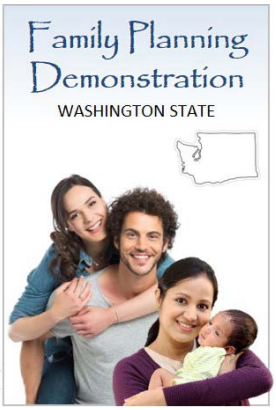

Washington State's 1115 Family Planning Demonstration Evaluation

Findings from January 2012 to May 2018

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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 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, January 1, 2012 through May 31, 2018.

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 2012-2018 Family Planning Waiver period, the State enrolled 180,941 individuals and provided 885,631 family planning and family planning-related services to 104,314 unique clients.** Peak enrollment occurred in November 2013 at 60,821, and then declined 88 percent from January 2014 to December 2015 after the implementation of the Affordable Care Act.
2. **The Affordable Care Act (ACA) had a large impact on the Family Planning Waiver Age Distribution.** As enrollment declined with ACA expansion to the Medicaid population, the population served by the Family Planning Waiver became younger. Specifically, the percentage of clients aged 13-18 increased from 12 percent in 2012 to 38 percent in 2018. This dramatic shift in the age composition likely accounts for the changes in waiver service utilization.
3. **Twice as many FPO Lower Income clients utilized family planning and family planning-related waiver services than the other waiver groups.** By 2018, 58 percent of FPO (Lower Income) clients utilized a family planning and family planning-related waiver service compared to 22 percent of FPO (Higher Income) and 20 percent of FPO (Pregnancy-Related).
4. **Greater participation by the FPO Pregnancy-Related waiver group in family planning waiver services was associated with longer interpregnancy intervals.** Clients who regularly utilized a most/moderately effective contraceptive method compared with those who did not had a longer average time between pregnancies (49 months vs. 42 months).

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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.

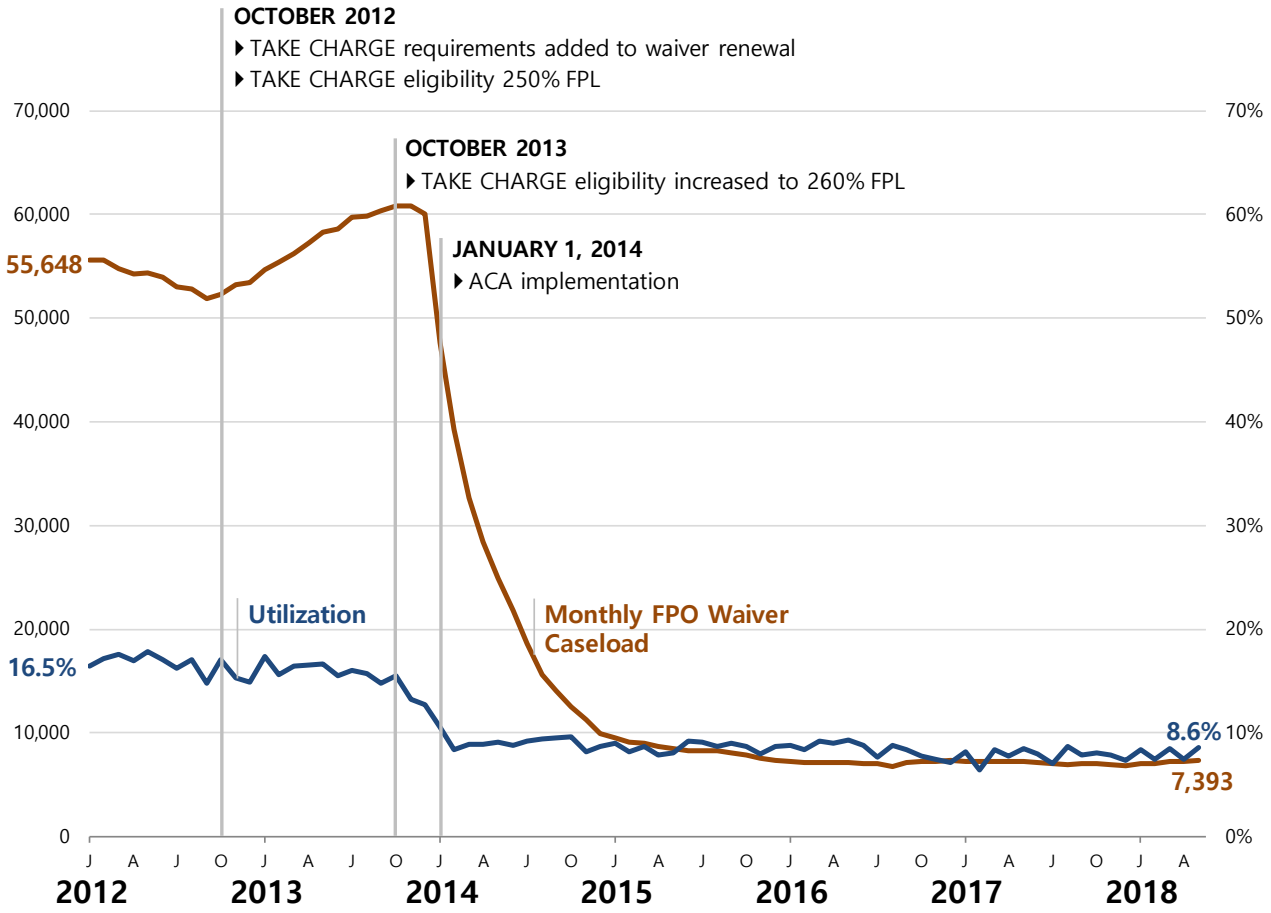
FINDING 1 | Family Planning Waiver enrollment and participation increased with state policy changes and declined with implementation of the Affordable Care Act (ACA).

