32.5		63,965	54.8		58.0	42.0		55,168	53.4		72.0	28.0
Hispanic	2,416	2.0		65.8	34.2		2,359	2.0		56.3	43.7		2,169	2.1		72.6	27.4
Asian/Pacific Islander	639	0.5		64.2	35.8		607	0.5		54.0	46.0		470	0.5		72.1	27.9
American Indian	425	0.4		59.3	40.7		374	0.3		58.3	41.7		317	0.3		76.0	24.0
Other race/ethnicity	4,595	3.8		66.5	33.5		6,459	5.5		78.4	21.6		7,599	7.4		76.7	23.3
Service use‡																	
Clinical services	31,142	26.1		75.9	24.1		23,749	20.4		64.0	36.0						
Non-clinical services only	8,703	7.3		69.5	30.5		9,121	7.8		61.9	38.1						
Case management only	4,873	4.1		62.6	37.4		6,208	5.3		65.0	35.0						
Did not use services	74,692	62.5		60.3	39.7		77,616	66.5		56.6	43.4						

Public Health District‡																	
Northern	18,939	15.9		62.6	37.4		19,884	17.0		59.4	40.6						
Northeastern	15,679	13.1		63.7	36.3		15,008	12.9		58.9	41.1						
Jefferson	14,330	12.0		64.5	35.5		14,267	12.2		62.3	37.7						
East Central	19,343	16.2		64.6	35.4		18,738	16.1		60.6	39.4						
West Central	11,956	10.0		67.0	33.0		11,979	10.3		55.3	44.7						
Southeastern	13,796	11.6		66.3	33.7		11,293	9.7		59.4	40.6						
Southwestern	11,308	9.5		67.6	32.4		11,460	9.8		57.9	42.1						
Mobile	14,059	11.8		66.8	33.2		14,065	12.1		56.8	43.2						
ACHN Region																	
Central							17,062	14.6		59.5	40.5		14,775	14.3		71.3	28.7
East							14,340	12.3		59.0	41.0		12,992	12.6		68.3	31.7
Gulf							21,936	18.8		57.5	42.8		19,254	18.6		72.2	27.8
Mid-state							16,240	13.9		61.9	38.1		14,943	14.5		73.9	26.1
Northeast							13,846	11.9		58.3	41.7		11,863	11.5		71.5	28.5
Northwest							16,610	14.2		57.6	42.5		14,187	13.7		72.9	27.1
Southeast							16,660	14.3		59.6	40.5		15,256	14.8		70.6	29.4

Table 1.4. Characteristics associated with re-enrollment in Plan First

	Odds ratio	**(95% CI)**	**Probability compared to chance**	**Odds ratio**	**(95% CI)**	**Probability compared to chance**
Age, years						
19-24	1	(ref)	reference	1.00	(ref)	Reference
25-34	1.09	(1.06-1.12)	more likely to enroll	0.73	(0.71-0.75)	Less likely to enroll
35-44	1.30	(1.25-1.35)	more likely to enroll	0.718	(0.69-0.74)	Less likely to enroll
45-54	1.06	(0.99-1.13)	no difference	0.63	(0.59-0.67)	Less likely to enroll
Race						
White	1	(ref)	reference	1.00	(ref)	Reference
Black	1.22	(1.19-1.25)	more likely to enroll	1.01	(0.98-1.04)	No difference
Hispanic	1.19	(1.09-1.30)	more likely to enroll	0.93	(0.85-1.02)	No difference
Asian/Pacific Islander	1.11	(0.94-1.31)	no difference	0.93	(0.79-1.10)	No difference
American Indian	--	--	--	1.04	(0.84-1.28)	No difference
Other race/ethnicity	1.22	(1.11-1.34)	more likely to enroll	2.69	(2.52-2.87)	More likely to enroll
Service use						
Clinical services	1	(ref)	reference	1.00	(ref)	Reference
Non-clinical services only	0.73	(0.69-0.77)	less likely to enroll	0.88	(0.84-0.94)	Less likely to enroll
Case Management only	0.53	(0.50-0.57)	less likely to enroll	1.02	(0.96-1.09)	No difference
Did not use services	0.48	(0.47-0.50)	less likely to enroll	0.73	(0.71-0.76)	Less likely to enroll
Public Health District						
Northern	1	(ref)	reference	1.00	(ref)	Reference
Northeastern	1.03	(0.99-1.08)	no difference	1.01	(0.96-1.05)	No difference
Jefferson	1.00	(0.96-1.05)	no difference	1.22	(1.17-1.28)	More likely to enroll
East Central	1.00	(0.96-1.04)	no difference	1.11	(1.06-1.16)	More likely to enroll
West Central	1.13	(1.07-1.19)	more likely to enroll	0.88	(0.83-0.92)	Less likely to enroll
Southeastern	1.09	(1.04-1.14)	more likely to enroll	1.00	(0.96-1.06)	No difference
Southwestern	1.12	(1.06-1.18)	more likely to enroll	0.98	(0.94-1.03)	No difference
Mobile	1.11	(1.06-1.16)	more likely to enroll	0.98	(0.93-1.03)	No difference
ACHN Region						
Northeast				1.00	(ref)	Reference
Northwest				0.98	(0.94-1.03)	No difference

Midstate				1.25	(1.19-1.31)	More likely to enroll
East				1.05	(1.00-1.11)	No difference
Central				1.10	(1.05-1.16)	More likely to enroll
Southeast				1.07	(1.02, 1.12)	More likely to enroll
Gulf				1.03	(0.98-1.08)	No difference

CI: confidence interval; -- unable to estimate due to sample size

1.5 Reasons women did not re-enroll in Plan First (survey)

All women not enrolled	DY18 (n=306)	DY19 (n=354)
Aware not enrolled	33.9% (104)	39.0% (138)
Not aware not enrolled	65.8% (202)	61.0% (216)
Main reason not re-enrolled:		
Health insurance	26.1% (80)	16.1% (57)
Tubes tied or hysterectomy	2.9% (9)	9.0% (32)
IUD/LARC	23.2% (71)	
Pregnant	14.1% (43)	22.9% (81)
No desired providers in area	10.1% (31)	0.28% (1)
Believed not eligible for Medicaid	22.2% (68)	4.0% (14)
Refused		27.1% (96)

† Among women who are not pregnant.

Goal 2 Results: Maintaining High Levels of Awareness of Plan First

Evaluation Question and Hypothesis

Target: The program goal is that 90% of surveyed enrollees will have heard of Plan First, and 85% will be aware that they are enrolled in the program.

Hypotheses: Since Plan First is a well-established program, we expect that the majority of women enrolled will have heard of it and will be aware that they are enrolled.

Goal 2 Overview

To assess women's awareness of Plan First and their own enrollment in the program, we conducted a telephone survey of 800 women. We determined the percentage of women who had heard of Plan First, who are aware they were enrolled in the program, and compared differences in characteristics according to women's awareness of their enrollment status, using chi-squared tests This sample size will provide 80% statistical power to determine whether there is a 6-percentage-point difference or larger in the number of women using family planning services and contraception who were unaware of their enrollment compared to those who were aware.

Goal 2 Results

In the latest Demonstration Year, over 96% of respondents to the survey were aware of Plan First, which is over the 90% benchmark. The percentage of those who are aware of Plan First and know that they are enrolled in program generally has exceeded the 85% target since DY7. The proportion of those who were aware of their enrollment among all those surveyed has increased over time. In DY18 and DY19, a higher proportion of women who knew they were enrolled in Plan First had a family planning visit in the last year. One-third of women who were surveyed in DY20 indicated that they did not need family planning because they are not having sex.

Goal 2 Discussion/Interpretation

The proportion of enrollees surveyed have heard of Plan First remains high and meets the benchmark. Given the findings related to knowledge of enrollment and having had a family planning visit in the past year, continued marketing and outreach of the program are important tools for engagement and clarity related to the available services. Given survey findings related to birth control not working and financial concerns, specific educational programs could be targeted for enrollees related to general contraception as well as costs associated.

Table 2.1. Awareness of Plan First program and program enrollment, DY1-DY20 (survey data)

	Had heard of Plan First before survey (%)	Aware of enrollment (%)	
		Among all surveyed	Among those who had heard of Plan First
DY1	76.8	56.2	73.1
DY2	82.5	64.2	77.9
DY3-4	81.0	64.9	80.2
DY5	85.3	63.6	74.9
DY6	86.8	70.2	82.5
DY7	92.9	80.8	87.1
DY8	88.9	85.3	85.9
DY9	90.8	79.7	87.8
DY10	88.7	78.3	88.2
DY11	90.1	79.3	88.1
DY12	88.7	77.2	87.0
DY13	89.9	79.9	88.9
DY14	90.1	74.9	83.2
DY15	92.6	78.8	85.0
DY16	91.1	77.6	85.2
DY18	90.5	77.8	86.0
DY19	100.0	87.6	87.6
*Results for DY17 and DY20 are not available as the survey was not conducted for these years.			

Table 2.2 Characteristics of survey respondents according to awareness of enrollment in Plan First, Available Years

	DY18		DY19	
	Know Enrolled (N=637)	**Do Not Know Enrolled** (N=182)	**Know Enrolled** (N=708)	**Do Not Know Enrolled** (N=97)
	(%)	(%)	(%)	(%)
All women	77.8	22.2	87.6	12.0
Has heard of Plan First				
Yes	100	57.1	100	100
No	0	40.1	0	0
Last family planning visit				
In last year	71.7	63.7	71.2	54.7
More than a year ago, but within 3 years	19.5	17.0	19.2	15.8
More than 3 years ago/don't know	6.4	11.0	4.8	26.6
Never	2.4	8.2	3.8	13.7
Reason for no visit in last year				
I did not think I needed one	9.8	7.7	18.9	15.6
I was too busy to arrange an appointment	22.9	11.5	32.9	9.4
I couldn't afford it	2.6	3.8	7.3	21.9
I did not want to go to the place I went before	2.0	0	1.2	3.1
The place I went before could not see me	2.0	3.8	4.3	3.1
I did not know that I was enrolled			3.7	25.0
I had a tubal ligation			4.3	9.4
Other	58.8	73.1	27.4	12.4
Reasons for not using family planning				
Don't like exam	4.5	5.0	7.9	4.5
No provider you wanted to see	6.7	6.0	5.8	4.5
Hard to reach on the phone	7.4	9.9	5.8	7.9
Couldn't get appointment soon enough	10.0	15.9	9.3	14.8
Waiting time too long at location	11.5	14.3	8.7	17.0
Hours not convenient	3.4	6.6	2.1	4.6
No transportation	2.8	5.5	2.7	1.1
No childcare	3.1	7.1	3.0	4.6
No money to pay for visit	9.1	14.3	6.7	14.4

	DY18		DY19	
	Know Enrolled (N=637)	**Do Not Know Enrolled** (N=182)	**Know Enrolled** (N=708)	**Do Not Know Enrolled** (N=97)
Preferred provider does not take Medicaid	12.7	12.6	12.7	16.7
Any birth control method used	78.7	79.7	60.3	50.0
Reasons for not using birth control				
Not having sex	25.7	17.4	25.9	30.8
Want to get pregnant	36.4	36.8	41.7	44.4
Concerned about side effects	43.6	36.8	36.7	33.3
Don't think birth control works	23.6	47.4	33.3	33.3
Religious reasons	5.4	5.3	1.7	0
Too much trouble	5.4	15.8	5.0	0
Don't think you can get pregnant	30.9	42.1	31.7	22.2
Partner doesn't want you to go	20.0	10.5	10.0	11.1
Can't pay for method	12.7	31.6	16.7	55.6
Can't find a place to go	16.4	21.1	20.0	22.2
Ever pregnant	82.0	80.2	79.0	82.2
Education				
< high school	6.9	7.7	6.1	8.9
high school	34.5	39.6	37.0	36.8
more than high school	58.1	52.2	56.4	53.3
Race/ethnicity				
White	33.3	33.0	37.2	31.0
Black+	59.3	55.5	57.3	66.6
Hispanic	3.1	6.0	3.4	4.4
Asian/Pacific Islander	0.2	1.1	0.6	0
American Indian	1.3	1.6	1.2	1.1
Other race/ethnicity	2.8	2.7	3.7	3.3
Marital Status				
Not married or in a relationship	41.9	46.4	38.6	37.9
Non-cohabiting relationship	20.2	14.4	17.7	20.7
Married or cohabiting	30.5	32.0	35.3	33.3
Previously married	7.3	7.2	7.5	5.5

Goal 3 Results: Increasing Family Planning Service Use among Plan First Enrollees

Evaluation Question and Hypothesis

Target: The program goal is to achieve 70% use of services in the initial year of enrollment and increase service use in subsequent years.

