**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**

April 5, 2021

MaryAnne Lindeblad
Director
Washington Health Care Authority
626 8th Avenue, PO Box 45502
Olympia, WA 98504-5050

Dear Ms Lindeblad:

The Centers for Medicare & Medicaid Services (CMS) completed its review of the Final Report, which was required by the Special Terms and Conditions (STCs), specifically STC 28 of Washington's section 1115 demonstration, "Take Charge" (Project No: 11-W-00134/0). This report covers the demonstration period from January 2012 to May 2018. In the context of the considerations outlined below, CMS accepts the evaluation report, dated September 2019. The evaluation report may now be posted to the state's Medicaid website. CMS will also post the evaluation report on Medicaid.gov.

We recognize the difficulty in measuring outcomes and performance, given the significant changes in characteristics of demonstration beneficiaries over the course of this demonstration period. With the implementation of the Medicaid expansion under the Affordable Care Act, enrollment in the limited Family Planning program declined by 88 percent, and we appreciate the thorough examination of the resulting shift in the demonstration population and service utilization. While more robust analytic strategies, such as those incorporated into the approved evaluation design for the current demonstration period (2018 – 2023), would have assisted in assessing the demonstration in these circumstances, CMS and the state have concluded that the state should devote its evaluation resources to the current period of performance.

We appreciate our continued partnership with the state on the Washington Take Charge/ Family Planning Only Program section 1115 demonstration. If you have any questions, please contact your CMS demonstration team.

Sincerely,

Danielle Daly -S
Digitally signed by Danielle Daly -S
Date: 2021.04.05 11:35:43 -04'00'

Andrea J. Casart -S
Digitally signed by Andrea J. Casart -S
Date: 2021.04.06 11:49:39 -04'00'

Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

Andrea Casart
Director
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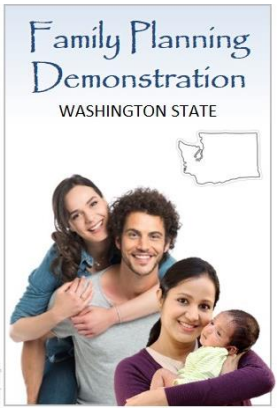
cc: Courtenay Savage, State Monitoring Lead, CMS Medicaid and CHIP Operations Group




# Washington State's 1115 Family Planning Demonstration Evaluation

## Findings from January 2012 to May 2018

Tenaya Sunbury, PhD • Dorothy Lyons, MPA • Z. Joyce Fan, PhD • Andrew Glenn, PhD
Barbara E.M. Felver, MES, MPA

In collaboration with Washington State Health Care Authority

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 Family Planning Demonstration Waiver in Washington State has undergone significant state and federal policy changes over the most recent waiver period, it continues to provide confidential family planning services. This report describes the access and utilization of family planning and family planning-related services and how services are impacting maternal and child outcomes in Washington State. The study examines three target populations eligible for services: 1) **Family Planning Only Pregnancy Related -** recently pregnant women who lose Medicaid coverage after their pregnancy ends; 2) **Family Planning Only (Lower Income)** - uninsured women and men with family incomes greater than 133% and less than or equal to 185% of the federal poverty limit (FPL) and 3) **Family Planning Only (Higher Income)** - uninsured women and men with family incomes greater than 185% and less than or equal to 260% FPL. The analyses follows these waiver eligible populations during the most recent waiver period, January 1, 2012 through May 31, 2018.

## Key Findings

1. **During the 2012-2018 Family Planning Waiver period, Washington State enrolled 180,941 individuals and provided 885,631 family planning and family planning-related services to 104,314 unique clients.** Peak enrollment was sustained in November 2013 at 60,821 until declining by 88 percent from January 2014 to December 2015 due to the implementation of the Affordable Care Act.
2. **The Affordable Care Act (ACA) had the largest impact on the Family Planning Waiver by changing the age composition of the program**. The percentage of clients aged 13-18 increased from 12 percent in 2012 to 38 percent in 2018. The dramatic shift in the age composition explains changes in waiver service utilization.
3. **Twice as many FPO (Lower Income) clients utilize family planning and family planning-related waiver services than the other waiver groups.** By 2018, 58 percent of FPO (Lower Income) clients utilized any family planning and family planning-related waiver service compared to 22 percent of FPO (Higher Income) and 20 percent of Family Planning Only Pregnancy Related.
4. **Greater participation by FPO Pregnancy Related waiver group in family planning waiver services is associated with longer interpregnancy intervals.** Clients who utilized a most/moderate effective contraceptive method with 50 percent or more eligible days covered had an average interpregnancy interval of 49 months, while clients with no contraceptive method claim had an interpregnancy interval of 42 months.

# 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 renewed and extended since 2001 (1). The Demonstration covers every FDA approved birth control methods and a narrow range of family planning services that help clients use their contraceptive methods 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.<br>• Decrease the number of unintended pregnancies.<br>• Increase the use of contraceptive methods.<br>• Increase the interval between pregnancies and births to improve positive birth and women's health outcomes.<br>• Reduce state and federal Medicaid expenditures for averted births from unintended pregnancies. | |
| **Historical demonstration population name** | Family Planning Only Extension | Take Charge |
| **Current demonstration population name** | 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% of the federal poverty level (FPL) | Income at or below 260% of the FPL |
| **Target population** | • Recently pregnant women who lose Medicaid coverage after their 60-days post pregnancy coverage ends, regardless of pregnancy outcomes and not eligible for Apple Health (Medicaid) coverage. | • Uninsured women and men seeking to prevent unintended pregnancy and not eligible for Apple Health (Medicaid) coverage.<br>• Teens and domestic violence victims who need confidential family planning services. |
| **Coverage period** | Additional 10-month coverage following Medicaid 60-days post-pregnancy coverage.<br>• When coverage ends must apply for Medicaid or Family Planning Only | 12-month coverage<br>• No limit on how many times they can reapply for coverage. |
| **Program coverage** | • Family planning-related services for women include an annual comprehensive family planning preventive medicine visit, 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-related services for women include an annual comprehensive family planning preventive medicine visit, 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<br>• Family planning-related services for men include an annual counseling session for reducing the risk of unintended pregnancy, condoms and spermicides, and services directly related to vasectomies. |

