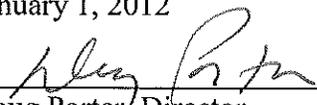


Application Template for Family Planning § 1115 Demonstration

STATE Washington
DEPARTMENT Washington State Health Care Authority
NAME OF DEMONSTRATION PROJECT TAKE CHARGE
DATE PROPOSAL SUBMITTED December 31, 2008
DATE PROPOSAL RE-SUBMITTED September 27, 2011
PROJECTED DATE OF IMPLEMENTATION January 1, 2012
AUTHORIZING TITLE AND SIGNATURE 
Doug Porter, Director
Health Care Authority

PRIMARY FAMILY PLANNING CONTACT:

Name Maureen C. Considine, ARNP
Title TAKE CHARGE Program Manager
Phone Number 360-725-1652
Email Address Maureen.Considine@hca.wa.gov

The Washington State Health Care Authority (formerly the State of Washington, Department of Social and Health Services), proposes a Section 1115 Waiver Family Planning Demonstration entitled **TAKE CHARGE**, which will increase the number of individuals receiving family planning services.

Date Proposal Submitted: December 31, 2008

Date Proposal Re-submitted: September 27, 2011

Projected Date of Implementation: January 1, 2012

I. ENROLLMENT PROJECTIONS AND GOALS

The **TAKE CHARGE** program has provided family planning services to an estimated 461,116 residents of Washington State over the life of the demonstration. Specifically, the Agency estimates that it will cover the following number of enrollees for each demonstration year:

Demonstration Year 11: 125,000

Demonstration Year 12: 138,000

Please describe the goals of the demonstration.

Washington State's TAKE CHARGE program, which began in July 2001, currently expands Medicaid Coverage for family planning services to men and women at or below 200% of the federal poverty level (FPL). As described in the December 1998 proposal submitted to the Centers for Medicare and Medicaid Services (CMS) entitled **TAKE CHARGE: Washington State's Family Planning Services Section 1115 Waiver Project**, this project is designed to reduce the number of unintended pregnancies in low income populations and the associated medical costs of maternity and infant care by providing comprehensive family planning education and medical services. To achieve true parity, so that all women who would be Medicaid-eligible if pregnant would be eligible for family planning coverage through the waiver, Washington is requesting an increase in eligibility for TAKE CHARGE to 250% of the FPL.

II. FAMILY PLANNING DEMONSTRATION STANDARD FEATURES

Please provide an assurance that the following requirements will be met by this demonstration, and include the signature of the authorizing official.

- The family planning demonstration will be subject to Special Terms and Conditions (STCs). The core set of STCs is included in the application package. Depending upon the design of the State's family planning demonstration, additional STCs may apply.

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- The Agency has utilized a public process to allow interested stakeholders to comment on its proposed family planning demonstration.
- Family planning demonstrations are intended to provide family planning services to low-income men and women who would not otherwise have access to services for averting pregnancy. Eligible individuals are those who are:
 - Uninsured, or those whose insurance does not completely cover their contraceptive needs
 - Not enrolled in Medicare, Medicaid or the Children’s Health Insurance Program (SCHIP)

Signature: _____
 Title: _____

III. ELIGIBILITY

A. Eligible Populations

Please indicate with check marks the populations which the State is proposing to include in the family planning demonstration, and fill in the age, sex and income information where appropriate. Note that these demonstrations are intended to cover uninsured, low-income individuals with incomes no higher than 200% of the FPL.

- Women losing Medicaid pregnancy coverage at the conclusion of 60 days postpartum.
Period for which individuals would have coverage: **ten (10) months**
- Individuals losing Medicaid coverage with gross income up to and including _____% FPL
- Individuals losing SCHIP coverage with gross income up to and including _____% FPL
- Individuals eligible based solely on income, with gross income from 0% FPL up to and including 250% FPL

The Agency is required by law to request that we change the income eligibility from 200% of the FPL to 250% of the FPL to correspond with income eligibility for publicly funded maternity care services. The Agency supports the implementation of this change to the waiver.

The Agency is required by new legislation to request that the language that bars clients with creditable insurance from applying for TAKE CHARGE be dropped. The Agency would like to enroll men and women with primary insurance who are

otherwise eligible, like any other Medicaid client. The Agency will require providers to bill the client's primary insurance first and the Agency will cover the balance, saving both state and federal dollars. The Agency supports the implementation of this legislation.

Men of reproductive age

Women of reproductive age

Eligibility for TAKE CHARGE is not restricted to a specified age range. The program will provide services to any eligible individual who is sexually active and capable of reproducing. Clients must therefore be of reproductive age to be eligible. For statistical reporting and forecasting, the standard child-bearing years for women are considered to be age 15–44. For Years 9 and 10 of the demonstration, 98.2% of all TAKE CHARGE clients were age 15–44. By comparison, 99.8% of all Washington births in 2008 – 09 occurred to women age 15–44. For clients age 12 or younger and women age 57 or older, the program manager verifies that the client actually needs family planning services.

B. Initial Eligibility Process

1. Please describe the initial eligibility process. Please note any differences in the eligibility process for different groups:

TAKE CHARGE clients include two groups whose application and enrollment processes differ:

a. Women who were eligible for full-scope Medicaid coverage because of pregnancy and whose medical coverage ends two months postpartum.

These clients are automatically enrolled in TAKE CHARGE sixty days postpartum and receive ten months of family planning coverage. (This program is referred to as the Family Planning Only program). At the end of the ten-month extension, these clients must reapply for TAKE CHARGE to continue their enrollment

b. Men and women who meet the eligibility criteria and are newly eligible for family planning services through the waiver.

These individuals apply for TAKE CHARGE at a TAKE CHARGE provider's office. If determined to be eligible, these clients receive twelve months of coverage and must reapply for TAKE CHARGE at the end of each twelve month period of eligibility to continue to receive services.

The application process for new and re-enrolling TAKE CHARGE clients is exactly the same and requires that clients apply in person for TAKE

CHARGE at a TAKE CHARGE provider's office. Providers are instructed to first check ProviderOne to determine whether the potential client is already enrolled in TAKE CHARGE or in another Medicaid program such as SCHIP. If the potential client has existing Medicaid family planning coverage as indicated by ProviderOne, then he or she must use that coverage to obtain needed family planning services.

A potential client completes a hard copy application form that includes self-declared income and insurance status (See Attachment E). The TAKE CHARGE provider has the option to review the completed application. The application is mailed or faxed to the Health Care Authority (HCA) TAKE CHARGE Eligibility Determination Unit. An eligibility worker in the HCA Eligibility Determination Unit reviews each application for accuracy and completeness. The worker then runs the potential client's name, DOB, Social Security number (SSN) and gender through State Medicaid and Income Verification System (IVS) databases to confirm that:

- The potential client is not already on TAKE CHARGE;
- The potential client is not already on another Medicaid program (e.g. SCHIP) and does not have current Medicaid coverage for pregnancy;
- The potential client's demographic information and SSN are consistent with any existing information about the client or the SSN; and
- The potential client's income does not exceed 250% of the FPL.

The HCA eligibility worker will:

- Approve the application, or
- Deny the application, or
- Pend the application and request additional information or verifying documentation.

If the provider or the client submits a completed application to HCA on the same day the client applies, the application could be processed within 25 working days. If the person applying for TAKE CHARGE submits an incomplete application, or HCA discovers conflicting information while working the application, the processing time may take longer than 25 days. Our goal is to complete processing for all applications within three weeks.

2. **Will the State use an automatic eligibility process for any of the groups described under III (A)? (e.g., will the State automatically enroll women losing Medicaid after 60 days postpartum?)**

- Yes
 No

Clients who received pregnancy related benefits are automatically enrolled into the Family Planning Only program at the conclusion of 60 days postpartum. They are notified by mail with a letter sent to an address provided by the client. The client's family planning benefits continue for 10 months. Near the conclusion of this 10 month period of eligibility, these clients are sent a second letter that gives them information about the TAKE CHARGE program.

3. **Please assure (with a check mark) that the State will not enroll individuals who are enrolled in Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), have private insurance, is pregnant or unable to become pregnant.**

The Agency is being required by law to request that the language that bars clients with creditable insurance from applying for TAKE CHARGE be dropped from the Special Terms and Conditions. The Agency would like to enroll men and women with primary insurance who are otherwise eligible, like any other Medicaid client. The Agency will require providers to bill the client's primary insurance first, just as for regular Medicaid clients, and the Agency will cover the balance, saving both state and federal dollars. As we are currently doing, there would be an exception for "Good Cause" for minors requesting confidential services and for clients in domestic violence situations who are covered under the perpetrators insurance. The Health Care Authority supports this language in the legislation.