Hypotheses: Based on prior evaluations of Plan First, we expect service use to be more common among younger women than among older women, since younger women tend to rely on shorter acting hormonal methods for contraception and are recommended for routine STI and cervical cancer screening, both of which require more regular contact with providers. Because Plan First offers no-cost contraception, we also expect more than half of women using services to have a claim for a moderate or highly effective contraceptive method.

Goal 3 Overview

The types of services that women enrolled in Plan First use are *key indicators of the quality of care* provided through the program. In addition to reporting the primary method used by women enrolled in the program (Table 3.2), we report on the overall percentage of women who were provided with a moderately or highly effective contraceptive method. We define this indicator according to the Health Care Quality Measures for Medicaid Eligible Adults (Measure CCW). Specifically, moderately and highly effective methods will include female sterilization, the contraceptive implant, intrauterine devices or systems (IUD/IUS), injectables, oral contraceptives, hormonal patch, ring and diaphragms.

We also used the claims data to compute the percentage of women using specific contraceptive methods and compare differences in use according to the type of provider from whom a participant obtained services and her public health district. This information, along with theoverall percentage of women using a long-acting reversible contraceptive method (IUD/IUS or implant), provides useful *indicators of women's access* to the full range of contraceptive methods and potential disparities to access.

As an indicator of the quality of contraceptive care, we determine whether women are using their preferred method of contraception. Following our approach in previous evaluations, we include questions about the birth control method women are currently using and the method they would like to use in our telephone survey and compute the percentage of women using their preferred method. We also ask women why they are not using the method they prefer to identify potential opportunities to decrease barriers. Screening for sexually transmitted infections (STIs), cervical and breast cancer are other quality of care indicators that are included in our evaluation report.

To assess screening for STIs, we use claims for chlamydia, gonorrhea, herpes, HIV, syphilis and trichomonas. We report this indicator for women only since STI screening is not a covered benefit for men enrolled in Plan First. We also report separately on chlamydia screening for sexually active women 21-24, following the Health Care Quality Measures for Medicaid Eligible Adults (Measure CHL-AD). We evaluate cervical cancer screening according to the Health Care Quality Measures for Medicaid Eligible Adults recommendation (Measure CCS-AD) by evaluating claims for a Pap test in the demonstration year or 2 prior years for women 21-55and claims for HPV co-testing in the demonstration year or 4 prior years for women 30-55. Claims for clinical breast exams are used to assess the number (percentage) of women who received this service.

We also assess how participation in Plan First varies according to women's initial and subsequent enrollment. We calculate the number and percentage of women using clinical and non-clinical services. This provides evidence of women's demand for services and identify potential sub-groups for focused outreach on program services. This assessment uses data from eligibility determination and Plan First claims.

Goal 3 Results

Over time, there has been an overall decline in the proportion of enrollees using services, but between DY19 and DY20, there was an increase of 10%. Younger women ages 19-29 have the highest use of services. The highest proportion utilizing services are Black, but the greatest increase in use in recent years is among Asian Indian/Pacific Islander. There are also differences in the proportion of utilization by ACHN region. (Table 3.1)

More than three-quarters of all women (76.7%) surveyed use any contraception; slightly less (72.1%) use effective contraception, defined as tubal ligation, partner vasectomy, IUD, implant, injectable contraceptives, oral contraceptives, vaginal ring and/or contraceptive patch. Table 3.4 shows trends in types of services by provider types. There has been an increase in the proportion of clients receiving care coordination. There has been a decline in Depo-Provera and no real change in tubal ligations over time. The proportion of visits conducted as health departments have declined and private provider visits have increased.

Tables 3.3a-c provide trends in contraceptive use by age categories. The percent of women who use of effective contraceptive method declines as age increases.

The proportion of screenings for sexually transmitted infections, cervical and breast cancer are lower among those enrolled compared to those who are using services (Table 3.5), but among those using services, screening for cervical cancer and breast cancer has increased over time. In DY20, almost 38% of enrollees using services were screened for chlamydia compared to roughly 20% for cervical cancer.

Table 3.6a-c show the proportion of new and re-enrollees over time. Among those newly enrolled, roughly 1 in 4 women utilize services. However, among re-enrollees, around 40% utilize services.

Goal 3 Discussion/Interpretation

With the ACHN organizations, there is a unique opportunity to increase the proportion of enrollees who use services, specifically effective contraceptive services, and screenings for STIs and cancer. There may be an opportunity to engage with re-enrollees to increase utilization of services, as these data consistently indicate that once women are in the program, they are more likely to continue using services and contraceptive services.

Table 3.1. Proportion of Plan First Enrollees Using Services in the DY Over Time (Enrollment and Claims data)

	DY16	DY17	DY18	DY19	DY20	% Change current year from previous year
Total	45.5%	41.8%	33.5%	34.1%	37.7%	10.6%
Age						
19-29	50.7%	46.9%	39.0%	40.3%	43.7%	8.4%
30-39	37.7%	34.7%	26.7%	28.0%	32.7%	16.8%
≥40	28.6%	26.8%	20.6%	22.8%	25.7%	12.7%
Race						
Black	49.1%	44.5%	35.0%	35.3%	40.4%	14.4%
White	41.4%	38.4%	32.1%	33.0%	34.8%	5.5%
Hispanic			31.2%	29.4%	32.8%	11.6%
Asian/Pacific Islander			22.1%	20.4%	24.5%	20.1%
American Indian			29.9%	34.1%	36.2%	6.2%
Other/unknown	42.3%	39.9%	29.9%	32.5%	34.9%	7.4%
ACHN Region						
Central				35.8%	37.0%	3.4%
East				37.7%	40.1%	6.4%
Gulf				34.7%	38.5%	11.0%
Mid-state				22.8%	31.8%	39.5%
Northeast				29.2%	34.4%	17.8%
Northwest				38.4%	41.8%	8.9%
Southeast				39.2%	40.2%	2.6%

Table 3.2 Contraceptive use among women, DY14-DY19

Use of Contraceptives	DY14	DY15	DY16	DY18	DY19
N	1,070	1,080	1,070	770	808
Used any contraception, %	84.1	85.6	81.6	80.9	76.7
Used effective contraception† %	75.8	81.3	74.5	74.5	72.1
Of those using any contraceptive method:					
Tubal ligation, %	5.3	5.0	9.7	3.3	2.8
Vasectomy, %	1.3	2.0	2.5	1.1	0.6
IUD, %	16.4	20.0	18.1	13.0	13.7
Contraceptive implant, %	15.1	15.6	15.7	8.8	9.6
Injectables, %	39.1	41.5	36.9	18.0	17.3
Oral contraceptive pills (OCs), %	58.0	53.5	53.3	26.1	22.2
Got OCs from Health Dept.	58.4	51.7	53.5	55.1	56.7
Got OCs from free sample	18.5	21.8	19.7	6.7	7.8
Got OCs from drug store	22.7	26.1	25.9	38.2	34.7
Don't know, not sure	0.4	0.4	0.9	0.0	0.7
Vaginal ring, %	8.5	7.6	7.9	2.6	**2.5**
Got ring from Health Dept.	46.7	47.1	34.8	41.2	62.5
Got ring from free sample	29.9	31.4	40.6	29.4	12.5
Got ring from drug store	20.8	21.4	23.2	29.4	25.0
Don't know, not sure	2.6	0.0	1.4	0.0	0.0
Patch, %	6.8	5.7	5.9	1.5	**1.6**
Got patch from Health Dept.	54.1	35.8	40.4	11.1	30.0
Got patch from free sample	24.6	26.4	30.8	22.2	0.0
Got patch from drug store	21.3	37.7	26.9	66.7	70.0
Don't know, not sure	0.2	0.0	1.9	0.0	0.0
Emergency contraception (ever used), %	9.3	7.8	7.4	0.0	7.7
Condoms, %	78.6	71.0	70.1	22.1	15.3
Withdrawal, %	50.3	51.0	48.2	2.8	3.9
Natural family planning, %	7.9	8.0	9.4	0.7	0.9

*Separate surveys were not conducted for DY17 or DY20 † Includes any respondent reporting use of tubal ligation, partner vasectomy, IUD, implant, injectable contraceptives, oral contraceptives, vaginal ring and/or contraceptive patch.