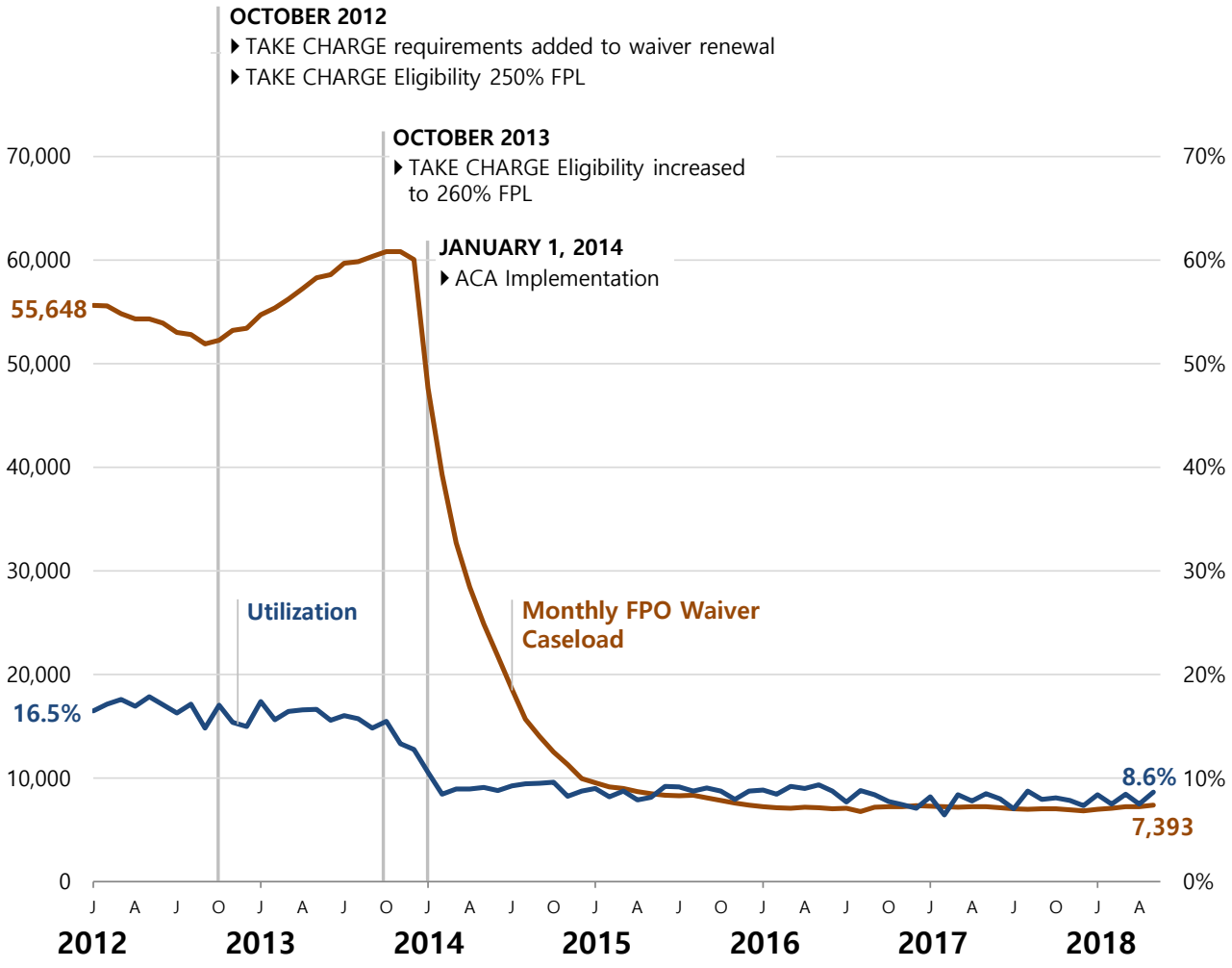
## FINDING 1 Family Planning Waiver enrollment and participation increased with state policy changes and declined with implementation of the Affordable Care Act (ACA).

During the most recent waiver period, there have been state and federal policy changes that have impacted enrollment demographics and participation (Figure 1). In October 2012, Washington State increased the financial eligibility for TAKE CHARGE (renamed Family Planning Only) population from 200% FPL to 250% of the federal poverty limit (FPL), then again in October 2013 to 260% FPL. Most likely because of these state policy changes, enrollment increased from 52,247 in October 2012 to 60,821 in October 2013 (a 16 percent increase). Peak enrollment was sustained in November 2013 until declining by 88 percent from January 2014 to December 2015.

In January 2014, the Affordable Care Act (ACA) provision Sec.2713 of the Public Health Service Act required most private health plans to provide coverage of contraceptive methods and counseling without additional out-of-pocket costs, such as copayment and deductibles (2). Women and men who may have previously relied on the Family Planning Demonstration for family planning services may have shifted to private plans. Figure 1 shows month-to-month percentage of clients utilizing services as less than 18 percent then decrease to almost 9 percent after ACA implementation.

FIGURE 1

Impact of ACA on Washington State's Family Planning Demonstration Caseload Decline



## Family Planning Waiver Group Characteristics

Given the dramatic impacts from ACA on enrollment and utilization, this section of the report examines and compares each eligible waiver group separately (Figure 2). While Table 1 describes two waiver groups, we further delineated the Family Planning Only group into a **Lower Income** group with family incomes greater than 133% and less than or equal to 185% FPL and **Higher Income** group with family incomes greater than 185% and less than or equal to 260% FPL.

Given the three target populations have different enrollment eligibility criteria, income eligibility, and coverage periods, examining the impact of family planning and family planning-related services offered through Washington State's Family Planning Demonstration Waiver required examining changes over time for the three target populations eligible to receive services.

While men are included in Family Planning Only groups, due to small numbers, they were removed from subsequent analysis and described in a separate section. The remainder of the analysis focuses on clients identifying as women and changes in Family Planning Waiver demographics, such as age, race/ethnicity, and urban/rural composition.

GROUP 1
**Family Planning Only**
PREGNANCY RELATED

❶ FPO Pregnancy Related

Recently pregnant who lose Medicaid coverage after their 60-day post pregnancy coverage ends

GROUP 2
**Family Planning Only**
LOWER INCOME

❷ FPO Lower Income

Women or men at risk of unintended pregnancy with incomes over 133% to 185% Federal Poverty Level

GROUP 3
**Family Planning Only**
HIGHER INCOME

❸ FPO Higher Income

Women or men at risk of unintended pregnancy with incomes over 185% to 260% Federal Poverty Level

**FINDING 2** | **ACA implementation had the greatest impact on Washington State's Family Planning Only age distribution.**

Age is an important predictor of choosing a contraceptive method and failure rates among barrier contraceptive methods (3, 4). The greatest impact from ACA implementation has been on the age composition of the FPO waiver groups. Figure 3 shows differences in age distribution in each waiver group and changes in utilization over time.

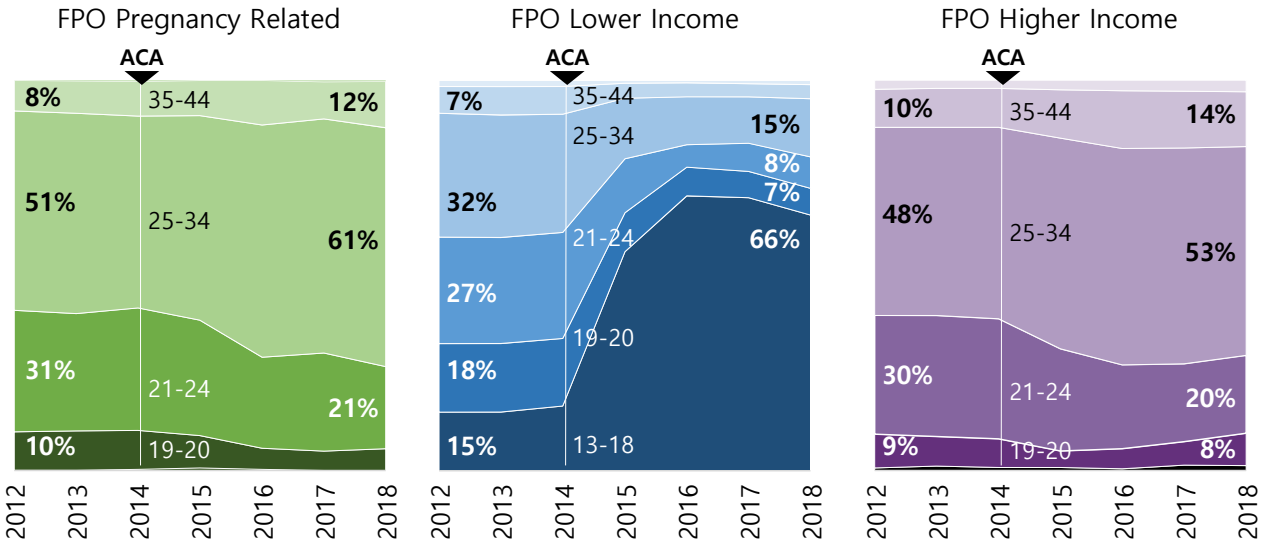
- In 2012, 15 percent of **FPO Lower Income** utilizers were in the 13-18 age group, however, by 2018 this age group increased to 66 percent of FPO Lower Income. Almost all Family Planning Waiver teens (i.e., 99 percent in 2018) age 13-18 years are found in the FPO Lower Income waiver group.