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 limits for the TAKE CHARGE (renamed Family Planning Only) population from 200 percent FPL to 250 percent of the federal poverty limit (FPL), then again in October 2013 to 260 percent FPL. Enrollment increased from 52,247 in October 2012 to 60,821 in October 2013 (a 16 percent increase). Peak enrollment occurred in November 2013. 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). Enrollment declined 88 percent from January 2014 to December 2015 as women and men who relied on the Family Planning Demonstration for family planning services may have shifted to private plans.

Utilization rates also changed after ACA implementation. Figure 1 shows month-to-month utilization rates for family planning services, before (about 17 percent) and after (9 percent) ACA implementation. In other words, about 9 percent of all eligible men and women used these services in 2018. The changes in utilization likely reflect changes in group characteristics that are detailed below.

FIGURE 1

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



Family Planning Waiver Group Characteristics

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. Given that these groups have different waiver enrollment eligibility criteria, income eligibility, and coverage periods, this report examines and compares each waiver group separately. Most analyses were focused on clients identifying as women. Due to small numbers, men were excluded from subsequent analyses and described in a separate section. To determine how ACA implementation might differentially affect other group characteristics, changes in Family Planning Waiver service delivery related to demographics such as age, race/ethnicity, and urban/rural composition are further detailed below.

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

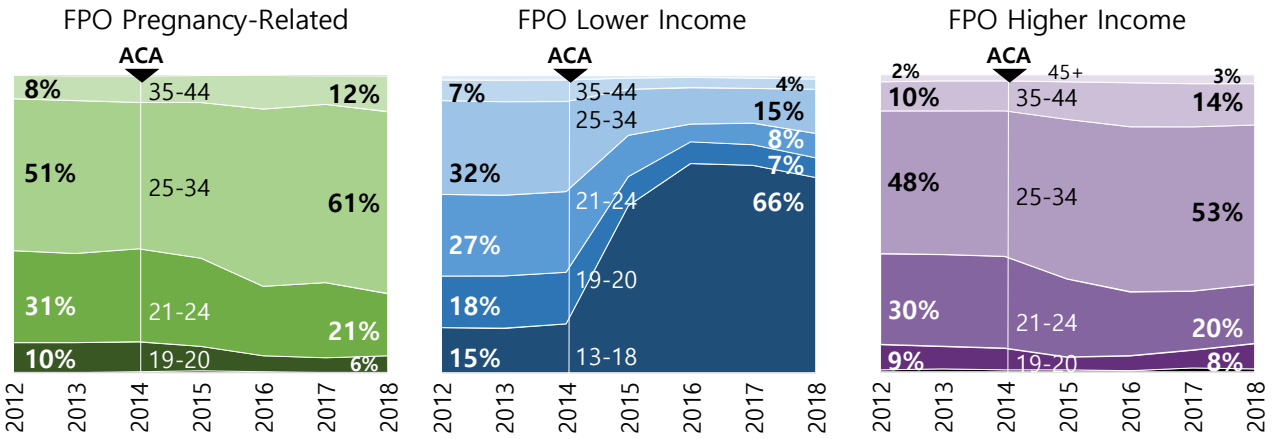
The greatest impact on population characteristics from ACA implementation has been on the age composition of the FPO waiver groups. This is a useful finding for program services because age is an important predictor of people choosing to use a contraceptive method, contraceptive method type, and failure rates among barrier contraceptive methods (3, 4). Figure 2 shows the age distribution of utilizers in each waiver group and changes in utilization by age group over time.

- Of the **FPO Pregnancy-Related** clients using services (utilizers), 31 percent were in the 21-24 age group in 2012 and this decreased 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 increased, reflecting the state's population-level trend in mother's increasing average age when giving birth.
- In 2012, 15 percent of **FPO Lower Income** utilizers were in the 13-18 age group, however, by 2018, 66 percent of the FPO Lower Income utilizers were age 13-18. 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.
- The **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 the age group 35-44 increased from 10 percent in 2012 to 14 percent in 2018.

