Florida Medicaid Family Planning Waiver Program

Final Evaluation Report DY25 (2022-2023)

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Executive Summary

Florida's Family Planning Waiver was initially approved by the Centers for Medicare and Medicaid Services (CMS) on August 23, 1998. At the program's inception, the Department of Health (DOH) determined participant eligibility and enrollment for Family Planning Waiver services, however eligibility and enrollment determinations were turned over to the Department of Children and Families beginning on February 12, 2022. The Bureau of Family Health Services within DOH works with the local county health departments to provide a vast array of both Medicaid and non-Medicaid community health and family planning services, including preconception counseling, pregnancy tests, screening and treatment of sexually transmitted infections, cancer screening, and contraception supplies.

The purpose of the program is to expand eligibility for family planning services for up to two years to individuals who otherwise are not financially eligible for full Medicaid. Eligibility is limited to women of childbearing age, 14 years of age up through and including women who are 55 years of age; who have a family income at or below 191 percent of the Federal Poverty Level (FPL) (post Modified Adjusted Gross Income (MAGI) conversion); who are not covered by a health insurance program that provides family planning services; and who have lost Medicaid coverage within the last two years, including women who lost Medicaid pregnancy coverage after 12 months postpartum. On June 17, 2024, the CMS approved the State's request to extend Florida's 1115(a) Family Planning Waiver through June 30, 2025.

Florida State University (FSU), in collaboration with the University of Florida (UF), was contracted to evaluate the FPW program through June 30, 2026. The evaluation team, in collaboration with the Agency and CMS, developed ten research questions (RQs) to guide this evaluation, which uses quantitative and qualitative analytical methods to support findings. The RQs addressed in this final report are:

- Research Question 1: What differences in recipient demographic characteristics exist between FPW enrollees and eligible women who do not enroll in FPW per Demonstration Year?
- Research Question 2: What are the interbirth intervals for FPW enrollees compared to eligible women who do not enroll in the FPW program who gave birth during the study period?

- Research Question 3: What is the rate of unintended pregnancies for FPW enrollees and eligible women who do not enroll in the FPW program per Demonstration Year?
- Research Question 4: What is the rate of low birth weight and preterm births for FPW enrollees compared to women who are eligible but do not enroll in the FPW program?
- Research Question 5: Is the FPW achieving cost savings by slowing the birth rate?
- Research Question 6: What are the reasons that women eligible for the FPW program choose to enroll or not enroll in the FPW program and the reasons women enrolled in the FPW program do not participate?
- Research Question 7: How do FPW enrollees utilize covered health services?
- Research Question 8: What gaps in coverage are experienced by FPW enrollees over time?
- Research Question 9: Are FPW enrollees satisfied with services?
- Research Question 10: What strategies are being used by the Department of Health to increase FPW participation rates?

According to the CMS approved Evaluation Design for the FPW approved extension period, the five objectives of the FPW program are:

1) to increase access to family planning services;
2) to increase child spacing intervals through effective contraceptive use;
3) to reduce the number of unintended pregnancies in Florida;
4) to reduce Florida's Medicaid costs by slowing the birth rate among females who would otherwise be eligible for Medicaid pregnancy-related services; and,
5) to improve or maintain health outcomes for the target population as a result of access to family planning services and/or family planning-related services.

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

Findings

Demographics (RQ1): The total number of FPW enrollees was 119,273 (Table 1a). The total number of FPW eligible females who did not enroll was 116,995 (Table 1b). In DY25 FPW enrollees were, on average, 31.8 years of age while non-enrollees were, on average, 30.8 years of age. Regarding race, most FPW enrollees identified as either Black (40.8%), White (31.1%), or Hispanic (23.1%). Most non-enrollees identified as either White (33.6%), Hispanic (30.3%), or Black (24.2%).

Interbirth Intervals (RQ2): Interbirth intervals (IBI) were slightly longer in DY25 for FPW enrollees compared to eligible women who did not enroll. As shown in Table 2, in DY25, the IBI for FPW enrollees was one month longer (17.4 vs. 16.4 months) compared to non-enrollees.

Unintended pregnancies (RQ3): In DY25, the percent of FPW enrollees who responded "No" to the question, "Is this a good time for you to be pregnant?" was 9.7% as compared to 11.7% of FPW non-enrollees. Responses to the question, "Thinking back to just before you got pregnant, did you want to be?" indicated that 50.2% of FPW enrollees answered "later" or "not pregnant" as compared to 53.1% of FPW non-enrollees. When combining all negative responses across both questions 5 and 14 to capture the overall rate of unintended pregnancies, 50.3% of FPW enrollees indicated that their pregnancy was unintended as compared to 54.2% of FPW non-enrollees. Odds ratios for logistic regression models of reported unintended pregnancies were conducted by FPW enrollee status and demonstration year. FPW enrollees have significantly lower odds of a reported unintended pregnancy for DY25 compared with FPW non-enrollees, when controlling for age and race/ethnicity.

Low birth weight and preterm births (RQ4): The proportion of low weight births and pre-term births were both slightly larger for the FPW enrollees compared to FPW non-enrollees in DY25. For DY25 FPW enrollees, 11.1% of births were considered low birth weight, compared with 9.6% for the FPW non-enrollees. The rate of pre-term births for the FPW enrollees in DY25 was 15.4%, compared with 13.5% for the FPW non-enrollees.

Cost savings (RQ5): Cost savings were calculated based on differences in the birth rate between FPW enrollees and eligible women who did not enroll in FPW. As shown in Table 5a, women enrolled in the FPW program during DY25 averted 16,067 births than women eligible but not enrolled in the FPW program for a cost savings of approximately $236 million dollars.

Reasons for non-enrollment or non-participation (RQ6): For the eligible but not enrolled group, the most cited reasons for not enrolling in the program were the lack of awareness and not receiving any information about the program; similarly, for the enrolled but not participated group, the most cited reasons for not participating in the program were not receiving any information about the program and the lack of awareness. For both groups (i.e., eligible but not enrolled and enrolled but not participated), a vast majority of respondents reported using a digital platform (i.e., email, Google search, or websites) or social media to gather information about health services and also reported being receptive to receiving emails and text messages about the FPW program.

Service utilization (RQ7): The overall participation rate, defined as the number of enrollees that used at least one covered service as a proportion of total enrollees, was 3.8%. The most commonly used services in DY25 was contraceptive services (1.5%), followed by STD screening (1.3%), and then cancer screening (0.3%).

Coverage gaps (RQ8): Among DY25 enrollees, 21.1% (n=25,171) began enrollment in 2019, 7.8% (n=9,292) began enrollment in 2020, 0.4% (n=424) began enrollment in 2021, and 70.8% (n=84,386) began enrollment in 2022. Among the women in DY25 who were enrolled beyond the first year, 48.4% lost coverage after two years. The average length of time between prior enrollment ending and DY25 enrollment beginning was 15.5 months and ranged from 2 to 28 months.

Satisfaction with services (RQ9): Of the 237 enrollees who participated in the survey, a vast majority of them (87%) reported being unaware of their enrollment into the program (n=207). Most enrollees that received services (82%; n=18) reported being satisfied (i.e., either "Satisfied" or "Very Satisfied") with the types of services offered. Of the enrollees reporting receiving information and/or customer service, all (n=18) reported being satisfied with the information and customer service provided to them regarding the FPW program. Among enrollees that received specified services (i.e., contraceptive care, STD testing, or cervical cancer screening), all of them reported being satisfied with contraceptive care (n=12) while a vast majority were satisfied with STD testing (88%; n=7), and cervical cancer screening (75%; n=6). Of enrollees who accessed the family planning services, a vast majority of them (89%; n=16) reported it was easy to access the family planning services (i.e., responded "Very easy" or "Somewhat easy" to the question).

Strategies being used by DOH clinics to increase participation in FPW (RQ10): Since, historically, survey responses have yielded similar results, the Agency chose not to conduct another survey with DOH frontline staff during the current demonstration period. Therefore, in accordance with the CMS approved Evaluation Design, no additional survey data was obtained for DY25. As reported for DY20/21, 9 of the 67 (13%) DOH clinics responded to the evaluation team's survey. Strategies identified included external outreach, staff incentivization, pre-appointment eligibility review, sharing information during appointments, and follow-up with eligible patients.

