DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850

State Demonstrations Group

July 28, 2023

Charissa Fotinos, MD, MSc
Medicaid Director
Washington State Health Care Authority
626 8th Avenue SE
P.O. Box 45502
Olympia, Washington 98504-5010

Dear Director Fotinos:

The Centers for Medicare & Medicaid Services (CMS) completed its review of the Family Planning Demonstration Interim Evaluation Report, which is required by the Special Terms and Conditions (STCs), specifically STC #51, "Interim Evaluation Report" of the section 1115 demonstration, "Washington Family Planning Only Program" (Project No: 11-W-00134/0). The demonstration extension was approved on May 9, 2018, and was effective through June 30, 2023. This Interim Evaluation Report covers the period from July 2018 through June 2022. CMS determined that the Evaluation Report, submitted on November 30, 2022 and revised on May 3, 2023, is in alignment with the CMS-approved Evaluation Design and the requirements set forth in the STCs, and therefore, approves the state's Interim Evaluation Report.

The results from the evaluation indicated that the demonstration has played an important role in helping low-income women who are not eligible for Medicaid gain access to family planning services. Overall, women who were in the family planning only lower income group tended to use more services than those in the higher income or in the pregnancy-related group. However, we understand the demonstration may have experienced a precipitous decline in enrollment due to the Public Health Emergency that extended full Medicaid coverage to some potential demonstration beneficiaries. We look forward to continued partnership with the state in evaluating this demonstration.

In accordance with STC #55, the approved Evaluation Report may now be posted to the state's Medicaid website within 30 days. CMS will also post the Interim Evaluation Report on Medicaid.gov.

We look forward to our continued partnership on the Washington Family Planning Only Program section 1115 demonstration. If you have any questions, please contact your CMS demonstration team.

Sincerely,

Paula M. Kazi -S Digitally signed by Paula M. Kazi -S
Date: 2023.07.28 06:34:33 -04'00'

Paula M. Kazi
Acting Director
Division of Demonstration Monitoring and Evaluation

cc: Edwin Walaszek, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

Washington State Health Care Authority

Washington State's 1115 Family Planning Demonstration Interim Evaluation

Findings from July 2018 to June 2022

May 1, 2023

Clinical Quality and Care Transformation Division
P.O. Box 45502
Olympia, WA 98504
Phone: (360) 725-1612
Fax: (360) 586-9551
hca.wa.gov

Acknowledgements

We want to acknowledge the work of our colleagues and our partner programs for all the work they do in serving Washington's vulnerable populations.

This document is part of a series of reports produced by Clinical Quality and Clinical Transformation (CQCT) with assistance from the DSHS Research and Data Analysis in evaluating the FPO waiver during its renewal from July 2018 through June 2022. Evaluations are required components of waiver renewals and are stipulated in the Special Terms and Conditions (STCs).

Executive Summary

THE 1115 FAMILY PLANNING DEMONSTRATION WAIVER in Washington State provides family planning and family planning-related services to low-income individuals not otherwise eligible for Medicaid. While the program has undergone significant state and federal policy changes over the most recent waiver period, it continues to provide valuable confidential family planning services. This report describes the access to and utilization of family planning and family planning-related services and how these services are impacting maternal and child outcomes in Washington State. The study examines three target populations eligible for Family Planning Only (FPO) services separated based on income level or pregnancy status: 1) FPO Pregnancy-Related, 2) FPO Lower Income, and 3) FPO Higher Income during the most recent waiver period, July 1, 2018 through June 30, 2022.

Family Planning Only	Family Planning Only	Family Planning Only
❶ FPO Pregnancy-Related	❷ FPO Lower Income	❸ FPO Higher Income
Recently pregnant who lose Medicaid coverage after their 60-day post pregnancy coverage ends	Women or men at risk of unintended pregnancy with incomes over 133% to 185% Federal Poverty Level	Women or men at risk of unintended pregnancy with incomes over 185% to 260% Federal Poverty Level

Key Findings

1. **During the 2018-2022 Family Planning Waiver period, the State enrolled 29,164 individuals and provided 56,425 family planning and family planning-related services to 9,205 unique clients**. Peak enrollment occurred in October 2018 at 7,971, and then declined 72 percent from March 2020 to December 2020 with the COVID-19 global pandemic quarantine measures.
2. **The COVID-19 quarantine, associated healthcare access restrictions, and subsequent Public Health Emergency (PHE) eroded enrollment and participation gains from the pre-pandemic period.** The PHE allowed many eligible FPO Pregnancy-Related clients to maintain full-scope Medicaid coverage after their pregnancy ended explaining most of the decreased enrollment in the overall waiver population.
3. **Twice as many FPO Lower Income clients utilized family planning and family planning-related waiver services than the other waiver groups.** By DY2021, 57 percent of FPO (Lower Income) clients utilized a family planning and family planning-related waiver service compared to 29 percent of FPO (Higher Income) and 13 percent of FPO (Pregnancy-Related).
4. According to PRAMS survey results, the proportion of Washington State **unintended births have declined** over the years in the current waiver period.

Introduction and Background

Washington State's 1115 Family Planning Waiver Demonstration was originally approved by the Centers for Medicare and Medicaid Services (CMS) and has been consistently extended since 2001 (1). The Demonstration covers every FDA-approved birth control method and a narrow range of family planning services that help clients use their contraception safely and effectively. The overarching program goals of the Demonstration have remained consistent since the initial approval (Table 1).

TABLE 1
Program Description

Program Goals		• Improve access to family planning and family planning related-services. • Decrease the number of unintended pregnancies. • Increase the use of contraceptive methods. • Increase the interval between pregnancies and births to improve positive birth and women's health outcomes. • Reduce state and federal Medicaid expenditures for averted births from unintended pregnancies.	
DEMONSTRATION POPULATION NAME	**Historic**	Family Planning Only Extension	Take Charge
	Current	① Family Planning Only – Pregnancy-Related (Effective 7/1/19)	② ③ Family Planning Only (Effective 7/1/19)
Income eligibility		• Income at or below 198 percent of the federal poverty level (FPL).	• Income at or below 260 percent of the federal poverty level (FPL). • Lower income – uninsured with family income >133 percent to 185 percent of FPL. • Higher income – uninsured with family income >185 to 260 percent of FPL.
Target population		• Recently pregnant women who lose Medicaid coverage after their 60-day post pregnancy coverage ends, regardless of pregnancy outcomes and who are not eligible for Apple Health (Medicaid) coverage.	• Uninsured women and men seeking to prevent unintended pregnancy and who are not eligible for Apple Health (Medicaid) coverage. • Teens and domestic violence victims who need confidential family planning services.
Coverage period		• Additional 10-month coverage following the standard Medicaid 60-day post-pregnancy coverage. • When coverage ends, must apply for Medicaid or Family Planning Only	• 12-month coverage. • No limit on how many times one can reapply for coverage.
Program coverage		• Family planning services for women, which include an annual comprehensive family planning preventive visit. Family planning-related services include screening for gonorrhea and chlamydia for women ages 13 through 25, cervical cancer screening, and services directly related to successfully using a chosen method of contraception.	• Family planning services for women, which include an annual comprehensive family planning preventive visit. Family planning-related services include screening for gonorrhea and chlamydia for women ages 13 through 25, cervical cancer screening, and services directly related to successfully using a chosen method of contraception. • Family planning services for men, which includes an annual counseling session for reducing the risk of unintended pregnancy, condoms and spermicides, and services directly related to vasectomies.