FIGURE 2

Utilization of Family Planning and Family Planning-Related Services

By Waiver Groups and Age (Women Only)



FINDING 3 | The racial/ethnic distribution for clients differs for the three target populations.

We examined impacts of ACA implementation on racial/ethnic composition by waiver groups. Some studies find racial/ethnic preferences associated with family planning and/or family planning-related services (5, 6). In addition, policy changes could unintentionally impact access to services, which could exacerbate racial/ethnic disparities in maternal and child health outcomes.

Figure 3 shows differences in racial/ethnic composition of utilizers for each waiver group and changes in utilization for each group over time by race/ethnicity.

- The percentage of Hispanic clients using services in the **FPO Pregnancy-Related** waiver group increased from 16 percent in 2012 to 28 percent in 2018.
- The percentage of Non-Hispanic Black clients using services in the **FPO Pregnancy-Related** waiver group modestly increased from 5 percent in 2012 to 9 percent in 2018.
- These utilization trends over time are proportionate to changes in racial/ethnic enrollment statistics for the **FPO Pregnancy-Related** waiver group (not shown).

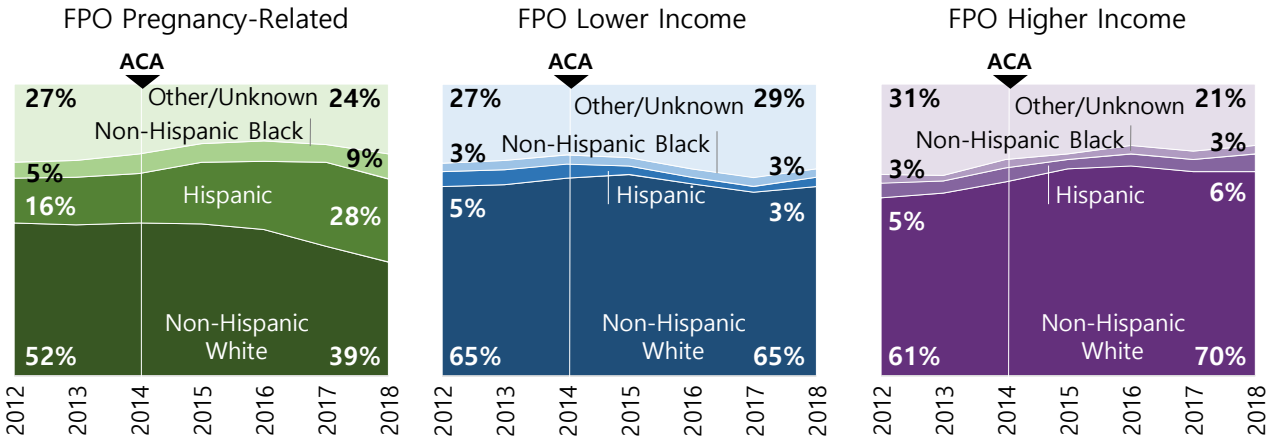
The racial/ethnic distribution for clients in **FPO Lower Income** and **FPO Higher Income** was much different than the **FPO Pregnancy-Related** waiver group.

- Sixty-five to 70 percent of **FPO Lower Income** and **FPO Higher Income** clients that used services were Non-Hispanic White, compared to 39 percent **FPO Pregnancy-Related** clients.
- Besides the **FPO Higher Income** Non-Hispanic White clients increase of 9 percent from 2012 to 2018, the racial/ethnic distribution of clients using services in **FPO Lower Income** and **FPO Higher Income** groups changed very little during the current waiver period.

FIGURE 3

Utilization of Family Planning and Family Planning-Related Services

By Waiver Groups and Race/Ethnicity (Women Only)



FINDING 4 **For all waiver groups, the percentage of utilizers was lower than the percentage of enrollees in urban medium-low density counties suggesting access gaps to family planning and/or family planning-related services in these less dense areas.**