Conclusions

Enrollment rates among women eligible for the FPW program remain low, with about 50% of eligible women enrolling in the program. Additionally, only 4% of FPW enrollees used any FPW services. While the FPW program has proven to be very successful among women who participated in the program, the impact of the program is greatly reduced because of very low enrollment and participation rates. The vast majority of eligible but unenrolled women who were interviewed indicated that they were unaware of the program. Even women who were enrolled and used services provided through the FPW program were often unaware that they were enrolled and that services were received through the FPW. Not only does DY25 represent the second full year of the public health emergency, which greatly reduced the number of women eligible for the FPW program since women were able to retain Medicaid coverage during this period, it also encompasses the end of the public health emergency which occurred in April of 2023. As a result, findings for DY25 were often different compared to previous demonstration years.

Recommendations

Given the consistent finding of lack of knowledge of the FPW program, both among eligible women who do not enroll and enrolled women, future activities should focus on increasing enrollment and enrollee participation rates in the FPW program through interventions designed to increase awareness of the program. Potential strategies should be considered and could include using strategies identified by the DOH clinics, including outreach, education, and proactively engaging with women to get them enrolled in the FPW program if/when additional information is needed for their enrollment for the second 12-month period. Additionally, engaging eligible women through digital platforms such as email, text messages, and social media may also help increase enrollment and engagement in the program. Increasing enrollment and

participation in the program will likely increase the number of women experiencing the positive outcomes of the program and potentially generate additional cost savings by improving or maintaining health outcomes.

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Definitions and Acronyms

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

Averted birth: A birth that might have occurred if an enrollee was not participating in the FPW program. The number of estimated averted births is calculated by comparing the observed birth rate of women enrolled in the FPW program in a given demonstration year versus the expected birth rate if they instead had the birth rate of women eligible for the FPW program but did not enroll.

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

Department of Children and Families (DCF): The Florida agency responsible for determining all Medicaid eligibility.

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

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

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

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

Demonstration Year (DY) 23: Represents the state fiscal year of July 1, 2020 to June 30, 2021.

Demonstration Year (DY) 24: Represents the state fiscal year of July 1, 2021 to June 30, 2022.

Demonstration Year (DY) 25: Represents the state fiscal year of July 1, 2022 to June 30, 2023.

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

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

Eligible: A woman who is 14 years of age through and including a woman who is 55 years of age with a family income at or below 191% of the Federal Poverty Level (FPL) who loses Medicaid pregnancy coverage after 60 days postpartum or a woman who is 14 years of age through and including a woman who

is 55 years of age with a family income at or below 191% of the FPL for a period of two years after losing Medicaid coverage for reasons other than the expiration of the 60-day postpartum period.

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

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

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

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

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

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

Target Population: All FPW program enrollees.

Introduction and Background

The Florida Medicaid Family Planning Waiver (FPW) program is a Section 1115(a) waiver demonstration approved by the U. S. Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS). The initial FPW demonstration was approved for a five-year period on August 23, 1998 and implemented October 1, 1998.

At the inception of the program in 1998, the Department of Health (DOH) determined participant eligibility and enrollment for Family Planning Waiver services, however eligibility and enrollment determinations were turned over to the Department of Children and Families beginning on February 12, 2022. The Bureau of Family Health Services within DOH works with the local county health departments to provide a vast array of both Medicaid and non-Medicaid community health and family planning services, including preconception counseling, pregnancy tests, screening and treatment of sexually transmitted infections, cancer screening, and contraception supplies.

The purpose of the program is to expand eligibility for family planning services for up to two years to individuals who otherwise are not financially eligible for full Medicaid. Eligibility is limited to women of childbearing age, 14 years of age up through and including women who are 55 years of age; who have a family income at or below 191 percent of the Federal Poverty Level (FPL) (post Modified Adjusted Gross Income (MAGI) conversion); who are not covered by a health insurance program that provides family planning services; and who have lost Medicaid coverage within the last two years, including women who lost Medicaid pregnancy coverage after 12 months postpartum.

On June 17, 2024, the Centers for Medicare and Medicaid Services (CMS) approved the State's request to extend Florida's 1115(a) Family Planning Waiver through June 30, 2025. As part of a previous extension request, CMS requested a change in the eligibility determination process from the FPW program. On February 12, 2022, the eligibility determination process for the program was integrated into the Medicaid State Plan eligibility system, operated by the Department of Children and Families (DCF). DCF is the Florida agency responsible for determining all Medicaid eligibility. They have ownership of Florida's MyACCESS portal where Medicaid applications are submitted and eligibility determinations are made. This system works in conjunction with the Florida Medicaid Management Information System to track individuals' Medicaid eligibility.

Additionally, the State began automatically enrolling all eligible women into the FPW program for the initial 12-month period as well as for the second 12-month period if no additional information is needed to determine eligibility. Thus, most eligible women are now automatically enrolled for the full 24-month period.

This final report is part of a series of reports produced by Florida State University (FSU), in collaboration with the University of Florida (UF), in evaluating the FPW program through June 30, 2026. The Special Terms and Conditions (STCs) of the 1115(a) waiver renewal requires an evaluation of the demonstration during the renewal period.

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

1. To increase access to family planning services;
2. To increase child spacing intervals through effective contraceptive use;
3. To reduce the number of unintended pregnancies in Florida;
4. To reduce Florida's Medicaid costs by slowing the birth rate among females who would otherwise be eligible for Medicaid pregnancy-related services; and,
5. To improve or maintain health outcomes for the target population as a result of access to family planning services and/or family planning-related services.

FPW Program Evaluation Research Questions

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

- Research Question 1: What differences in recipient demographic characteristics exist between FPW enrollees and eligible women who do not enroll in FPW per Demonstration Year?
- Research Question 2: What are the interbirth intervals for FPW enrollees compared to eligible women who do not enroll in the FPW program who gave birth during the study period?
- Research Question 3: What is the rate of unintended pregnancies for FPW enrollees and eligible women who do not enroll in the FPW program per Demonstration Year?

- Research Question 4: What is the rate of low birth weight and preterm births for FPW enrollees compared to women who are eligible but do not enroll in the FPW program?
- Research Question 5: Is the FPW achieving cost savings by slowing the birth rate?
- Research Question 6: What are the reasons that women eligible for the FPW program choose to enroll or not enroll in the FPW program and the reasons women enrolled in the FPW program do not participate?
- Research Question 7: How do FPW enrollees utilize covered health services?
- Research Question 8: What gaps in coverage are experienced by FPW enrollees over time?
- Research Question 9: Are FPW enrollees satisfied with services?
- Research Question 10: What strategies are being used by the Department of Health to increase FPW participation rates?

Data and Methods

Data

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

DOH Birth Vital Statistics (BVS) birth certificates (CY2000 – CY2023)

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

DOH Healthy Start Prenatal Screens (CY2011 – CY2023)

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

Medicaid Eligibility Files (CY2015-CY2023)

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

Medicaid Claims Files (CY2015-CY2023)

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

Medicaid Enrollment Files (CY2015-CY2023)

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

FPW Eligibility and Enrollment Survey

Qualitative interviews were conducted with FPW enrollees and eligible women who do not enroll in FPW program through online surveys in SFY2023-2024 to assess the reasons that women eligible for the FPW program choose to enroll or not enroll in the FPW program. The surveys also asked women where they obtained information about family planning services and their openness to receiving information through various platforms (mail, email, text message, social media) to help target future efforts to increase enrollment.

FPW Eligible Women and Enrollee Participation Surveys

Qualitative interviews were conducted with women enrolled in FPW who did not use any of the covered services through online surveys to understand reasons for not using services. The surveys also asked women where they obtained information about the FPW program and their openness to receiving information through various platforms (mail, email, text message, social media) to help target future efforts to increase use of covered services by enrolled women.

FPW Enrollee Satisfaction Survey

Quantitative/qualitative interviews were conducted in January and February 2024 with FPW enrollees who used FPW services during DY25 through a telephone-based satisfaction survey.

DOH Staff Survey

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

FPW engagement/participation rates. In accordance with the CMS approved Evaluation Design, no additional survey data was obtained for DY25.

Methods

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

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

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

i. The number of eligible women receiving Title XIX funded family planning services each year of the demonstration.

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

i. Average interbirth intervals (IBI) in number of months for FPW enrollees compared to eligible women who did not enroll in the FPW program.

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

i. The number of unintended pregnancies among FPW enrollees and eligible women who did not enroll in the FPW program.

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

i. Cost savings to Medicaid for the number of averted births.

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

i. Number of low birth weight and preterm births.