Table 3.3a. Trends in Contraceptive use, by age, DY14-DY19

	Age 19-24				
	DY14	DY15	DY16	DY18	DY19
N	385	345	239	186	170
% Used any method	88.0	88.5	81.6	91.4	81.0
% Used effective method†	80.6	85.0	74.7	76.9	75.4
Tubal ligation	1.2	1.8	2.1	0.6	0
Vasectomy	0.3	0.3	0.0	0	0
IUD	11.5	14.8	9.6	8.3	15.1
Contraceptive implant	16.5	16.6	18.7	8.9	14.2
Injectable contraceptives	46.8	43.0	43.8	17.3	19.1
Oral contraceptive pills	58.5	55.3	50.3	33.9	28.4
Vaginal Ring	10.3	5.6	8.0	3.6	2.1
Contraceptive patch	6.5	3.5	4.3	2.4	0.7
Plan B	10.9	8.1	8.0	0	12.5
Condoms	81.5	72.2	74.3	22.0	14.9
Natural family planning	5.0	4.9	9.1	3.0	4.3
Withdrawal	59.1	59.1	56.7	0	0.7

*Separate surveys were not conducted for DY17 or DY20 † Includes any respondent reporting use of tubal ligation, partner vasectomy, IUD, implant, injectable contraceptives, oral contraceptives, vaginal ring and/or contraceptive patch

Table 3.3b. Trends in Contraceptive use, age 25-34, DY14-DY19

	Age 25-34				
	DY14	**DY15**	**DY16**	**DY18**	**DY19**
N	515	594	629	323	396
% Used any method	85.6	85.6	83.4	79.9	77.7
% Used effective method[†]	77.6	81.6	76.2	79.9	74.0
Tubal ligation	7.0	5.3	9.4	2.8	2.9
Vasectomy	1.8	2.2	1.2	1.2	1.0
IUD	21.5	24.9	20.5	14.9	14.6
Contraceptive implant	14.9	17.4	16.7	11.6	10.1
Injectable contraceptives	35.1	39.5	36.2	16.5	17.5
Oral contraceptive pills	58.8	53.6	54.3	23.7	22.1
Vaginal Ring	8.1	9.3	8.1	2.8	3.6
Contraceptive patch	7.9	6.7	6.3	1.2	2.3
Plan B	8.4	7.9	8.9	0	8.1
Condoms	79.2	71.5	69.7	22.1	1.3
Natural family planning	9.3	9.3	9.2	3.2	14.9
Withdrawal	47.7	49.8	47.6	0	3.2

*Separate surveys were not conducted for DY17 or DY20 † Includes any respondent reporting use of tubal ligation, partner vasectomy, IUD, implant, injectable contraceptives, oral contraceptives, vaginal ring and/or contraceptive patch

Table 3.3c. Trends in Contraceptive use, age 35+, DY14-DY19

	Age 35+				
	DY14	**DY15**	**DY16**	**DY18**	**DY19**
N	170	184	244	193	238
% Used any method	70.6	80.6	76.8	74.5	72.7
% Used effective method[†]	58.7	73.9	69.8	80.3	65.9
Tubal ligation	10.7	10.3	18.2	6.3	5.2
Vasectomy	2.5	4.8	6.6	2.1	0.6
IUD	11.6	13.7	20.4	14.7	16.2
Contraceptive implant	11.6	7.5	9.9	5.2	5.8
Injectable contraceptives	32.2	45.2	31.5	20.4	16.8
Oral contraceptive pills	53.7	50.0	53.6	22.0	19.1
Vaginal Ring	5.0	5.5	7.2	1.6	1.1
Contraceptive patch	3.3	6.8	6.6	1.0	1.1
Plan B	8.3	6.8	2.8	0	4.0
Condoms	68.6	67.1	66.8	22.5	17.3
Natural family planning	10.7	9.6	9.9	2.1	5.2
Withdrawal	34.7	39.0	40.9	2.1	0.6

*Separate surveys were not conducted for DY17 or DY20 † Includes any respondent reporting use of tubal ligation, partner vasectomy, IUD, implant, injectable contraceptives, oral contraceptives, vaginal ring and/or contraceptive patch

Table 3.4. Trends in Types of Services, by provider type, DY14-DY20

Service Type	**Provider Type**	**DY14**	**DY15**	**DY16**	**DY17**	**DY18**	**DY19**	**DY20**
Care Coordination	Health Department	52.5%	53.3%	50.3%	52.8%	53.7%	51.4%	--
	Private	11.6%	4.6%	3.5%	3.2%	2.6%	2.4%	--
	Both	60.6%	57.1%	52.1%	57.3%	50.1%	40.4%	--
	Neither	34.2%	33.4%	20.3%	31.9%	40.4%	37.3%	--
	Total with Service	25,654	21,559	13,258	18,360	14,989	12,836	14,930
	% All Clients	37.6%	37.2%	29.6%	36.8%	38.4%	36.4%	43.7%
HIV Counseling	Health Department	44.6%	61.7%	61.9%	64.0%	48.6%	50.6%	34.6%
	Private	1.7%	2.5%	2.4%	3.5%	2.3%	2.3%	1.1%
	Both	37.1%	56.1%	57.2%	62.3%	34.9%	34.3%	47.2%
	Neither	6.8%	8.1%	8.5%	14.5%	8.3%	12.0%	0.0%
	Total with Service	16,391	20,042	13,464	18,432	9,146	9,131	8,935
	% All Clients	24.0%	34.5%	30.1%	36.9%	23.4%	25.9%	26.5%
Tubal Ligations	Health Department	0.2%	0.1%	0.2%	0.1%	0.1%	0.1%	0%
	Private	1.0%	1.2%	1.0%	1.2%	0.8%	1.2%	3.1%
	Both	6.3%	5.8%	4.8%	5.0%	3.0%	3.8%	2.1%
	Neither	1.5%	1.7%	1.0%	1.0%	0.5%	0.8%	0%
	Total with Service	564	515	340	345	173	220	249
	% All Clients	0.8%	0.9%	0.8%	0.7%	0.4%	0.6%	0.7%
Depo Provera	Health Department	40.6%	42.2%	44.4%	38.6%	41.4%	38.6%	9.8%
	Private	37.3%	38.1%	39.1%	41.1%	42.9%	36.4%	26.5%
	Both	42.2%	45.0%	47.4%	48.1%	67.5%	52.4%	22.2%
	Neither	0%	0%	0%	0%	0%	0%	15.0%*
	Total with Service	20,257	17,895	12,374	13,666	10,107	8,093	4870
	% All Clients	29.7%	30.8%	27.6%	37.4%	25.9%	23.0%	14.5%
Birth Control Pills	Health Department	28.5%	36.6%	36.5%	39.6%	37.1%	35.9%	33.4%
	Private	18.0%	1.4%	8.5%	12.2%	19.4%	17.6%	23.7%
	Both	24.8%	29.2%	28.7%	34.0%	22.0%	30.0%	33.6%
	Neither	27.7%	6.3%	14.2%	25.3%	33.2%	31.1%	85.5%*
	Total with Service	17,406	12,036	10,029	14,835	12,427	10,719	12,650
	% All Clients	25.5%	20.7%	22.4%	29.7%	31.8%	30.5%	37.6%

*Indicates “Pharmacy only”

Table 3.5. Beneficiaries screened for sexually transmitted infections, cervical and breast cancer during the demonstration year

	2018			2019			2020		
	# tested or screened	% Enrolled	% Using services	# tested or screened	% Enrolled	% Using services	# tested or screened	% Enrolled	% Using services
Sexually transmitted infections*	16,559	14.2	42.2	15,162	14.7	43.0	12,820	14.1	37.5
Chlamydia†	3,540	14.3	35.6	3,423	15.8	35.5	3,720	18.4	39.0
Cervical cancer‡	13,776	11.8	35.1	6,150	6.0	17.5	2,682	6.3	20.4
Breast cancer	11,194	9.6	28.6	8,719	8.4	24.8	12,256	13.5	35.9

* Includes chlamydia, gonorrhea, herpes, HIV, syphilis and trichomonas

† Reported for women 21-24 only

‡ Assessed using claims for a Pap test in the demonstration year or 2 prior years for women 21-55 and claims for HPV co-testing in the demonstration year or 4 prior years for women 30-55.

Table 3.6a. Plan First service use in DY18, according to women's duration of enrollment

	Newly enrolled		**Re-enrolled**	
	Postpartum	Not postpartum	From DY17	From DY17 & DY16
	N (%) *	N (%) *	N (%) *	N (%) *
TOTAL	5,979	32,903	25,720	52,069
Used clinical services†				
Any service	836 (14.0)	5,519 (16.8)	5,981 (23.2)	11,411 (21.9)
Contraceptive services	557 (9.4)	2,865 (8.7)	3,329 (12.9)	6,387 (12.3)
Non-clinical services only	693 (11.6)	2,215 (6.7)	1,964 (7.6)	4,249 (8.2)
Case management only	130 (2.2)	1,864 (5.7)	1,626 (6.3)	2,588 (5.0)
Did not use services	4,320 (72.2)	23,305 (70.8)	16,149 (62.8)	33,821 (65.0)

DY: Demonstration Year

* Column percentages

† chi-square p-value <.001

Table 3.6b. Plan First service use in DY19, according to women's duration of enrollment

	Newly enrolled		Re-enrolled	
	Postpartum	Not postpartum	From DY18	From DY18 & DY17
	N (%)	N (%)	N (%)	N (%)
Total Enrolled	8,271	26,168	34,823	34,019
Used clinical services and contraceptive method	939 (11.3)	3967 (15.2)	5500 (15.8)	5057 (14.9)
Used contraceptive method only	605 (7.3)	872 (3.3)	1420 (4.1)	1213 (3.6)
Used case management and a contraceptive method	12 (0.1)	203 (0.8)	341 (1.0)	307 (0.9)
Subtotal with claim for a contraceptive method	**1,556 (18.8)**	**5,042 (19.3)**	**7,261 (20.8)**	**6,577 (19.3)**
Used clinical services, no contraceptive method	329 (4.0)	1624 (6.2)	2023 (5.8)	1828 (5.4)
Used other services no contraceptive method	377 (4.6)	1289 (4.9)	1413 (4.0)	1488 (4.4)
Used case management, no contraceptive method	107 (1.3)	1341 (5.1)	1459 (4.2)	1466 (4.3)
Subtotal using any services	**2,369 (28.6)**	**9,296 (35.5)**	**12,156 (34.9)**	**11,359 (33.4)**
Did not use services	5,902 (71.3)	16,872 (63.1)	22,667 (65.1)	22,660 (66.6)

DY: Demonstration Year

Table 3.6c. Plan First service use in DY20, according to women's duration of enrollment (Claims and Enrollment data)

	Newly enrolled		Re-enrolled	
	Entered from other Medicaid program	Newly entered	Renewed from previous year only	Renewed from previous year and before
	N (column %)	N (column %)	N (column %)	N (column %)
Total Enrolled (row %)	**8716 (9.6%)**	**6614 (7.3%)**	**33,617 (37.1%)**	**41,736 (46.0%)**
Used contraceptive method, clinical services and care coordination	149 (1.7%)	409 (6.2%)	2,809 (8.3%)	3,228 (7.7%)
Used contraceptive method and clinical services	671 (7.7%)	519 (7.8%)	2,515 (7.5%)	2,642 (6.3%)
Used contraceptive method and care coordination	20 (0.2%)	10 (0.1%)	109 (0.3%)	177 (0.04%)
Used contraceptive method only	822 (9.4%)	238 (3.6%)	1,592 (4.7%)	1,496 (3.6%)
Subtotal with claim for a contraceptive method	**1,662 (19.1%)**	**1,176 (17.8%)**	**7,025 (20.9%)**	**7,543 (18.1%)**
Used clinical services and care coordination, no contraceptive method	135 (1.5%)	441 (6.6%)	2,486 (7.4%)	2,849 (6.8%)
Used clinical services, no contraceptive method	748 (8.5%)	781 (11.8%)	3,509 (10.4%)	3,662 (8.8%)
Used care coordination, no contraceptive method	85 (1.0%)	29 (0.4%)	857 (2.5%)	1,137 (2.7%)
Subtotal using services but no contraceptive method	**968 (11.1%)**	**1,251 (18.9%)**	**6,852 (20.4%)**	**7,677 (18.4%)**
Did not use services	**6,086 (69.8%)**	**4,187 (63.3%)**	**19,740 (58.7%)**	**26,516 (63.5%)**

DY: Demonstration Year

Goal 4 Results: Increasing Use of Smoking Cessation Modalities

Evaluation Questions and Hypothesis

Smoking cessation coverage has been available in Plan First since 2012.
Target: The program goal is to have 85% of smokers receiving these services.