The Agency will not enroll clients already enrolled in Medicaid, SCHIP or who are pregnant or are unable to become pregnant. Since Medicare does not cover any family planning services or diagnoses, we enroll otherwise eligible Medicare clients. We bill Medicare first and when they deny the claim the Agency will cover the costs of the Family Planning services provided.

4. **Where is the initial application accepted?**

- Medicaid eligibility sites
- County health department/local health agency
- Provider**
- Mail-in
- On-line
- Other

The Agency is exploring an on-line application process to become a part of a project funded by the Gates Foundation that would facilitate screening and application for all state entitlement programs.

5. Is the application for family planning simplified or the same as full Medicaid?

Please attach a copy of the application.

- Simplified** (see copy of application in Attachment E)
 Same as full Medicaid

6. Is point-of-service eligibility granted?

- Yes
 No

The Agency does not reimburse for any services until Medicaid eligibility has been determined by the TAKE CHARGE Eligibility Unit. However, we are requesting a waiver to the Medicaid rule that requires us to use the date of submission to our office rather than the date of signature on the application. Even knowing that they may not be reimbursed, most of the family planning clinics provide some services on the day of application. For clients applying the last five working days of the month, there is a risk that their application may not reach our office in time for eligibility during the month that their application was signed. This is especially true for clinics that have evening and weekend hours.

- 7. Please assure (with a checkmark) that the State uses gross income prior to applying any income disregards.**
- 8. What income disregards does the State use? Please indicate any differences by eligibility group or age.**

The Agency uses the following income disregards:

- Clients may subtract \$90 from their gross monthly wages if they work.
- Clients may subtract \$90 from their gross monthly wages if their spouse works.
- Clients may subtract any monthly work-related child or adult care expenses from their gross monthly wages.
- Clients may subtract all monthly court-ordered payments for a child living outside the home.

9. Are these income disregards the same as in the Medicaid State Plan?

- Yes
 No

10. What elements and verification must be provided in the initial application process? For those elements that are required, please check a

box indicating whether the State allows self-declaration or requires documentation. Please also indicate whether there are differences by eligibility or age.

a. Proof of Income

- Self Declaration
 Documentation required
- What documents are sufficient to document income?
 - When are documents required?
 - Are there differences by eligibility group or age?
- Income Verification and Eligibility System

Note: The Agency requests that we limit our income verification of adult applicants to the Employment Security Data Base and the TALX income verification system or a future improvement of either of those two data bases.

The Agency requests the option of using self declared income for all applicants who are minors. The income verification process is labor and time intensive. In the first ten years of the waiver we have had only one teenager (out of tens of thousands) who was over income. As we raise the income eligibility to 250% of the FPL it is even less likely that any minor applying for the program would be over income. The income verification requirement for this age group is burdensome and provides no benefit to the integrity of the program.

b. Proof of Resources

- Self declaration
 Documentation required
- What documents are sufficient to document resources?
 - When are documents required?
 - Are there differences by eligibility group or age?

Note: Clients applying for the waiver are not required to provide information about resources other than income.

c. Social Security Number

Please assure (with a check mark) that the State requires a SSN for all family planning demonstration enrollees.

- Documentation required
- What documents are sufficient to document SSN?
 - When are documents required?
 - Are there differences by eligibility?

Note: TAKE CHARGE applicants are currently required to provide their SSN. The number that they give is checked by the TAKE CHARGE

Eligibility Unit using the State Online Query (SOLQ) data base to verify that it is a valid number and not assigned to any other person.

The Agency is being required by law to request that the current SSN requirement be dropped. We are requesting a return to the eligibility standards of the original waiver when clients were strongly encouraged to provide their SSN.

In the first five years of the waiver, over 95% of clients supplied their SSN. The remaining applicants who did not were primarily younger teenagers with strong concerns about confidentiality. They are afraid to ask their parents for their SSN because they understand that their parents will want to know why they need it and who they are planning on sharing it with - reasonable questions for any parent of a young teen. Providers give these clients information about how to get their SSN from the local Social Security Administration Office. For younger teens who do not drive, or more rural teens who live a distance from the SSA office and have no public transportation, just getting to the SSA office is a daunting task and a barrier.

d. Citizenship Status

Please assure *(with a check mark)* that the State is in compliance with the citizenship documentation requirements of the Deficit Reduction Act in its Medicaid State Plan and will require *(or continue to require for renewals)* the same documentation under the family planning demonstration.

The Agency is being required by law to request that the citizenship eligibility standards for the first five years of the waiver be reinstated. During this period of the waiver, a declaration of US citizenship was sufficient. No proof of citizenship was required. The Agency currently is using a valid SSN as proof of citizenship, however, for minors, as stated above; it is sometimes difficult for them to obtain their SSN. The Agency would support the option of a signed citizenship declaration form for minors and for the very small number of other individuals who do not have access to their SSN.

11. What entity is responsible for determining final eligibility for the demonstration?

- State Agency
 County Agency

C. Eligibility Redetermination Process

1. Please assure *(with a check mark)* that the State will conduct an eligibility redetermination at a minimum of every 12 months.

2. **Is the eligibility determination process identical to the initial eligibility process?**

Yes. The process for re-enrolling is identical to the initial eligibility process. The Agency has given serious thought to making the renewal process easier for clients and offering a passive renewal process. We are not, however, able to make the required systems changes to our Automated Client Eligibility System (ACES) until December 2013, the end of this current waiver.

IV. PROGRAM INTEGRITY

A. Please describe the State's overall program integrity plan including system edits and checks that the State uses to ensure the integrity of eligibility determination.

Program integrity is very important to the Agency. The Agency uses multiple resources for quality assurance and program monitoring beginning with eligibility and ending with post payment review.

1. **Eligibility Determination:** Eligibility for TAKE CHARGE clients is determined by eligibility workers whose sole responsibility is processing TAKE CHARGE applications. The program has had a Medical Eligibility Quality Control (MEQC) review during the first five years of the Waiver and during the first renewal period.
2. **ProviderOne System Audits and Edits:** There are multiple audits and edits built into the new ProviderOne system to assure that only services related to Family Planning are paid. The following are examples of system edits and audits:
 - Any claim that does not have a family planning diagnosis is denied.
 - There are system edits that put limits on the number of services and supplies provided in a specific time frame.
 - The system will deny any claim that is not delivered in an outpatient setting.
 - The system also only allows payments for TAKE CHARGE services provided for enrolled clients by designated TAKE CHARGE providers. The three exceptions are pharmacies, laboratories, and sterilization providers. These three providers can serve TAKE CHARGE clients using their regular Medicaid billing number.
3. **Surveillance and Utilization Reviews (SURS) and Audits:** Our program has a close and collaborative relationship with the SURS and Audit sections within HCA. We have used algorithms to look for anomalous billing patterns and irregularities. With this method of monitoring and analysis we have

recouped overpayments. These findings have generated new edits and audits to both the earlier MMIS and current ProviderOne.

We have provided technical and clinical assistance during two full medical audits.

We also work to ensure that the integrity of the program is assured by following up on client allegations that they were eligible but denied services. The most frequent valid complaint is clients being denied over-the-counter family planning drugs and supplies when our rules clearly allow it.

We believe that all eligible clients should be enrolled in the program and that only eligible clients are to be enrolled. We also believe that the clients should receive every medically necessary service allowed them within program rules and which they are entitled to receive. This program management philosophy is reiterated in our Administrative Codes, our Billing Instructions, our provider training, our provider correspondence, our eligibility process, and our payment system.

B. Please assure (with a check mark) that the State assures that all claims made for Federal Financial Participation (FFP) under this demonstration, if approved by CMS, will meet all Medicaid financial requirements.

C. Please describe the process the State will use to monitor and ensure that eligibility determinations are conducted according to State and Federal requirements.

- Medicaid Eligibility Quality Check (MEQC)
 Other (Please specify)

1. Medicaid Eligibility Quality Check:

The Agency has had two Medicaid Eligibility Quality Reviews during the ten years of the waiver:

a. MEQC Review October 2002 Project 32

The project goal was to determine:

- 1) Whether TAKE CHARGE providers had filed fictitious eligibility claims;
- 2) Whether clients approved for TAKE CHARGE were eligible for the program;
- 3) Whether providers correctly followed the TAKE CHARGE application process;
- 4) The level of client satisfaction with the TAKE CHARGE program.