FPW Program Study Population

The study population includes all women who were enrolled in the FPW program during DY25 (SFY2022-2023). While not all evaluation questions will use a comparison population, those that do will use women who are eligible for the FPW program in a given year, but who do not enroll in the program. This will maximize comparability, as these women will also be of childbearing age and will have recently lost Medicaid coverage and will, thus, likely have similar incomes and sociodemographic characteristics as FPW enrollees. While selection bias using this population is possible, it will be minimal given that fewer than 20% of eligible women enroll in FPW in any given year. Because most of the eligible women who do not enroll are likely to still have need for and benefit from family planning services, it is unlikely that the decision to enroll or not enroll is strongly correlated with need for these services, which is the main cause of selection bias. Depending on the research question, qualitative analyses target eligible women who do not enroll in the FPW, FPW enrollees, FPW enrollees who do not use FPW services, FPW enrollees who use services, and Department of Health (DOH) staff who administer the FPW program.

Additionally, some of the evaluation questions will compare first year FPW enrollees to second year FPW enrollees. First year enrollees are those enrollees within 12 months of their Aid Category Effective Date in the study period (e.g., for DY25, an Aid Category Effective Date between July 1, 2022, and June 30, 2023). Second year enrollees are those enrollees between 12 and 24 months of their Aid Category Effective Date within the study period.

General Findings

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

Table 1a and 1b present the demographic characteristics existing between 119,273 FPW enrolled women and 116,995 eligible FPW non-enrollees for DY25.

FPW Enrollees. Table 1a presents the demographic characteristics of FPW enrollees for DY25 (SFY2022-2023) by age, race, and ethnicity group. Specifically, the total number of eligible FPW enrollees was 119,273 with known race, age and ethnicity data; the average age of enrollees was 31.8 years (SD = 9.3; range = 13-57). Most enrollees identified as either Black (40.8%), White (31.1%), or Hispanic (23.1).

Table 1a: Demographic Characteristics of FPW Enrollees, DY25

	Age Group (years)					Total	
Race/Ethnicity	**14-19**	**20-29**	**30-34**	**35-44**	**45-55**	**Number**	**Percent***
American/Asian Indian & Other	253	2,292	924	1,232	618	**5,319**	**4.5**
Asian	43	260	85	155	98	**641**	**0.5**
Black	2,066	20,187	8,885	12,732	4,840	**48,710**	**40.8**
Hispanic	1,687	11,811	4,620	6,044	3,377	**27,539**	**23.1**
White	1,163	14,285	7,320	9,843	4,453	**37,064**	**31.1**
Total FPW Enrollees (%)*	**5,212**	**48,835**	**21,834**	**30,006**	**13,386**	**119,273**	**100**
	4.4	**40.9**	**18.3**	**25.2**	**11.2**		

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

FPW Eligible Non-Enrollees. Table 1b presents the demographic characteristics of FPW eligible females who did not enroll in DY25 (SFY2022-2023) by age, race, and ethnicity group. Specifically, the total number of FPW eligible females who did not enroll in DY25 with known age, race, and ethnicity data was 116,995; the average age of non-enrollees was 30.8 years (SD=10.5; range = 13-57). Most eligible females with known race and ethnicity data who did not enroll identified as either White (33.6%), Hispanic (30.3%), or Black (24.2%).

Table 1b: Demographic Characteristics of FPW Eligible Non-Enrollees, DY25

	Age Group (years)					Total	
Race/Ethnicity	**14-19**	**20-29**	**30-34**	**35-44**	**45-55**	**Number**	**Percent***
American/Asian Indian & Other	2,016	3,678	2,089	2,591	2,307	**12,681**	**10.8**
Asian	211	361	259	379	126	**1,338**	**1.1**
Black	3,786	10,884	5,824	5,329	2,520	**28,343**	**24.2**
Hispanic	4,679	13,400	7,177	6,794	3,338	**35,388**	**30.2**
White	5,542	13,334	6,930	7,786	5,655	**39,247**	**33.5**
Total FPW Enrollees (%)*	**16,234**	**41,657**	**22,279**	**22,879**	**13,946**	**116,995**	**100**
	13.9	**35.6**	**19.0**	**19.6**	**11.9**		

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

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

To measure the impact of the FPW increasing the child spacing interval through effective contraceptive use, the research team compared the average IBI of enrollees and FPW eligible non-enrollees for DY25. For this report, the research team conducted comparisons of average IBI length in number of months by enrollment status. To answer this question, birth records are required for 24 months after the end of the demonstration year. In the analysis, the denominator includes only women who had at least two births within the 24-month index period. Only those women who have a second birth were included in the calculations, thus, dropping all women who did not give birth a second time during the study period, which should be considered a positive outcome attributable to the program. By calculating the number of women who do not give birth within 24 months of enrollment in the program, women who do not have a second birth can be included in the calculations related to the positive outcomes of the program. The methods and inclusion and exclusion criteria for calculating the interbirth intervals are found in detail in *Appendix D.*

The average IBIs in number of months for FPW enrollees and FPW non-enrollees for DY25 are shown in Table 2. In DY25, the average IBI for women enrolled in the FPW program was 17.4 months, one month longer than the average IBI for women not enrolled in the FPW program of 16.4 months.

Table 2: DY25 Average Interbirth Intervals in Months for FPW Enrollees and Non-Enrollees

	DY25 (2022-2023)
Average IBI for FPW Enrollees (months)	17.4
Average IBI for FPW Non-Enrollees (months)	16.4

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

The number of unintended pregnancies was measured by comparing responses to questions 5 and 14 on the Healthy Start Prenatal Risk Screen among FPW participants and non-participants. For women who became pregnant anytime during DY25, the research team identified FPW enrollees who indicated on the Healthy Start Prenatal Risk Screens that their pregnancies were unwanted or unintended. The methods and inclusion and exclusion criteria for calculating the unintended pregnancies are found in detail in Appendix E. Tables 3a and 3b illustrate the number of responses to each question on the Healthy Start Prenatal Risk Screen as well as the rates of unintended pregnancies. Table 3c shows odds ratios for logistic regression models of unintended pregnancies, by FPW enrollee status.

For DY25, 9.7% (Table 3a) of FPW enrollees indicated that it was not a good time to be pregnant (question 5) as compared to 11.7% (Table 3b) of FPW non-enrollees. Responses to question 14 indicated that 50.2% of FPW enrollees answered "later" or "not pregnant" as compared to 53.1% of FPW non-enrollees. When combining all negative responses across both questions 5 and 14 to capture the overall rate of unintended pregnancies, 50.3% of FPW enrollees indicated that their pregnancy was unintended as compared to 54.2% of FPW non-enrollees. In addition, FPW enrollees have significantly lower odds of a reported unintended pregnancy (OR: 0.83, $p < .01$) compared with FPW non-enrollees, when controlling for age and race/ethnicity (Table 3c).

The Centers for Disease Control and Prevention's Pregnancy Risk Assessment and Monitoring System (PRAMS) presents national and state-level estimates of pregnancy intention as four categories: 1) mistimed pregnancy, 2) unwanted pregnancy, 3) unsure whether wanted pregnancy, and 4) intended pregnancy. In 2020 (the latest publicly available year of data), PRAMS found that 17.7% of pregnancies were reported as mistimed, 6.3% were reported as unwanted, 15.5% were unsure whether they wanted the pregnancy, for a

total unintended pregnancy rate of 39.5% among U.S. women (and a reported intended pregnancy rate of 60.4%) (PRAMS, 2023). It is important to note that the national PRAMS estimates do not account for income or Medicaid status and are therefore not likely to be directly comparable to the FPW enrollee and FPW non-enrollee groups.