Hypothesis: Data from recent surveys of Plan First enrollees indicate that approximately 25% are smokers. We expect that the majority of enrolled smokers will report that their health care provider advised them to quit smoking and about half will report they were provided with information about smoking cessation services.

Goal 4 Overview

Smoking cessation coverage has been available in Plan First since 2012. As a key *process indicator* of offering this coverage, we calculate the number and percentage of Plan First participants in the telephone survey who were asked by their Plan First provider about smoking and which smoking cessation options were discussed: use of Nicotine gum, patch, spray, pill or referral to the Alabama Quit Line. We also assess the number and percentage of women who are interested in using these products and services to quit smoking. Following previous evaluations, we also continue to assess two main *outcomes*: the number of PlanFirst participants who were referred to the Alabama Quit Line and the number who had a claim for a smoking cessation product.

Goal 4 Results

Approximately 23% of women enrolled in Plan First report smoke or use e-cigarettes. Generally, more than 90% of smokers surveyed reported that they were asked about smoking by their Plan First provider. More than 80% reported that their family planning provider advised them to quit smoking, but less than half of smokers reported discussing how to quit with their provider. Roughly 60% received either a referral to the Quit Line, a recommendation to use a Nicotine Replacement Therapy (NRT) product, or a prescription for NRT products. Thus, as in past evaluation years, the portion of Plan First service users receiving some type of smoking cessation services is lower than the target of 85% of smokers (Table 4.1).

Goal 4 Interpretation/Discussion

Given the high rates of obesity, hypertension, and other morbidities in the target population for Plan First, smoking cessation is critical. Although many providers are asking about smoking and the need to quit, the follow-through regarding NRT and referral to the Quit Line is still low. Engagement with the ACHNs and providers to address the disconnect on this issue is an important step in increasing the uptake of these services.

Table 4.1 Smoking cessation based on enrollee survey data

	DY14 N (%)	**DY15** N (%)	**DY16** N (%)	**DY18** N (%)	**DY19** N (%)
Reported Smoking	283 (28.6)	269 (25.8)	265 (26.1)	190 (24.2)	179 (22.8)
Asked about smoking at FP visit	265 (93.6)	248 (92.2)	240 (90.6)	174 (91.6)	160 (89.4)
Advised to quit by FP provider	212 (80.0)	205 (82.7)	197 (82.1)	133 (76.4)	124 (69.3)
Received NRT	111 (41.9)	121 (48.8)	112 (46.7)	76 (43.7)	87 (48.6)
Referred to Quit Line	110 (41.5)	132 (53.2)	133 (55.4)	88 (50.6)	76 (42.4)
Received either NRT or Quit Line referral	149 (56.2)	158 (63.7)	158 (65.8)	113 (64.9)	107 (59.7)
Paid out of pocket for NRT products	--	30 (12.1)	27 (11.2)	25 (14.4)	22 (12.2)

-- Not asked in Enrollee Survey

* Separate surveys were not conducted for DY17 and DY20

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

	DY 18		DY 19		DY 20	
	N	%	N	%	N	%
Plan First service users	39,196	--	35,180	--	34,154	--
Estimated number of smokers (based on survey data)	9,485	24.2	8,021	22.8	7,787*	22.8
Service users with claims for covered NRT products (% of estimated number of smokers)	102	1.1%	63	0.8%	38	0.5%

*Estimate

Goal 5 Results: Maintaining Low Birth Rates among Plan First Service Users

Evaluation Questions and Hypothesis

Target: A rate of about 100 births per 1000 enrollees is estimated to be sufficient to achieve budget neutrality for Plan First.

Hypothesis: Based on prior evaluations of Plan First, we hypothesize that the birth rate among program participants will be less than the expected birth rate in the absence of the program. We also anticipate that birth rates will be lower among women who used Plan First services than those who enrolled but did not have a clinical encounter.

Goal 5 Overview

We evaluate this *outcome* of the program for all women enrolled in Plan First and according to their use of services in the program using SOBRA maternity claims matched to Plan First enrollment and claims files. Following our approach for estimating the birth rate in prior evaluations, we count births that occurred through 9 months after the end of the demonstration year and exclude births from pregnancies that occurred before women enrolled. Therefore, reports of the birth rate and births averted will be available with a one-year lag (i.e., the birth rate reported in DY18 will reflect those that occurred to women enrolled in DY17).

Goal 5 Results

Table 5.1 reports birth rates from the previous demonstration year, to allow time for pregnancies starting during the demonstration year, to be counted through the following year. Birth rates remain much lower with the Plan First program than estimated, based on pre-program birth rates. Additionally, birth rates were lower for clinical service users than for enrollees who did not use services.

Goal 5 Discussion/Interpretation

Consistently, the birth rates of Plan First enrollees are roughly half of the target of 100 births per 1000 enrollees. As noted previously, the majority enrollees in Plan First, even if not utilizing services, are using effective contraceptive methods. Because birth rates are consistently lower among clinical service users, continued focus on engaging enrollees in clinical services is important.

Table 5.1 Estimated and actual birth rates to women enrolled in Plan First

	DY18			DY19			DY20		
	# Enrollees	**# of Births**	**Births/1000**	**# Enrollees**	**# of Births**	**Births/1000**	**# Enrollees**	**# of Births**	**Births/1000**
		Assuming pre-waiver fertility levels*			**Assuming pre-waiver fertility levels***			**Assuming pre-waiver fertility levels***	
All enrollees			176.9	116,693	18,692	160.2	103,281	16,484	159.6
		Actual births after enrollment			**Actual births after enrollment**			**Actual births after enrollment**	
All enrollees not pregnant at enrollment	113,137	5,254	46.4	116,415	4,161	35.7	102,990	5,257	51.0
Service Users not pregnant at first visit	42,344	1,460	34.5	38,842	942	24.3	35,173	1,725	49.0
Non-service users not pregnant at enrollment	70,793	3,794	53.6	77,377	2821	36.5	67,817	3,532	52.1

*Adjusted for age and race

Table 5.1 Estimated and actual birth rates to women enrolled in Plan First (Claims data)

	Estimated birth rate if fertility rates continued at pre-waiver levels*	**Actual birth rates <u>all enrollees</u> – pregnancies starting during DY**	**Actual birth rates <u>service users</u> – pregnancies starting during DY**	**Actual birth rates <u>non-service users</u> – pregnancies starting during DY**
DY1	189.8	60.0	47.8	72.3
DY2	200.7	87.5	54.3	118.9
DY3	204.7	96.6	56.5	131.1
DY4	205.9	92.0	56.2	122.9
DY5	202.6	98.3	58.6	121.7
DY6	224.1	81.8	31.1	105.4
DY7	215.0	57.2	44.0	69.7
DY8	214.8	75.7	65.0	86.6
DY9	127.1	59.1	43.3	78.2
DY10	202.3	69.1	60.8	97.0
DY11	200.1	73.3	58.3	92.6
DY12	180.1	77.3	60.8	97.0
DY13	199.9	84.0	72.5	88.6
DY14	203.1	72.4	58.3	84.9
DY15	196.7	62.7	61.0	63.9
DY16	182.4	60.9	63.1	59.0
DY17	176.9	46.4	34.5	53.6
DY18	160.2	42.4	40.8	43.1
DY19	159.6	51.0	49.0	52.1

*Adjusted for age and race

Goal 6 Results: Increase Male Enrollment and Vasectomy Service Use

Evaluation Questions and Hypothesis

Target: Our goal is that the number of men enrolled in Plan First for vasectomies and vasectomy-related covered services will increase by 10% annually, 85% of male Plan First enrollees will receive care coordination services, and 75% of male enrollees will undergo the procedure within the enrollment year. We will evaluate this goal based on the number of men enrolled and claims for care coordination and vasectomies.

Hypothesis: We anticipate that men's use of vasectomy services will increase over time, and that those who receive care coordination services will be more likely to obtain a vasectomy through Plan First than those who do not receive care coordination.

Goal 6 Overview

We compare differences in vasectomy use among enrolled men according to their race, receipt of care coordination services and public health district. This helps us identify sub-groups where additional education and outreach may be needed to improve access to care.

Goal 6 Results

Male enrollment in Plan First increased almost 10% (9.8%) between DY 19 and DY 20. In previous years, the increase in enrollment was greater. However, the portion of male enrollees receiving a vasectomy remains extremely low, at less than 1% (Table 6.1).

Goal 6 Discussion/Interpretation

Additional exploration of vasectomy services is needed. Given COVID-19 delays and the initial years of the ACHNs, there have been limited opportunities to engage with enrolled men, as originally outlined in the evaluation plan. At this point in the demonstration period, the qualitative methods have not been conducted, so we will continue to work with AL Medicaid to identify ways to approach this goal.

Because of low response rates to phone surveys, we wanted to try to engage this population in a unique way. In DY20/21, we created an online survey accessible via QR code. Postcards were created and distributed to all male enrollees. Unfortunately, this technique was not successful in increasing the response rate. We will continue to evaluate how best to engage with the enrollees as well as work with the ACHNs to better understand the needs and experiences of this population.

Table 6.1. Percentage of Men Enrolled Who Obtained a Vasectomy through Plan First (Claims and Enrollment data)

	DY15 (10/14-9/15)	DY16	DY17	DY18	DY19	DY20
Number of men enrolled	n/a	823	1241	1159	1500	1647
Enrollment percent increase			50.8%	-6.6%	29.4%	9.8%
Number obtaining vasectomy	0	14	29	34	14	11
% Enrolled obtaining vasectomy	--	1.7%	2.3%	2.9%	0.9%	0.7%

n/a – information on gender was not included in the enrollment files
Services began in DY15

Table 6.2. Percentage of men enrolled who obtained a vasectomy through Plan First