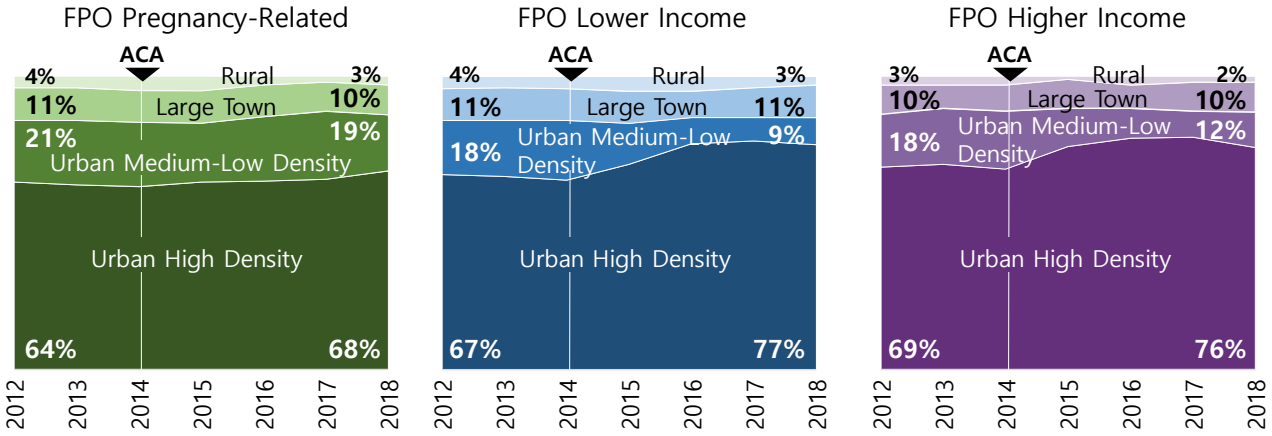
Rural counties (or counties with less population density) are often associated with medically underserved areas or environments with additional barriers to clients seeking confidential family planning services (7). We compared the percentage of enrollees to utilizers to identify potential gaps in urban/rural geographical access. Figure 4 shows differences in urban/rural composition of utilizers in each waiver group and changes in utilization by urban/rural group over the waiver period.

- The **FPO Pregnancy-Related** waiver group increased enrollment in urban-high density from 68 percent to 70 percent (not shown) and percent of utilizers living in urban-high density areas increased from 64 percent to 68 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 suggesting access gaps in these less dense areas.
- There was very little change in the large towns or rural areas over time suggesting there was little or no impact of ACA on geographical areas considered rural or with low population density.

FIGURE 4

Utilization of Family Planning and Family Planning-Related Services

By Waiver Groups and Urban/Rural (Women Only)



Enrollment and Utilization by Waiver Group

As discussed in the previous section, the implementation of the Affordable Care Act (ACA) impacted overall caseload and Family Planning Waiver group demographics. Figure 5 is similar to Figure 1 but shows caseload and utilization rates for each waiver group. 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.

Utilization is shown as a monthly rate of use by enrollees in each waiver group in Figure 5. We show the percentage of services used by each waiver group per year in Figure 6.

- In 2012, **FPO Lower Income** had the most enrollees of any waiver group, however by 2018, **FPO Pregnancy-Related** had the most enrollees (Figure 5).

- Despite dramatic changes in enrollment over time and a decline 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** (Figure 5).
- The **FPO Lower Income** waiver group consisted of 80 percent of all clients utilizing services in 2012. While this group still used most of the services in 2018, the proportion was lower (58 percent, Figure 6).
- In contrast, both the **FPO Pregnancy-Related** and the **FPO Higher Income** groups increased as a proportion of those using services overall (Figure 6).

FIGURE 5

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

Caseloads and Utilization By Waiver Group (Women Only)