Evaluation Questions and Hypotheses

To evaluate whether Washington State's FPO program achieved its objectives, the following evaluation questions were addressed:

Demonstration Objectives:

There are three demonstration objectives that were measured during the interim evaluation. 1) Ensure access to and utilization of family planning and/or family planning-related services for individuals not otherwise eligible for Medicaid, 2) Improve or maintain health outcomes for the target population as a result of access to family planning and family-planning related services, and 3) Reduce the number of unintended pregnancies in the waiver population.

Summary of Key Evaluation Questions and Hypotheses

Evaluation Component	Evaluation Question	Evaluation Hypotheses
Process	How did beneficiaries utilize covered health services?	Enrollees will utilize family planning services and/or family planning related services.
Process	Do beneficiaries maintain coverage long-term (12 months or more)?	Beneficiaries will maintain coverage for one or more 12 month enrollment period
Process	Does the demonstration increase the use of more effective contraceptive methods among FPO beneficiaries?	Beneficiaries will have a higher rate of using more effective contraceptive methods compared to other members of Medicaid beneficiaries.
Outcome/Impact	Does the demonstration improve health outcomes?	Health outcomes will improve as a result of the demonstration.
Outcome/Impact	Does the demonstration decrease the number of unintended pregnancies?	The number of women reporting unintended pregnancy will decrease.

Methodology

Data

The data sources for this evaluation come from the Washington State Department of Health (DOH) and the Health Care Authority (HCA). The sources include; 1) Vital Statistical birth certificate data, 2) Pregnancy Risk Assessment Monitoring System (PRAMS) survey data, 3) Medicaid eligibility, enrollment, and claims files. Each data source is described below.

Data for the evaluation are based on eligibility, birth certificates, and linked claims file with vital records also known as the First Steps Database (FSDB). Claims and eligibility data are available for all Medicaid clients.

Medicaid eligibility, enrollment, and claims data

Washington State's Medicaid Management Information System, ProviderOne, contains eligibility recipient aid category (RAC) codes, the eligibility begin and end dates, which are used to derive enrollment and participation in the program. ProviderOne also contains enrollment data for all clients deemed eligible for the Program, including date of birth, race/ethnicity, county of residence, and other demographics. Finally, ProviderOne also contains claims data, a record for every claim submitted for reimbursement. Data elements in the claim files include date of service, program code, procedures and diagnosis used to derive program participation measures. For all FPO eligible clients, the FSDB staff obtains a service history for appropriate time periods for each client. ProviderOne services history data are used to describe the types of FP services provided. ProviderOne is updated monthly.

First Steps Database (birth certificates linked to Medicaid clients)

: All Washington birth certificates are linked at the individual level to Medicaid claims and eligibility history. FSDB begins with births in August 1988 and currently contains linked birth certificates through 2021. The annual unduplicated count of FPO eligible clients is linked to the FSDB by ProviderOne ID. The First Steps Database is created biannually.

Pregnancy Risk Assessment Monitoring System (PRAMS) survey

: To evaluate the program goal of reducing the number of unintended pregnancies, Washington will rely on the PRAMS survey to describe unintended pregnancy rates. PRAMS is a surveillance survey by the Centers for Disease Control and Prevention (CDC) developed to report maternal attitudes and experiences before, during, and shortly after pregnancy. As of 2023, forty-six states participated in PRAMS, covering approximately 81 percent of all live births in the United States. These data can be used to identify groups of women and infants at high risk for health problems, monitor changes in health status, and to measure progress towards goals in improving the health of mothers and infants. PRAMS data allows evaluators to compare state-specific rates against national trends and Healthy People 2030 goals.

Methods

Evaluating the impact of FPO on key outcomes is complicated by the longevity of the waiver and lack of experimental comparison. The original evaluation design proposed to utilize a post-only assessment with a simulated comparison group created using propensity score methodology. However, the differences between FPO and Medicaid population were difficult to statistically match given enrollment and utilization shocks from COVID-19, Public Health Emergency extended coverage, and impacts from a new state program, After Pregnancy Coverage (APC).

The original evaluation design stipulated that if a comparison group could not be constructed via propensity score methodology, then descriptive statistics would be used to evaluate process and outcome measures over time for the FPO beneficiaries only. Each measure was stratified by each waiver group summarized in Table 1. Moreover, given most program enrollees identify as women, we excluded some sub-populations (e.g., males,

teens, and domestic violence victims) due to data availability and small sample sizes which would lead to less power to detect statistical differences.

The timeframe for the post-only period will begin when the current demonstration period begins on 7/1/2018 and ends when the current demonstration period ends on 06/30/2023.

FPO Waiver Study Populations

The study examines and compares three target populations eligible for Family Planning Only (FPO) services separated based on income level or pregnancy status: Family Planning Only Waiver groups were identified by the RAC codes (1097 (FPO Pregnancy-Related), 1099 (FPO Lower Income), and 1100 (FPO Higher Income)). While Table 1 describes two waiver groups, we further delineated the non-pregnancy-related Family Planning Only group into a **Lower Income** group with family incomes greater than 133 percent and less than or equal to 185 percent FPL and **a Higher Income** group with family incomes greater than 185 percent and less than or equal to 260 percent FPL. This report examines and compares each waiver group separately given that these waiver groups have different waiver enrollment eligibility criteria, income eligibility, and coverage periods. Most analyses were focused on clients identifying as women. Due to small numbers, clients identifying as men were excluded from subsequent analyses and described in a separate section.

Definitions and Measures

Full-scope Medicaid: Full-scope Medicaid provides full health care coverage such as early and periodic screening, diagnostic, and treatment services, maternity and newborn care, and mental health services. States have been required to include family planning services in their Medicaid programs.

Disenrollment: A gap in Medicaid enrollment of more than four months.

Enrollees: Individuals enrolled in the demonstration for the specified waiver period.

Family planning services: Women and men who are waiver enrollees are eligible to receive an annual comprehensive family planning preventive visit, FDA-approved birth control methods, and a narrow range of family planning services that help clients use their contraception safely and effectively.

Family planning-related services: Includes screening for gonorrhea and chlamydia for women ages 13 through 25 and cervical cancer screening.

Participants or Utilizers: Individuals who obtain one or more covered family planning service through the demonstration waiver.

Relative Risk Ratio: The risk of one subgroup in comparison to the risk of all other subgroups to experience any disproportionate outcome. A Relative Risk Ratio of 1 means a subgroup faces no disproportionality and less than 1 means underrepresentation of a subgroup.