- While **FPO Lower Income** utilizers shifted to a younger age composition, **FPO Higher Income** utilizers shifted to an older age composition. In 2012, 30 percent of the of FPO Higher Income participants were in the 21-24 age group, however by 2018 this age group declined to 20 percent. The 25-34 age group increased from 48 percent in 2012 to 53 percent in 2018 and age group 35-44 increased from 10 percent in 2012 to 14 percent in 2018.
- The percentage of **FPO Pregnancy Related** clients using services decreased for the 21-24 age group from 31 percent of the waiver group in 2012 to 21 percent in 2018. The 25-34 age group increased from 51 percent in 2012 to 61 percent in 2018. Average age at enrollment has increased reflecting Washington State population-level trend in mother's increasing average age when giving birth.

FIGURE 3

## Utilization of Family Planning and Family Planning-Related Services

By Waiver Groups and Age




**FINDING 3** **The racial/ethnic distribution for clients in FPO Lower Income and FPO Higher Income is much different than FPO Pregnancy Related waiver group.**

We examined any potential impact from ACA implementation on racial/ethnic composition by waiver groups. While some studies find racial/ethnic preferences associated with family planning and/or family planning-related services (5, 6), changes to policy could unintentionally impact access to services, which would exacerbate racial/ethnic disparities in maternal and child health outcomes. Figure 4 shows differences in racial/ethnic composition in each waiver group and changes in utilization over time.

- The percentage of Hispanic clients in **FPO Pregnancy Related** using services increased from 15 percent of the waiver group in 2012 to 29 percent in 2018.
- Non-Hispanic Black clients in **FPO Pregnancy Related** waiver group showed a modest increase from 5 percent in 2012 to 9 percent in 2018.
- These trends over time also reflect changes in enrollment statistics for the **FPO Pregnancy Related** waiver group, suggesting the percentage of non-White clients utilizing services has increased.

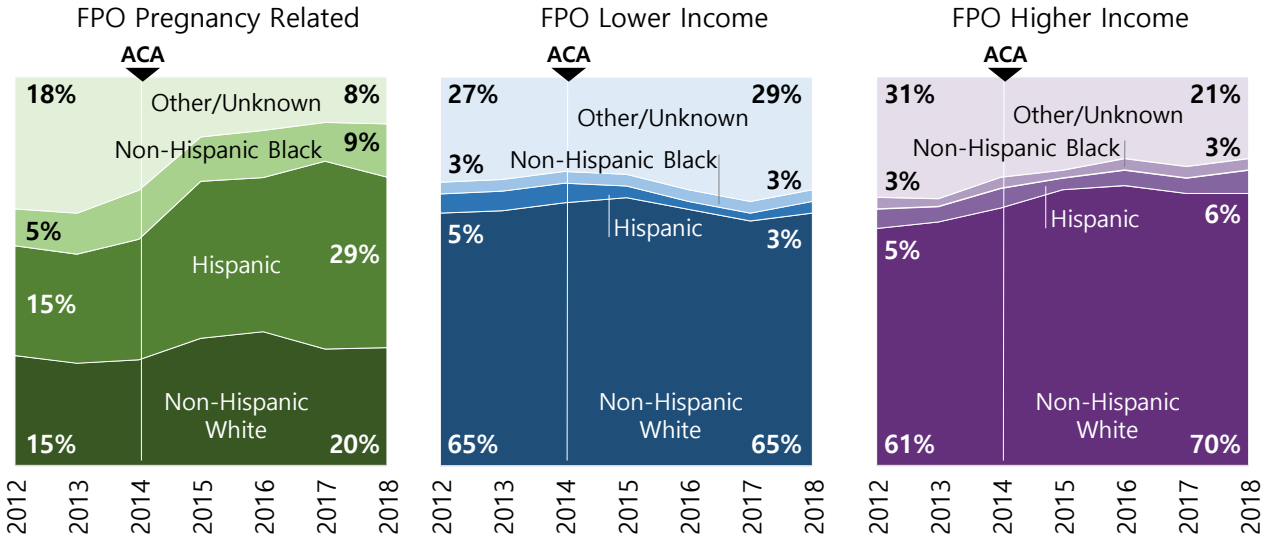
The racial/ethnic distribution for clients in **FPO Lower Income** and **FPO Higher Income** is much different than **FPO Pregnancy Related** waiver group.

- Approximately two out of three **FPO Lower Income** and **FPO Higher Income** clients are Non-Hispanic White, compared to one out of five **FPO Pregnancy Related** clients.
- The racial/ethnic distribution for clients in **FPO Lower Income** and **FPO Higher Income** demonstrated very little change during the current waiver period.

FIGURE 4

## Utilization of Family Planning and Family Planning-Related Services

By Waiver Groups and Race/Ethnicity




**FINDING 4** **For all waiver groups, the percentage of utilizers was higher than the percentage of enrollees in urban-high density counties suggesting a greater need for family planning and/or family planning-related services in those areas.**

Changes to policy could unintentionally impact geographical access to services. Rural counties (or counties with less population density) are often associated with medically underserved areas or environments with additional barriers to clients seeking confidential family planning services (7).

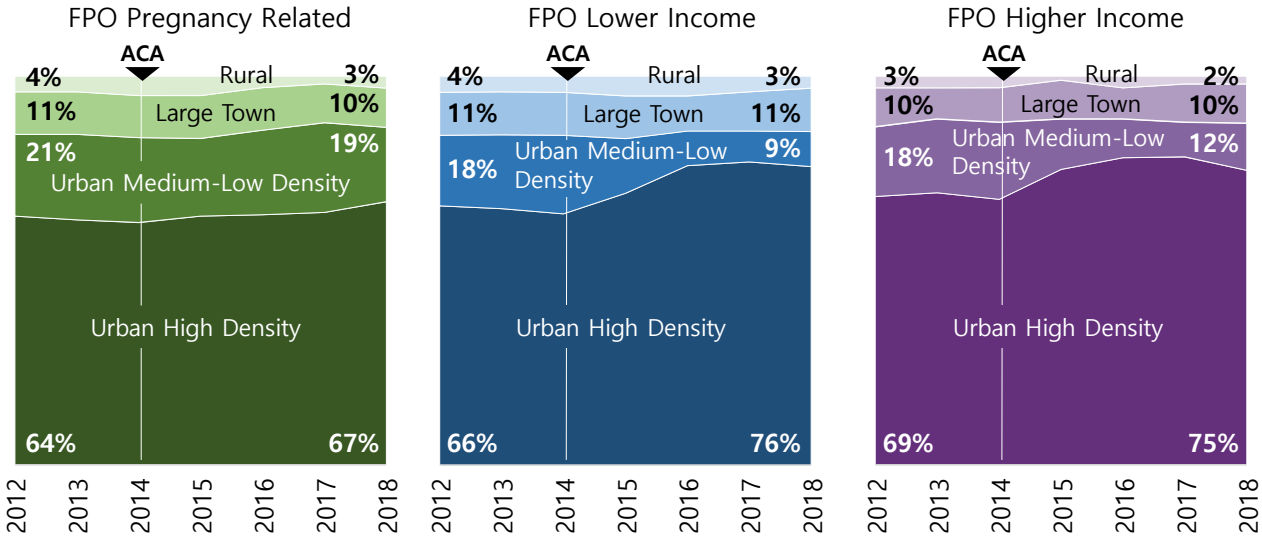
We compared the percentage of enrollees to utilizers to identify potential gaps in urban/rural geographical access. Figure 5 shows differences in urban/rural composition in each waiver group and changes in utilization over the waiver period.