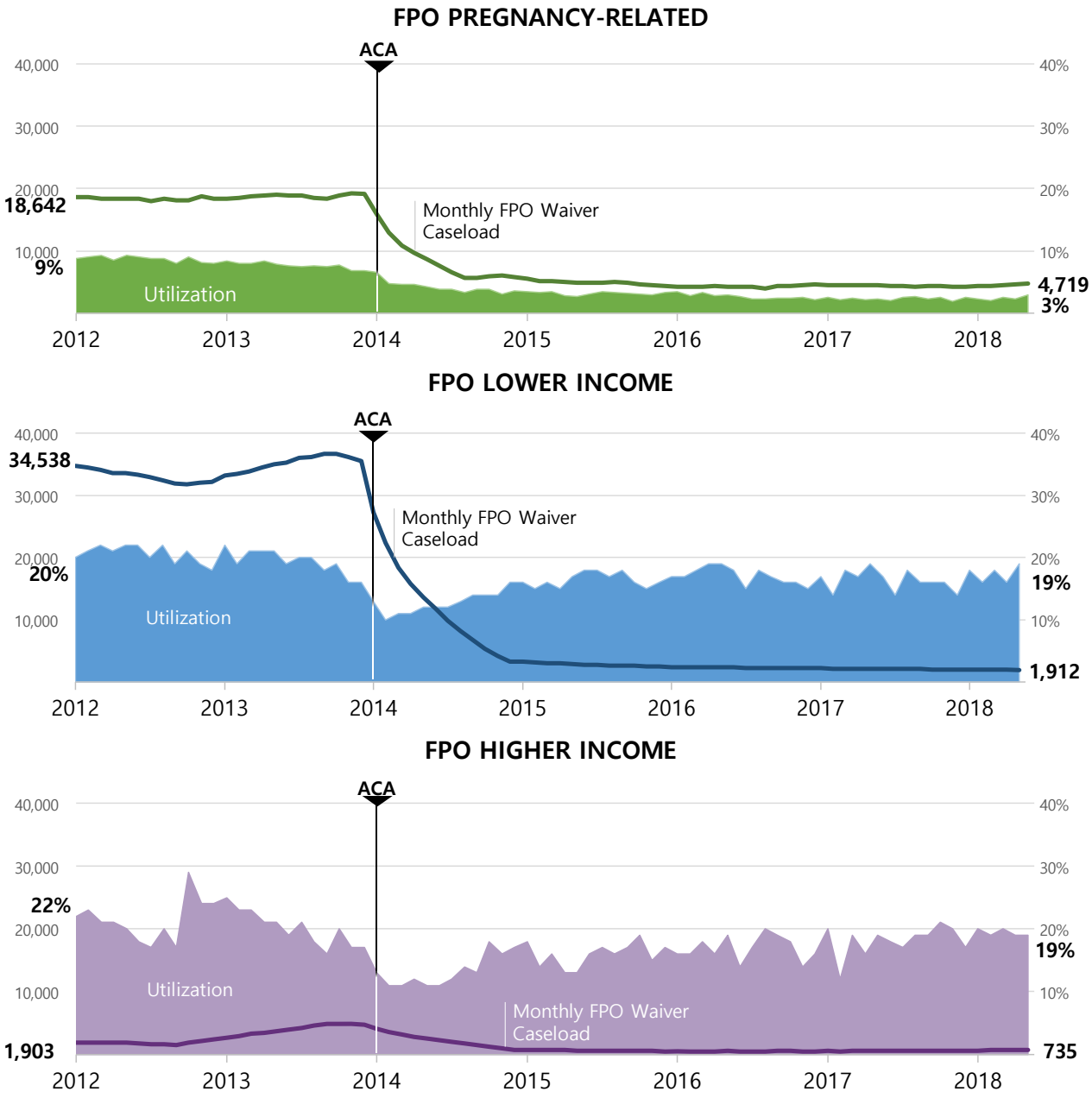
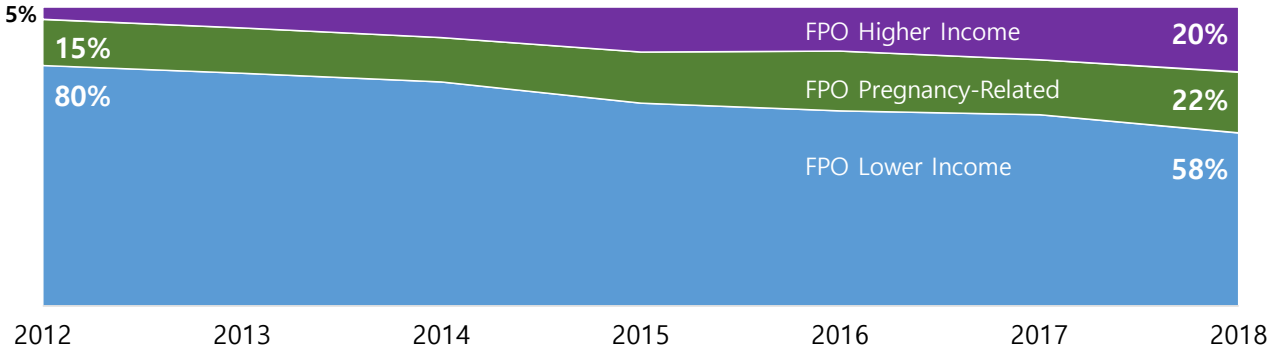


FIGURE 6

Utilization of Family Planning and Family Planning-Related Services

By Waiver Groups (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 ACA on the Family Planning Waiver group demographics, we anticipated changes to process measures.

EVALUATION QUESTION

How did Family Planning Waiver clients utilize services?

Any Contraceptives Used by Female Participants

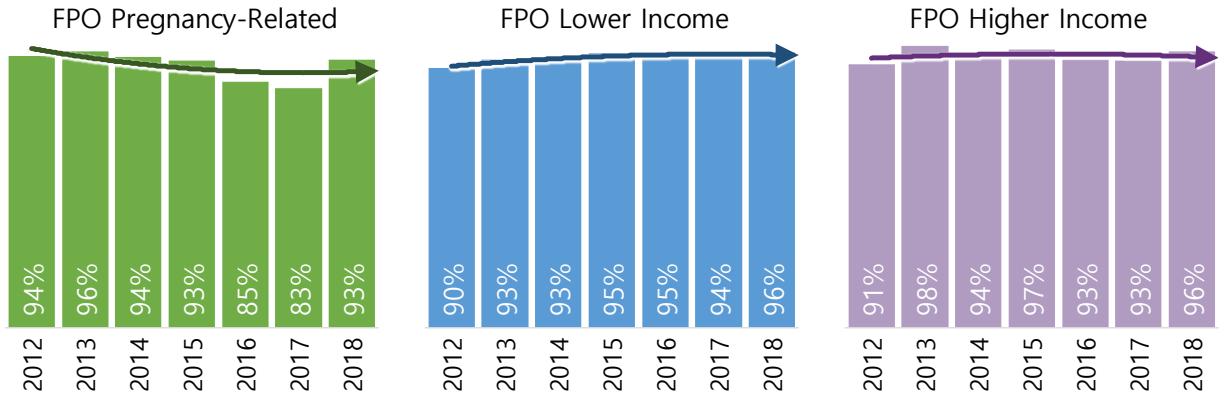
We measured any contraceptive use by reporting clients in a waiver group who obtained any contraceptive method out of the total number of participating clients in the same waiver group. Figure 7 shows the annual percentages of any contraceptive use, by waiver group.