Retention: A client continuously enrolled or experiencing a gap in eligibility of no more than four months.

Domestic Violence: Domestic violence was flagged based on domestic violence identified in the comprehensive evaluation, participation in the address confidentiality program, or being granted permission not to cooperate with Division of Child Support due to domestic violence as recorded in ACES; or based on domestic violence arrests or convictions of the client.

URBAN RURAL COUNTY CLASSIFICATION

- **Rural Counties:** Adams, Asotin, Columbia, Ferry, Garfield, Jefferson, Klickitat, Lincoln, Okanogan, Pacific, Pend Oreille, San Juan, Skamania, Stevens, Wahkiakum.
- **Large Town Counties:** Chelan, Clallam, Douglas, Grant, Grays Harbor, Island, Kittitas, Lewis, Mason, Whitman.
- **Urban–Medium and Low-Density Counties:** Benton, Cowlitz, Franklin, Skagit, Walla Walla, Whatcom, Yakima.
- **Urban–High Density Counties:** Clark, King, Kitsap, Pierce, Snohomish, Spokane, Thurston.

MATERNAL/CHILD OUTCOME VARIABLES

- **Interpregnancy Interval (IPI):** A measure of birth spacing operationalized as the time (in months) elapsed between the women's last delivery and the conception of the next pregnancy.
- **Low Birth Weight:** Low birth weight refers to infants born weighing less than 2,500 grams. Birth weight was collected as a continuous variable on the birth certificate. For analysis purposes, low birth weight was treated as a dichotomous variable. Birth weight on the second birth per client was used to analyze the effect of the waiver on birth weight.
- **Preterm Birth:** To determine whether an infant was considered preterm, the clinical estimate of weeks gestation on the birth certificate was used. Infants born at less than 37 weeks gestation were considered preterm. While weeks gestation is a continuous variable, it was dichotomized for analyses. Preterm birth data from the second birth was used in this evaluation.

CONTRACEPTIVE METHODS

- **Most Effective (>99 percent):** Sterilization, contraceptive implants, IUD
- **Moderately Effective (88-94 percent):** Injectables, oral pills, patch, vaginal ring, diaphragm
- **Least Effective (<82 percent):** Female condom, cervical cap, sponge, fertility awareness-based methods, spermicide
- **Emergency Contraception:** Emergency contraceptive pills or copper IUD after unprotected intercourse

Quantitative Methods

Monotonic Trend Analysis

There are several statistical tests available to identify and quantify monotonic trends. Statistical trend analysis is a hypothesis testing process. The null hypothesis is that there is no trend, and each test has its own parameters for accepting or rejecting the null hypothesis given assumptions of normal distribution and sample size. We chose to test for trends using Mann-Kendall given that it is a nonparametric test providing higher statistical power in cases of nonnormality, is robust against outliers, large data gaps, and some autocorrelation as clients and their family planning choices are not independent over time. This test evaluates whether values tend to increase or decrease over time and whether the trend in either direction is statistically significant, but does not assess the magnitude of change. Alpha was set to $p < 0.05$. Statistical analysis was performed using SAS software, version 9.

For objective #1 (Ensure access to and utilization of family planning and/or family planning-related services for individuals not otherwise eligible for Medicaid), we applied descriptive methods of frequency, proportions, and test for trend to demonstrate service utilization of FPO for all the service utilization measures specified below:

- Proportion of beneficiaries who had a family planning or family planning related service encounter in each year of the demonstration.
- Proportion of family planning services utilized.
- Proportion of female beneficiaries who utilized any contraceptive in each year of the demonstration.
- Proportion of female beneficiaries who utilized long-acting reversible contraceptives in each year of the demonstration.
- Proportion of beneficiaries tested for any sexually transmitted disease (by STD).
- Proportion of female beneficiaries who obtained a cervical cancer screening.

To measure: 1) whether the beneficiaries maintain coverage long term, i.e., continues enrollment of 10 or 12 months or more, and 2) whether there is a re-enrollment for at least the second spell of coverage three years prior to and three years post the current enrollment year, the eligibility start and end month over time was used

to determine whether Program clients were eligible for re-enrollment and applied, were ineligible for re-enrollment (e.g., due to sterilization), or had become eligible for another federal/state program.

For objective #2 (Improve or maintain health outcomes for the waiver population as a result of access to family planning and family planning-related services), For the outcome measures of birth span, low birth weight and premature babies, the differences in proportions of the outcomes will be tested at an annual basis. We will also calculate the proportions of these outcome measures at a biannual basis and therefore, Cochran-Armitage test for trend can be conducted when applicable.

For objective #3 (Reduce the number of unintended pregnancies in the waiver population), pregnancy intentions on the PRAMS survey are obtained by asking respondents to think back to the time just before their pregnancy and to recall how they felt about becoming pregnant at that time. The pregnancy intention question is a part of the "core" set of questions, asked in each participating state's uniform set of questions. The PRAMS questionnaire is mailed to women who have had a recent live birth (usually within 2 to 6 months after delivery), with each state's sample drawn from vital records, and including oversampling by specific characteristics to create annual, representative data at the state level of all women delivering in that year.

Respondents may choose one of five response options: 'I wanted to be pregnant sooner', 'I wanted to be pregnant later', 'I wanted to be pregnant then', 'I didn't want to be pregnant then or any time in the future', or 'I wasn't sure what I wanted'. Beginning in 2012, the last response, 'I wasn't sure what I wanted' was added to the responses. As a result, unintended pregnancy rates computed from 2013 onward are not directly comparable to those prior to 2013.

Traditionally, respondents who select, 'I didn't want to be pregnant then or any time in the future' are defined as unwanted pregnancies. To evaluate the program goal of reducing the number of unintended pregnancies, Washington will rely on the PRAMS survey to describe unintended pregnancy rates. The original evaluation design proposed to link PRAMS survey results to Medicaid and FPO clients so the survey results can be reported for the waiver population of the family planning waiver. However, given impacts from COVID-19, the Public Health Emergency extended coverage to any **FPO Pregnancy-Related** potential population, and implementation of a state program, After Pregnancy Coverage (APC), we proposed to report on state-wide rates compared to other participating PRAMS locations.

Methodological and Study Limitations

This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.

There were four main limitations for this study. **First**, we can only account for **contraceptive methods** obtained via paid claims through Washington State's Medicaid program and/or the Family Planning Waiver. Any contraceptive methods or medical administrative claims paid by a private insurer or out-of-pocket were not included in these analyses.

Second, we can only account for **family planning services** obtained via Washington State's Medicaid program and/or the Family Planning Waiver. Washington State provides a variety of programs and options for women and men to receive family planning services throughout their reproductive years, so the utilization in one program may impact utilization in another program. For example, pregnant women at or below 198 percent FPL are covered by Medicaid and receive 60-days post pregnancy healthcare which includes contraception. **FPO Pregnancy-Related** utilization in the Family Planning Waiver may be misleading given the receipt of services post-pregnancy.