- **FPO Pregnancy Related** waiver group increased enrollment in urban-high density from 68 percent to 70 percent (not shown) and utilization increased in urban-high density from 64 percent to 67 percent. Urban-medium and low density enrollment decreased from 18 percent to 16 percent (not shown) and utilization decreased from 21 percent to 19 percent.
- There were very little changes in large towns or rural areas suggesting there was no impact of ACA on geographical areas considered rural or with less population density.

FIGURE 5

## Utilization of Family Planning and Family Planning-Related Services

By Waiver Groups and Urban/Rural




# Family Planning Services

As discussed in the previous section, the implementation of the Affordable Care Act (ACA) impacted overall caseload and Family Planning Waiver group demographics. 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 utilization of family planning and family planning-related services associated with favorable maternal and child health outcomes. Given the impacts of ACA to the Family Planning Waiver group demographics, we anticipated changes to process measures. Prior research has shown contraceptive method preference varies by age and pregnancy intention (3).

**Evaluation Question: How did Family Planning Waiver clients utilize services?**

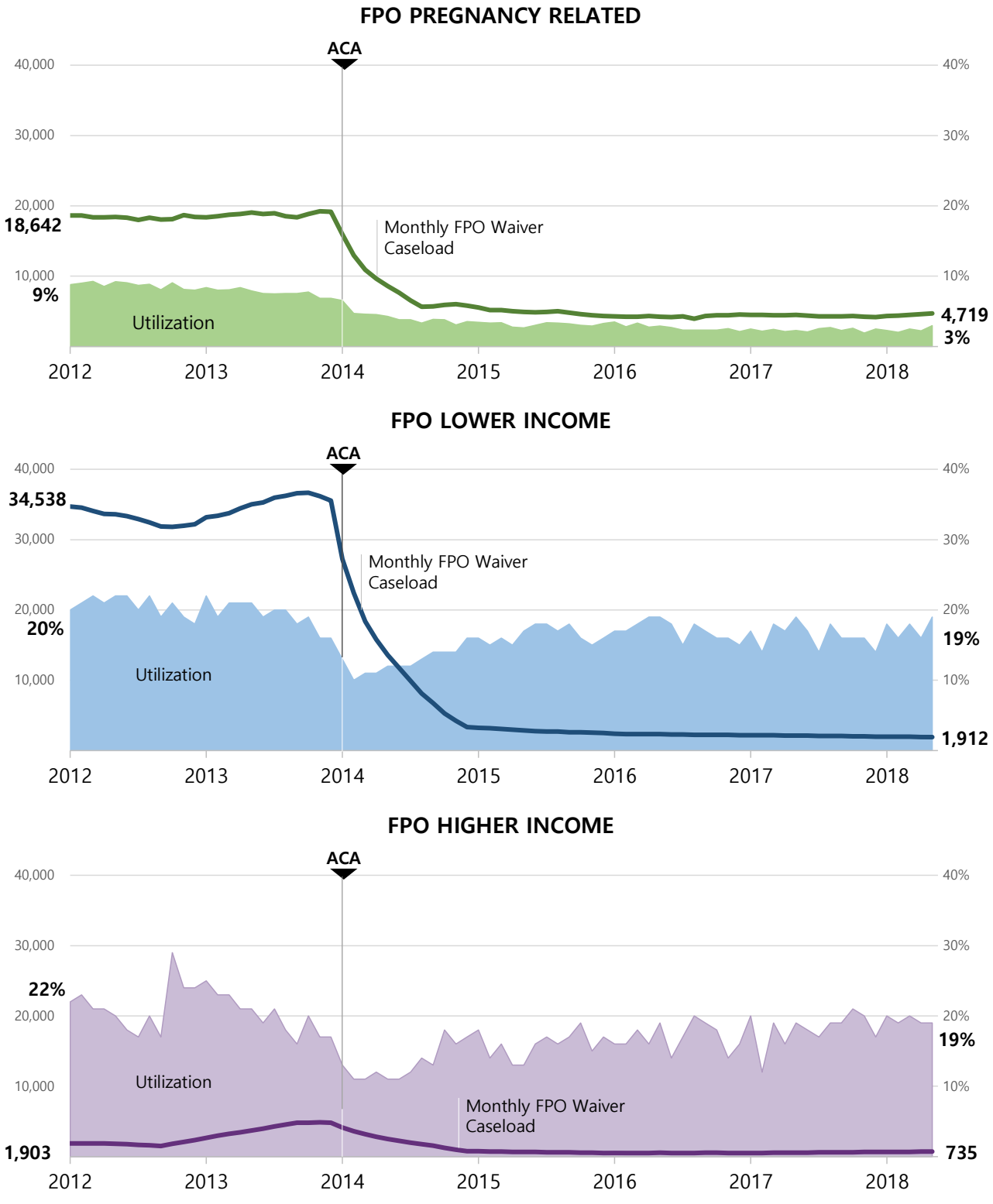
Figure 6 replicates Figure 1 to show caseload and utilization patterns for each waiver group. Understanding the changes in caseload is important because caseload (i.e., clients that are enrolled in the program) is used as a denominator for one process measure, while the remaining process measures use participation (i.e., clients that are both enrolled and using services in the program) as the denominator.

- In 2012, **FPO Lower Income** had the most enrollees of any waiver group, followed by **FPO Pregnancy Related**, then **FPO Higher Income,** however by 2018 **FPO Pregnancy Related** had the most enrollees, followed by **FPO Lower Income**, then **FPO Higher Income**.
- Despite dramatic changes in enrollment over time and a dip due to ACA implementation, the month-to-month percentage of clients utilizing services remained higher for both **FPO Lower Income** and **FPO Higher Income** relative to **FPO Pregnancy Related**.
- Even though **FPO Pregnancy Related** clients are enrolled in greater numbers than other waiver groups, **FPO Higher and Lower Income** utilize program services more than FPO Pregnancy Related clients.