Table 3a: Rate of Unintended Pregnancies for FPW Enrollees, DY25 (SFY2022-2023)

Question 5. Is this a good time for you to be pregnant?	
Yes (#)	1,992
No (#)	215
Total Responses Question 5 (#)	**2,207**
Question 5 Rate of Unintended Pregnancies (%)	**9.74**
Question 14. Thinking back to just before you got pregnant, did you want to be?	
Pregnant Now (#)	1,104
Pregnant Later (#)	856
Not Pregnant (#)	257
Total Pregnant Later & Not Pregnant (#)	1,113
Total All Responses Question 14 (#)	**2,217**
Question 14 Rate of Unintended Pregnancies (%)	**50.20**
Negative Responses Question 5 & Question 14	
Question 5 = No (#)	215
Question 5 = Yes & Question 14 = “pregnant later” or “not pregnant” (#)	900
Total Number of Negative Responses Question 5 & Question 14 (#)	**1,115**
Total Number of Responses Question 5 & Question 14* (#)	**2,217**
Overall Rate of FPW Participant Unintended Pregnancies (%)	**50.29**

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

Table 3b: Rate of Unintended Pregnancies for FPW Non-Enrollees, DY25 (SFY2022-23)

Question 5. Is this a good time for you to be pregnant?	
Yes (#)	2,260
No (#)	300
Total Responses Question 5 (#)	**2,560**
Question 5 Rate of Unintended Pregnancies (%)	**11.72**
Question 14. Thinking back to just before you got pregnant, did you want to be?	
Pregnant Now (#)	1,206
Pregnant Later (#)	999
Not Pregnant (#)	368
Total Pregnant Later & Not Pregnant (#)	1,367
Total All Responses Question 14 (#)	**2,573**
Question 14 Rate of Unintended Pregnancies (%)	**53.13**
Negative Responses Question 5 & Question 14	
Question 5 = No (#)	300
Question 5 = Yes & Question 14 = "pregnant later" or "not pregnant" (#)	1,095
Total Number of Negative Responses Question 5 & Question 14 (#)	**1,395**
Total Number of Responses Question 5 & Question 14* (#)	**2,573**
Overall Rate of FPW Non-Participant Unintended Pregnancies (%)	**54.22**

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

Table 3c: Adjusted Odds Ratios (95% CI) for Unintended Pregnancies, DY25 (SFY2022-23)

	Unintended Pregnancy (Total # of Negative Responses to Question 5 & Question 14)
FPW Enrollee	0.83** (0.74-0.94)
Age	0.97*** (0.96-0.98)
Race/Ethnicity	
White	Reference
Black	1.95*** (1.69-2.26)
Hispanic	1.04 (0.90-1.21)
Asian	0.63 (0.35-1.12)
American/Asian Indian & Other	1.29* (1.01-1.65)

†p<10;*p<05;**p<01;***p<001

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

DY25 births were identified by a date of birth that occurred during DY25 (July 1, 2022-June 30, 2023). Cases with missing birth weight and/or clinical conception dates were excluded (n=20). Low birth weight births were identified by reported birth weight less than 2,500 grams. Pre-term births were classified as births occurring before 37 weeks gestation. Gestation length was calculated using the estimated clinical conception dates and dates of birth. These birth records were then matched to DY25 FPW enrollees and FPW non-enrollees. For the DY25 FPW enrollees, DY25 births were excluded if they did not happen during the woman's enrollment span (n=1,369), for a total of 2,585 births to DY25 FPW enrollees. There were 18,296 DY25 births to non-enrollees.

Table 4a shows the number of births considered "low birth weight" (<2,500 grams) and "pre-term births" (<37 weeks) to FPW enrollees and non-enrollees for DY25. In DY25, there were 2,585 births to FPW enrollees and 18,296 births to FPW non-enrollees. Of the 2,585 births to FPW enrollees in DY25, 11.1% (287 births) were classified as low birth weight, compared to 9.6% (1,749) of births to FPW non-enrollees.

The proportion of pre-term births to FPW enrollees was slightly larger at 15.4% (397 births), compared with 13.5% (2,461) of births to FPW non-enrollees. National Vital Statistics Data show that 8.6% of all U.S. births in 2022 were classified as low birth weight, and 10.4% of all births were classified as pre-term (CDC, 2024). Note that "low birth weight" and "pre-term births" are not mutually exclusive categories and may overlap.

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

	DY25	
Low birth weight (<2,500 grams)	**Count**	**%**
FPW Enrollees	287	11.10%
FPW Non-Enrollees	1,749	9.56%
Pre-term births (<37 weeks)		
FPW Enrollees	397	15.36%
FPW Non-Enrollees	2,461	13.45%
Total births		
FPW Enrollees	2,585	100%
FPW Non-Enrollees	18,296	100%

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

Table 4b: Odds Ratios (95% CI) for Low Birth Weight Births and Pre-term Births

	Low Birth Weight	Pre-Term Birth
FPW Enrollee	1.21**	1.16*
	(1.06-1.38)	(1.04-1.31)
Age	1.01†	1.03***
	(1.00-1.01)	(1.02-1.03)
Race/Ethnicity		
Black	1.94***	1.50***
	(1.73-2.17)	(1.36-1.66)
Hispanic	0.88†	1.03*
	(0.77-1.01)	(0.92-1.14)
Other (Am/Asian Indian, Asian, & Other)	1.22*	0.98
	(1.00-1.49)	(0.82-1.17)

†p<10;*p<05;**p<01;***p<001

Table 4b shows odds ratios for logistic regression models of low birth weight births and also pre-term births, by FPW enrollee status for DY25. FPW enrollees have significantly increased odds of both a low birth weight birth and a pre-term birth, compared with FPW non-enrollees, when controlling for age and race/ethnicity.

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

The analytic strategy used for this question was determining the total number of averted births attributed to the FPW program. The team examined the differences in birth rates calculated for women enrolled in the FPW program and eligible women who did not enroll in the FPW program. In DY25, estimated cost savings were evident driven by the difference in birth rates for FPW enrolled women compared to those eligible but not enrolled. Generally, the eligible but not enrolled group had a higher rate of births than FPW enrollees. As shown in Table 5a, there were 16,067 births that were averted for FPW enrollees during DY25 for a total cost savings of approximately $236 million dollars.

Table 5a: DY25 Medicaid Cost Savings

Demonstration Year (DY)	Difference in Number of Births	Average Medicaid Birth Costs ($)	Gross Savings	FPW Program Expenditures*	Total Cost Savings ($)
DY25	16,067	$14,959	$240,349,199	$4,357,752	$235,991,447

*Program expenditure data provided by AHCA.

Cost Savings Calculation

The analytic strategy used for this question was to determine the total number of averted births that were attributed to the FPW program. This was done by comparing a combined birth and conception rate between women enrolled in FPW and eligible women who did not enroll in the FPW program. Net cost savings was calculated by multiplying the number of averted births by average birth costs which includes the costs for the birth and the first year of the baby's life and then subtracting FPW program expenditures. The methods and inclusion and exclusion criteria for calculating the cost savings are found in detail in Appendix F.

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

Number of Births Averted = (Estimated number of births of FPW enrollees assuming they had the same birth rate as eligible women not enrolled in FPW in DY25 – Observed number of births by FPW enrollees in DY25 (SFY2022-2023)

Total Medicaid birth/infant costs for DY25 (SFY2022-2023) was estimated using the following formula:

Total DY25 Medicaid Birth Costs = Cost of services for the birth + costs of services provided to infants from birth to age 1

Average DY25 (SFY2022-2023) FPW Medicaid birth costs was calculated using the following formula:

Average DY25 Medicaid Birth Costs for FPW Enrollees = Total DY25 Medicaid birth costs / Total number of FPW enrollee births during DY25

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

DY25 (SFY2022-2023) Averted Births Gross Cost Savings = DY25 (SFY2022-2023) Number of FPW Enrollee Births Averted x Average DY25 Medicaid Birth Costs for FPW Enrollees

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

Eligible but not enrolled. Among of the 10 individuals from this group who participated in the survey, the most cited reasons for not enrolling in the program were the lack of awareness (80%; n=8) and not receiving any information about the program (80%; n=8). Another reason cited for not enrolling was the enrollment process being lengthy or confusing (10%; n=1).

Additionally, women from this group were asked about the sources they utilize to gather information about health services such as social media, television, radio, or another digital platform. A vast majority of respondents reported using a digital platform (i.e., email, Google search, or websites) (90%; n=9) or social media (70%; n=7). Other platforms cited included television (30%; n=3) and radio (10%; n=1).

Furthermore, women from this group were asked to rate their receptivity to various outreach methods for receiving communication about the FPW program on a 5-point scale ranging from "1-Not at all receptive" to "5-Extremely receptive." In this context, "receptive" is defined as respondents choosing "3-Moderately receptive.", "4-Very receptive.", or "5-Extremely receptive." All of the respondents reported being receptive to receiving emails (n=10) while a majority reported being receptive to receiving text messages (80%; n=8), phone calls (70%; n=7), being contacted through social media (70%; n=7), and outreach through physicians and/or medical clinics (60%; n=6). A minority of respondents reported being receptive to outreach through home visits (30%; n=3).