Third, while administrative data provide the means to identify and describe utilization, it is limited in providing information regarding sexual behavior and/or pregnancy intention. Additionally, claims data were used to analyze contraceptive methods prescribed, however this cannot measure adherence. As a result, any calculation intended to measure medication adherence analysis might overestimate the true adherence rate because it assumes clients took all medication as intended (13).

Finally, the fourth limitation, the intended study design proposed to simulate a comparison group using propensity score methodology with the aim to balance FPO waiver groups (especially, the **FPO Pregnancy-Related waiver group)** and comparable Medicaid program on *observed* characteristics to obtain *less* biased estimates of any waiver treatment effects. There are several federal/state programs in Washington State that offer family planning methods and services and the intent was to match client characteristics, social services and medical program utilization. However, given impacts from the Public Health Emergency and implementation of a state program, After Pregnancy Coverage (APC) – both of which extend full-scope coverage to post-pregnancy clients – reduced the FPO Pregnancy-Related potential population and data were not available to match on FPO Pregnancy-Related waiver clients that decided to enroll/re-enroll and those that maintain other full-scope coverage.

Results

The COVID-19 quarantine, associated healthcare access restrictions, and subsequent Public Health Emergency (PHE) eroded enrollment and participation gains from the pre-pandemic period.

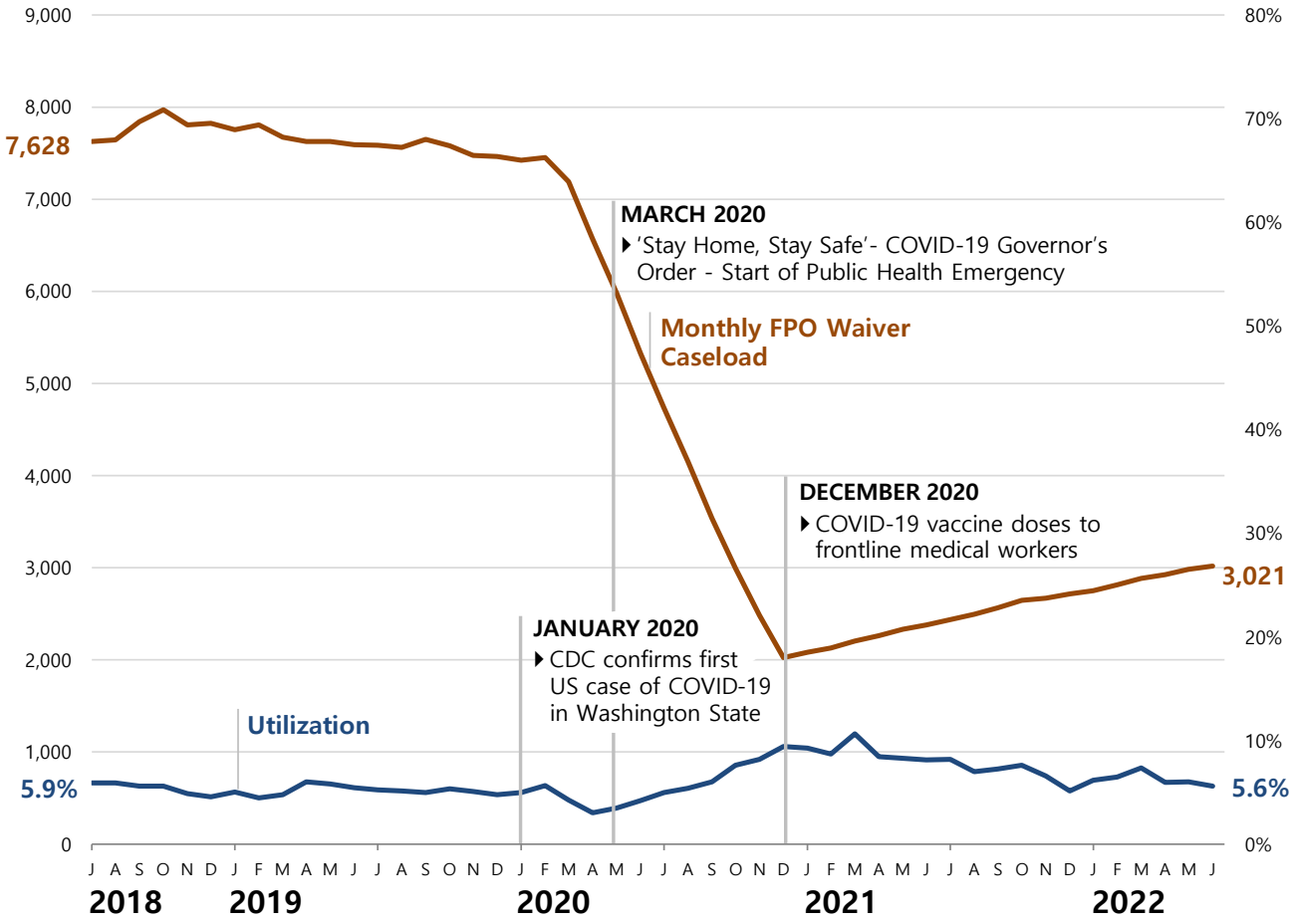
During the most recent waiver period, there have been state and federal policy changes that have impacted enrollment demographics and participation (Figure 1). On January 21, 2020, the Centers for Disease Control and Prevention (CDC) confirmed the first case of COVID-19 in Washington State. Two months later, Governor Inslee issued 'Stay Home, Stay Safe' proclamation starting the Public Health Emergency.

Peak enrollment occurred in October 2018. Enrollment declined 72 percent from March 2020 to December 2020 as recently pregnant clients were eligible to maintain full-scope Medicaid coverage and explaining the decreased enrollment of this waiver group.

Utilization (or participation) rates also changed with COVID-19 quarantine restrictions. Figure 1 shows month-to-month utilization rates for family planning services. Before COVID-19 quarantine restrictions, the participation was about 6 percent, followed by a small decrease during the quarantine restriction, and an increase in December 2020.