FIGURE 6

## Impact of ACA on Washington State's Family Planning Demonstration Caseload Decline

By Waiver Groups



## Any Family Planning and Family Planning-Related Service Use

**FINDING 5** **FPO Pregnancy Related and FPO Higher Income waiver groups increased utilization during the waiver period, while FPO Lower Income decreased utilization**

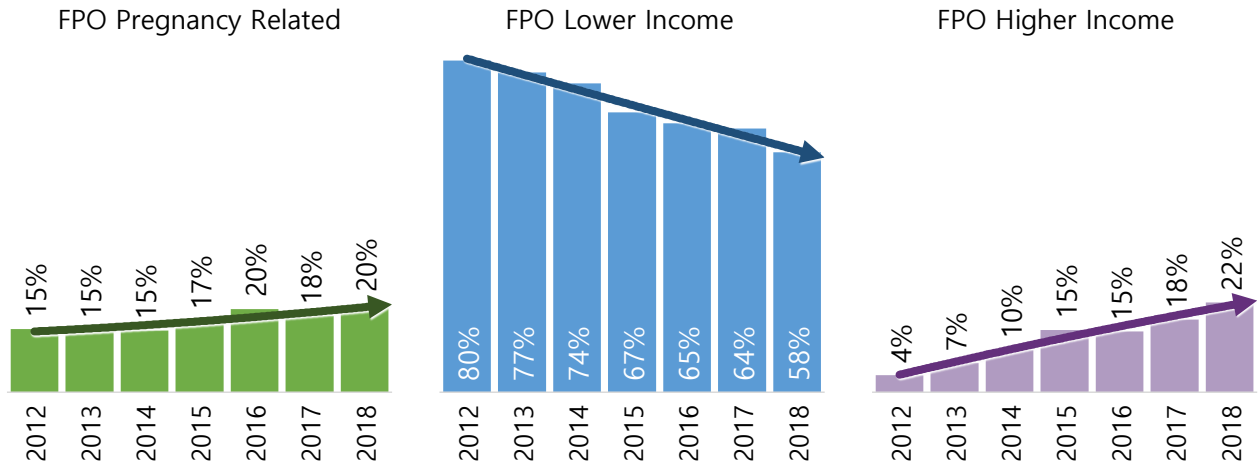
We measured access to family planning and family planning-related services by dividing participating clients to enrolled clients in the waiver. While Figure 6 shows utilization month-to-month, Figure 7 (below) shows annual percentage of enrollees utilizing any family planning and/or family planning related service by waiver group.

- In 2012, clients from **FPO Lower Income** waiver group were the greatest percentage of utilizers at 80 percent, followed by 15 percent in the **FPO Pregnancy Related**. **FPO Higher Income** were the smallest utilizer waiver group at 4 percent.
- In 2018, **FPO Lower Income** declined to 58 percent while **FPO Higher Income** clients increased from 4 percent to 22 percent in 2018, followed by **FPO Pregnancy Related** at 20 percent.
- **FPO Pregnancy Related** and **FPO Higher Income** waiver groups have increased utilization during the waiver period, while **FPO Lower Income** decreased utilization.

FIGURE 7

Utilization of Family Planning and Family Planning-Related Services

By Waiver Groups




## Any Contraceptives used by Female Participants

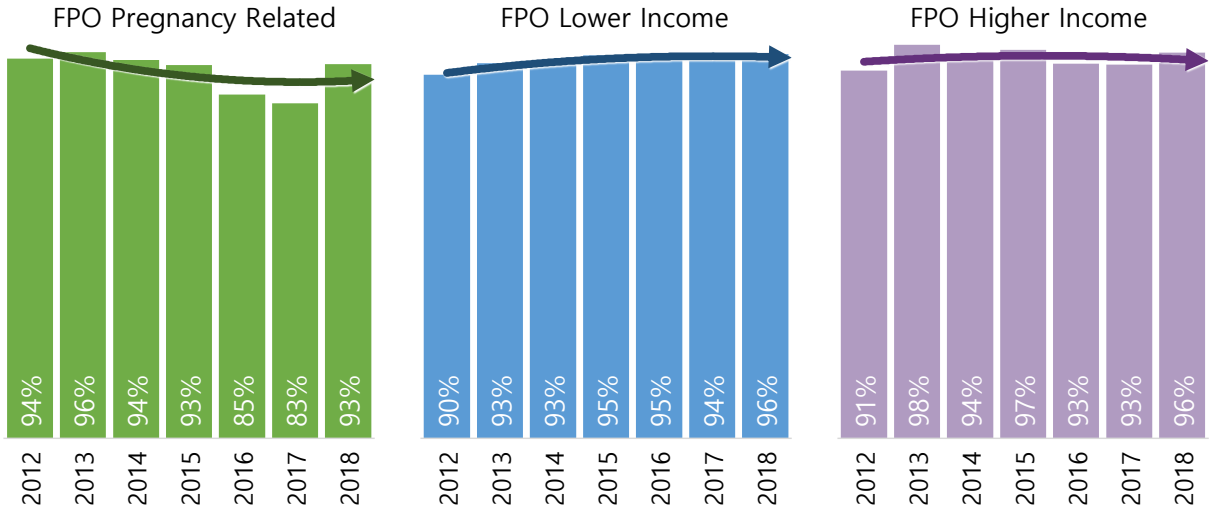
We measured any contraceptive use by dividing clients obtaining any contraceptive method by clients participating in the waiver. Figure 8 shows annual percentages of any contraceptive use by waiver group.

- The percentage of participants accessing any contraceptive method remained above 90% and increased for clients participating in **FPO Lower Income** and **FPO Higher Income** waiver groups.
- For **FPO Pregnancy Related** waiver group, the percentage of participating clients accessing any contraceptive method declined for both the 2016 and 2017 cohorts, but increased to 93% in 2018.

FIGURE 8

## Any Contraceptive Used by Waiver Group Female Participants

By Waiver Groups




### Number of Family Planning Services Utilized

Clients may obtain refill prescriptions or more than one contraceptive method during their coverage period. Therefore, we measured the number of family planning services utilized by first categorizing family planning methods as most effective, moderately effective, least effective, and emergency contraceptives, then dividing each category by the total number of family planning methods utilized in that year by waiver group (Figure 9).

**Most effective** contraception consists of reversible methods (e.g., implants or intrauterine devices) and permanent methods (e.g., sterilization) that have experienced less than 1 pregnancy per 100 women within the first year of use.

**Moderately effective** contraception consists of hormonal or barrier reversible methods (e.g., oral contraceptive pill, injectables, etc.) that rely on correct use and where women have experienced approximately 6-12 pregnancies per 100 women within the first year of use.

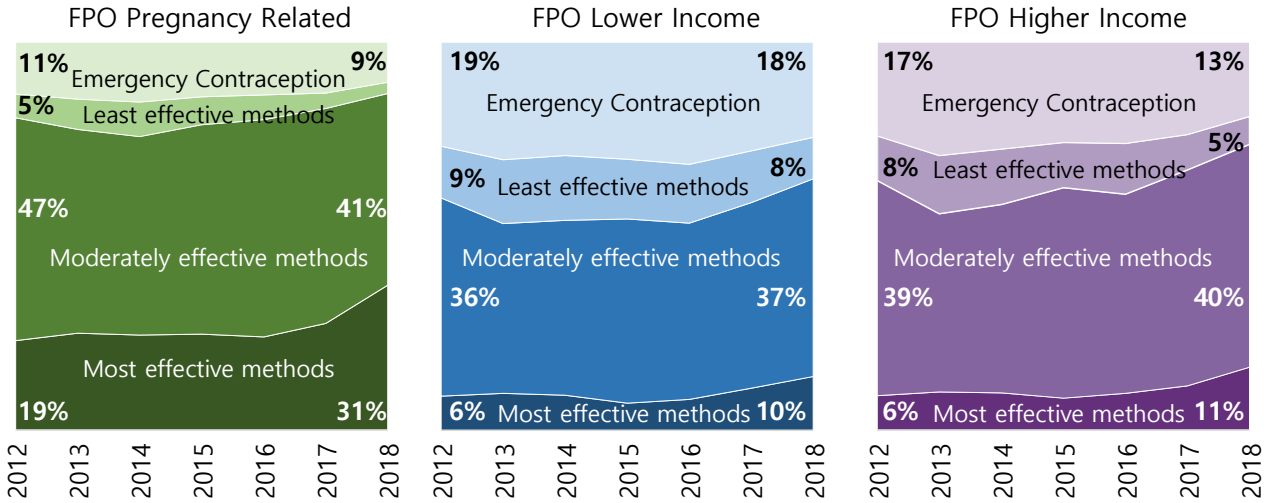
**Least effective** contraception consists of barrier reversible methods (e.g., female/male condom, natural family planning, etc.) that rely on correct use or abstinence and where women have experienced approximately 18 or more pregnancies per 100 women within the first year of use.