Finally, women from this group were given an open-ended question about the ways they could be better supported in the process of enrollment into the FPW program. Three individuals responded to the question. The responses encompassed the following thematic categories:

1. General outreach (n=2)- Defined by the need for any kind of communication providing information concerning what the program entails and their current qualification status for the program (e.g., "… I would like to find out some more information about this program to make sure I do qualify still so I can get the services that both me and my teenager would need.")
2. Targeted Provider Outreach (n=1)- Defined by the need for a clinician to directly contact them to provide education concerning the program (e.g., "Having a provider reach out and establish what the program fully transpires.")

Enrolled but not participated. Similar patterns emerged for the enrolled, but not participated group as for the eligible, but not enrolled group. Among the 8 enrollees from this group who participated in the survey, the most cited reasons for not participating in the program were not receiving any information about the program (75%; n=6) and the lack of awareness (50%; n=4). Other reasons cited for not enrolling were the lack of need for the program (13%; n=1), and moving out of state (13%; n=1).

Additionally, women from this group were asked whether they were aware of (i.e., yes/no) the following three services provided by the FPW program: contraceptive care, sexually transmitted disease (STD) testing, and cervical cancer screening. All individuals who responded to these questions (n=7) reported being unaware of all three services.

Women from this group were also asked about the sources they utilize to gather information about health services. Similar to the eligible but not enrolled group, a majority of this group who responded to the question (n=7) reported using a digital platform (i.e., email, Google search, or websites) (71%; n=5) or social media (71%; n=5) to gather information. Other reported platforms included television (43%; n=3) and radio (29%; n=2).

Furthermore, women from this group were also asked to rate their receptivity to various outreach methods for receiving communication about the FPW program. As with the eligible but not enrolled group, all of the respondents reported being receptive to receiving emails (n=7). However, unlike the eligible but not enrolled group, all of the respondents in this group also reported being receptive to outreach through physicians and/or medical clinics (n=7). Similar to the eligible but not enrolled group, a vast majority reported being receptive to receiving text messages (86%; n=6); however, unlike the eligible but not enrolled group, a slight minority reported being receptive to receiving phone calls (43%; n=3) and being contacted through social media (43%; n=3). Similar to the eligible but not enrolled group, a minority reported being receptive to outreach through home visits (43%; n=3).

Finally, women from this group were given an open-ended question about how marketing efforts could be improved to promote their utilization of the services offered by the FPW program. Three individuals responded to the question. The responses encompassed the following thematic categories:

1. General outreach (n=2)- Defined by the need for either phone-based or electronic communication to promote awareness of the benefits associated with the program (e.g., "By putting out more information whether it be phone call text or email some type of form of communication where it makes us aware or remind us of what benefits are out there.")
2. Targeted Program Outreach (n=1)- Defined by the need for direct communication from the Women, Infants, and Children (WIC) program representatives to provide information concerning the program (e.g., "You could have the WIC office provide information and have parents sign off that they have received information.")

RQ7: How do FPW enrollees utilize covered health services?

Table 7 presents the numbers and participation rates of enrollees who used at least one covered service by covered service category and enrollee year.

Table 7. Utilization of Covered Services by FPW Enrollees, DY25

Covered Service	Total	
	N	%**
Any Received	4,544	3.8%
Contraception	1,751	1.5%
STD Screening	1,593	1.3%
Cancer Screening	333	0.3%
Other* **	3,927	3.4%

*Participation rates are based on total enrollees (119,273).
**Other services category contains CPT codes that are services not categorized as contraceptive, STD, or cancer screening services from the "Medicaid Family Planning Waiver Services CPT Codes and ICD-10 Diagnosis Codes" document provided by the Agency.

The overall participation rate, defined as the number of enrollees that used at least one covered service as a proportion of total enrollees for a given DY, is 3.8%. The most commonly used services in DY25 was contraceptive services (1.5%), followed by STD screening (1.3%), and then cancer screening (0.3%). The participation rate for other services provided through the FPW program was 3.4%. Note, while relative participation rates declined between DY24 and DY25, the absolute number of services covered was similar. The reason for the decline in participation rates is due to the fact that the number of enrollees enrolled in the FPW program increased substantially between DY24 and DY25.

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

Table 8.1 shows the total number of FPW enrollees by the year enrollment began. There are 119,273 DY25 enrollees, and among these enrollees, 21.1% (25,171 individuals) began enrollment in 2019, 7.79% (n=9,292) began enrollment in 2020, 0.36% (n=424) began enrollment in 2021, and 70.75% (n=84,386) began enrollment in 2022. Note that the sample of FPW enrollees is limited to individuals with at least 6 consecutive months of enrollment, therefore, records with only 1-5 months of enrollment are excluded (n=57,934). Additionally, those who were enrolled in 2019-2020 were excluded as FPW enrollees if they did not have a full 12 months enrolled in DY25 (n=3,242).

Table 8.1: First and Second Year FPW Enrollment in DY25

Enrollment Start Year	DY25 Enrollees
2019	25,171 (21.10%)
2020	9,292 (7.79%)
2021	424 (0.36%)
2022	84,386 (70.75%)
Total	119,273 (100%)

Table 8.2 shows the total number of women who maintain coverage beyond the first year, broken down by those who lose coverage after two years, and those who maintain coverage beyond 2 years. Among the 76,700 DY25 women who are enrolled beyond the first year, 48.37% (n=37,101) lose coverage after two years.

Table 8.2: Enrollees who Lose Coverage after Two Years in DY25, among Individuals Enrolled Beyond 1 Year

Enrollment	DY25 Enrollees
Lose Coverage after 2 Years	37,101 (48.37%)
Maintain Coverage beyond 2 years	39,599 (51.63%)
Total	76,700 (100%)

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

Table 8.3 looks at gaps in FPW coverage between enrollment spans. Among the enrollees, 1,459 individuals had a prior enrollment span in the last 5 years. The average length of time between prior enrollment ending and DY25 enrollment beginning is 15.52 months, and ranges from 2 to 28 months.

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

DY	N	Mean	Std Dev	Min	Max
DY25	1,459	15.52	6.24	2	28

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

RQ9: Are FPW enrollees satisfied with services?

The primary data source for research question 9 is the responses to the quantitative telephone-based surveys completed by FPW enrollees who used services during DY25.

Enrollee Awareness of Enrollment. Within the qualitative interview, one screening question probed enrollees whether they were aware of being enrolled in the FPW program. A vast majority of them (87%) reported being unaware of their enrollment into the program (n=207). Of the rest, only 13% (n=30) reported being aware of their enrollment into the program. Thus, an overarching theme gleaned from these interviews was the lack of awareness of enrollment into the FPW program.

Enrollee Satisfaction. In the qualitative interviews, FPW enrollees were asked to report their level of satisfaction with the types of services offered through the FPW. There were 8 individuals that reported either not having used any family planning services or not being aware of their enrollment. Of the rest that responded to this question, nearly all of them (82%; n=18) reported being satisfied (i.e., either "Satisfied" or "Very Satisfied") with the types of services offered. Additionally, FPW enrollees were asked to report their level of satisfaction with the information and customer service provided to them regarding the FPW program. Of those that reported receiving information and customer service, all enrollees (n=18) reported being satisfied with the information and customer service provided to them regarding the FPW program.
In the qualitative interviews, FPW enrollees were asked to specify whether they received any of three types of services: contraceptive care, sexually transmitted disease (STD) testing, and cervical cancer screening. Of those who responded to the question, 68% (n=13) reported receiving contraceptive care, 42% (n=8) reported receiving STD testing, and 42% (n=8) reported receiving cervical cancer screening.

In the qualitative interviews, FPW enrollees were asked to report their level of satisfaction with three types of services: contraceptive care, sexually transmitted disease (STD) testing, and cervical cancer screening.

Of the individuals that responded to these questions, all of them reported being satisfied (i.e. either "Satisfied" or "Very Satisfied") with contraceptive care (n=12) while a vast majority were satisfied with STD testing (88%; n=7), and cervical cancer screening (75%; n=6). The results of the enrollee satisfaction among those who reported receiving services are displayed in Table 9.

Table 9: Enrollee Satisfaction Survey Quantitative Results for DY25

	Satisfaction Category		
Response Category	**Contraceptive care (n=12)**	**STD Testing (n=8)**	**Cervical Cancer Screening (n=8)**
	% (n)	**% (n)**	**% (n)**
Very Satisfied	83 (10)	63 (5)	75 (6)
Satisfied	17 (2)	25 (2)	0 (0)
Dissatisfied	0 (0)	0 (0)	0 (0)
Very Dissatisfied	0 (0)	12 (1)	25 (2)

Enrollee Ease of Access to Services. In the qualitative interviews, FPW enrollees were asked to report the ease with which they were able to access family planning services. A few individuals (31%; n=8) reported not attempting to access the family planning services. Of those that attempted to access the family planning services and responded (n=18), a vast majority of them (89%; n=16) reported it was easy to access the family planning services (i.e., responded "Very easy" or "Somewhat easy" to the question).