FIGURE 1

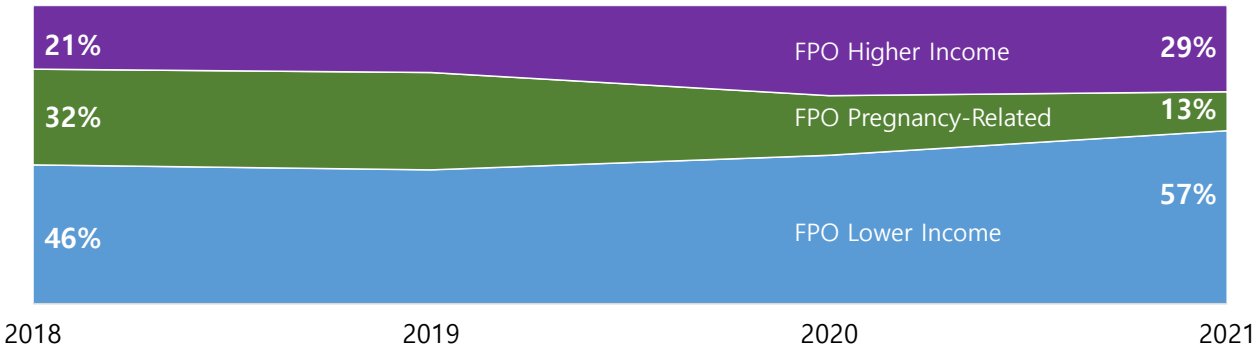
Impact of COVID-19 on Washington State's Family Planning Demonstration Caseload



Enrollment and Participation by Waiver Group

As discussed in the previous section, the COVID-19 global pandemic and quarantine impacted overall caseload and Family Planning Waiver group demographics. Figure 2 shows the proportion of participation for each waiver group to total participants for each demonstration year to provide an overview of changes during the current waiver period. The proportion of waiver participants using services increased at the same rate for both **FPO Lower Income** and **FPO High Income** waiver groups, while **FPO Pregnancy-Related** participation decreased (Figure 2). This finding is also seen in the month-to-month changes in Figure 3.

FIGURE 2
Participation of Family Planning and Family Planning-Related Services
By Waiver Groups (Women Only)



To determine whether COVID-19 impacted disproportionality related to family planning service participation, risk ratios were calculated for each waiver group by demonstration year, for age, race/ethnicity, and urban/rural composition (Tables not shown).

- Younger aged clients were more likely to participate in family planning waiver services than older aged clients, regardless of waiver group.
- Some racial/ethnic groups in the **FPO Lower Income** waiver group were underrepresented in family planning waiver participation which further declined over the waiver period.
- Clients living in Urban – Medium and Low-density counties were more likely to participate in family planning waiver services than Urban – High density, regardless of waiver group.

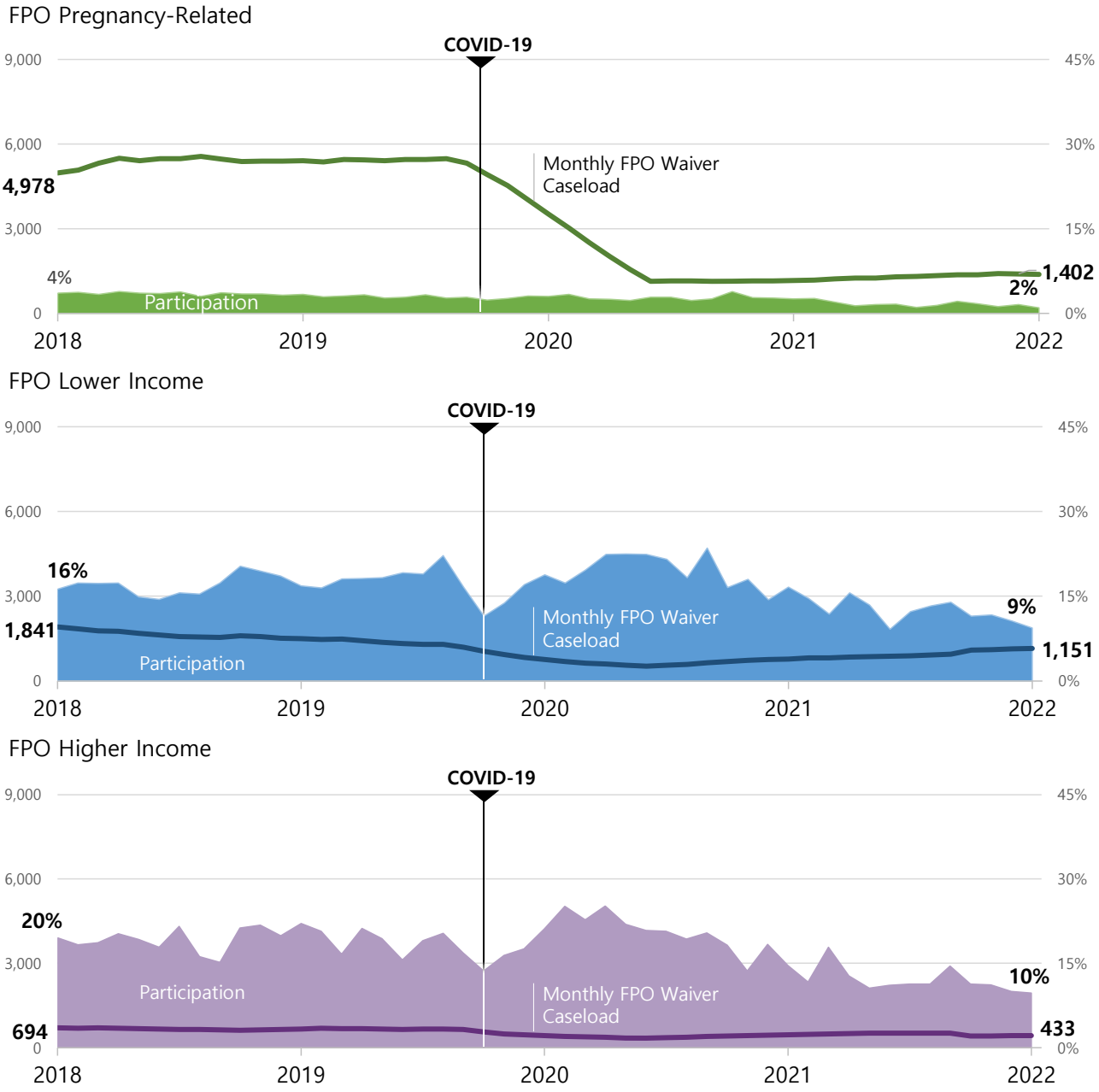
Figure 3 is similar to Figure 1 but shows caseload and participation rates month-to-month for each waiver group over the current demonstration period. Understanding the changes in caseload is important because caseload (i.e., Medicaid clients who are enrolled in the program) is used as a denominator for one process measure, while the remaining process measures use participation (i.e., Medicaid clients who are both enrolled and using services in the program) as the denominator.

- Despite the extension of full-scope Medicaid benefits to recently pregnant clients, **FPO Pregnancy-Related** waiver group had the highest enrollment of any waiver group during the demonstration period, yet the smallest participation of any waiver group.

FIGURE 3

Impact of COVID-19 on Washington State's Family Planning Demonstration Caseload

Caseloads and Participation By Waiver Group (Women Only)



Family Planning Services

The remainder of this report describes trends in family planning process and outcome measures based on the waiver groups defined in the previous section. Process measures describe the utilization of family planning and family planning-related services traditionally associated with favorable maternal and child health outcomes. Given the impacts of COVID-19 on the Family Planning Waiver group enrollment and participation, we anticipated changes to process measures.

EVALUATION QUESTION

How did Family Planning Waiver clients utilize services?