	2018		2019		2020	
	Enrolled N (%)	**Obtained vasectomy N (%)**	**Enrolled N (%)**	**Obtained vasectomy N (%)**	**Enrolled N (%)**	**Obtained vasectomy N (%)**
TOTAL	1,159	34 (2.9)	1,500 (100)	14 (0.9)	1,647	11 (0.7)
Race						
White	735 (61.8)	21 (2.9)	905 (60.3)	14 (1.5)	988 (60.0)	9 (0.9)
Black	250 (21.6)	6 (2.4)	382 (25.5)	0 (0.0)	448 (27.2)	0 (0.0)
Hispanic	39 (3.4)	2 (5.1)	37 (2.5)	0 (0.0)	45 (2.7)	0 (0.0)
Asian/Pacific Islander	16 (1.4)	0 (0)	16 (1.1)	0 (0.0)	16 (1.0)	0 (0.0)
American Indian	6 (0.5)	1 (16.7)	14 (0.9)	0 (0.0)	12 (0.7)	0 (0.0)
Other race/ethnicity	113 (9.7)	4 (3.5)	146 (9.7)	0 (0.0)	138 (8.4)	1 (0.7)
Care Coordination						
Received care coordination	21 (1.8)	21 (100)	21 (1.4)	5 (23.8)	14 (0.9)	1 (7.1)
Did not receive care coordination	1,138 (98.2)	13 (1.1)	1479 (98.6)	9 (0.6)	1633 (99.2)	10 (0.6)
Public Health District						
Northern	256 (22.1)	6 (2.3)	349 (23.3)	2 (0.6)		
Northeastern	205 (17.7)	12 (5.8)	252 (16.8)	8 (3.2)		
Jefferson	116 (10.0)	1 (0.9)	187 (12.5)	0 (0.0)		
East Central	157 (13.5)	2 (1.3)	188 (12.5)	1 (0.5)		
West Central	86 (7.4)	0 (0)	114 (7.6)	1 (0.9)		
Southeastern	110 (9.5)	4 (3.6)	123 (8.2)	1 (0.8)		
Southwestern	121 (10.4)	8 (6.6)	141 (9.4)	1 (0.7)		
Mobile	108 (9.3)	1 (0.9)	146 (9.7)	0 (0.0)		
ACHN Regions						
Central			145 (9.7)	1 (0.7)	145 (8.8)	0 (0.0)
East			230 (15.3)	8 (3.5)	234 (14.2)	5 (2.1)
Gulf			266 (17.7)	1 (0.4)	317 (19.3)	0 (0.0)
Mid-state			221 (14.7)	0 (0.0)	258 (15.7)	0 (0.0)
Northeast			268 (17.9)	0 (0.0)	288 (17.5)	1 (0.3)
Northwest			170 (11.3)	2 (1.2)	191 (11.6)	2 (1.0)
Southeast			200 (13.3)	2 (13.3)	214 (13.0)	2 (1.0)

Table 6.3. Hours of contact for men who received care coordination services

	DY18	DY19	DY20
Number of male clients	21	21	
Mean number of encounters (hours of contact)	(1.1)	2.8 (1.04)	

Conclusions

The overall program goal of Alabama's Plan First program, to reduce unintended pregnancies, has been consistently exceeded since the beginning of the program. Consistently, actual birth rates among all enrollees have been lower than the estimated birth rates if fertility rates continued at pre-waiver levels. The actual birth rates among clinical service users generally have been lower compared to all enrollees or non-service users. Specific recommendations are included in each goal section of the evaluation report.

Although some progress has been made related to addressing disparities, the goal has only partially been met throughout the program demonstration period. With changes in the program administration and geographic changes, additional examination is needed. (Goal 1)

Awareness of Plan First has been generally consistent and high over time. Among those surveyed, awareness of the program has increased. However, the goal was not met consistently until DY7. (Goal 2)

Utilization of services among enrollees has varied over time, but the percent of service use has not exceeded 60%. (Goal 3)

The percent of women who reported smoking has declined over time. The proportion of women who smoked who received a referral to the Quit Line or NRT has been consistent over time but not at the 85% goal. (Goal 4)

Since the inception of the program, the birth rate per 1000 enrollees has been about half of the number needed for budget neutrality. (Goal 5)

Since the introduction of this goal, there has been an increase in enrollment except in DY18. However, the proportion of men receiving a vasectomy has been consistently below the 75% goal. (Goal 6)

Interpretations and Policy Implications and Interactions with Other State Initiatives

Care coordination among clinical service users has increased in the most recent years of the program. Changes in the provision of case management from the health department to the ACHNs seems to have had an influence in uptake of users versus eligible women, but COVID-19 has further complicated understanding of trends and the achievement toward program goals.

Lessons Learned and Recommendations

Specific recommendations are included in the individual goal sections. Overall, shifts in service provision from the Alabama Department of Public Health to the Alabama Coordinated Health Networks (ACHNs) has influenced levels of engagement in the Plan First program. Further analyses of disparities by age, race/ethnicity, and geography are needed to understand the context of these changes. COVID-19 changes in Medicaid eligibility should be further examined as well. The number of private providers has declined over time, so additional focus on this issue related to access is needed. Increased communication and referral to the Quit Line and smoking cessation resources are critical.

Attachment 1: Approved Evaluation Design Plan

Alabama Medicaid Agency

Evaluation Design for the 1115 Plan First Demonstration Waiver

Waiver Period November 27, 2017 through September 30, 2022

Developed by Kari White, PhD MPH

School of Public Health

University of Alabama at Birmingham

Revised May 31, 2018

CMS APROVED EVALUATION DESIGN JULY 11, 2018

Evaluation for Plan First, 2018-2022

Introduction

The Evaluation for Plan First during the 2018-2022 reporting period will consist of two parts. Part I will report on the core objectives of the demonstration program, as stated in the renewal application and described below. This section of the report will highlight program outcomes of care for participants enrolled in Plan First (e.g., enrollment, births), quality of care (e.g., use of effective contraception, screened for cervical cancer), and access to care (e.g., geographic differences in service use, provider participation). Following previous evaluations, Part II of the report will provide an overview of trends for select outcome and utilization indicators by summarizing data from the current reporting period and prior years. Finally, our report will include the costs of operating the program.

We will use 8 sources of data for the evaluation. From the Alabama Medicaid Agency information system, we will obtain (1) monthly enrollment data and (2) claims for the Plan First program. We also will obtain (3) delivery claims on a quarterly basis that can be matched to Plan First participants, and (4) the number of Plan First participants who have been referred to the smoking cessation telephone counseling service (Quit Line). We will use (5) the American Community Survey (ACS) to estimate the age, race and geographic distribution of uninsured women who may be eligible for Plan First. Finally, we will conduct (6) a survey of 800 women enrolled in Plan First about their experiences in the program; (7) a survey of 300 women who are no longer enrolled in Plan First to assess their reasons for not re-enrolling; and (8) a survey of 100 men enrolled in Plan First about their experiences obtaining vasectomy services.

PART I: Assessment of reporting-period specific goals

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

The program goal is to enroll into Plan First 80% of eligible women between ages 19 and 40 across all racial/ethnic groups and geographic areas.

Hypotheses: We anticipate that the composition of the enrolled population will be demographically similar to the population of eligible participants because of programmatic features designed to reduce barriers to enrollment, such as automatic enrollment following delivery and allowing re-enrollment through Express Lane Eligibility. However, we do not expect the enrolled population to reflect the exact distribution of eligible women because enrollment in the program is voluntary. For example, based on past evaluations of Plan First, we anticipate lower enrollment rates among older women compared to younger women.

Enrollment of income-eligible women is a key metric that documents the impact of the demonstration program on providing coverage. We will report on this outcome using the table templates presented below. Men's enrollment is reported as part of Goal 6, since vasectomy and vasectomy-related care coordination are the only services available to men in Plan First.

Table 1.1. Unduplicated number of female enrollees, by age group and quarter

	19-20*	21-44	45-55	Total enrollment
Quarter 1 (October-December)				
Quarter 2 (January-March)				
Quarter 3 (April-June)				
Quarter 4 (July-September)				

*Women <19 years of age are not eligible for Plan First.

To assess enrollment, we will compare the number of women enrolled in Plan First to estimates of the number of income-eligible women in the American Community Survey, overall and according to age, race/ethnicity and geographic sub-groups. By computing the percentage of potentially eligible women enrolled, we will be able to assess any disparities in enrollment. We will highlight sub-populations where enrollment is less than 80% of the estimated population that is eligible.

Table 1.2. Estimates of low-income women eligible for and enrolled in Plan First, by age, race andpublic health district.

	ACS Population Estimate	Enrolled inPlan First	% Enrolled
Age, years			
19-24*****			
24-44			
45-54			
Race			
White			
Black			
Hispanic			
Asian/Pacific Islander			
American Indian			
Other race/ethnicity			
Public Health District			
Northern			
Northeastern			
Jefferson			
East Central			
West Central			
Southeastern			
Southwestern			
Mobile			
TOTAL			

*County-level population estimates of low-income women are not available for those 19-20 and 21-24, separately, due to ACS reporting.

We also will examine patterns of re-enrollment in Plan First since this is an important *process indicator* that likely contributes to the overall number of eligible women enrolled in the program. We will use consecutive years of enrollment data to assess re-enrollment patterns. We will compute the overall percentage of women enrolled in the prior demonstration year (e.g., DY17) who re-enrolled in Plan First in the reporting period (e.g., DY18), and assess differences in re-enrollment across sub-groups using chi-squared tests (Table 1.3). We also will estimate the likelihood of re-enrollment after accounting for

differences in characteristics of women in the program using multivariable-adjusted logistic regression (Table 1.4).

Table 1.3. Percentage of Plan First participants who re-enrolled in the reporting year

	Enrolled in DY17	% Enrolled in DY18		Re-enrolled in DY18	Did not re-enroll
Age, years					
19-24					
24-44					
45-54					
Race					
White					
Black					
Hispanic					
Asian/Pacific Islander					
American Indian					
Other race/ethnicity					
Service use					
Clinical services					
Non-clinical services only					
Did not use services					
Public Health District					
Northern					
Northeastern					
Jefferson					
East Central					
West Central					
Southeastern					
Southwestern					
Mobile					
TOTAL					

Table 1.4. Characteristics associated with re-enrollment in Plan First

	Odds ratio	(95% CI)	Probability compared to chance
Age, years			
19-24			
24-44			
45-54			
Race			
White			
Black			
Hispanic			
Asian/Pacific Islander			
American Indian			
Other race/ethnicity			
Service use			
Clinical services			
Non-clinical services only			
Did not use services			
Public Health District			
Northern			
Northeastern			
Jefferson			
East Central			
West Central			
Southeastern			
Southwestern			
Mobile			

CI: confidence interval

We also will conduct a telephone survey of 300 women who have been terminated from the Plan First program to better understand women's reasons for not re-enrolling in Plan First and identify potential solutions to reduce barriers to re-enrollment. This sample size is feasible given anticipated changes in women's contact information. The survey will be stratified by age because we expect women's eligibility and reasons for not re-enrolling in the program may be different for younger as compared to older women. We will compute percentages and compare differences by age group using chi-squared tests. With a sample size of 300 women and an estimated 30% of women in all age groups reporting that they were unaware that they were no longer enrolled, the margin of error attributable to sampling is estimated to be ±5.2%. Additionally, this sample size will provide 80% statistical power to determine whether there is a 21-percentage-point difference or larger in the number of older women who are eligible but not enrolled versus younger women (e.g., 28% or fewer women aged ≥35 are eligible but not enrolled vs 50% of women under age 35).

Table 1.5. Reasons women did not re-enroll in Plan First and contraceptive use, by age

	Age, years			
	19-24 (n=125)	25-34 (n=125)	35-44 (n=25)	45-54 (n=25)
Aware not enrolled in Plan First				
Yes				
No				

Eligibility for Plan First				
Eligible				
Ineligible, currently pregnant				
Ineligible, had tubal ligation, hysterectomy				
Ineligible, enrolled in MLIF				
Ineligible, income ≥146% FPL				
Reasons not enrolled in Plan First*				
Did not know how to re-enroll				
Problems getting transportation to re-enroll				
Problems providing documents to re-enroll				
No providers she wanted to see in the area				
Does not want family planning services				
Other reason				
Current contraceptive use†				
Sterilization				
IUD or implant				
Injectable				
Oral contraceptives				
Patch, ring				
Condoms, diaphragm, withdrawal				
No method				

*Among women eligible for the program. † Among women who are not pregnant.