**Emergency contraception** consists of emergency contraceptive pills or a copper IUD after unprotected intercourse and substantially reduced risk of pregnancy (3). Emergency contraceptives may have been prescribed in conjunction with another contraceptive method for clients to have in case of an unplanned emergency.

- **FPO Pregnancy Related** waiver group utilization of most effective methods increased from 19 percent in 2012 to 31 percent in 2018, whereas all other methods decreased. Because this waiver group is older and already have children, their family planning priorities may include spacing future pregnancies or not having any more children.
- **FPO (Lower Income and Higher Income)** waiver groups had similar distributions of effective contraceptive methods. While the percentage of most effective methods increased for both waiver groups from 2012 to 2018, the percentage of emergency contraceptives remains the highest, 18 percent, in the **FPO Lower Income** group. Given that FPO Lower Income represents younger clients, there may be a few reasons for this pattern, but reason for contraceptive method choice cannot be determined from these data alone.

FIGURE 9

## Number of Family Planning Services by Waiver Groups



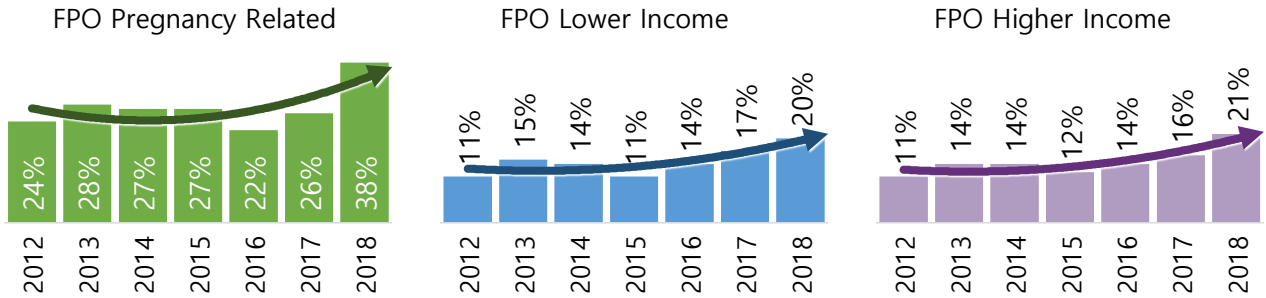

### Long-Acting Reversible Contraceptives (LARC)

We use this measure to describe the utilization of most effective reversible methods (e.g., implants or intrauterine devices). Long-acting reversible contraception (LARC) is highly effective at preventing unintended pregnancy (8). We measured LARC utilization by dividing the number of women with LARC methods used in a year by the total number of participants in each waiver group (Figure 10).

- Utilization of a LARC method was almost twice as high among the **FPO Pregnancy Related** waiver group compared to clients in either FPO waiver group.
- While all three waiver groups showed an increase in LARC utilization among participants, the percentage of **FPO (Lower and Higher Income)** LARC users doubled from 2012 to the 2018 cohort.
- Previous research, examining LARC use among full-scope Medicaid compared to Family Planning Waiver participants, found 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 (9).

FIGURE 10

## LARC use by Waiver Group Female Participants



# Special Populations

### 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 (10). However, less than one percent of all enrollees (or participants) are clients identifying as male. Vasectomies are the most popular method of contraception, 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).

### Domestic Violence Victims

The waiver provides services to domestic violence victims seeking confidential services and determines eligibility by using the client's income regardless of health insurance coverage. Over the current waiver period, 5 percent (or 8,295 individuals) of enrollees were identified as domestic violence victims. Although domestic violence victims can be found in every waiver group, in 2012, the majority of domestic violence enrollees were in **FPO Pregnancy Related** (at 53 percent) and **FPO (Low Income)** (at 44 percent) waiver groups. In 2018, 84 percent of domestic violence victims were found in **FPO Pregnancy Related** waiver group.

# 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" (11). States vary in their coverage of family planning-related services, however, 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.

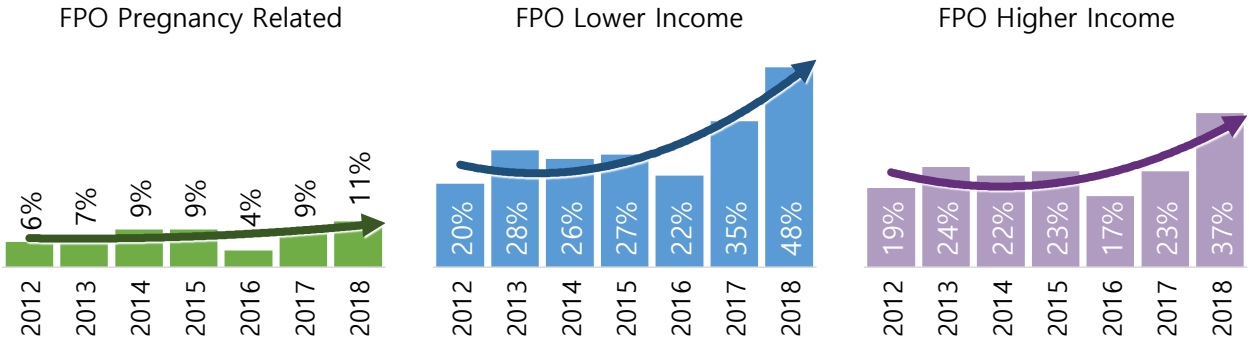
### Sexual Transmitted Infections (STI) Testing

Figure 11 shows the number of *Neisseria gonorrhea* (GC) and *Chlamydia trachomatis* (CT) screens and tests provided to clients. Women 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. We obtained this measure by dividing the number of STI screens used in a year by the total number of participants in each waiver group.

- Overall, the percentage of participants receiving a STI screen increased from 18 percent in 2012 to 38 percent in 2018. This increase was largely driven by the change in the age composition of the waiver population.
- As the percentage of teens (age 13-18) increased post-ACA, there is a corresponding increase in the percentage of STI screens for the **FPO Lower Income** waiver group from 20 percent in 2012 to 48 percent in 2018.
- **FPO Higher Income** with older clients also increased from 19 percent in 2012 to 37 percent in 2018.
- **FPO Pregnancy Related** usually receive STI screenings as part of prenatal exams, therefore we expect waiver utilization to be lower compared to other waiver groups, however screenings almost doubled from 6 percent in 2012 to 11 percent in 2018.