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

FIGURE 7

Any Contraceptive Used by Waiver Group

By Waiver Groups (Women Only)



Utilization by Contraceptive Method Effectiveness

We categorized all contraceptive methods used as most effective, moderately effective, least effective, and emergency to show the distribution of contraceptive categories utilized per year by each waiver group (Figure 8).

Most effective contraception consists of reversible methods (e.g., implants or intrauterine devices) and permanent methods (e.g., sterilization) that result in 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 result in approximately 6-12 pregnancies per 100 women within the first year of use.

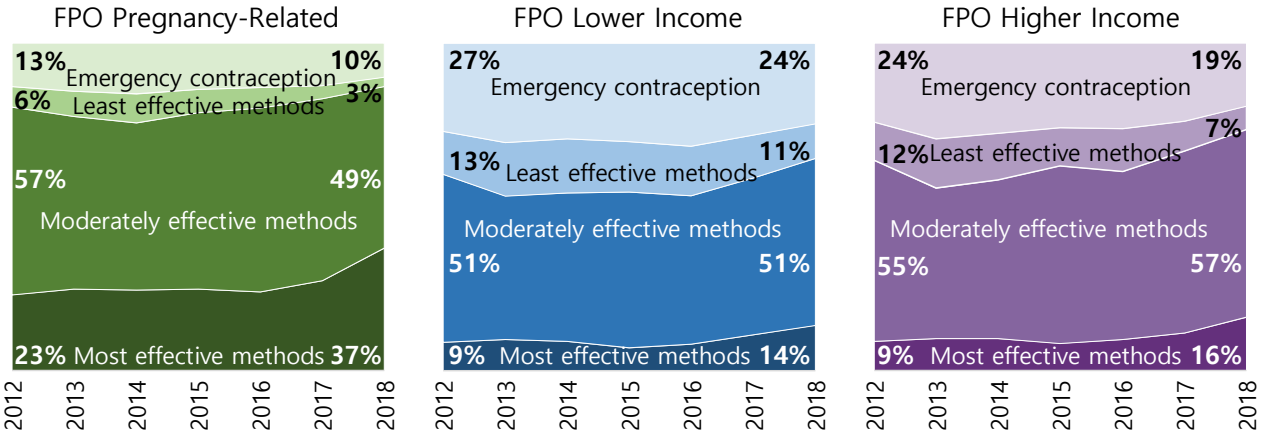
Least effective contraception consists of barrier reversible methods (e.g., female/male condom, natural family planning, etc.) that rely on correct use or abstinence and result in approximately 18 or more pregnancies per 100 women within the first year of use.

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

- The **FPO Pregnancy-Related** waiver group utilization of the most effective methods increased from 23 percent in 2012 to 37 percent in 2018, whereas the use of all other methods decreased. Because this waiver group is older and clients 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 non-emergency contraceptive method utilization. While the percentage of most effective methods increased for both waiver groups from 2012 to 2018, the percentage of emergency contraceptives was highest in the **FPO Lower Income** group across all years.

FIGURE 8

Distribution of Contraceptive Categories Utilized by Waiver Groups (Women Only)



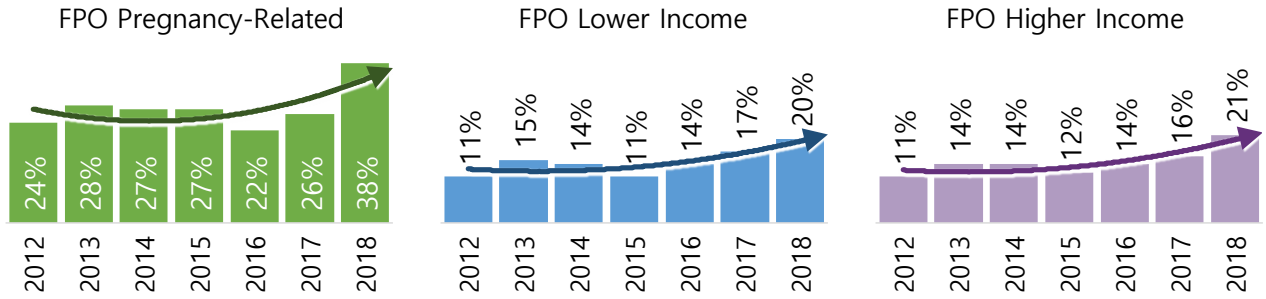
Long-Acting Reversible Contraceptives (LARC)

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 9).