Goal 2. Maintain a high level of awareness of the Plan First program among female enrollees. The program goal is that 90% of surveyed enrollees will have heard of Plan First, and 85% will be awarethat they are enrolled in the program.
Hypotheses: Since Plan First is a well-established program, we expect that the majority of womenenrolled will have heard of it and will be aware that they are enrolled.

To assess women's awareness of Plan First and their own enrollment in the program, we will conduct a telephone survey of 800 women. We will determine the percentage of women who have heard of Plan First, who are aware they are enrolled in the program, and compare differences in characteristics according to women's awareness of their enrollment status, using chi-squared tests and following the table template below. This sample size will provide 80% statistical power to determine whether there is a 6-percentage-point difference or larger in the number of women using family planning services and contraception who are unaware of their enrollment compared to those who are aware.

Table 2.1. Characteristics of survey respondents, according to awareness of enrollment in PlanFirst

	Know Enrolled	**Do Not Know Enrolled**
	(%)	(%)
Has heard of Plan First		
Yes		
No		
Last family planning visit		
In last year		
More than year ago		
Never		
Reason for no visit in last year		
I did not think I needed one		

I was too busy to arrange an appointment		
I couldn't afford it		
I did not want to go to the place I went before		

	Know Enrolled	Do Not Know Enrolled
The place I went before could not see me		
Other		
Reasons for not using family planning		
Don't like exam		
No provider you wanted to see		
Hard to reach on the phone		
Couldn't get appointment soon enough		
Waiting time too long at location		
Hours not convenient		
No transportation		
Family member opposes		
No childcare		
No money to pay for visit		
Preferred provider does not take Medicaid		
Any birth control method used		
Reasons for not using birth control		
Not having sex		
Want to get pregnant		
Concerned about side effects		
Don't think birth control works		
Religious reasons		
Too much trouble		
Don't think you can get pregnant		
Partner doesn't want you to		
Can't pay for method		
Can't find a place to go		
Ever pregnant		
Age (mean)		
Education		
< high school		
high school		
more than high school		
Race/ethnicity		
White		
Black		
Hispanic		
Asian/Pacific Islander		
American Indian		
Other race/ethnicity		
Marital Status		
Never married		
Married		
Previously married		

Goal 3. Increase the proportion of Plan First enrollees who use family planning services in the initial year of enrollment and in subsequent years.
The program goal is to achieve 70% in the initial year and increase service use to 60% in subsequent years.
Hypotheses: Based on prior evaluations of Plan First, we expect service use to be more common among younger women than among older women, since younger women tend to rely on shorter acting hormonal methods for contraception and are recommended for routine STI and cervical cancer screening, both of which require more regular contact with providers. Because Plan First offers no-cost contraception, we also expect more than half of women using services to have a claim for a moderate or highly effective contraceptive method.

The types of services that women enrolled in Plan First use are *key indicators of the quality of care* provided through the program. We will report on these indicators using the table templates presented below. Men's use vasectomy-specific services is reported as part of Goal 6, since vasectomy and vasectomy-related care coordination are the only services available to men in Plan First.

Table 3.1. Unduplicated number of female beneficiaries with any claim for services, age group andquarter

	19-20*	**21-44**	**45-55**	**Total Users**	**Percent of women enrolled**
Quarter 1 (October-December)					
Quarter 2 (January-March)					
Quarter 3 (April-June)					
Quarter 4 (July-September)					

*Women <19 years of age are not eligible for Plan First.

In addition to reporting the primary method used by women enrolled in the program (Table 3.2), we willreport on the overall percentage of women who were provided with a moderately or highly effective contraceptive method. We will define this indicator according to the Health Care Quality Measures for Medicaid Eligible Adults (Measure CCW). Specifically, moderately and highly effective methods will include female sterilization, the contraceptive implant, intrauterine devices or systems (IUD/IUS), injectables, oral contraceptives, hormonal patch, ring and diaphragms.

Table 3.2. Utilization of primary method by age group

	19-20	21-44	45-55	Total	Percentageof all methods
Sterilization					
Emergency contraception					
IUD					
Implant					
Injectable					
Oral contraceptives					
Patch					
Ring					
Diaphragm					

Female condoms*	--	--	--	--	--
Male condoms*	--	--	--	--	--

*Not included in claims for Plan First

We also will use the claims data to compute the percentage of women using specific contraceptive methods and compare differences in use according to the type of provider from whom a participant obtained services and her public health district, using chi-squared tests. This information, along with the overall percentage of women using a long-acting reversible contraceptive method (IUD/IUS or implant), will provide useful *indicators of women's access* to the full range of contraceptive methods and potential disparities in access.

Table 3.3. Utilization of primary method, by provider type and public health district

	Sterilization	IUD/IUS or implant	Injectables	Oral contraceptives	Other hormonal method
	N (%)	N (%)	N (%)	N (%)	N (%)
Provider type					
Health Department (Title X)					
Private provider					
Other provider					
Public Health District					
Northern					
Northeastern					
Jefferson					
East Central					
West Central					
Southeastern					
Southwestern					
Mobile					

As an indicator of the quality of contraceptive care, we will determine whether women are using their preferred method of contraception. Following our approach in previous evaluations, we will include questions about the birth control method women are currently using and the method they would like touse in our telephone survey, and compute the percentage of women using their preferred method. Wealso will ask women why they are not using the method they prefer to identify potential opportunities tomeet women's contraceptive preferences in Plan First.

Table 3.4. Current Contraceptive Method Use and Preference

Method Using Now	**% Using method**	**% Prefer using this method**
Tubal ligation		
Vasectomy		
IUD		
Implanon/Nexplanon		
Injectables		
Oral contraceptives		
Patch		
Condoms		
Natural Family Planning		
Withdrawal		
Other method		

Screening for sexually transmitted infections (STIs), cervical and breast cancer are other quality of care indicators that will be included in our evaluation report. To assess screening for STIs, we will use claims for chlamydia, gonorrhea, herpes, HIV, syphilis and trichomonas. We will report this indicator for women only since STI screening is not a covered benefit for men enrolled in Plan First. We also will report separately on chlamydia screening for sexually active women 21-24, following the Health Care Quality Measures for Medicaid Eligible Adults (Measure CHL-AD). We will evaluate cervical cancer screening according to the Health Care Quality Measures for Medicaid Eligible Adults recommendation (Measure CCS-AD) by evaluating claims for a Pap test in the demonstration year or 2 prior years for women 21-55 and claims for HPV co-testing in the demonstration year or 4 prior years for women 30-55. Claims for clinical breast exams will be used to assess the number (percentage) of women who received this service.

Table 3.5. Beneficiaries screened for sexually transmitted infections, cervical and breast cancerduring the demonstration year

	Number of women tested or screened	Percent of women enrolled
Sexually transmitted infections		
Chlamydia*		
Cervical cancer		
Breast cancer		

*Reported for women 21-24 only

We also will assess how participation in Plan First varies according to women's initial and subsequent enrollment. We will calculate the number and percentage of women using clinical and non-clinical services and compare differences according to women's type and duration of enrollment using chi-squared tests. This will provide evidence of women's demand for services and identify potential sub-groups for focused outreach on program services. This assessment will use data from eligibility determination and Plan First claims.

Table 3.6. Type of Plan First participation, according to women's duration of enrollment

	Newly enrolled		**Re-enrolled**	
	Postpartum	Not postpartum	From DY17	From DY17& DY16
Used clinical services				
Any service				
Contraceptive services				
Only had non-clinical encounter				
Only had case management				
Did not use services				
Total				

DY: Demonstration Year

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

Hypothesis: Data from recent surveys of Plan First enrollees indicate that approximately 25% are smokers. We expect that the majority of enrolled smokers will report that their health care provideradvised them to quit smoking and about half will report they were provided with information about smoking cessation services.

Smoking cessation coverage has been available in Plan First since 2012. As a key *process indicator* of offering this coverage, we calculate the number and percentage of Plan First participants in the telephone survey who were asked by their Plan First provider about smoking and which smoking cessation options were discussed: use of Nicotine gum, patch, spray, pill or referral to the Alabama Quit Line. We also will assess the number and percentage of women who are interested in using these products and services to quit smoking.

Table 4.1. Smoking among Plan First participants and content of smoking cessation discussions at family planning visits

	N	**%**
Reported Smoking		
Asked about smoking at FP visit		
Advised to quit by FP provider		
Received NRT		
Referred to Quit Line		
Received either NRT or Quit Line referral		
Paid out of pocket for NRT products		
Interest in using products/services to quit		

Following previous evaluations, we also will continue to assess two main *outcomes*: the number of Plan First participants who were referred to the Alabama Quit Line and the number who had a claim for a smoking cessation product.

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

	N	%
Plan First service users		--
Estimated number of smokers		
Paid claims for covered NRT products		
Quit Line referrals received from care coordinator		

Goal 5. Maintain birth rates among Plan First participants, which are lower than the estimatedbirth rates that would have occurred in the absence of the Plan First demonstration.
A rate of about 100 births per 1000 enrollees is estimated to be sufficient to achieve budget neutrality for Plan First.
Hypothesis: Based on prior evaluations of Plan First, we hypothesize that the birth rate among program participants will be less than the expected birth rate in the absence of the program. We also anticipate that birth rates will be lower among women who used Plan First services than those who enrolled but did not have a clinical encounter.

We will evaluate this *outcome* of the program for all women enrolled in Plan First and according to their use of services in the program using SOBRA maternity claims matched to Plan First enrollment and claims files. Following our approach for estimating the birth rate in prior evaluations, we will count births that occurred through 9 months after the end of the demonstration year and exclude births from pregnancies that occurred before women enrolled. Therefore, reports of the birth rate and births averted will be available with a one-year lag (i.e., the birth rate reported in DY18 will reflect those that occurred to women enrolled in DY17). We will compare differences in birth rates among categories of service and non-service users using Poisson regression. Data on cost savings from births averted will be reported separately in the budget neutrality section.

Table 5.1 Estimated and actual birth rates to women enrolled in Plan First

	Number Enrollees	**Number of Births**	**Births/1000**
All enrollees (Assuming pre-waiver fertility levels)	**--**	**--**	
All Enrollees (actual births)			
Service Users			
Any risk assessment or case management			
No risk assessment or case management			
Any visit to Title X clinic			
No visit to Title X clinic			
Non-service users			

Goal 6. Increase the number of income-eligible men age ≥21 years who are enrolled in the Plan First program and the proportion of male enrollees undergoing vasectomy.
Our goal is that the number of men enrolled in Plan First for vasectomies and vasectomy-related covered services will increase by 10% annually, 85% of male Plan First enrollees will receive care coordination services, and 75% of male enrollees will undergo the procedure within the enrollment year. We will evaluate this goal based on the number of men enrolled and claims for care coordination and vasectomies.

Hypothesis: We anticipate that men's use of vasectomy services will increase over time, and that those who receive care coordination services will be more likely to obtain a vasectomy through Plan First than those who do not receive care coordination.

We will track men's enrollment and use of vasectomy services using the table templates below.