Any Contraceptives Used by Female Participants

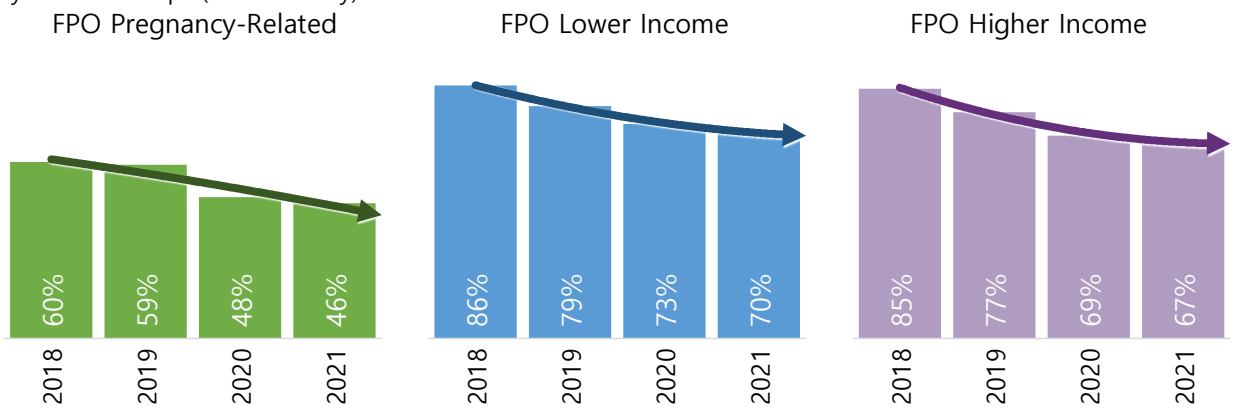
We measured any contraceptive use by reporting clients in a waiver group who obtained any contraceptive method out of the total number of participating clients in the same waiver group. Figure 4 shows the annual percentages of any contraceptive use, by waiver group.

- The percentage of participants accessing any contraceptive method remained higher among clients in the **FPO Lower Income** and **FPO Higher Income** waiver groups compared to **FPO Pregnancy-Related** waiver group.
- There was a significant trend in the decreased proportion of participating clients accessing any contraceptive method for all waiver groups ($p<0.05$).

FIGURE 4

Any Contraceptive Used by Waiver Group

By Waiver Groups (Women Only)



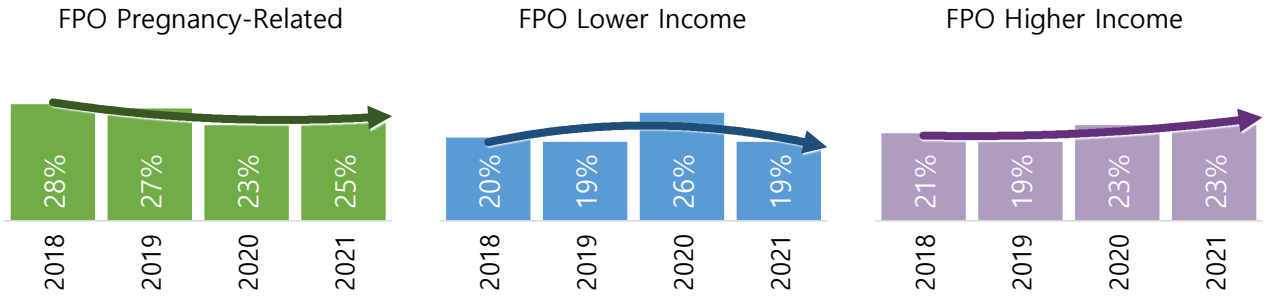
Long-Acting Reversible Contraceptives (LARC)

Long-acting reversible contraception (LARC), such as use of implants or intrauterine devices, is highly effective at preventing unintended pregnancy (8). We measured LARC utilization by reporting the number of women with LARC methods used in a year out of the total number of participants in each group (Figure 5).

- Utilization of a LARC method was highest among the **FPO Pregnancy-Related** waiver group compared to clients in other waiver groups.
- The percentage of both **FPO Pregnancy-Related** and **FPO Higher Income** LARC users demonstrated modest increases from the DY2018 to the DY2021 cohort, while **FPO Lower Income** waiver group had the highest proportion of LARC utilizers in DY2020, then declined by the next year. However, none of these trends were statistically significant.

FIGURE 5

LARC use by Waiver Group (Women Only)



Family Planning-Related Services

CMS defines family planning-related services as "medical diagnosis and treatment services that are provided pursuant to a family planning service in a family planning setting" (10), but states vary in their coverage of family planning-related services. Washington State family planning-related services include testing for sexually transmitted infections specifically related to the effective and safe use of the chosen contraceptive and cervical cancer screening.

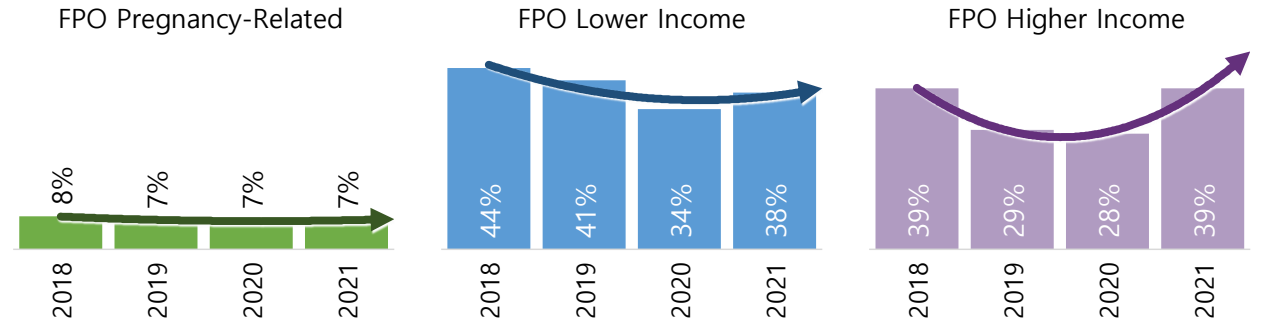
Sexual Transmitted Infections (STI) Screening and Testing

All women in the target groups ages 13–25 receive screening and all women receive testing when symptoms or exposure are reported. Men are limited to testing only when exposure or symptoms are reported. Figure 6 shows the number of Neisseria gonorrhea (GC) and Chlamydia trachomatis (CT) screens and tests provided to clients in a year out of the total number of participants in each waiver group.

- **FPO Lower Income** waiver group, with the greatest proportion of teens aged 13-18 years, continued to have the greatest percentage of STI screens/tests in DY2018, which declined in DY2019 and DY2020, but increased to 38 percent in DY2021. There was a significant trend in the decreased rate of participating **FPO Lower Income** waiver group accessing any STI screens/test ($p<0.05$).
- There was no significant trend in the rate of STI Screenings in the **FPO Higher Income** group.
- STI screenings for **FPO Pregnancy-Related** clients demonstrated no statistical trend and remained relatively the same from 8 percent in DY2018 to 7 percent in DY2021.