MEQC found no evidence of fictitious eligibility claims in the 471 cases they reviewed. Reviewers stated they were not able to confirm eligibility for the majority of the cases because they did not have enough information, including income verification. At the time of the review, income eligibility was based on client declaration under the terms of the waiver. Some issues related to provider training were also identified and training was completed according to the recommendations.

b. MEQC Review May 2007 Project 53

The audit objectives were to determine whether:

- 1) Eligibility was appropriately assigned in accordance with the applicable state and federal statutes and rules; and
- 2) New programming for TAKE CHARGE in ACES, Washington's automated eligibility system, works to auto-determine eligibility correctly.

Although the review was completed, a final report was not forwarded to TAKE CHARGE staff. In general the draft findings supported the accuracy of the new programming in ACES. Of the 294 active cases reviewed for the month of May 2007, 89% were found eligible for the program and 11% were found ineligible for a variety of reasons including excess income, no need for FP services, FP services available through private insurance, no verified immigration/citizen status and other.

2. Payment Error Rate Measurement Program

The Washington State Health Care Authority also participates in the Payment Error Rate Measurement program (PERM). The PERM program is a comprehensive, on-going federal audit. This federal audit includes a sampling and review of eligibility determinations. The Agency's monthly PERM samples are conducted according to the same process as the reviews that occur every three years. While we receive additional federal funds for the once-every-three-years PERM studies, the costs of the monthly studies are born by the Agency. We are not seeking additional funds from CMS for these monthly studies; HCA has decided to keep the monthly process ongoing as a part of an internal eligibility self-review to maintain program integrity as a less costly alternative to full MEQC reviews.

D. How does the State ensure that services billed to the Medicaid family planning demonstration program are also not billed to Title X?

In Washington State, TAKE CHARGE and Title X are organized quite differently. TAKE CHARGE is administered by the Washington State Health Care Authority (HCA) which is the single state agency that administers the Medicaid program in the State. Title X is administered by the Department of

Health (DOH). Title X has a relatively small amount of funding, approximately \$3 million in core federal funding and approximately \$5 million in state funds, 93% of which is administered to providers in prospective, lump sum grants. Title X providers are required to offer a broader range of reproductive health services than is covered under TAKE CHARGE. They are also required to do community education and outreach. Instead of billing on a fee-for-service basis, like TAKE CHARGE, Title X providers account for the use of their grant funds in *Revenue and Expenditure Reports*. Title X clinics are mandated to serve all who seek services from them, regardless of residency, citizenship, or ability to pay. Providers are closely audited on a regular basis to ensure accurate reporting. Billings from the delegate agencies to Title X are for the allowable cost associated with clients who qualify with Title X rules. Time and effort reporting requirements, or some other approved alternate method of determining effort, segregate grant supported clients from vendor program clients and their corresponding costs. As a grant program, allowable cost rules apply.

E. How does the State ensure that enrollees are not dually enrolled in Medicaid or SCHIP and also in the family planning demonstration?

A client is only allowed to be enrolled in one Medicaid program at a time. Before enrollment, the client's name, DOB, SSN, and gender are entered into the HCA Automated Client Eligibility System (ACES) database and screened to confirm that the client is not on SCHIP or another Medicaid program that would cover family planning. System edits prevent dual enrollment.

F. How does the State ensure that the services billed to this family planning program are also not billed under the regular Medicaid State Plan or the SCHIP State Plan?

System edits, as described above, prevent clients from having dual eligibility, and therefore dual payments are prevented.

G. How does the State ensure that the enrollee does not have creditable health insurance?

As stated earlier in the waiver application, the Agency requests that the language that bars clients with creditable insurance from applying for TAKE CHARGE be dropped. The Agency would like to enroll men and women with primary insurance who are otherwise eligible, like any other Medicaid client. The Agency will require providers to bill the client's primary insurance first and the Agency will cover the balance, saving both state and federal dollars. As we are currently doing, there would be an exception for "Good Cause" for minors requesting confidential services and for clients in domestic violence situations who are covered under the perpetrators insurance. The Health Care Authority supports this language in the legislation.

V. SERVICE CODES:

We are pleased to learn that that we will no longer have to provide a list of service codes that needs approval by CMS.

- A. **STD Testing and Treatment:** The Agency is being required by legislation to request coverage for STD testing and diagnosis under the Waiver renewal. While the Agency recognizes the important relationship between family planning and STD treatment and diagnosis there is an enormous unmet need for STD services in Washington State. The Agency is concerned that by opening up this coverage we will become the default STD program in the State. We want to continue to cover Gonorrhea and Chlamydia testing for women between the ages of 13 and 25 at the time of their annual family planning preventative exam. We will also continue to cover STD services that are directly related to the safe and effective use of a clients chosen contraceptive method. An example of this would be GC and CT testing prior to an IUD insertion. The state cannot afford at this time to expand STD testing and treatment any further.
- B. **Request to change federal match:** The Agency is requesting coverage for pelvic ultrasounds when the placement/location of an intrauterine device (IUD) is in question. This procedure will not be used as part of a routine IUD insertion. The CPT codes that we would like to add to the service at a 90/10 match are 76830, 76856 and 76857.

During the first five years of the waiver we covered IUD complications at a 50/50 match. During the renewal period we were told that we could not claim federal match and had to use all state dollars for any complications. IUDs are the most effective contraception available. A Mirena IUD has a higher effectiveness rate than a tubal ligation. We would like to cover IUD complications at a 50/50 rate. The services provided are directly related to the client's contraceptive method.

VI. DELIVERY SYSTEM

- A. **Please describe the general delivery system for the family planning program.**

- Fee for Service**
 Primary Care Case management
 Other

- B. **Please describe the provider network being used under the family planning demonstration. Please also provide the percentage of patients each of these provider types will be serving.**

TAKE CHARGE has 70 providers serving clients at 192 clinic sites. The maps in Attachments F and G display population density and TAKE CHARGE provider

distribution across Washington State. The distribution of TAKE CHARGE clinics reflects population density within the state, with at least one TAKE CHARGE provider in nearly every county and more in populous counties. As expected, fewer clinics are located in the sparsely populated counties of Eastern Washington. In these counties, residents routinely travel to small towns in order to access goods and services such as groceries, banks, local government agencies and medical care.

We continue to receive a small number of requests from providers who would like to enroll as TAKE CHARGE providers. These requests primarily come from existing providers who are opening a new clinic site, or who have taken employment with a non-TAKE CHARGE provider and have generated interest in the program with their new employer.

<input type="checkbox"/>	Managed Care Organizations	Estimated Percentage of Patients: 0%
<input type="checkbox"/>	All Medicaid Providers	Estimated Percentage of Patients: 0%
<input checked="" type="checkbox"/>	Health Department FP Clinics	Estimated Percentage of Patients: 11.8%
<input checked="" type="checkbox"/>	Other Family Planning Clinics	Estimated Percentage of Patients: 83%
<input checked="" type="checkbox"/>	FQHCs/RHCs	Estimated Percentage of Patients: 2.5%
<input checked="" type="checkbox"/>	Private Providers	Estimated Percentage of Patients: 3.2%

Note: All TAKE CHARGE providers are Medicaid providers.

C. Primary Care Referrals: Under the demonstration, the Agency is required to evaluate primary care referrals as described in Section IX: Evaluation

We are reluctant to proceed with repeating the primary care client survey. It is unlikely that useful information would be obtained and in light of Washington's severe budget issues, it would not be a prudent use of scarce resources.

1. **Please assure (with a check mark) that the State will provide primary care referrals.**

Title X clinics serve 95% of TAKE CHARGE clients, and all Title X clinics are mandated under Title X guidelines to coordinate referrals for women and men who require primary health services. In addition, many Community Health Centers and Rural Health Centers in Washington are TAKE CHARGE providers, so referrals and follow-up for primary care services should in many cases occur automatically within the same clinic/provider setting.

For the first waiver renewal period (July 2006 – June 2009), the TAKE CHARGE program added new activities to strengthen the primary care referral process:

- The development of and distribution of a culturally appropriate brochure informing TAKE CHARGE clients of ways to access primary care;

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- The revision of Washington Administrative Code (WAC) and Billing Instructions to **require** that providers refer clients to available and affordable non-family planning primary care services as needed; and
- The addition of a telephone hotline provided through a contract with WithinReach (formerly Healthy Mothers Healthy Babies) as a resource for primary care referrals.

Overall, TAKE CHARGE providers are assisting clients with primary care needs by making referrals and engaging in referral practices that facilitate those referrals. However, community resources available for primary care services at low or no cost to clients are limited and many clients express concern about the lack of affordable health insurance, at times simply going without needed services because of the high cost of medical care.

2. How is information about primary care services given to people enrolled in the demonstration?

- Mailed to enrollees by the State Medicaid Agency
- Distributed at application sites during enrollment
- Given by providers during family planning visits
- Other (Please specify.)