FIGURE 11

## STI Screenings by Waiver Group Female Participants



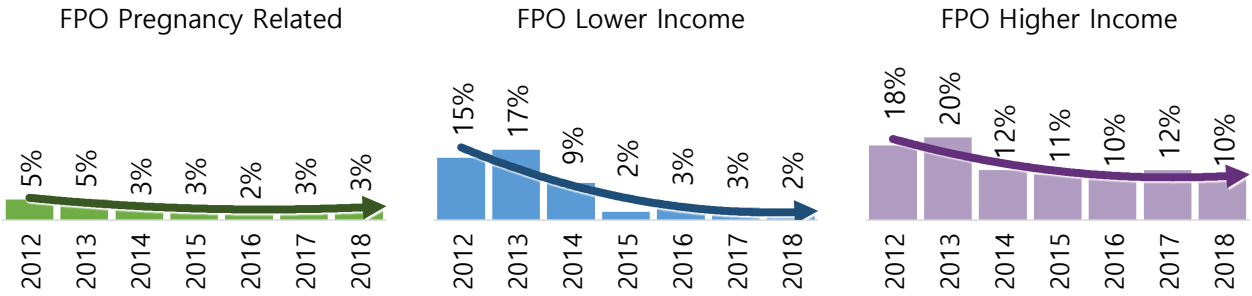

### Cervical Cancer Screening

Figure 12 shows the number of females who have received cervical cancer screening using cervical cytology (Pap test) and/or human papilloma (HPV) testing. We measured cervical cancer screenings by dividing the number of cervical cancer screens in a year by the total number of participants in each waiver group. Providers must follow nationally recognized clinical guidelines, which recommend screenings every 3 to 5 years depending age and exposure risk.

- Overall the percentage of female participants receiving cervical cancer screenings declined from 13 percent in 2012 to 4 percent in 2018.
- This decline was more dramatic for the **FPO Lower Income** waiver group, however given that in 2018, 73 percent of participants were under 21 years, the younger age composition in this waiver group did not meet the cervical cancer screening age recommendations (12, 13).
- The majority of **FPO Higher Income** participants are over 21 years, yet cervical cancer screenings declined from 18 percent in 2012 to 10 percent in 2018.

FIGURE 12

## 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. **Family Planning Only Pregnancy Related** offers an additional 10-months of coverage following Medicaid 60-days post pregnancy coverage. However, once clients in **Family Planning Only Pregnancy Related** complete 10-months, they can reapply as a **Family Planning Only** client if they meet eligibility requirements**.** Moreover**, Family Planning Only (Lower and Higher Income)** eligible clients have 12-months coverage, but can reapply if they continue to meet eligibility requirements.

**Evaluation Question: Do Family Planning Waiver clients maintain coverage long-term?**

Disenrollment and retention trends are important to monitor given that inconsistent use of a contraceptive method 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. Over the past five demonstration years (with complete data) patterns have been similar and appear to be returning to pre-ACA patterns.

Over this waiver period, annual retention of enrolled clients increased from 30 percent in 2012 to 54 percent in 2013 and has decreased to 47 percent in 2017, the most recent and complete data year. The percentage of disenrolled clients who did not renew their eligibility without a specific reason has fluctuated from almost 52 percent in 2013 to 83 percent in 2014 and decreased to pre-ACA level at 75 percent in 2017. These disenrollments could be due to obtaining commercial coverage or increase in use of LARCs. There were similar fluctuations in the rate of those disenrolled who then became eligible for full Medicaid benefits either through expanded Medicaid or pregnancy or another state funded program. These variations show the impact that health reform has had on the family planning waiver program and that more disenrolled clients are obtaining complete health coverage through Medicaid expansion.

# PART 2 | Outcome/Impact Measures

**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 woman's life and spacing the time between pregnancies. We assessed whether Family Planning Waiver services impacted maternal and child health outcomes with three measures:

1. Interpregnancy interval (i.e., time from the birth of baby to the conception of another baby) which 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 (14).
2. Low birth weight, and
3. Preterm birth are indirect measures because they are mediated by interpregnancy interval, but are also influenced by maternal health conditions and other socioeconomic disparities (15, 16).

## Interpregnancy Interval

Only **FPO Pregnancy Related** women who had at least two births and had not received a most effective contraceptive during their 60-days postpartum Medicaid coverage were included in this outcome measure. We pooled all clients enrolled in **FPO Pregnancy Related** waiver group and restricted analysis to clients in their first enrollment during the waiver period. By restricting analysis to their first enrollment, we control for any potential dosage effect or decay from being in a program multiple times.

Of the 85,544 **FPO Pregnancy Related** women in their first enrollment period, 32 percent (or 27,575) had received any contraceptive method during their 60-days postpartum coverage, while 13 percent (or 11,016) were identified as receiving a most effective contraceptive method during their 60-days postpartum period. During the waiver period, 62 percent (or 45,476) had not given birth to another child and were excluded from the final sample.

The final sample consisted of 23,096 **FPO Pregnancy Related** women having two singleton live births to calculate interpregnancy interval.

In order to assess the impact of the waiver on interpregnancy interval, we calculated the number of months of contraceptive coverage under the waiver on the basis of paid claims data on the quantity and type of contraceptive dispensed. For example, the coverage for LARCs was calculated as the number of months between the insertion date and clients last date of waiver eligibility. For each FPO Pregnancy Related client, we calculated a **proportion of days covered (PDC)** combining moderately effective (e.g., months of oral contraceptive pills dispensed) and most effective methods (e.g., LARC) provided by the waiver as a description of total days of contraceptive coverage. Finally, PDC was dichotomized as clients who had less than 50 percent of their eligibility covered under the waiver and clients who had 50 percent or more of their eligibility covered under the waiver.

Table 2 shows that for **FPO Pregnancy Related** clients with two singleton live births during the waiver period, 78 percent (or 18,090) of clients had no paid claims for a contraceptive method, 1 percent (or 331) of clients had a paid claim for a least effective contraceptive method only, followed by 13 percent (or 3,037) of clients using a moderate/most effective method less than 50 percent PDC of their eligibility, 7 percent (1,638) of clients using a moderate/most effective method 50 percent or more PDC of their eligibility covered.

Even with no paid claims for a contraceptive method, **FPO Pregnancy Related** clients had an average of 41.5 months between births compared to clients with a moderate/most effective method 50 percent or more PDC of their eligibility covered having an average of 49.1 months between pregnancies. Greater participation by **Family Planning Expansion** waiver group in family planning waiver services is associated with longer interpregnancy intervals.

TABLE 2

### Mean Interpregnancy Interval (in months)

| Contraceptive Coverage | Number | Mean (months) | Standard Deviation |
|---|---|---|---|
| No known contraceptive method | 18,090 | 41.5 | 15.6 |
| Least effective contraceptive method | 331 | 44.7 | 16.4 |
| Moderate/most effective method <50% PDC | 3,037 | 45.7 | 16.2 |
| Moderate/most effective method >=50% PDC | 1,638 | 49.1 | 14.9 |

### Low Birth Weight and Preterm Births

Finally, we examined two birth outcomes; low birth weight and preterm birth, to determine whether participation among the **FPO Pregnancy Related** waiver group was protective of negative birth outcomes. However, we found no statistical association between contraceptive coverage and birth outcomes. Table 3 shows the prevalence of low birth weight and preterm birth for each contraceptive coverage category.

TABLE 3

Prevalence of Low Birth Weight and Preterm Births

| Contraceptive Coverage | TOTAL Births | Number Low Birth Weight | Percent Low Birth Weight | Number Preterm | Percent Preterm |
|---|---|---|---|---|---|
| No known contraceptive method | 17,991 | 781 | 4.3% | 1,288 | 7.1% |
| Least effective contraceptive method ONLY | 329 | 17 | 5.2% | 24 | 7.3% |
| Moderate/most effective method <50% PDC | 3,025 | 116 | 3.8% | 213 | 7.0% |
| Moderate/most effective method >=50% PDC | 1,633 | 66 | 4.0% | 104 | 6.4% |

## 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 (17).

However, the results of this evaluation suggest Washington State's Family Planning Demonstration Waiver continues to have an important role for low-income women not eligible for Medicaid seeking to secure high-quality, confidential family planning services. Family planning can be a major gateway into the healthcare system for low-income and racial/ethnically diverse clients of reproductive age. Given the majority of utilizers in 2018 were younger than 21 years, HCA is uniquely poised to influence a population with the greatest number of potential fertile years by instilling and supporting sustainable family planning behaviors.