Enrollee Recommendations for Florida Medicaid. In the qualitative interviews, FPW enrollees were asked to provide recommendations for improving access or other aspects of the program. A total of 5 individuals responded to this question. These responses fell under the following thematic categories of suggestions for improvement:

1) Communication (n=3)- Defined by a need to improve clarity of program features during outreach (e.g., "explain more regarding the aspects of the program and the safety of it."), establish consistency in the enrollee information available to both providers and third-party vendors (e.g., "recommend cohesive amongst providers and third party centers and have the same insurance information so that is not on the patient."), and develop a centralized application for relevant information about the program (e.g., "If there were an easier way to get in contact with people, maybe if there were a special app or portal dedicated specifically to that.").

2) Providers (n=1)- Defined by a need for more cognizance on the part of physicians concerning the program to better assist the enrollees (e.g., "Better understanding from the doctors who provide these services.").
3) Services (n=1)- Defined by a need for expanding the types of procedures covered as part of the program (e.g., "adding pap checkups.").

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

The primary data source for research question 10 was the responses to a qualitative survey completed by DOH frontline staff (n=9) in DY20, as the survey was not administered in any year following DY20. Among the nine individuals who participated in the survey, two of them stated their agency does not use any strategies to increase FPW participation rates.

The strategies cited by DOH employees to increase FPW participation rates include the 1) employee incentivization (i.e., conducting a competition for identifying and enrolling the most individuals into the program); 2) active external outreach (i.e., direct communication with community partners to facilitate the process for potential enrollees); 3) passive external outreach (i.e., using flyers and postings in outside clinics and agencies); 4) pre-appointment patient eligibility review (i.e., using systems such as FLMMIS Medicaid and Department of Labor's Suntax to determine eligibility of individuals); 5) pre-appointment and in-appointment information sharing (i.e., distributing FPW materials or information before or during the appointment); and 6) following up with potential enrollees post-appointment concerning application materials. Selected quotes are presented in Table 10.1.

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

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

Conclusions, Positive Outcomes, Challenges, and Lessons Learned

One positive finding that remains consistent among those women who used FPW services was that they were overwhelmingly satisfied with those services and indicated that the services were easy to access. Additionally, compared to previous years, the enrollment rate among women eligible for the FPW program for this year increased to 50.5%.

Some challenges were also observed:

- Only 3.8% of FPW enrollees used any FPW services in DY25. While the types of services provided through the FPW program have been shown to be effective at producing positive outcomes, the impact of the program is greatly reduced because of low enrollment and participation rates. The majority of women who were interviewed indicated that they were unaware of the program, including women who used services provided through the FPW program.
- There was some ambiguity on whether to use the estimated clinical conception date or the date or birth to classify the demonstration year of births as the span of a pregnancy can last through parts of two demonstration years. For RQ4, date of birth was used because it gave the fewest missing cases, and the question is focused specifically on the birth outcomes.
- Challenges primarily stemmed from managing and using the data to properly classify enrollees vs. non-enrollees. More specifically, enrollee data had many cases with multiple, short enrollment spans, that often overlapped. The evaluation team addressed this challenge by using the multiple dates to identify the full enrollment span.

Lessons Learned and Recommendations

Given the consistent finding of lack of knowledge of the FPW program, both among eligible women who do not enroll and enrolled women, future activities should focus on increasing enrollment and enrollee participation rates in the FPW program. Activities associated with the eligibility determination process were recently transferred from the DOH to the DCF. Because the DCF currently does all eligibility determinations for Florida's Medicaid program, FPW eligible women are now automatically enrolled for the initial 12-month period as well as the second 12-month period if no additional information is needed to determine eligibility. Thus, most eligible women will be automatically enrolled for the full 24-month period, improving enrollment rates; however, this strategy is unlikely to increase awareness or participation in the FPW

program. Addressing this issue is important, particularly given the large increase in women becoming eligible for the program when the public health emergency ended in April 2023 which likely resulted in many women losing Medicaid coverage. As indicated in the Healthy People 2030 initiative, increased awareness of family planning services is needed and can be achieved through public outreach and improved collaboration between health care providers. Marketing of the program through social media and other platforms such as television, radio, and billboards has successfully increased awareness of public health programs, as well as additional mailings, text messages, and emails by the Agency to inform eligible and/or enrolled women of the program and benefits of the program. The Agency should also attempt to collaborate more with providers of FPW services to encourage participation as well as using strategies identified by some of the DOH clinics, including outreach, education, and proactively engaging with women to get them enrolled in the FPW program. Additionally, a significant portion of DY25 took place during the public health emergency, which greatly reduced the number of women eligible for the FPW program, as women were able to retain their Medicaid coverage through the public health emergency. As compared to previous demonstration years that were included in the public health emergency, DY25 saw a dramatic increase in the number of enrolled women, most likely due to the ending of the public health emergency in the Spring of 2023. The end of the public health emergency resulted in a large number of people who lost their Medicaid coverage, contributing to a large number of new individuals who were then eligible for the program. Future demonstration years outside of the public health emergency will provide additional context on the impact on the FPW program.

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Appendices

Appendix A: Specific Methods for Each Research Question

For research question 1 (What differences in recipient demographic characteristics exist between FPW enrollees and eligible women who do not enroll in FPW per DY?), Medicaid eligibility files were used to identify women who are eligible for the FPW program as well as women enrolled in the FPW program. Medicaid eligibility files were also used to identify demographic characteristics for eligible and enrolled women, and descriptive statistics of the demographic characteristics of FPW enrollees as well as eligible women who did not enroll in the FPW program were calculated for DY25. Eligible women were identified as women 14 years of age up through and including women who are 55 years of age who lost Medicaid eligibility for any reason in the two years prior to the DY being examined. FPW enrollees were identified from Medicaid eligibility files.

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

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

For research question 4 (What is the rate of low birth weight and preterm births for FPW enrollees compared to women who are eligible but do not enroll in the FPW program?), Medicaid eligibility and claims data were merged with Vital Statistics birth certificate data and hospital discharge data to identify low birth weight births, defined as a baby that is less than 2,500 grams at birth, and preterm births, defined as a birth at

less than 37 weeks gestation. The rate of preterm births and rates of low birth weight were calculated for both FPW enrollees and eligible women who do not enroll in the FPW program by dividing the total number of preterm or low birth weight births in a DY by the total number of births by each group in the DY. Preterm and low birth weight rates were compared between FPW enrollees and eligible women who are not enrolled in the FPW program using descriptive statistics for each DY.

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

For research question 6 (What are the reasons that women eligible for the FPW program choose to enroll or not enroll in the FPW program and the reasons women enrolled in the FPW program do not participate?), qualitative interviews were administered to identify common themes. Separate qualitative interviews were administered to eligible women who do not enroll in the FPW program and FPW enrollees who do not use FPW services (non-participants). Eligible women who do not enroll were asked for reasons why they did not enroll. FPW non-participants were asked why they did not use any FPW services. The samples (FPW enrollee non-participants, eligible women who do not enroll in the FPW program) for the qualitative interviews were identified from Medicaid eligibility and claims data. A total of 25 women were interviewed from each group or until saturation was achieved, whichever came first. Interviews took place in SFY2020-2021. Interviews will not be repeated in future DYs as the evaluation team does not expect responses to change from year to year. Common themes were identified using a grounded theory approach utilizing NVivo qualitative data analysis software. Draft survey questions are included in Appendix B.

For research question 7 (How do FPW enrollees utilize covered health services?), Medicaid eligibility, enrollment, and claims data were used to assess enrollment rates, utilization rates (use of any service covered by FPW), contraceptive services utilization rates, cancer screening utilization rates, and sexually transmitted disease (STD) screening utilization rates for all FPW enrollees per DY. Overall utilization rates were also compared between first year FPW enrollees and second year FPW enrollees. FPW contraceptive care rates were calculated as the total number of FPW enrollees who use contraceptive services/total number of FPW enrollees. FPW cancer screening rates were calculated as the total number of FPW enrollees who use any

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

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

For research question 9 (Are FPW enrollees satisfied with services?), satisfaction surveys were administered to FPW enrollees. Surveys will be administered during each DY. FPW enrollees will be randomly selected and administered a telephone-based satisfaction survey (see Appendix B for satisfaction survey instrument). Surveys will be administered each year until 300 completed surveys are achieved. Surveys for DY25 were administered during the first quarter of CY2024. Descriptive statistics of survey responses will be used to summarize FPW enrollee experiences and satisfaction.