Table 6.1. Unduplicated number of male enrollees by quarter

	19-20*	21-44	45-55	Total enrollment
Quarter 1 (October-December)	--			
Quarter 2 (January-March)	--			
Quarter 3 (April-June)	--			
Quarter 4 (July-September)	--			

*Men <21 years of age are not eligible for Plan First.

Table 6.2. Unduplicated number of men with claims for vasectomy services, by age group and quarter

	19-20*	21-44	45-55	Total Users	Percent of men enrolled
Quarter 1 (October-December)	--				
Quarter 2 (January-March)	--				
Quarter 3 (April-June)	--				
Quarter 4 (July-September)	--				

*Men <21 years of age are not eligible for Plan First.

We also will compare differences in vasectomy use among enrolled men according to their race, receiptof care coordination services and public health district, using chi-squared tests. This will help us identifysub-groups where additional education and outreach may be needed to improve access to care.

Table 6.3. Percentage of men enrolled who obtained a vasectomy through Plan First

	Enrolled N (%)	Obtained vasectomy N (%)
Race		

White		
Black		
Hispanic		
Asian/Pacific Islander		

American Indian		
Other race/ethnicity		
Care Coordination		
Received care coordination		
Did not receive care coordination		
Public Health District		
Northern		
Northeastern		
Jefferson		
East Central		
West Central		
Southeastern		
Southwestern		
Mobile		
TOTAL		

We also will track the number of care coordination hours billed for male Plan First enrollees.

Table 6.4. Hours of contact for men who received care coordination services.

	DY18	DY19	DY20	DY21	DY22
Number of male clients					
Mean number of encounters (hours of contact)					

Since vasectomy coverage for men is a new component of Plan First, we will evaluate men's experiences with this service, including their perceptions of access to Plan First providers, the quality of care from care coordinators and vasectomy providers, and their overall satisfaction with the program. In DY18, we plan to conduct up to 25 in-depth interviews with men enrolled in Plan First - those with and without a claim for vasectomy – to capture a range of experiences in their processes enrolling for, seeking and obtaining vasectomy services through Plan First. This information will be used to develop a survey, which we plan to field with 100 men in each of the remaining 4 years of the current demonstration. This sample size is feasible, given the number of men enrolled who we expect to be able to contact. With a sample size of 100 men and an estimated 75% of men reporting that it was somewhat or very easy to make an appointment with a vasectomy provider, the margin of error attributable to sampling is estimated to be ±8.5%.

PART II: Continue monitoring trends in Plan First

In this second part of the evaluation plan, we propose to continue monitoring trends in enrollment and service use, awareness of the program among those enrolled, contraceptive service use and provider participation, use of smoking cessation services, and the impact of the Plan First Program on birth rates. Comparisons largely will be descriptive, and we will use Poisson regression to compute the average annual change over time, as appropriate. Below are tables that we propose monitor these trends.

Trends in enrollment and overall service use

Table 1.1. Plan First enrollment

	DY14	DY15	DY16	DY17	DY18	Annual changeN (%)
Age						
19-29	102,469	86,147	86,487			
30-39	34,982	32,566	34,524			
≥40	10,609	9,760	10,276			
Race						
Black	76,716	68,247	69,951			
White	65,889	55,390	53,932			
Hispanic	--	--	--			
Asian/Pacific Islander	--	--	--			
American Indian	--	--	--			
Other	5,455	4,836	7,404			
Public Health Area						
1	9,587	8,309	8,583		--	
2	19,530	16,845	17,149		--	
3	9,144	8,161	8,233		--	
4	19,516	16,004	15,980		--	
5	11,898	10,099	10,105		--	
6	11,466	10,251	10,422		--	
7	7,121	6,370	6,539		--	
8	20,959	18,312	19,173		--	
9	11,350	9,864	10,272		--	
10	10,724	9,737	10,050		--	
11	16,765	14,481	14,880		--	
Public Health District						
Northern	--	--	--	--		
Northeastern	--	--	--	--		
Jefferson	--	--	--	--		
East Central	--	--	--	--		
West Central	--	--	--	--		
Southeastern	--	--	--	--		
Southwestern	--	--	--	--		
Mobile	--	--	--	--		

Table 1.2. Plan First service use

	DY14	DY15	DY16	DY17	DY18	Annual changeN (%)
Age						
19-29	52,334	43,132	43,834			
30-39	12,856	12,801	13,007			
≥40	3,009	2,796	2,934			
Race						

Black	38,795	34,139	34,328			
White	27,191	21,928	22,314			
Hispanic	--	--	--			
Asian/Pacific Islander	--	--	--			
American Indian	--	--	--			
Other	2,213	1,942	3,133			
Public Health Area						
1	5,079	4,230	4,652		--	
2	7,822	6,320	6,524		--	
3	4,628	3,996	4,139		--	
4	6,266	5,438	5,279		--	
5	5,050	4,182	4,421		--	
6	5,890	5,066	5,372		--	
7	4,515	3,967	3,972		--	
8	9,476	8,059	8,340		--	
9	5,987	5,055	4,999		--	
10	5,703	5,055	5,622		--	
11	7,783	6,641	6,455		--	
Public Health District	--	--	--	--		
Northern	--	--	--	--		
Northeastern	--	--	--	--		
Jefferson	--	--	--	--		
East Central	--	--	--	--		
West Central	--	--	--	--		
Southeastern	--	--	--	--		
Southwestern	--	--	--	--		
Mobile	--	--	--	--		

Table 1.3. Plan First Participation by Women with Recent Medicaid Maternity Care, by MaternityCare Program District

Maternity Care District	**Demonstration Year (DY)**				
	DY14	**DY15**	**DY16**	**DY17**	**DY18**
Total					
Women with SOBRA deliveries in the previous year and this year	49,760	38,575	36,978		
Women with Plan First participation in DY	13,901	10,406	8,345		
% Of women with deliveries participatingin Plan First	27.9%	27.0%	22.6%		
District 1 (Colbert, Franklin, Lauderdale, Marion)					
Women with SOBRA deliveries in the previous year and this year	2,194	1,627	1,606		
Women with Plan First participation in DY	684	493	431		
% Of women with deliveries participatingin Plan First	31.2%	30.3%	26.8%		
District 2 (Jackson, Lawrence, Limestone, Madison, Marshall, Morgan)					

Women with SOBRA deliveries in the previous year and this year	7,099	5,500	5,569		
Women with Plan First participation in DY	1,658	1,242	1,043		
% of women with deliveries participatingin Plan First	23.4%	22.6%	18.7%		
District 3 (Calhoun, Cherokee, Cleburne, DeKalb, Etowah)					
Women with SOBRA deliveries in the previous year and this year	3,686	2,934	2,817		
Women with Plan First participation in DY	953	764	625		
% of women with deliveries participating	25.8%	26.0%	22.2%		

in Plan First					
District 4 (Bibb, Fayette, Lamar, Pickens, Tuscaloosa)					
Women with SOBRA deliveries in the previous year and this year	2,618	2,089	2,157		
Women with Plan First participation in DY	731	550	515		
% Of women with deliveries participatingin Plan First	27.9%	26.3%	23.9%		
District 5 (Blount, Chilton, Cullman, Jefferson, St. Clair, Shelby, Walker, Winston)					
Women with SOBRA deliveries in the previous year and this year	10,797	8,353	7,249		
Women with Plan First participation in DY	2,277	1,692	1,105		
% Of women with deliveries participatingin Plan First	16.4%	20.3%	15.2%		
District 6 (Clay, Coosa, Randolph, Talladega, Tallapoosa)					
Women with SOBRA deliveries in the previous year and this year	1,849	1,509	1,461		
Women with Plan First participation in DY	550	445	425		
% Of women with deliveries participatingin Plan First	29.7%	29.5%	29.1%		
District 7 (Greene, Hale)					
Women with SOBRA deliveries in the previous year and this year	332	257	226		
Women with Plan First participation in DY	122	93	38		
% Of women with deliveries participatingin Plan First	36.7%	36.2%	16.8%		
District 8 (Choctaw, Marengo, Sumter)					
Women with SOBRA deliveries in the previous year and this year	469	356	333		
Women with Plan First participation in DY	172	131	108		
% Of women with deliveries participatingin Plan First	36.7%	36.8%	32.4%		
District 9 (Dallas, Perry, Wilcox)					

Women with SOBRA deliveries in the previous year and this year	838	541	554		
Women with Plan First participation in DY	390	233	239		
% of women with deliveries participatingin Plan First	46.5%	43.1%	43.1%		
District 10 (Autauga, Bullock, Butler, Crenshaw, Elmore, Lowndes, Montgomery, Pike)					
Women with SOBRA deliveries in the previous year and this year	5,062	4,019	3,770		
Women with Plan First participation in DY	1,465	1,120	877		
% of women with deliveries participatingin Plan First	28.9%	27.9%	23.3%		
District 11					
(Barbour, Chambers, Lee, Macon, Russell)					
Women with SOBRA deliveries in the previous year and this year	2,783	2,125	2,094		
Women with Plan First participation in DY	817	595	495		
% of women with deliveries participatingin Plan First	29.4%	28.0%	23.6%		
District 12 (Baldwin, Clarke, Conecuh, Covington, Escambia, Monroe, Washington)					
Women with SOBRA deliveries in the previous year and this year	3,476	3,598	3,612		
Women with Plan First participation in DY	1,209	644	1,410		
% of women with deliveries participatingin Plan First	34.8%	17.9%	39.0%		
District 13 (Coffee, Dale, Geneva, Henry, Houston)					
Women with SOBRA deliveries in the previous year and this year	2,366	2,604	2,667		
Women with Plan First participation in DY	880	494	1,029		
% of women with deliveries participatingin Plan First	37.2%	19.0%	38.6%		
District 14 (Mobile)					
Women with SOBRA deliveries in the previous year and this year	5,156	5,424	5,454		
Women with Plan First participation in DY	1,912	929	1,935		
% of women with deliveries participatingin Plan First	37.1%	17.1%	35.5%		

Table 1.4. Availability and Visit Volume for Private Providers

PHA	# Private Providers			# Visits to Private Providers			% Total Visits to Private Providers		
	DY16	DY17	DY18	DY16	DY17	DY18	DY16	DY17	DY18
Total	960			29,929			24.9		
1	63			1,216			17.1		
2	178			3,915			40.7		

3	47			901			14.4		
4	83			1,703			22.2		
5	58			812			12.2		
6	75			1,770			22.3		
7	45			1,927			27.6		
8	133			7,353			17.8		
9	99			3,137			39.4		
10	63			720			8.4		
11	116			6,475			63.6		

Awareness of Plan First

Table 2.1. Awareness of Plan First

	Had heard of Plan First before survey (%)	Aware of enrollment (%)	
		Among all surveyed	Among those who had heard of Plan First
DY1	76.8	56.2	73.1
DY2	82.5	64.2	77.9
DY3-4	81.0	64.9	80.2
DY5	85.3	63.6	74.9
DY6	86.8	70.2	82.5
DY7	92.9	80.8	87.1
DY8	88.9	85.3	85.9
DY9	90.8	79.7	87.8
DY10	88.7	78.3	88.2
DY11	90.1	79.3	88.1
DY12	88.7	77.2	87.0
DY13	89.9	79.9	88.9
DY14	90.1	74.9	83.2
DY15	92.6	78.8	85.0
DY16	91.1	77.6	85.2