Process measures in this evaluation suggest maintenance or improvements regarding quality of contraceptive methods dispensed and the impact of the waiver on maternal and child health outcomes demonstrated a positive association between days of contraceptive coverage and interpregnancy interval, such that more days of contraceptive coverage were associated with a larger interpregnancy interval. However, only 13 percent of clients had consistent contraceptive coverage for 50 percent or more of their eligibility. Given that nearly half of unintended pregnancies are due to incorrect or inconsistent use of a contraceptive method, improvements can be made to improve the quality and consistency of coverage.

- HCA has already increased reimbursement rates to providers regarding LARC insertion or implantation in 2015 associated with increasing LARC use (9).
- However, past research has shown that dispensation of one-year supply of oral contraceptives (the most popular form of family planning method among FPO Pregnancy Related and FPO (Higher and Lower Income) clients) was not implemented as broadly as intended (18).

Other areas of improvement include increasing utilization among clients identifying as 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 (10). Family planning services offered through Washington State's Demonstration Waiver include an annual counseling session for reducing the risk of unintended pregnancy, condoms (which also protect against sexually transmitted infections), spermicides, vasectomies, and STI screenings if experiencing symptoms. CDC data show increasing trends, nationwide and in Washington State, for Gonorrhea and Chlamydia, which can lead to infertility if left untreated (19).

The implementation of ACA had its greatest impact on increasing the percentage of younger clients enrolled and using FPO Waiver services and HCA's new changes show great promise in meeting these client needs, especially policies intended to decrease the time between eligibility determination and enrollment or others reducing administrative barriers. Other policy changes as of July 1, 2019 include:

- Increasing application submission options to include mail, email, fax, or phone.
- Revision of approval and denial letters to improve communication around eligibility determination period. Reminder notice of when client needs to re-apply in order to maintain benefits. Revision of Medicaid denial letters to include information about the Family Planning Demonstration Waiver.
- Expansion of provider network to meet "freedom of choice" of provider so that FP Pregnancy Related and FPO waiver groups all have access to the same providers.

All of these administrative and operational changes have the potential to reduce barriers for client enrollment and eligibility, but especially for younger clients seeking access to family planning services (20). Future evaluations should determine whether these changes improved geographic proximity of providers to enrollees, appropriateness of care, and improved provider/client interaction. Additionally, with all the past and current policy changes, it is important to re-educate providers about changes to eligibility requirements and enrollment processes.

Results also reflect Washington State population-level trends in maternal outcomes. Regardless of the Medicaid program (i.e., Regular Medicaid/TANF or Pregnancy Medical), Washington State women's average age when giving birth increased during the waiver period. During the waiver period (2012 – 2018), the average age of Medicaid women in Washington State who gave birth increased from 26.4 years in 2012 to 27.7 years in 2017 (the most recent year that data is available). The percentage of Medicaid women less than 18 years who gave birth has also decreased from 3.2 percent in 2012 to 1.7 percent in 2017 (the most recent year that data are available) (21).

## Study Limitations

There were three 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 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 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 type of utilization in one program impacts the type of utilization in another program. For example, pregnant women at or below 198% FPL are covered by Medicaid and receive 60-days post pregnancy healthcare which includes contraception. In our **FPO Pregnancy Related,** 32 percent (or 27,575) of women received any contraceptive method during their 60-days postpartum period, while 13 percent (or 11,016) of women received a most effective method during their 60-days postpartum period. **FPO Pregnancy Related** utilization in the Family Planning Waiver may be misleading given their receipt of services

post-pregnancy. **Third**, while administrative data provides the means to identify and describe utilization, it is limited in providing information or conclusions regarding sexual behavior and/or pregnancy intention. Additionally, claims data were used to analyze contraceptive methods prescribed, however this cannot definitely state whether a patient took medications as prescribed. As a result, the percentage of days covered (PDC) calculation used for medication adherence analysis might overestimate true adherence rate because it assumes clients took all their medication as intended (22).

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## TECHNICAL NOTES

### FAMILY PLANNING ONLY DEMONSTRATION WAIVER GROUPS

Washington State provides family planning services through the Family Planning Only program, an 1115 Family Planning Demonstration Waiver. Contraception is one of the primary services included as family planning (23). Family planning only services cover not only all FDA approved birth control methods but also additional benefits such as limited screening and treatment for sexually transmitted infections (STIs, STDs) and screening for cervical cancer and a well woman physical exam. Vaccinations, mammograms, and services unrelated to family planning such as pregnancy care are not covered by family planning only services. Family planning only waiver groups were identified by the RAC codes (1097 (FPO Pregnancy Related), 1099 (FPO Lower Income), and 1100 (FPO Higher Income)).

### 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.

### DATA SOURCES AND MEASURES

Analyses utilized RDA's research repository of Medicaid claims data from ProviderOne, Washington's Medicaid Management Information System. The First Steps Database (FSDB) links all Washington State birth and death certificates at the individual level to Medicaid-paid maternity services and Medicaid eligibility. FSDB relies on information obtained from the Health Care Authority and the Center for Health Statistics, Department of Health, which provides birth certificate files.

- **Demographic Characteristics:** Race and gender information comes from eligibility records.
- **Disenrollment:** A gap in enrollment of more than four months.
- **Enrollees:** Individuals enrolled in the demonstration for the specified waiver period.
- **Participants:** Individuals who obtain one or more covered family planning service through the demonstration waiver.
- **Retention:** A client continuously enrolled or experiencing a gap in eligibility of no more than four months.
- **Proportion of Days Covered (PDC):** A calculation based on the fill dates and days of supply for each prescription filled. It differs from Medication Possession Ratio (MPR) in that PDC is not a simple summation of the days' supply. The denominator for PDC (at the client-level) is the number of days between the first fill of the medication during the waiver period and the end of the waiver period. For example, if the measurement period is a 12-months (365 days), and if the patient's first fill of the medication (or date of service) is on day 60 of the 12-months, then the denominator period is 305 days (365-60=305). Additionally, this means a patient who discontinues the contraceptive method during the measurement period will still be tracked through the end of the waiver period, and thus the non-persistence is accounted for in the PDC. The client-level numerator for the PDC is the number of days covered by contraceptive method fills during the denominator period.

- **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. It was measured based on ACES, arrest, and conviction data during the waiver period.

**URBAN RURAL COUNTY CLASSIFICATION**

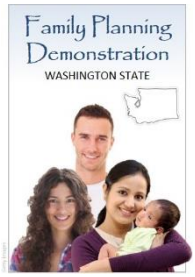
- **Rural Counties:** Adams, Asotin, Columbia, Ferry, Garfield, Jefferson, Klickitat, Lincoln, Okanogan, Pacific, Pend Oreille, San Juan, Skamania, Stevens, Wahkiakum
- **Large Town Counties:** Chelan, Clallam, Douglas, Grant, Grays Harbor, Island, Kittitas, Lewis, Mason, Whitman
- **Urban–Medium and 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 in the data was used to analyze the effect of 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%):** Sterilization, contraceptive implants, IUD
- **Moderately Effective (88-94%):** Injectables, oral pills, patch, vaginal ring, diaphragm
- **Least Effective (<82%):** Female condom, cervical cap, sponge, fertility awareness-based methods, spermicide)
- **Emergency Contraception:** Emergency contraceptive pills or copper IUD after unprotected intercourse and substantially reduce the risk of pregnancy.

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