3. Does the State verify that referrals to primary care services are being made? If so, how?

Findings from the primary care evaluation (see Attachment H) show that TAKE CHARGE providers offered primary care services on-site to 41.1% of clients reported on the primary care referral forms and 24% of survey clients with a referral or recommendation. Additionally, TAKE CHARGE providers were the most frequent referral providers for various primary care services including: education/advice/diet for endocrine metabolic problems (100%); evaluation and treatment-Rx for STDs/vaginitis/pelvic inflammatory disease (89.4%); screening, evaluation and management for risk factors and other medical problems (88.2%); and repeat pap smears for abnormality of the cervix/neck (76.5%).

The data also show that 6.1% of the referrals for colposcopy, the most frequent primary care services requested on the referral forms, were made to a family planning clinic, either on-site or to an affiliated clinic.

During the current waiver period, the former Department (now the Health Care Authority) contracted with DSHS Research and Data Analysis (RDA) to conduct evaluation of the primary care referral process. RDA's evaluation was comprehensive: they surveyed providers about their referral processes, they collected data on the specific medical conditions for which referrals were

made, and they surveyed clients about their experience in obtaining needed medical services not covered by TAKE CHARGE.

4. **How does the State notify primary care providers that enrollees in the demonstration will be receiving primary care referrals and may seek their services?**

The Agency has formalized the long standing relationship of referrals in the renewal period of the waiver. The majority of TAKE CHARGE clients are seen in Title X family planning clinics. Title X clinics are required by federal guidelines to coordinate referrals for women and men who need primary health care services.

Many Community Health and Migrant Clinics are already TAKE CHARGE providers and have integrated TAKE CHARGE into their primary care operations. These clinics are the safety net providers in Washington State, offering accessible, affordable primary care services to low income and uninsured residents of Washington.

VII. Program Administration and Coordination

A. What other state agencies or program staff coordinate or collaborate on the family planning demonstration program? Please describe the relationship and function of each office in this demonstration.

- | | |
|---|----------------------------------|
| <input checked="" type="checkbox"/> Primary Care Office | Relationship/Function: see below |
| <input checked="" type="checkbox"/> Maternal and Child Health | Relationship/Function: see below |
| <input checked="" type="checkbox"/> Family Planning | Relationship/Function: see below |
| <input checked="" type="checkbox"/> Public Health | Relationship/Function: see below |
| <input checked="" type="checkbox"/> Other (please specify) | Relationship/Function: see below |

Primary Care Office: The Primary Care Office is operated under the umbrella of the Washington State Department of Health (DOH). Many of the Community Health and Migrant clinics, Rural Health Centers, and FQHCs in the state are TAKE CHARGE providers who also provide primary care services to TAKE CHARGE clients. See the attached (Attachment A-1) letter of support from the Primary Care Association.

Family Planning: In Washington State, the Title X grants are managed by the Access to Care Coordination Section (formerly the Office of Infectious Disease and Reproductive Health) at DOH. There is a long history of collaboration between the DOH and HCA for the provision of accessible, quality family planning services in Washington State. See the letter of support from DOH (Attachment A-2).

Public Health: As stated above, the Primary Care Office, and the Access to Care Coordination Section are both part of the Washington State DOH. Also, half (50%) of Title X clinics are located in local health departments across the state.

Other: Research and Data Analysis (RDA) is a division within Planning, Performance and Accountability (PPA) of the Department of Social and Health Services (DSHS). RDA provides valid, rigorous, and policy-relevant analyses of government-funded social and health services in the State of Washington.

The TAKE CHARGE program is administered by the Washington State Health Care Authority (HCA). HCA has delegated the responsibility for conducting the evaluation of TAKE CHARGE to RDA through an Interlocal Agreement

B. Please describe how the Medicaid agency coordinates with the Title X family planning program.

HCA and DOH have been partners for decades in the provision of family planning services in Washington State. The TAKE CHARGE Waiver has strengthened that partnership, drawing on the different strengths and the distinct contributions that each agency has to offer. The Title X clinics serve the majority (95%) of the waiver clients, but they are also required to see clients not eligible for the waiver or other Medicaid services (non-citizens, non-residents) and to provide a broader range of reproductive health services.

In Spring 2008, at the request of family planning providers, HCA and DOH convened the Family Planning Leadership Group, with executive representation from all types of family planning providers in Washington State. This quarterly meeting is chaired by Division Directors from both agencies who report directly to the Secretary of Health and to the Director of HCA. The goal is to more fully and effectively coordinate services, maximize our resources in times of economic crisis and to plan effectively for the future.

C. How will the State provide training/monitoring to providers?

Training: Training is provided to TAKE CHARGE providers via Billing Instructions and Numbered Memos, an On-line Eligibility Manual, face-to-face training, web-based training, and individual provider consultation and problem solving via telephone and email.

Monitoring: See Section IV for monitoring and program integrity activities.

D. How often will provider training/monitoring being offered?

Provider Training: Face-to-face training will be offered as the current budget allows. We will continue to explore new web-based and distance learning

technologies to increase accessibility to training. HCA staff is available to answer questions and provide clarification to providers five days a week.

Monitoring: As noted in Section IV, we have on-going activities and we will respond quickly to any problems brought to our attention by clients, providers or stakeholders as well as those within HCA who have questions or concerns.

E. Will the State provide a written manual for providers on claiming for family planning demonstration services? Claiming guidance to providers should be separate and distinct from claiming guidance provided for family planning services under the Medicaid State Plan.

- Yes
 No

F. How does the State communicate information to providers in the demonstration program?

The Agency communicates with providers through:

1. Face-to-face training
2. Web-based training
3. The Statewide Family Planning Leadership Group
4. Billing Instructions and Numbered Memos
5. Individual provider consultation via telephone and email

VIII. EVALUATION

A. Demonstration Purpose, Aim, and Objectives

1. **Objectives/Hypothesis: Please describe the purpose, aim and objectives of the demonstration, including the overarching strategy, principles, goals, and objectives; the State's hypotheses on outcomes of the demonstration; and key interventions planned.**

Background: Washington State's TAKE CHARGE family planning demonstration, which began in July 2001, expanded Medicaid coverage for family planning services to men and women with family incomes at or below 200% of the federal poverty level (FPL). Since its implementation, TAKE CHARGE has successfully enrolled and served over 460,000 men and women, by providing increased access to family planning services across the state. TAKE CHARGE goals include:

- Improve the health of women, children, and families in Washington State;
- Reduce unintended pregnancies and lengthening the interval between births; and

- Reduce state and federal Medicaid expenditures and the associated costs for unintended births.

TAKE CHARGE represents a change in Medicaid policy in that TAKE CHARGE provides family planning services prior to pregnancy for low-income women not otherwise Medicaid eligible, and includes low-income men in its target population.

In the first five years of the demonstration, the TAKE CHARGE program was shown to have greatly impacted access to and provision of family planning services in Washington State. During the first few months of the program, client enrollment exceeded all expectations and continued to increase steadily until the fourth year of the demonstration. With such a large demand for program services, the HCA has invested in building capacity by streamlining application and billing processes and providing extensive training to providers. The concepts of Education, Counseling, and Risk Reduction (ECRR) are beginning to diffuse throughout the State and establish a new standard of care for family planning practice.

More than 50% of the deliveries in Washington State in 2010 were publicly funded, and women who were Medicaid eligible solely because of pregnancy represented the single largest group of pregnant women with Medicaid-funded deliveries, with nearly 20,000 deliveries (just under half of all Medicaid deliveries). While these women automatically receive family planning coverage at the end of their maternity coverage, many were not eligible for TAKE CHARGE before pregnancy because eligibility for pregnancy-related programs takes into account the unborn child in determining family size, resulting in more generous eligibility for pregnant women than for women enrolling in the family planning waiver. To achieve true parity, so that all women who would be Medicaid-eligible if pregnant would also be eligible for family planning coverage through the waiver, Washington is requesting an increase in eligibility for TAKE CHARGE to 250% of the FPL.

In the future, after the implementation of health care reform, it is equally important that all women who would be Medicaid-eligible if pregnant have access to family planning services. While survey responses from some women indicate that they are acutely aware of their need for health insurance, those who are younger, and healthier, may perceive their out-of-pocket cost for health insurance as exceeding the cost of the family planning services that they are using. In this case, it may be difficult to persuade them to purchase health insurance as even subsidized premiums (with potentially large deductibles or co-pays) may look too costly to this population. Understanding the reasons that account for the lack of health insurance (other than family planning coverage) in these women may help to predict their behavior after health care reform.