- Utilization of a LARC method was almost twice as high among the **FPO Pregnancy-Related** waiver group compared to clients in other waiver groups.
- While all three waiver groups showed increased LARC utilization, the percentage of both **FPO Lower and Higher Income** LARC users almost doubled from 2012 to the 2018 cohort.

FIGURE 9

LARC use by Waiver Group (Women Only)



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 (9). However, less than one 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).

Domestic Violence Involvement

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 all female enrollees were involved in domestic violence. Although domestic violence involvement can be found in every waiver group, in 2012, the majority of domestic violence enrollees were in the **FPO Pregnancy-Related** (53 percent) and **FPO Low Income** (44 percent) waiver groups. In 2018, 84 percent of domestic violence-involved persons were found in the **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" (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.

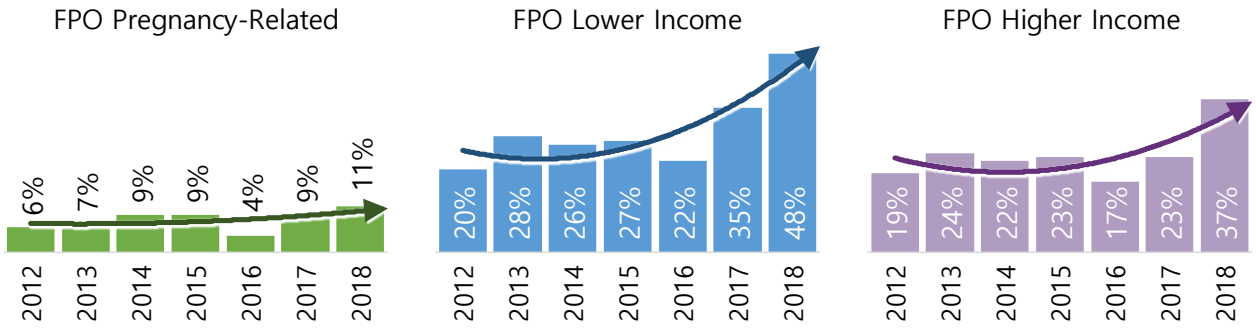
Sexual Transmitted Infections (STI) Screening and Testing

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 10 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.

- Overall, the percentage of participants receiving an STI screen/test 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 (not shown).
- As the percentage of teens (age 13-18) increased post-ACA, there was a corresponding increase in the percentage of STI screens/tests for the **FPO Lower Income** waiver group from 20 percent in 2012 to 48 percent in 2018.
- The rate of STI Screenings in the **FPO Higher Income** group, with older clients, increased from 19 percent in 2012 to 37 percent in 2018.
- STI screenings for **FPO Pregnancy-Related** clients almost doubled from 6 percent in 2012 to 11 percent in 2018.

FIGURE 10

STI Screenings/tests by Waiver Group Female Participants



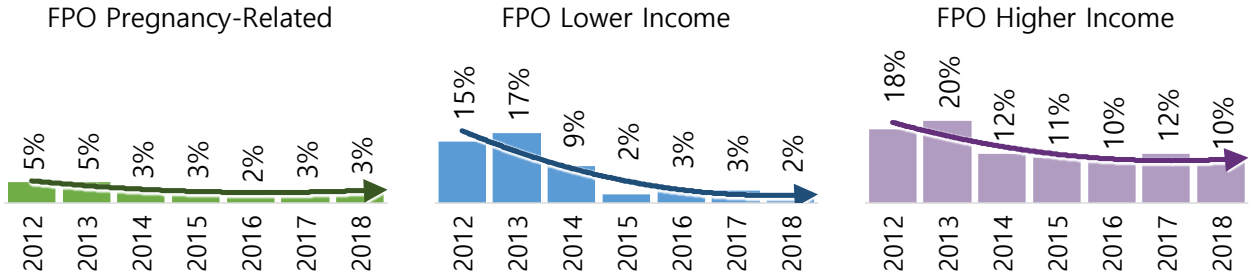
Cervical Cancer Screening

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 11 shows the percentage of females who received cervical cancer screening using cervical cytology (Pap test) and/or human papilloma (HPV) testing.

- Overall, the percentage of female participants receiving cervical cancer screenings declined from 13 percent in 2012 to 4 percent in 2018 (not shown).
- The decline in testing was most dramatic in the **FPO Lower Income** waiver group. However, in 2018, 73 percent of participants in the group were under 21 years, and this age category is not included under the cervical cancer screening age recommendations (11, 12).
- The majority of **FPO Higher Income** participants were over 21 years, yet cervical cancer screenings declined from 18 percent in 2012 to 10 percent in 2018.

FIGURE 11

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.