Contraceptive service use

Table 3.1. Contraceptive use among women

Use of Contraceptives	DY14	DY15	DY16	DY17	DY18
N	1,070	1,080	1,070		
% Used any contraception	84.1	85.6	81.6		
% Used effective contraception*	75.8	81.3	74.5		
% Tubal	5.3	5.0	9.7		
% Vasectomy	1.3	2.0	2.5		
% IUD	16.4	20.0	18.1		
% Implanon/Nexplanon	15.1	15.6	15.7		
% Depo	39.1	41.5	36.9		
% BC Pills	58.0	53.5	53.3		
Got BC pills from Health Dept.	58.4	51.7	53.5		
Got BC pills from free sample	18.5	21.8	19.7		
Got BC pills from drug store	22.7	26.1	25.9		
Don't know, not sure	0.4	0.4	0.9		
% Nuva-Ring	8.5	7.6	7.9		
Got ring from Health Dept.	46.7	47.1	34.8		
Got ring from free sample	29.9	31.4	40.6		
Got ring from drug store	20.8	21.4	23.2		
Don't know, not sure	2.6	0.0	1.4		
% Patch	6.8	5.7	5.9		
Got patch from Health Dept.	54.1	35.8	40.4		
Got patch from free sample	24.6	26.4	30.8		
Got patch from drug store	21.3	37.7	26.9		
Don't know, not sure	0.2	0.0	1.9		
% Plan B	9.3	7.8	7.4		
% Condoms	78.6	71.0	70.1		
% Natural FP	7.9	8.0	9.4		
% Withdrawal	50.3	51.0	48.2		

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

Table 3.2. Contraceptive use by age

	Age 19-24			Age 25-34			Age ≥35		
Methods	**DY16**	**DY17**	**DY18**	**DY16**	**DY17**	**DY18**	**DY16**	**DY17**	**DY18**
	N=239			N=629			N=244		
% Used any method	81.6			83.4			76.8		
% Used effective method*	74.7			76.2			69.8		
Tubal ligation	2.1			9.4			18.2		
Vasectomy	0.0			1.2			6.6		
IUD	9.6			20.5			20.4		
Implanon/Nexplanon	18.7			16.7			9.9		
Depo	43.8			36.2			31.5		
BC pills	50.3			54.3			53.6		
Nuva-Ring	8.0			8.1			7.2		
Patch	4.3			6.3			6.6		
Plan B	8.0			8.9			2.8		
Condoms	74.3			69.7			66.8		
Natural FP	9.1			9.2			9.9		
Withdrawal	56.7			47.6			40.9		

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

Table 3.3. Services provided according to provider type

Service Type	**Provider Type**	**DY14**	**DY15**	**DY16**	**DY17**	**DY18**
Care Coordination	Health Department	52.5%	53.3%	50.3%		
	Private	11.6%	4.6%	3.5%		
	Both	60.6%	57.1%	52.1%		
	Neither	34.2%	33.4%	20.3%		
	Total with Service	25,654	21,559	13,258		
	% All Clients	37.6%	37.2%	29.6%		
HIV Counseling	Health Department	44.6%	61.7%	61.9%		
	Private	1.7%	2.5%	2.4%		
	Both	37.1%	56.1%	57.2%		
	Neither	6.8%	8.1%	8.5%		
	Total with Service	16,391	20,042	13,464		
	% All Clients	24.0%	34.5%	30.1%		
Tubal Ligations	Health Department	0.2%	0.1%	0.2%		
	Private	1.0%	1.2%	1.0%		
	Both	6.3%	5.8%	4.8%		
	Neither	1.5%	1.7%	1.0%		
	Total with Service	564	515	340		
	% All Clients	0.8%	0.9%	0.8%		
Depo Provera	Health Department	40.6%	42.2%	44.4%		
	Private	37.3%	38.1%	39.1%		
	Both	42.2%	45.0%	47.4%		
	Neither	0%	0%	0%		
	Total with Service	20,257	17,895	12,374		
	% All Clients	29.7%	30.8%	27.6%		
Birth Control Pills	Health Department	28.5%	36.6%	36.5%		
	Private	18.0%	1.4%	8.5%		
	Both	24.8%	29.2%	28.7%		
	Neither	27.7%	6.3%	14.2%		
	Total with Service	17,406	12,036	10,029		
	% All Clients	25.5%	20.7%	22.4%		

Smoking cessation

Table 4.1 Smoking Cessation Based on Enrollee Survey Data

	DY14 N (%)	**DY15** N (%)	**DY16** N (%)	**DY17** N (%)	**DY18** N (%)
Reported Smoking	283 (28.6)	269 (25.8)	265 (26.1)		
Asked about smoking at FP visit	265 (93.6)	248 (92.2)	240 (90.6)		
Advised to quit by FP provider	212 (80.0)	205 (82.7)	197 (82.1)		
Received NRT	111 (41.9)	121 (48.8)	112 (46.7)		
Referred to Quit Line	110 (41.5)	132 (53.2)	133 (55.4)		
Received either NRT or Quit Line referral	149 (56.2)	158 (63.7)	158 (65.8)		
Paid out of pocket for NRT products	--	30 (12.1)	27 (11.2)		

-- Not asked in Enrollee Survey

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

	DY16N (%)	DY17N (%)	DY18N (%)
Number of service users	62,608		
Estimated number of smokers	16,341		
Number receiving NRT (paid claim)	39		
Number receiving Quit Line referral from care coordinator	93		

Estimated and actual birth rates

Table 5.1. Birth Rates per 1000

	Estimated birth rateif fertility rates continued at pre-waiver levels	Actual birth ratesall enrollees – pregnancies starting during DY	Actual birth rates service users – pregnancies starting during DY	Actual birth rates non-service users – pregnancies starting during DY
DY1	189.8	60.0	47.8	72.3
DY2	200.7	87.5	54.3	118.9
DY3	204.7	96.6	56.5	131.1
DY4	205.9	92.0	56.2	122.9
DY5	202.6	98.3	58.6	121.7
DY6	224.1	81.8	31.1	105.4
DY7	215.0	57.2	44.0	69.7
DY8	214.8	75.7	65.0	86.6
DY9	127.1	59.1	43.3	78.2
DY10	202.3	69.1	60.8	97.0
DY11	200.1	73.3	58.3	92.6
DY12	180.1	77.3	60.8	97.0
DY13	199.9	84.0	72.5	88.6
DY14	203.1	72.4	58.3	84.9
DY15	196.7	62.7	61.0	63.9

Evaluation Budget

We estimate the total cost of the Evaluation Design for the waiver approval period at $86,841 per year. The staffing, data collection and administrative costs are listed in the accompanying table and described below.

Line Item	Components of budget	Cost of each line item
1	Estimated staff	$37,854
2	Survey administration	$26,000
3	Other administrative cost	$22,984
	Total Amount	$86,841

Staffing

Kari White, PhD MPH, Associate Professor, University of Alabama at Birmingham. Dr. White willhave overall responsibility for the evaluation, including the developing the evaluation design and data collection instruments, overseeing evaluation staff and analysis of the claims and survey data, and preparing the annual reports. We estimate her annual effort at $9,193.

Janet Bronstein, PhD, Professor Emeritus, University of Alabama at Birmingham. Dr. Bronstein willprovide guidance on the evaluation design and data collection instruments and will assist with data analysis and conceptualizing results for the annual report, based on her experience as the lead evaluatorfor Plan First between 2000 and 2017. We estimate her annual effort at $988.

Lei Huang, MPH, Statistician, University of Alabama at Birmingham. Ms. Huang will be responsible for data management, data cleaning and analyzing the enrollment, claims and survey data for the annualreports. We estimate her annual effort at $18,674.

Elizabeth Howard, MPH, Program Director, University of Alabama at Birmingham. Ms. Howard willcoordinate the administration of the annual surveys with the Survey Research Unit at UAB, prepare protocols for Institutional Review Board submissions, and assist with preparing the annual reports. We estimate her annual effort at $8,999.

Survey Administration

Survey Research Unit, University of Alabama at Birmingham. The Survey Research Unit (SRU) willbe responsible for contacting Plan First enrollees for the annual survey, administering the survey and preparing a dataset and codebook of survey responses for Dr. White and Ms. Huang to analyze. We estimate the annual cost for these tasks at $26,000.

Other administrative costs

Indirect costs ($22,987) have been calculated at 36% of UAB's base direct costs ($63,854).

Attachment 2. Evaluation Goals Overview

Goals	Results Summary
Overall Goal. Reduce unintended pregnancies.	*Goal exceeded.* Actual birth rates among all enrollees have been lower than the estimated birth rates if fertility rates continued at pre-waiver levels. The actual birth rates among clinical service users generally have been lower compared to all enrollees or non-service users.
Goal 1. Addressing Disparities in Enrollment Increase the proportion of women eligible for Plan First who enroll and reduce racial/ethnic and geographic disparities in enrollment. The program goal is to enroll into Plan First 80% of eligible women between ages 19 and 40 across all racial/ethnic groups and geographic areas.	*Goal partially met.* Between DY2 and DY13, younger women (<30 years) who were eligible for the program enrolled in the program. In later years, the percentage of enrollees declined. For race/ethnicity, there was variation, but no group met or exceeded the 80% expectation.
Goal 2. Maintaining High Levels of Awareness of Plan First The program goal is that 90% of surveyed enrollees will have heard of Plan First, and 85% will be aware that they are enrolled in the program.	*Goal partially met.* Ninety percent of all surveyed had heard of the program beginning in DY5 through DY20. The goal related to those who had heard of Plan First was met consistently in DY7. Over time, among those surveyed, awareness of enrollment increased.
Goal 3. Increasing Family Planning Service Use among Plan First Enrollees The program goal is to achieve 70% in the initial year and increase service use to 60% in subsequent years.	*Goal not met.* In DYs 9-11, roughly 55% of enrollees utilized services. In DY18, the percent was around 33%.
Goal 4. Increasing Use of Smoking Cessation Modalities Smoking cessation coverage has been available in Plan First since 2012. The program goal is to have 85% of smokers receiving these services.	*Goal not met.* Receipt of either NRT or Quit Line referral ranged from roughly 56% to about 66% from DY14 to DY20.
Goal 5. Maintaining Low Birth Rates among Plan First Service Users A rate of about 100 births per 1000 enrollees is estimated to be sufficient to achieve budget neutrality for Plan First.	*Goal exceeded consistently.* Since the inception of the program, the birth rate per 1000 enrollees has been about half of the number needed for budget neutrality.
Goal 6 Results: Increase Male Enrollment and Vasectomy Service Use Our goal is that the number of men enrolled in Plan First for vasectomies and vasectomy-related covered services will increase by 10% annually, 85% of male Plan First enrollees will receive care	*Goal partially met.* Since the introduction of this goal, there has been an increase in enrollment except in one year. However, the proportion of men receiving a vasectomy has been consistently below the 75% goal.

coordination services, and 75% of male enrollees will undergo the procedure within the enrollment year.	