We propose a survey of women who have recently enrolled in the TAKE CHARGE family planning waiver to ask them why they do not have other health insurance and to probe their expectations about the affordability of health insurance in the future and the relative importance of costs for premiums, co-pays/deductibles, and prescription drugs.

Objectives for January 2012 through December 2013:

During this renewal period, Washington State seeks to:

- Increase enrollment in the family planning waiver by expanding eligibility to 250% of the FPL;
- Increase the number of births averted due to the waiver since more women will be eligible for family planning services through the waiver; and
- Reduce state and federal Medicaid expenditures and associated costs for unintended births.

In addition, we seek to understand the range of potential responses of this population to health care reform by performing a client survey. This survey would ask recently enrolled clients about the reasons that they lack health insurance other than TAKE CHARGE and how they might respond to opportunities for obtaining health insurance in the future.

Hypothesis: Washington's family planning waiver has been shown to help women avoid unintended pregnancy by enabling them to improve their use of contraception. By expanding the population eligible for the waiver, the magnitude of these impacts should increase.

Key Interventions: During this two-year renewal period, we propose to change the TAKE CHARGE program in the following ways:

- Eligibility will be increased to 250% of the FPL;
- Women and men with primary insurance who are otherwise eligible will be eligible for the waiver;
- Income of minors will not be subject to verification;
- Provision of SSN will be encouraged but not required; and
- U.S. citizenship may be self-declared without additional documentation.

B. Evaluation Design

1. **Coordination:** The HCA has contracted with the DSHS Research and Data Analysis Division to conduct the TAKE CHARGE evaluation. Research and Data Analysis (RDA) is a division within Planning, Performance, and Accountability (PPA) of the Department of Social and Health Services

(DSHS). RDA provides valid, rigorous, and policy-relevant analyses of government-funded social and health services in the State of Washington.

Since RDA staff have performed the TAKE CHARGE evaluations for the first five years of the waiver and the first renewal period, along with other maternity and family-planning-related studies, they are very knowledgeable about Medicaid programs in general and TAKE CHARGE in particular, and are prepared to begin evaluation activities for the coming two-year period promptly, upon approval of the renewal and the evaluation design report.

The draft final report for the three-year renewal will be completed and submitted to CMS no later than June 30, 2014 (180 days after the end of the award period), and the final report will be completed and submitted to CMS within 60 days of receipt of final comments from CMS.

Application Template for Family Planning § 1115 Demonstration

TAKE CHARGE Performance Measures: Target Population, Time Periods, and Data Sources

Performance Measures	Target Population	Time Periods	Data Source(s)
1 Enrollment	Program G (women & men) Program S (women)	Available on a monthly basis approx 1 month after the end of each quarter	Eligibility History
2 Averted Births	All Medicaid women (excluding non-citizens)	Computed for each year of the demonstration; preliminary fertility rates available approx 3 months after the end of the demonstration year	Eligibility History, ProviderOne/MMIS, FSDB/birth certificates
3 S Women enrolled in TAKE CHARGE	S Women who enroll in Program G after their family planning extension ends	Available on a quarterly basis, 16 months after S Women delivered	Eligibility History, FSDB/birth certificates
4 Family Planning Methods	S Women (postpartum and 1 year follow-up)	Postpartum methods available 6 months after delivery; 1 year follow-up data available 18 months after delivery	ProviderOne/MMIS
5 Unintended Pregnancy Rates	S Women and TANF Women	Annual rates available 18-24 months after the end of the CY in which birth occurred	PRAMS, matched to FSDB (to determine Medicaid program at delivery)
6 Subsequent Birth Rates	S Women and TANF Women	Retrospective subsequent birth rates available approx 12-15 months after the end of the CY in which birth occurred	FSDB, with births linked across multiple years
7 Client Surveys	G Women (recently enrolled)	Available approx. 6 months after approval	Primary data collection from a statewide sample

2. Performance Measures/Data Sources:

The performance measures (shown in the accompanying table) were selected based on the measurable outcomes anticipated for the demonstration and CMS's recommended measures. Performance measures based on eligibility data, birth certificates, and the First Steps Database are highly reliable and valid. Claims data is subject to more interpretation as providers submitting claims do not necessarily conform to uniform standards for the finer details describing services provided; in some cases, claims may reflect family planning methods provided, not the method in use by the client as clients may discontinue methods. Claims and eligibility data are available for all Medicaid clients. We propose to use client surveys to learn more about the reasons for these clients' lack of health insurance other than TAKE CHARGE and how they might respond to opportunities for obtaining health insurance in the future.

PRAMS data about pregnancy intention is based on a sample of women who gave birth, approx 1200 Washington women each year. Analysis of PRAMS data will be limited to large groups of Medicaid women, defined by their Medicaid program at delivery (such as Program S or TANF). The PRAMS sample is so small that it is not feasible to analyze data linked to individual clients or small groups of clients.

Data Sources

- **Office of Financial Management (OFM) Medicaid Eligibility History:** Spans of eligibility for specific entitlement programs are recorded with start and end dates for each Medicaid client. Specific Recipient Aid Categories (RACs) identify individual programs.
- **First Steps Database (birth certificates linked to Medicaid clients):** All Washington birth certificates are linked at the individual level to Medicaid claims and eligibility history. FSDB begins with births in July 1988 and currently contains linked birth certificates through 2009 (with preliminary data for 2010). The annual unduplicated count of TAKE CHARGE eligible clients is linked to the FSDB by Personal Identification Code (PIC) or ProviderOne ID.
- **ProviderOne (P1, formerly MMIS):** HCA's claims file contains a record for every claim submitted for reimbursement. For all TAKE CHARGE eligible clients, the FSDB staff obtains a service history for appropriate time periods for each client. ProviderOne services history data are used to describe the types of family planning services provided.
- **Pregnancy Risk Assessment Monitoring System (PRAMS):** PRAMS is an annual, population-based survey sponsored by the CDC and administered in Washington by the Department of Health. PRAMS surveys women 2-4 months after delivery and provides information about pregnancy intention.

Application Template for Family Planning § 1115 Demonstration

- **Client surveys:** Primary data collection from clients will consist of brief surveys. Survey samples will be drawn from recently enrolled TAKE CHARGE (Program G) clients.

3. **Primary Care referrals:** During the first renewal period, the HCA contracted with DSHS Research and Data Analysis (RDA) to conduct an evaluation of the primary care referral process. The results of that study, *TAKE CHARGE Final Evaluation, three-Year Renewal July 2006 – June 2009, Primary Care Referral*, are included with the waiver renewal application. RDA’s evaluation was comprehensive: they surveyed providers about their referral processes; they collected data on the specific medical conditions for which referrals were made; and they surveyed clients about their experience in obtaining needed medical services not covered by TAKE CHARGE.

It is unlikely that additional useful information would be obtained from another evaluation of primary care referrals, and in view of the state’s budget issues, we respectfully request not to repeat the primary care client evaluation during the second renewal period.

IX. BUDGET NEUTRALITY AGREEMENT: The State needs to provide a budget neutrality spreadsheet as provided in Attachment C. The State also needs to describe the assumptions on which the budget neutrality spreadsheet is based. *(For renewal the State also needs to provide the annual budget limits data described in the State’s Special Terms and Conditions for each year of the demonstration.)*

Year	Target Expenditures (per ST&Cs)	Actual Expenditures (2009 Projected)	Percentage Allowance	Variance
2007 (SFY06)	\$265,848,563	\$270,447,402	4%, or \$276,482,506	Year 1: Below Target + 4%
2008 (SFY07)	\$282,917,335	\$282,409,162	2%, or \$559,741,216	Year 1+2: Below Target + 2%
2009 (SFY08)	\$295,909,679	\$305,744,724		
Total	\$844,675,577	\$858,601,288	0%	Years 1-3: Above Target
2010 (SFY09)		\$285,065,267		
2010 (SFY10)		\$288,096,724		

Application Template for Family Planning § 1115 Demonstration

A. State assumptions on which the budget spreadsheet is based.

Please refer to Attachment B: BUDGET NEUTRALITY: Definitions, Assumptions, and Methodology.

B. State Source of Funds: Please also describe the source of funds that will make up the State's share of the demonstration.

The funding source for the State share of TAKE CHARGE costs is legislatively appropriated General Fund-State which is unencumbered cash from non-dedicated state tax revenue sources, on deposit in and under the control of the State Treasurer.