EVALUATION QUESTION

Do Family Planning Waiver clients maintain coverage long-term?

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 five demonstration years (2014 through 2017 are 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 decreased to 47 percent in 2017, the most recent and complete data year. The percentage of disenrolled clients (i.e., those who did not renew eligibility without a specific reason) has varied year-to-year; the rate in 2017 was 75 percent.

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 woman's life and spacing the time between pregnancies. We assessed 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** were also used. These 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).

Interpregnancy Interval

To measure the effect of contraceptive use in the waiver program on interpregnancy intervals, we combined all clients enrolled in the **FPO Pregnancy-Related** waiver for this period (2012-2018). Of these, only **FPO Pregnancy-Related** women who had at least two singleton births and had not received a most effective contraceptive during their 60-days postpartum Medicaid coverage were included in this outcome measure. The analysis was further restricted to clients in their first enrollment during the waiver period. This restriction controlled 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 a contraceptive method during their 60-days postpartum coverage, but only 13 percent (or 11,016) were identified as receiving a most effective contraceptive method during that time. During

the waiver period, 62 percent (or 45,476) had not given birth to another child and were excluded from the final sample. Interpregnacy intervals were calculated on a final sample consisting of 23,096 **FPO Pregnancy-Related** women having two singleton live births during the waiver period. To assess the impact of the waiver on interpregnancy interval, we calculated the number of months of contraceptive coverage based on paid claims data regarding 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 the 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. PDC was dichotomized as clients who had less than 50 percent PDC and clients who had 50 percent or more of PDC. 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. About one percent (or 331) of clients had a paid claim for a least effective contraceptive method only; 13 percent (or 3,037) of clients using a moderate/most effective method less than 50 percent PDC; seven percent (1,638) of clients using a moderate/most effective method 50 percent or more PDC of their eligibility covered.

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 had an average of 49.1 months between pregnancies. Greater participation in family planning waiver services is associated with longer interpregnancy intervals.

TABLE 2

Mean Interpregnancy Interval (in months)

For women with two or more births during waiver period

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. From the final sample of 23,096 clients with two singleton lives births, only 22,978 clients had valid birth weight and gestational age information. 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

For women with available birth weight and gestational age data during the waiver period

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 (16). 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 who are seeking high-quality, confidential family planning services. Family planning can be an important gateway into the healthcare system for low-income and racially/ethnically diverse clients of reproductive age. Given that the majority of program participants in 2018 were younger than 21 years, the Washington State Health Care Authority (HCA) is uniquely poised to influence a population with the greatest number of potential fertile years by supporting sustainable family planning behaviors.

Results also reflect Washington State population-level trends in maternal outcomes. Regardless of the Medicaid program (i.e., Regular Medicaid/TANF or Pregnancy Medical), the average age when giving birth increased during the waiver period from 26.4 years in 2012 to 27.7 years in 2017. 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 (17). Study results indicate 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 included in the analysis 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, focusing on improvements in this area may positively impact maternal health outcomes.

Several efforts have already been made to improve the use of available services:

- 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 (18). HCA increased reimbursement rates to providers regarding LARC insertion or implantation in 2015 and this was associated with increasing LARC use (19).
- 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 (19).
- 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 (10). 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.
- The implementation of ACA had its greatest impact on increasing the enrollment of younger clients. Several new policies show great promise in meeting these clients' needs by reducing administrative barriers (20): 1) increasing application submission options to include mail, email, fax, or phone; 2) efforts to improve communication such as revision of approval and denial letters and re-application reminders; and 3) expansion of provider networks to meet "freedom of choice" of provider so that **FPO Pregnancy-Related** and **FPO Higher and Lower Income** waiver groups all have access to the same providers.

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 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. In our **FPO Pregnancy-Related** group**,** 32 percent (or 27,575) of women received any contraception 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 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, the percentage of days covered (PDC) calculation used for medication adherence analysis might overestimate the true adherence rate because it assumes clients took all medication as intended (21).

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FAMILY PLANNING ONLY DEMONSTRATION WAIVER GROUPS

Washington State provides family planning services through the Family Planning Only program, a 1115 Family Planning Demonstration Waiver. Contraception is one of the primary services included as family planning (1). 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), 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 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.
- **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 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-month period, 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.

URBAN RURAL COUNTY CLASSIFICATION

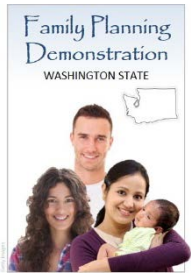
- **Rural Counties:** Adams, Asotin, Columbia, Ferry, Garfield, Jefferson, Klickitat, Lincoln, Okanogan, Pacific, Pend Oreille, San Juan, Skamania, Stevens, Wahkiakum
- **Large Town Counties:** Chelan, Clallam, Douglas, Grant, Grays Harbor, Island, Kittitas, Lewis, Mason, Whitman
- **Urban–Medium and 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



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