FIGURE 6

STI Screenings/tests by Waiver Group Female Participants



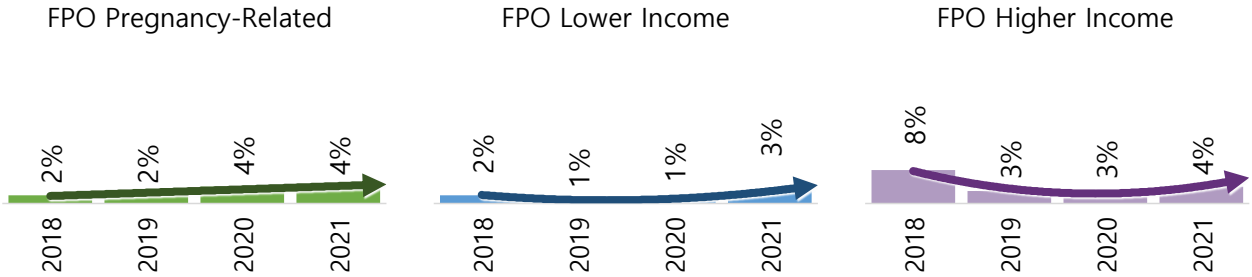
Cervical Cancer Screening

Providers must follow nationally recognized clinical guidelines for cervical cancer screening, which recommend screenings every 3 to 5 years depending on age and exposure risk. We measured cervical cancer screenings by reporting the number of cervical cancer screens in a year out of the total number of participants in each waiver group. Figure 7 shows the percentage of females who received cervical cancer screening using cervical cytology (Pap test) and/or human papilloma (HPV) testing.

- **FPO Lower Income** waiver group had the lowest rates of cervical cancer screening. However, in DY2018, 65 percent of participants in the group were under 21 years. Given this age category is not included under the cervical cancer screening age recommendations (11,12) it makes sense there would be less screening in this waiver group.
- While the majority of FPO **Higher Income** participants were over 21 years, there was a statistically significant trend in cervical cancer screenings ($p < 0.05$) which declined from 8 percent in DY2018 to 4 percent in DY2021.

FIGURE 7

Cervical Cancer Screening by Waiver Group Female Participants



Disenrollment and Retention

As mentioned in Table 1, Washington State's Family Planning Waiver has different coverage periods for different waiver groups. FPO Pregnancy-Related offers an additional 10-months of coverage following the standard Medicaid 60-days post pregnancy coverage. However, once clients in **FPO Pregnancy-Related** complete 10-months, they can reapply as a Family Planning Only client if they meet eligibility requirements**. FPO Lower and Higher Income** eligible clients have 12-months of coverage, but can reapply if they continue to meet eligibility requirements.

TABLE 2

Annual Disenrollment and Retention

For all clients by demonstration year

Reason for Disenrollment	**2018**		**2019**		**2020**		**2021**	
	n	%	n	%	n	%	n	%
Sterilization	357	3.6	287	2.9	113	2.3	47	4.7
Eligible for full benefits due to pregnancy	673	6.8	724	7.4	384	7.7	214	21.5
Eligible for full benefits	1,144	11.6	1,495	15.3	593	11.9	298	29.9
Re-enrolled	168	1.7	121	1.2	36	0.7	16	1.6
Did not renew	7,210	73.3	6,865	70.1	2,960	59.6	205	20.6
Eligible for other state-funded program	285	2.9	298	3.0	879	17.7	216	21.7
Total Disenrollment Number	**9,837**		**9,790**		**4,965**		**996**	

EVALUATION QUESTION

Do beneficiaries maintain coverage long-term (12-months or more)?

Disenrollment and retention are important to monitor given that inconsistent use of contraception is a cause of nearly half of unintended pregnancies (8). As a result of Medicaid expansion and health care reform, the pattern of disenrollment and retention dramatically changed in 2013. However, over the past four demonstration years (2018 through 2021 are years with complete data), patterns have been impacted indirectly by changing client eligibility due to COVID-19. Over this waiver period, the percentage of clients eligible for full benefits increased from almost 12 percent in DY2020 to almost 30 percent in DY2021. Similarly, the percentage of clients eligible for other state-funded program increased from 3 percent in DY2019 to almost 18 percent in DY2020.

Special Population

Any contraceptives used by Male Participants

National studies have estimated that 60 percent of men were in need of family planning, especially young and unmarried men (9). However, less than two percent of all enrollees (or participants) in the FPO groups in Washington are clients identifying as male. Vasectomies are the most popular method of contraception for these men, followed by male condoms. However, once sterilized, clients are no longer eligible for waiver services, such as family planning-related services (e.g., screenings for sexually transmitted infections).

Maternal and Child Health Outcomes

EVALUATION QUESTION

Does the Family Planning Waiver improve maternal and child health outcomes?

Access to family planning may impact maternal and child health outcomes by delaying pregnancies that occur too early or too late in a person's life and spacing the time between pregnancies. We will assess whether Family Planning Waiver services impacted maternal and child health outcomes using three measures: 1) **Interpregnancy interval** (i.e., time from the birth of baby to the conception of another baby) may be extended by the correct use of effective contraceptive methods. Interpregnancy intervals of 18 months or longer are ideal and are strongly associated with a decreased risk of low birth weight, preterm birth, and/or small for gestational age (13), 2) **Low birth weight,** and 3) **preterm birth**. These last two measures are indirect since they are affected by interpregnancy intervals, but both measures are also influenced by maternal health conditions and other socioeconomic disparities (14,15).

Given the decreased enrollment and participation among the **FPO Pregnancy-Related** waiver group, the interim evaluation report will not include these findings as we continue to assess any systematic differences between **FPO Pregnancy-Related** enrollees and participants, eligible **FPO Pregnancy-Related** clients who maintained full-scope Medicaid coverage due the Public Health Emergency, and eligible **FPO Pregnancy-Related** clients participating in After Pregnancy Care(APC), a new state program extending postpartum care which was implemented in June 2022.