X. WAIVERS AND AUTHORITY REQUESTED

The following waivers are requested pursuant to the authority of Section 1115 of the Social Security Act (Please check all applicable that the state is requesting and attach further information if necessary):

- Amount, Duration and Scope 1902 9(a) (10) (B) and (C)** – The State will offer to the demonstration population a benefit package consisting only of approved family planning services.
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) 1902(a) (43) (A)** – The State will not furnish or arrange EPSDT services to the demonstration population.
- Retroactive Coverage 1902(a) (34)** – Individuals in the family planning demonstration program will not be retroactively eligible. Eligibility will begin the first day of the month that the application was signed
- Eligibility Procedures 1902(a) (17)** –
 - Parental income will not be included when determining a minor's (*individuals under age 18*) eligibility for the family planning demonstration.
 - Income verification will not be required for minors (*individuals under age 18*).
 - Income verification for adult applicants will be limited to currently available data bases and any improved data bases that become available in the future.
 - US citizenship may be attested to with a signature on a Citizenship and Identity Declaration form.
 - Applicants will be strongly encouraged but not required to provide a Social Security Number.
- Prospective Payment for Federally Qualified Health Centers and Rural Health Centers and Rural Health Clinics 1902(a) (15)** – The agency will reimburse these clinics on a fee for service basis for a very limited scope of services that include family planning and family planning related services only.

Application Template for Family Planning § 1115 Demonstration

Methods of Administration: Transportation 1902(a)(4) insofar as it incorporates 42CFR 431.53 – The state will not be required to assure transportation to and from providers for the Demonstration population.

XI. ATTACHMENTS

Place check marks beside the attachments you are including with the application.

- Attachment A-1: Letter of Support from State Primary Care Association
- Attachment A-2: Letter of Support from DOH Title X Program
- Attachment B: Budget Neutrality: Definitions, Assumptions and Methodology
- Attachment C: Budget Neutrality Worksheet
- Attachment D: Implementation Schedule
- Attachment E: Application
- Other Attachments (*Please indicate subject of attachment*)
 - Attachment F: Population Density Map
 - Attachment G: Provider Distribution Map
 - Attachment H: Primary Care Referrals Report
 - Attachment I: Final Evaluation Report

Application Template for Family Planning § 1115 Demonstration

XII. CONTACT INFORMATION

Please provide contact information for the person that CMS should contact for questions related to the family planning demonstration project.

Family Planning Contact:

Name: Maureen C. Considine, ARNP
Title: TAKE CHARGE Family Planning Program Manager
Phone Number: 360-725-1652
Email: Maureen.Considine@hca.wa.gov

Doug Porter, Director
Washington State Health Care Authority



Signature of Authorizing State Official



Date

Take Charge Application for Family Planning Services

Fax Completed Application to 1-866-841-2267

If you already have health insurance that covers family planning services, you are not eligible for Take Charge, **UNLESS you are a** (check if yes):

- Minor child age 18 or younger, covered under your parent's health insurance and you do not want your parents to know you are seeking family planning services.
- Victim of domestic violence and covered under the perpetrator's health insurance.

If you checked one of the boxes above, what is the name of your insurance? Medicare Tricare
 Indian Health Services Long-Term Care Insurance Other health insurance: _____

PROVIDER NAME	PROVIDER TELEPHONE NUMBER
---------------	---------------------------

1. FIRST NAME	MIDDLE INITIAL	LAST NAME
---------------	----------------	-----------

2. ADDRESS WHERE YOU LIVE	STREET	CITY	STATE	ZIP CODE
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3. MAILING ADDRESS (if different from above):	STREET	CITY	STATE	ZIP CODE
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4. TELEPHONE NUMBER(S)	HOME, CELL, PREFERRED NUMBER	WORK/MESSAGE NUMBER	E-MAIL ADDRESS
------------------------	------------------------------	---------------------	----------------

5. Do you have trouble speaking, reading, or writing English? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you need an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No	What language do you speak?
--	--	-----------------------------

General Information

SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH	Do you intend to use a birth control method to prevent unintended pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No
--	---------------	---

SOCIAL SECURITY NUMBER	U.S. CITIZEN OR NATIONAL? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not a U.S. citizen or national, are you in the country legally? (Provide a copy of immigration documents) <input type="checkbox"/> Yes <input type="checkbox"/> No
------------------------	---	---

6. To determine eligibility for this program, we need to know your family size (spouse and/or dependent children living with you). Including yourself, what is your family size?

7. If you are married and living with your spouse, enter spouse's name and Social Security Number (SSN) :
 (First, Middle, Last): _____ SSN _____

Race/Ethnic Background

8. We ask you to voluntarily tell us your race or ethnic background. This information will not be used in considering your eligibility for services.

- Caucasian Black or African American Vietnamese/Laotian/Cambodian Other Asian or Pacific Islander
- Hispanic American Indian or Alaskan Native; tribe name: _____
- Other: _____

Optional Authorized Representative (AREP)
 (An AREP is someone you allow the department to talk with about your benefits, and/or receive Take Charge mail for you). To name an AREP, complete the information below.

NAME / ORGANIZATION	TELEPHONE NUMBER
---------------------	------------------

MAILING ADDRESS	STREET	CITY	STATE	ZIP CODE
-----------------	--------	------	-------	----------

- Send my Take Charge mail to my address. Send my Take Charge mail to this AREP's address.



13781

CLIENT NAME	SOCIAL SECURITY NUMBER
-------------	------------------------

Income

Have you quit or lost a job in the last 90 days? <input type="checkbox"/> Yes <input type="checkbox"/> No Date last worked	Has your spouse quit or lost a job in the last 90 days? <input type="checkbox"/> Yes <input type="checkbox"/> No Date last worked
--	---

Your income from employment / self-employment	Spouse's income from employment / self-employment
--	--

EMPLOYER NAME	TELEPHONE NUMBER	EMPLOYER NAME	TELEPHONE NUMBER
---------------	------------------	---------------	------------------

Gross income before taxes or expenses: \$ _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Every two weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly Hours worked each week: _____	Gross income before taxes or expenses: \$ _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Every two weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly Hours worked each week: _____
---	---

OTHER INCOME	AMOUNT	HOW OFTEN DO YOU GET THIS INCOME?	WHICH FAMILY MEMBER GETS THIS INCOME?
9. Child support or alimony			
10. Social Security payment			
11. Unemployment services			
12. Veterans services/military allotments			
13. Labor and Industries			
14. Investment Income			
15. Other Income (Examples: supported by parents, student loans)			

Expenses

	YES	NO	IF YES, AMOUNT
16. Do you pay for child care or adult dependent care while you work?	<input type="checkbox"/>	<input type="checkbox"/>	_____
17. Do you pay child support for a child who is not living in your home?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Read Carefully Before Signing Below

I understand that:

- HCA may ask me to prove the information I provide. HCA may help me get the proof or contact other agencies or persons for it.
- My information may be reviewed by other state or federal agencies. This information will NOT be shared with U.S. Customs and immigration Services (USCIS).
- By asking for and receiving medical care benefits, I assign to the state of Washington all rights to any medical support, and to any third party payments for medical care.
- I understand this application is for family planning services to prevent pregnancy only. If my family needs other medical services, financial assistance, or food stamps, we must apply through a DSHS Community Services Office.

Declaration and Signature

I have read and understood the information in this application. I declare, under penalty of perjury, the information I have given in this application is true, correct, and complete to the best of my knowledge.

SIGNATURE OF APPLICANT	DATE
------------------------	------



STATE OF WASHINGTON
HEALTH CARE AUTHORITY

626 8th Avenue, SE • P.O. Box 45502 • Olympia, Washington 98504-5502

September 30, 2011

Rebecca Burch Mack, Technical Director
Division of State Demonstrations and Waivers
Centers for Medicare and Medicaid Services
7500 Security Boulevard, MS S2-01-16
Baltimore, MD 21244-1850

Dear Ms. Burch-Mack:

SUBJECT: Resubmission of Family Planning Demonstration Waiver for TAKE CHARGE

Enclosed is Washington State's resubmission of our Family Planning Demonstration Waiver for TAKE CHARGE.

There are some changes to this resubmission from the original submission in December 2008. Legislation directed the Health Care Authority (HCA) to request many of the following changes:

Increase to 250% of the Federal Poverty Level (FPL): State law requires us to request the FPL be raised from 200% to 250% to correspond with income eligibility for publicly funded maternity services. The Health Care Authority supports this language in the legislation.

Insurance Coverage and Waiver Participants: State law requires us to request the language that bars clients with creditable insurance from applying for TAKE CHARGE be dropped. The Health Care Authority would like to enroll men and women with primary insurance, who are otherwise eligible, like any other Medicaid client. We will require providers to bill the client's primary insurance first and the state will cover the balance, saving both state and federal dollars. There would continue be an exception for "Good Cause" for minors requesting confidential services, and for clients in domestic violence situations who are covered under the perpetrator's insurance. The Health Care Authority supports this language in the legislation.