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

Appendix B: Qualitative Surveys

Family Planning Waiver Satisfaction Surveys

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

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

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

3. How easy was it to access these family planning services?
    a. Very easy
    b. Somewhat easy
    c. Somewhat difficult
    d. Very difficult
    e. I did not attempt to access family planning services (if selected, exit survey)

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

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

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

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

You are eligible for Florida's Family Planning Waiver program which offers access to services like contraception, cervical cancer screening, and STD screening. We have contracted with Florida's Agency for Health Care Administration to assess why women who are eligible for the program are not enrolled; we hope you participate. This survey is voluntary. Your responses are anonymous and won't affect your eligibility for the program. You can refuse to answer any question and can stop at any time.

1. Although you are eligible for the Family Planning Waiver program, you have not chosen to enroll in the program. Why have you chosen not to enroll in this program? Please choose ALL that apply.
    a. I am not aware of what the program is
    b. I did not receive any information about the program
    c. I am not interested in receiving the services offered by this program
    d. I am ineligible for the program
    e. I moved out of state
    f. The enrollment process is too lengthy or confusing
    g. Other: please specify (open response)

2. What sources do you utilize to gather information?
    a. Social Media (e.g., Facebook, Instagram, and Twitter)
    b. Other digital platform (e.g., email, Google search, websites)
    c. Television
    d. Radio
    e. Other: please specify (open response)

3. To what extent would be receptive to following outreach methods for receiving communication about the FPW program? (Response options for each method were "Extremely receptive", "Very receptive", "Moderately receptive", "Slightly receptive", or "Not at all receptive")
    a. Emails
    b. Phone Calls
    c. SMS/Text Messaging
    d. Social Media
    e. Home Visits
    f. Physicians and/or medical clinics
    g. Other: please specify (open response)

4. In what ways could we better support you in the process of enrollment into the FPW program?

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

You are enrolled in Florida's Family Planning Waiver program which gives you access to services like contraception, cervical cancer screening, and STD screening. We have contracted with Florida's Agency for Health Care Administration to assess why women who are enrolled the program haven't used any of the program's services; we hope you participate. This survey is voluntary. Your responses are anonymous and won't impact your enrollment in the program. You can refuse to answer any question and can stop at any time.

1. Although you are eligible for the Family Planning Waiver program, you have not chosen to enroll in the program. Why have you chosen not to enroll in this program? Please choose ALL that apply.
    a. I am not aware of what services are offered
    b. I did not receive any information about what services are offered
    c. I am not interested in receiving the services offered by this program
    d. I am ineligible for the program
    e. I moved out of state
    f. The participation process is inconvenient
    g. Other: please specify (open response)

2. Were you aware of the following services provided by the FPW program?
    a. Contraceptive care (Yes/No)
    b. STD Testing (Yes/No)
    c. Cervical cancer screening (Yes/No)

3. What sources do you utilize to gather information about health services?
    a. Social Media (e.g., Facebook, Instagram, and Twitter)
    b. Other digital platform (e.g., email, Google search, websites)
    c. Television
    d. Radio
    e. Other: please specify (open response)

4. To what extent would be receptive to following outreach methods for receiving communication about the FPW program? (Response options for each method were "Extremely receptive", "Very receptive", "Moderately receptive", "Slightly receptive", or "Not at all receptive")
    a. Emails
    b. Phone Calls
    c. SMS/Text Messaging
    d. Social Media
    e. Home Visits
    f. Physicians and/or medical clinics
    g. Other: please specify (open response)

5. How could we improve our marketing efforts to promote your utilization of the services offered by the FPW program?

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

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

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

Appendix C: Healthy Start Prenatal Screen

Help your baby have a healthy start in life!

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

Today's Date: _____

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

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

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

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

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

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

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

PATIENT INFORMATION

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

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

Patient Signature: _____ **Date:** _____

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

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

Signature: _____ *Date:* _____

PROVIDER ONLY

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

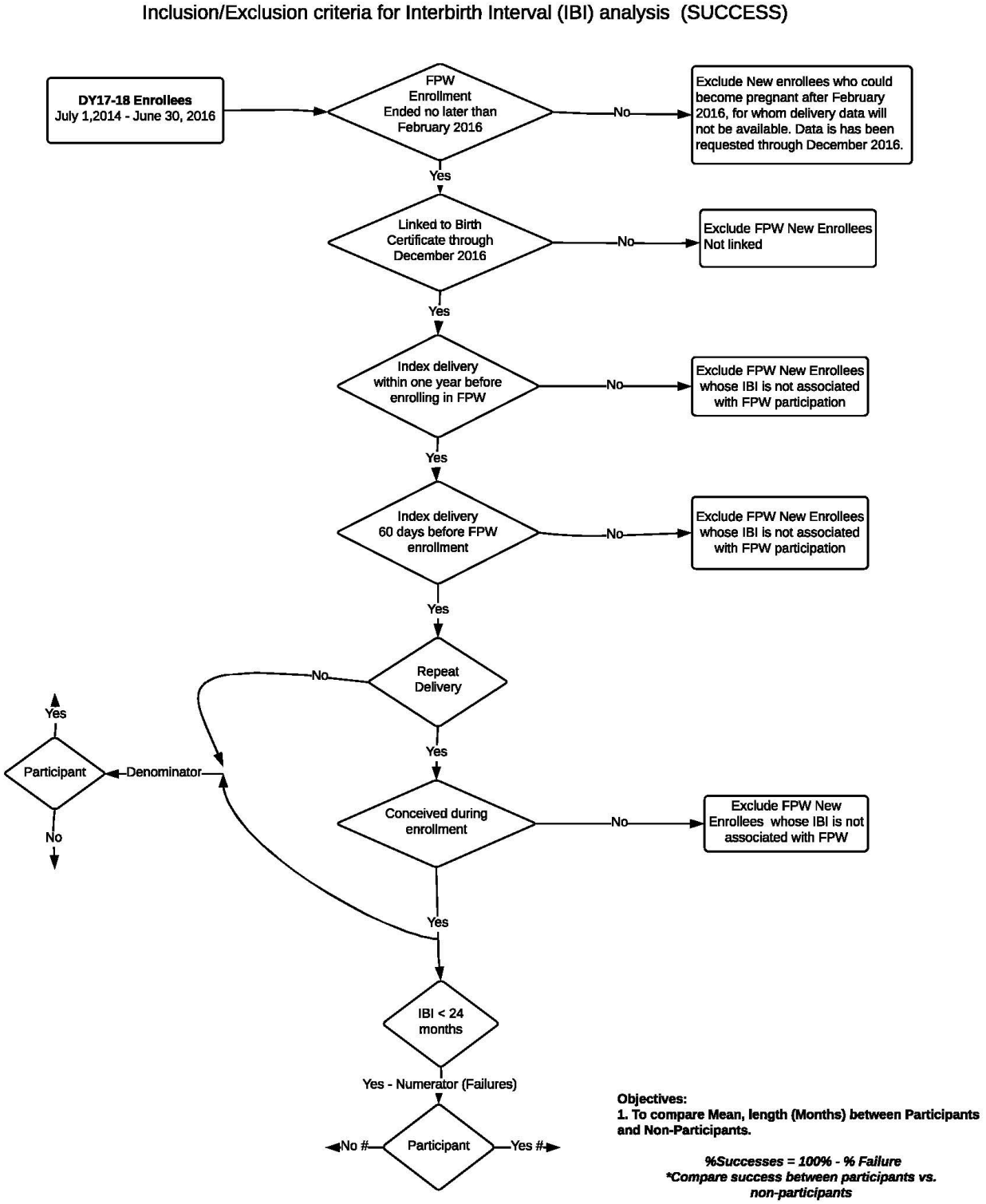
DH 3134, 04/08, stock number 5744-100-3134-7 Distribution of copies: WHITE & YELLOW—County Health Department in county where screening occurred PINK—Retained in patient's record GREEN—Patient's Copy

Appendix D: Interbirth Interval (IBI) Methodology and Flowchart

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

1. Inclusion Criteria for enrollees and eligible non-enrollees for IBI
    a. For DY24 enrollees, FPW enrollment ended no later than March 2021
    b. Linked to birth certificate data through December 2021
    c. Conceived after enrolling in FPW
    d. Conceived no later than one year after the end of FPW enrollment
    e. Previous delivery within one year before enrolling in FPW.
2. Exclusion Criteria for IBI
    a. Exclude enrollees who could become pregnant after March 2021 for whom 2021 birth certificate data is not available
    b. Exclude enrollees not linked to a birth certificate
    c. Exclude enrollees whose IBI cannot be extended by FPW services
    d. Exclude FPW non- enrollees who received Family Planning Services through Title X (Planned Parenthood).