Unintended Pregnancies

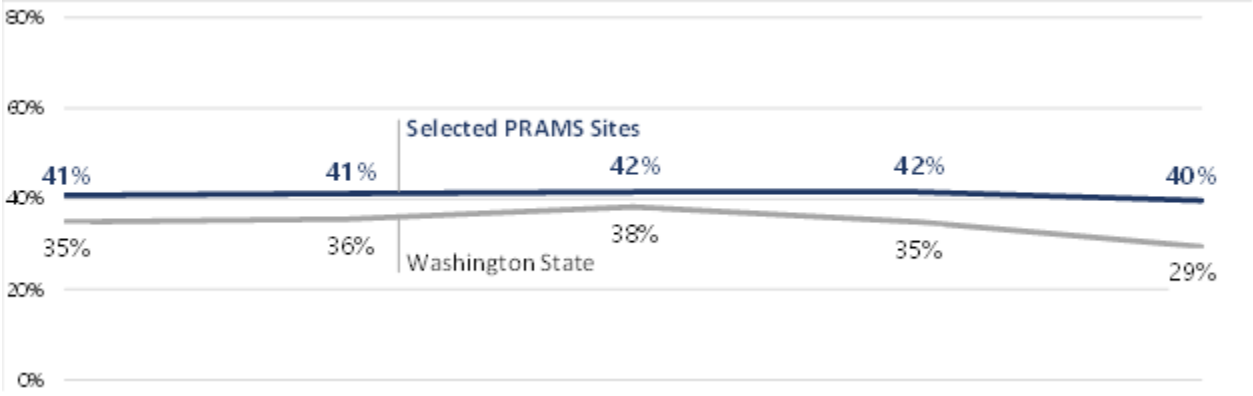
EVALUATION QUESTION

Does the Family Planning Waiver decrease the number of unintended pregnancies?

Results from Washington State Pregnancy Risk Assessment Monitoring System (PRAMS) are used to assess pregnancy intent. Survey respondents are asked to think back before their recent pregnancy and report whether they had wanted to become pregnant at that time, sooner, later, or not at all.

Pregnancies that occur too soon are classified as mistimed those that are not wanted at all are labeled unwanted, and those two categories together form the unintended group. Pregnancies that occur too late or "at about the right time" are considered intended. Based on analysis of previous year' response breakdowns, the unsure responses have been grouped as part of the unintended category. Figure 8 details the proportion of Washington births that were unintended, starting in 2016 and compares annual percentages to all selected PRAMS sites that met the required 55% response rate threshold. The proportion of Washington State births classified as unintended have declined over the years in the current waiver period and are consistently lower than the national comparison.

FIGURE 8
Proportion of Washington State Births that were Unintended
Pregnancy Risk Assessment Monitoring Program (PRAMS) results from 2016-2020



Discussion

As part of a section 1115 demonstration authority, states must conduct an evaluation to inform policy decisions as per 42 CFR 431.424. Given the ACA mandate requiring preventative well-women visits, some states discontinued pursuing Family Planning waiver renewals assuming clients would be able to secure family planning services through comprehensive Medicaid or a Marketplace plan (10). However, the results of the interim evaluation suggest Washington State's Family Planning Demonstration Waiver continues to have an important role for low-income women not eligible for Medicaid who are seeking high-quality, confidential family planning services.

More details on efforts to improve the use of available family planning services in Washington State:

- As of June 2022, Washington State has elected to extend postpartum coverage from 60 days to 12 months (After Pregnancy Coverage). This change means that postpartum clients are no longer automatically/passively enrolled in **FPO Pregnancy-Related.**

- Beginning in DY2019, individuals enrolled in any FPO waiver group could see any contracted Medicaid provider for family planning services, rather than the more limited pool of qualified Take Charge providers.

- Previous research examining LARC use among full-scope Medicaid compared to Family Planning Waiver participants found that the percentage of Family Planning Waiver LARC users was twice that of full-scope Medicaid clients for all women aged 15-44 at risk of unintended pregnancy (11). HCA increased reimbursement rates to providers regarding LARC insertion or implantation in 2015 and this was associated with increasing LARC use (12).

- Efforts were made to increase ease of obtaining consistent supplies of oral contraceptives, the most popular form of family planning method among **FPO Pregnancy-Related** and **FPO (Higher and Lower Income)** clients. However, past research has shown that dispensing a one-year supply of oral contraceptives was not implemented as broadly as intended (12).

- Another area of needed improvement is increasing utilization among men. As mentioned previously, research from the National Survey of Family Growth showed that 60 percent of men aged 15-44 years were in need of family planning (4). Family planning services offered through Washington State's Demonstration Waiver include an annual counseling session for reducing the risk of unintended pregnancy, use of condoms, spermicides, and vasectomies, and STI screenings if experiencing symptoms.

Lessons Learned and Recommendations

The final evaluation report will extend analyses to Program demonstration year 2022 and attempt to reduce confounding from any state legislative or federal changes impacting the Program since the start of this waiver period. As mentioned, the feasibility to evaluate maternal-child health outcome measures have been challenged by the reduction of **FPO Pregnancy-Related** enrollees due to Public Health Emergency extension of full-scope Medicaid and/or participation in After Pregnancy Coverage.

Given these state policy changes, we recommend the following changes to allow for more meaningful and actionable results:

- **Adding process measures regarding equity and application barriers/challenges to evaluate access to family planning and family planning-related services.**
    - **Process measures aimed to measure equitable access to contraceptive methods by race/ethnicity, age, sexual orientation, gender identity, and expression (SOGIE), and urbanicity**. In Washington State, COVID-19 and related quarantine restrictions, impacted family planning disproportionality service participation. For example, during the current waiver period, some racial/ethnic groups in the **FPO Lower Income** waiver group were underrepresented in family planning waiver participation which were further exacerbated over the waiver period. Additionally, clients living in Urban - Medium and Low - density counties were more likely to participate in family planning waiver services than Urban – High density, regardless of waiver group.
    - **Process measures aimed at measuring barriers/challenges in the application process.** Any program enrollment and re-enrollment begins with the application process (e.g., client language preference, timing and receipt of reminder notifications, determining and meeting eligibility criteria, support documents needed, whether client needed assistance completing an application, time from starting to submitting an application). While the evaluation showed a decrease in the proportion of FPO Waiver eligibility clients that did not renew, this change was due to clients being eligible for other programs with full-scope coverage. Adding additional process evaluation measures regarding the application process could inform client/provider outreach activities, reduce lapses in service, and increase continuity of contraceptive method utilization.
- **Adding qualitative/mixed-methods analysis for sub-population(s) of interest.**
    - **Incorporating client perspectives on populations of interest e.g., teens, intimate partner violence victims, and clients identified as male**. Between 2012 and 2021, teen births have declined 63 percent in Washington State. Despite this decline, 95 percent of teen births were Medicaid-paid highlighting a continued need for confidential family planning services. Results from this interim evaluation showed that younger aged clients were more likely to participate in family planning waiver services than older aged clients, regardless of waiver group, but were more likely to use less effective methods (e.g., emergency contraceptive pill). However, due to data availability and small sample sizes, these sub-populations are often excluded from quantitative analysis. Therefore, alternative methods (e.g., focus group discussions) involving providers/Community Health Workers might be an effective approach to supplement future evaluation findings.
- **Incorporate evaluation measures that focus on patient experience of contraceptive care.**
    - Relying on family planning utilization measures are imperfect proxies of quality and access. Additionally, evaluation measures that focus on only one contraceptive method (e.g., LARCs) may lead to client coercion and assumptions that 'one-size fits all' even though research shows that contraceptive method choice is highly preference-sensitive and influenced by availability, costs, life stage, and counseling.

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