Proof of Citizenship: State law requires that we request a return to the application process of the first five years of the Waiver and allow applicants to declare their citizenship and sign a *Citizenship Documentation and Identity Declaration* that they are United States citizens. The Health Care Authority supports this language in the legislation.

Social Security number: State law requests that the Agency ask CMS waive the requirement for applicants to provide a Social Security number (SSN). We request a return to the eligibility standards of the original waiver when clients were *strongly encouraged* to provide their SSN. In the first five years of the waiver, over 95% of clients supplied their SSN. The remaining applicants

Rebecca Burch Mack

September 30, 2011

Page 2

were primarily young teens with serious concerns about confidentiality. The Health Care Authority supports this change.

Verifying Income of Minors: The Health Care Authority requests CMS waive the Medicaid rule requiring us to verify income of all minors who apply for TAKE CHARGE. That step in processing applications is time and labor intensive. In ten years of administering the Waiver, we found only one teenager who was over-income. As we move the income eligibility to 250% of the FPL, it will be even less probable that we would ever have a minor apply who is over the income limit.

Signature Date of Application: The Health Care Authority requests CMS waive the Medicaid rule requiring us to use the date of submission to our office rather than the date of signature on the application. Most family planning clinics provide some services on the day of application. For clients applying in the last five working days of the month, there is a risk their application will not be submitted in time for eligibility during the month the application was signed, especially at clinics with evening and weekend hours.

STD Testing and Treatment: State law requires us to request coverage for STD testing and diagnosis under the Waiver renewal. While we recognize the important relationship between family planning and STD treatment and diagnosis, there is an enormous unmet need for STD services in Washington State. The Health Care Authority is concerned that by opening up this coverage we will become the default STD program in the State. We want to continue to cover GC and CT testing for women between the ages of 13 and 25 at the time of their annual family planning preventative exam. At this time, the State cannot afford to expand STD testing and treatment any further.

We look forward to our discussion with you as we move forward together to continue the TAKE CHARGE Waiver in Washington State.

Sincerely,

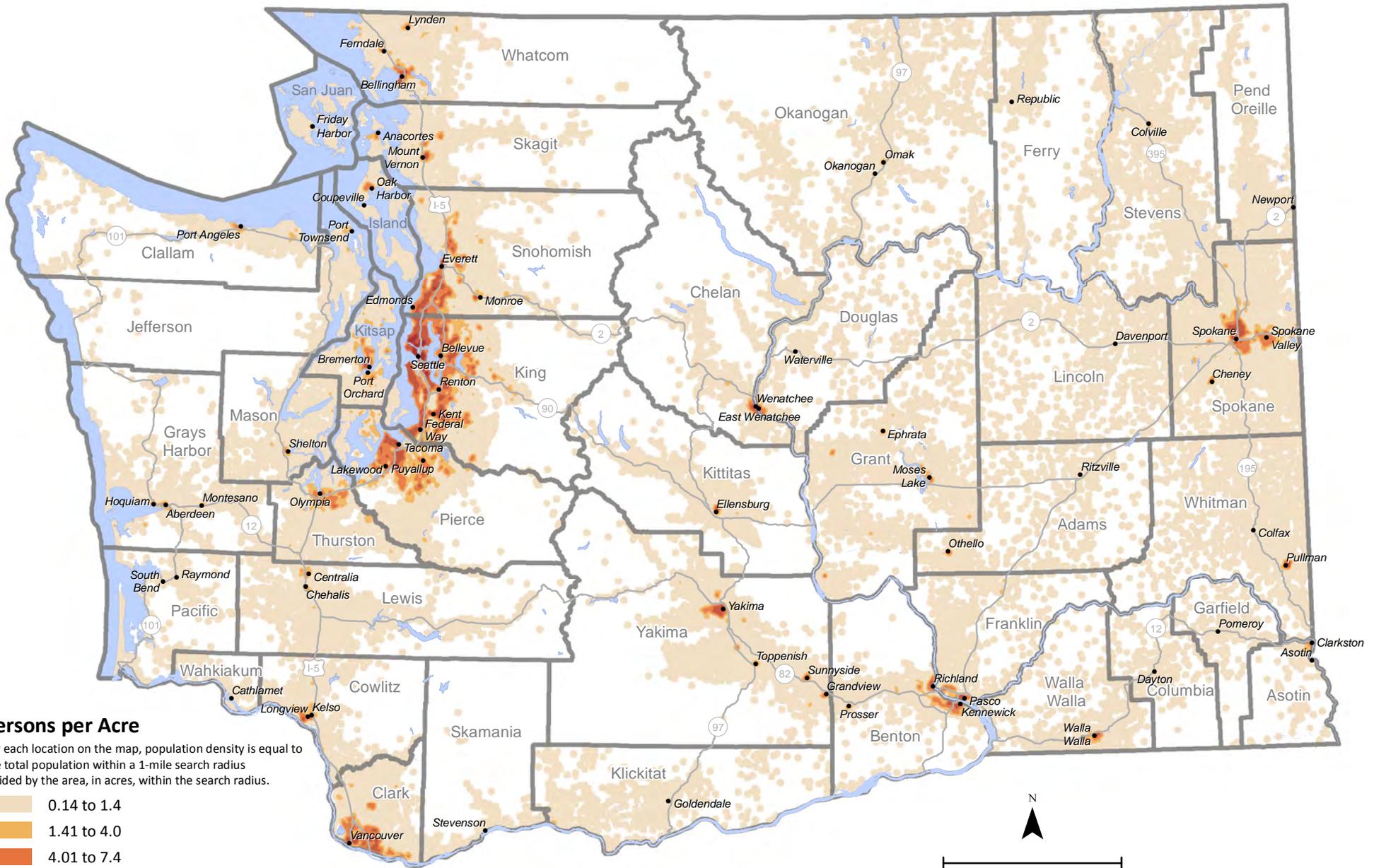


Doug Porter
Director

Enclosure

cc: Preston W. Cody, Assistant Director, Division of Health Care Services, HCA
Todd Slettvet, Section Manager, Office of Community Services, DHS, HCA
Maureen Considine, Program Manager, OCS, DHS, HCA
Janice Adams, Health Insurance Specialist, CMS Region X
Maria Garza, Health Insurance Specialist, CMS Region X
Angela Garner, Technical Director, CMS

2010 Washington State Population Density

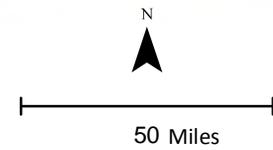


Persons per Acre

For each location on the map, population density is equal to the total population within a 1-mile search radius divided by the area, in acres, within the search radius.

- 0.14 to 1.4
- 1.41 to 4.0
- 4.01 to 7.4
- 7.41 to 14.2
- 14.21 to 36.3

White areas are unpopulated



CERTIFICATION OF ENROLLMENT
SUBSTITUTE SENATE BILL 5912

62nd Legislature
2011 1st Special Session

Passed by the Senate May 17, 2011
YEAS 30 NAYS 17

President of the Senate

Passed by the House May 22, 2011
YEAS 52 NAYS 36

Speaker of the House of Representatives

Approved

Governor of the State of Washington

CERTIFICATE

I, Thomas Hoemann, Secretary of the Senate of the State of Washington, do hereby certify that the attached is **SUBSTITUTE SENATE BILL 5912** as passed by the Senate and the House of Representatives on the dates hereon set forth.

Secretary

FILED

**Secretary of State
State of Washington**

SUBSTITUTE SENATE BILL 5912

Passed Legislature - 2011 1st Special Session

State of Washington 62nd Legislature 2011 1st Special Session

By Senate Ways & Means (originally sponsored by Senators Keiser, Pflug, Kohl-Welles, and Kline)

READ FIRST TIME 05/06/11.

1 AN ACT Relating to the expansion of family planning services to two
2 hundred fifty percent of the federal poverty level; amending RCW
3 74.09.659; adding a new section to chapter 74.09 RCW; and creating a
4 new section.

5 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

6 NEW SECTION. **Sec. 1.** A new section is added to chapter 74.09 RCW
7 to read as follows:

8 The legislature finds that:

9 (1) Over half of all births in Washington state are covered by
10 public programs;

11 (2) Research has demonstrated that children of unintended
12 pregnancies receive less prenatal care and are at higher risk for
13 premature birth, low birth weight, neurological disorders, and poor
14 academic performance;

15 (3) In Washington state, over fifty percent of unintended
16 pregnancies occur in women age twenty-five years and older;

17 (4) Washington state's take charge program has been successful in
18 helping women avoid unintended pregnancies; however, when the caseload

1 declined due to federally mandated changes, the rate of unintended
2 pregnancies increased dramatically;

3 (5) Expanding family planning services to cover women to two
4 hundred fifty percent of the federal poverty level would align that
5 program's eligibility standard with income eligibility for publicly
6 funded maternity care service; and

7 (6) Such an expansion would reduce unintended pregnancies and
8 associated costs to the state.