Inclusion/Exclusion criteria for Interbirth Interval (IBI) Analysis

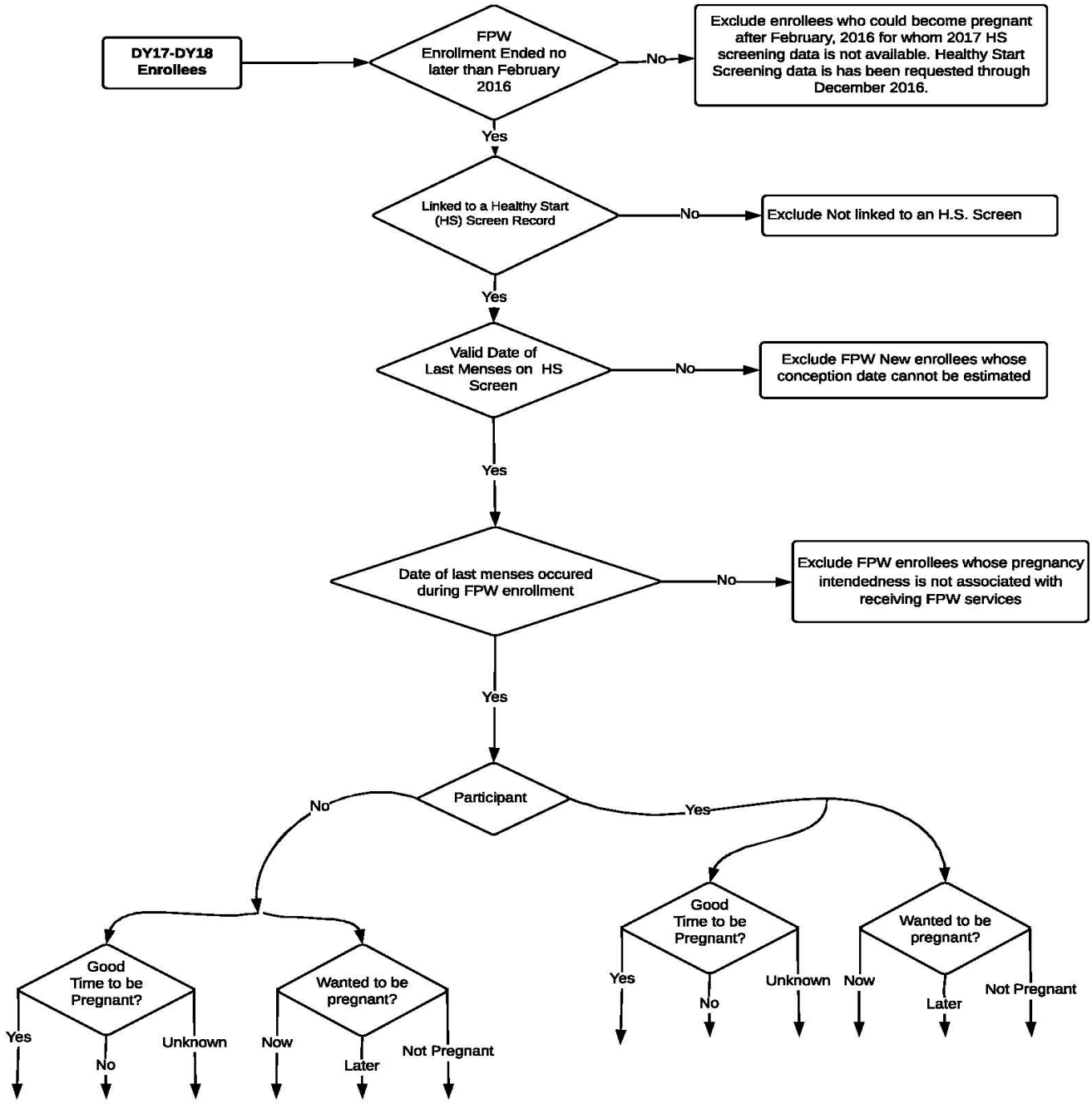


Appendix E: Unintended Pregnancies Methodology and Flowchart

To measure the impact of the FPW in reducing the number of unintended pregnancies through provision of Family Planning services, the research team assessed whether there was a difference in the rate of unintended pregnancies during DY20 among Participants and Non-Participants. The research team employed the following steps for determining and comparing the rate of unintended pregnancies between participants and non-participants:

1. Identify DY20 Participants who meet the following three conditions:
    a. Are linked to at least one Healthy Start Prenatal Risk Screen record dated July 1, 2017 through June 30, 2019.
    b. Their date of last menses as reported on at least one linked Healthy Start Prenatal Risk Screen record is not missing.
    c. Their date of last menses as reported on at least one linked Healthy Start Prenatal Risk Screen record occurred on or after their date of enrollment and on or before the end of the waiver period, June 30, 2024.
2. Among Participants who meet the three conditions in Step 1, identify DY20 Participants (received at least one FPW service during enrollment with a date of service on or before the end of the waiver period, June 30, 2024) who also meet the following condition:
    a. Their date of last menses as reported on at least one linked Healthy Start Prenatal Risk Screen record occurred on or after their first FPW service.
3. Among Participants who meet the three conditions in Step 1 and do not meet the first condition of Step 2 (did not receive FPW services during enrollment with a date of service that is on or before the end of the waiver period, June 30, 2024) identify those who also meet the following condition:
    a. Did not receive a family planning service through a different Medicaid delivery system than the FPW while enrolled in the FPW.

Inclusion/Exclusion criteria for Unintended Pregnancies Analysis



Objective: Compare proportion of unintended pregnancies between participants and Non-participants

Appendix F: Cost Saving Methodology

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

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

Appendix G: Procedure Codes for All FPW Services

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

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

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

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

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

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

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

Family Planning Evaluation and Management Services	
Evaluation and Management CPT Code	***Description of Covered Codes***
99384FP	Family planning new visit
99385FP	
99386FP	
99394FP	Family planning established visit
99395FP	
99396FP	
99403FP	Family planning counseling visit
99211FP	Family planning supply visit
Contraceptive Services	
Medication/Device CPT Code	***Description of Covered Codes***
J1050	Injection medroxyprogesterone acetate (Depo-Provera)
J7300	Intrauterine copper device (Paraguard)
J7301	Levonorgestrel-releasing intrauterine contraceptive system (Skyla), 13.5 mg
J7297	Levonorgestrel-releasing intrauterine contraceptive system (Liletta), 52 mg
J7298	Levonorgestrel-releasing intrauterine contraceptive system (Mirena), 52 mg
J7307	Etonogestrel implant system, including implant and supplies (Nexplanon)
J7296	Levonorgestrel-releasing intrauterine contraceptive (Kylenna), 19.5 mg
Anesthesia, Surgical and Radiology CPT Code	***Description of Covered Codes***
11981	Insertion, non-biodegradable drug delivery implant
11983	Removal with reinsertion, non-biodegradable drug delivery implant
57170	Diaphragm or cervical cap fitting with instructions
58300	Insertion of intrauterine device
58600	Ligation or transection of fallopian tube(s)
58615	Occlusion of fallopian tube(s) by device (e.g., band, clip, Falope ring)
58670	Surgical laparoscopy, with fulguration of oviducts (with or without transection)
58671	Surgical laparoscopy, with occlusion of oviducts by device (e.g., band, clip, or Falope ring)
76856	Ultrasound of pelvis, non-obstetric (to check placement of intrauterine devices)
76882	Ultrasound of extremity, limited, anatomic specific (to check for implantable contraceptive device)
88302	Level II surgical pathology, gross and microscopic (sterilization)
Laboratory CPT Code	***Description of Covered Codes***
81025	Urine pregnancy test, by visual color comparison

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

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

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