9 **Sec. 2.** RCW 74.09.659 and 2009 c 545 s 5 are each amended to read
10 as follows:

11 (1) The department shall continue to submit applications for the
12 family planning waiver program.

13 (2) The department shall submit a request to the federal department
14 of health and human services to amend the current family planning
15 waiver program as follows:

16 (a) Provide coverage for sexually transmitted disease testing and
17 treatment;

18 (b) Return to the eligibility standards used in 2005 including, but
19 not limited to, citizenship determination based on declaration or
20 matching with federal social security databases, insurance eligibility
21 standards comparable to 2005, and confidential service availability for
22 minors and survivors of domestic and sexual violence; and

23 (c) (~~Within available funds,~~) By September 30, 2011, submit an
24 application to increase income eligibility to two hundred fifty percent
25 of the federal poverty level, to correspond with income eligibility for
26 publicly funded maternity care services.

27 NEW SECTION. **Sec. 3.** Upon implementation of the expansion
28 directed in RCW 74.09.659, the office of financial management shall
29 reduce general fund--state allotments for the medical assistance
30 program by one million five hundred thousand dollars for fiscal year
31 2012 and by two million three hundred fifty thousand dollars for fiscal
32 year 2013. The amounts reduced from allotments shall be placed in
33 reserve status and remain unexpended.

--- END ---

**BUDGET NEUTRALITY:
Definitions, Assumptions, and Methodology
DEMONSTRATION YEARS 1-10 (SFYS 2002-2011)**

All years use actual data. After March 2010, Washington's claims processing system changed from MMIS to ProviderOne.

All Current Medicaid Eligibles (data not shown):

These are all clients eligible for family planning services with full-scope medical coverage. This population includes men & women, ages 13-55, having Medicaid eligibility during the specified periods (source: OFM Eligibility History File). Records showing alien and family planning services only eligibility are excluded.

All Current Medicaid Participants:

This group is defined as "all women and men who obtain one or more covered medical family planning service(s)." Family planning services were specified by ICD-9 and procedure codes that were sufficient to define them as family planning services

Cost per person:

FP services costs = [actual total TXIX payments (MMIS or ProviderOne) for FP services ÷ total number of eligible clients].

Deliveries under Medicaid State Plan (without waiver):

Number of TXIX deliveries to eligible female clients based on linkage of individual piccodes/ ProviderOne IDs for eligibles in base year & birth certificates contained in First Steps Database.

Base year fertility rate, 128.0 per 1000, computed for all full-scope Medicaid clients in CY 2000 e.g., FertRate = [1000 X 27,074 TXIX deliveries ÷ 211,592 female TXIX clients age 15-44].

Without-waiver deliveries were estimated by adding the "annual estimate of averted births to with-demonstration deliveries" to the actual number of deliveries to eligible clients.

Deliveries under Medicaid State Plan Adjusted for Effects of the Demonstration (with waiver):

Number of TXIX deliveries to eligible female clients based on linkage of individual piccodes/ ProviderOne IDs for eligibles in base year & birth certificates contained in First Steps Database.

Base year fertility rate, 128.0 per 1000, computed for all full-scope Medicaid clients in CY 2000 e.g., Fert Rate = [1000 X 27,074 TXIX deliveries ÷ 211,592 female TXIX clients age 15-44].

The number of deliveries that occurred to demonstration participants in the first nine months of demonstration year one (4,195) was subtracted from the total number of Medicaid deliveries in year one (27,625), resulting in 23,430 deliveries for which the demonstration could have had an effect. Actual data for DY9-10 are preliminary at this time because final birth certificates were not available.

Family Planning Services for Demonstration Participants:

Participants are defined as all women and men who obtain one or more covered medical family planning service(s) through their Medicaid full-scope medical coverage.
(annual unduplicated count)

Historical Births Averted Methodology

Base Year: In 5/2006, at CMS's request, our previous method for computing the base year fertility rate was changed to correspond to the "Medicaid fertility rate."

$$128.0 = 1000 * 27,074 \text{ Medicaid-paid births} \div 211,592 \text{ Medicaid women, age 15-44, all full-scope Medicaid and S Pregnancy Medical women, excluding Non-citizens}$$

The denominator (N=211,592) was determined from client/eligibility history files. Deliveries with Washington birth certificates were individually linked to the clients in the denominator using mother's name, mother's date of birth, baby's date of birth, and address information. Medicaid status of the delivery was determined by reviewing claims data.

Demonstration Years 1-10:

In accordance with Attachment A of the Special Terms and Conditions: The fertility rate, computed for each year of the waiver, equals the actual number of Medicaid-paid live births to demonstration participants (times 1000) divided by the total number of demonstration participants.

Demonstration participants are defined as all women (and men) who obtain one or more covered medical family planning service(s) through the demonstration. Only women (age 15-44 with few exceptions) are included in the denominator. Receipt of a covered medical family planning service is determined by reviewing the claims history for all TAKE CHARGE enrolled female clients; eligible clients without a paid claim for a covered medical family planning service are excluded from the denominator. The female TAKE CHARGE participants are individually matched to birth certificates contained in the First Steps Database (and previously matched to Medicaid claims and eligibility history to determine which deliveries were Medicaid-paid). The total number of actual Medicaid-paid births (times 1000) divided by the number of female participants equals the (unadjusted) fertility rate. An age-adjusted fertility rate is also computed.

**Draft Implementation Plan
TAKE CHARGE Waiver Extension**

DEMONSTRATION YEAR 10: July 1, 2011 – June 30, 2012

September 30, 2011	<i>CMS Deliverable:</i> Waiver Renewal
September 30, 2011	<i>CMS Deliverable:</i> DY 10 Annual Report
September 30, 2011	<i>CMS Deliverable:</i> Annual CMS – 64 Expenditure Report
October 31, 2011	<i>CMS Deliverable:</i> Correction of expenditure reports for DY1-DY5
October 31, 2011	<i>CMS Deliverable:</i> First Quarter Report DY 11
October 31, 2011	<i>CMS Deliverable:</i> CMS - 64 Quarterly Expenditure Report
1	Waiver extension approved by CMS
January 31, 2012	<i>CMS Deliverable:</i> Second Quarter Report
January 31, 2012	<i>CMS Deliverable: Revised and Updated Implementation Plan</i>
January 31, 2012	<i>CMS Deliverable: Final Evaluation Design Report</i>
January 31, 2012	<i>CMS Deliverable: Acceptance letter to CMS</i>
January 31, 2012	<i>CMS Deliverable:</i> CMS - 64 Quarterly Expenditure Report
April 30, 2012	<i>CMS Deliverable:</i> Third Quarter Report
April 30, 2012	<i>CMS Deliverable:</i> CMS – 64 Quarterly Expenditure Report
June 30, 2012	End of the 4 th quarter and end of the 10 th year of the demonstration project

DEMONSTRATION YEAR 11: July 1, 2012 – June 30, 2013

September 30, 2012	CMS Deliverable: DY 11 Annual Report, including average cost of Medicaid-funded birth and number of actual births to TC participants
September 30, 2012	CMS Deliverable: CMS – 64 Annual Expenditure Report
October 31, 2012	CMS Deliverable: CMS - 64 Quarterly Expenditure Report
October 31, 2012	CMS Deliverable: DY 12 First Quarter Report
January 31, 2013	CMS Deliverable: CMS – 64 Quarterly Expenditure Report
January 31, 2013	CMS Deliverable: DY 12 Second Quarter report

TAKE CHARGE Final Evaluation
Three-Year Renewal: July 2006 – June 2009
A Study of Recently Pregnant Medicaid Women

Laurie Cawthon, M.D., M.P.H.
Kristal Rust, B.S.
Brett W. Efaw, B.S.

September 2009

Department of Social and Health Services
Planning, Performance, and Accountability
Research and Data Analysis Division
Olympia, WA 98504-5204

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

Susan N. Dreyfus, Secretary

PLANNING, PERFORMANCE, AND ACCOUNTABILITY

Jody Becker-Green, Ph.D., Senior Director

RESEARCH AND DATA ANALYSIS DIVISION

Elizabeth Kohlenberg, Ph.D., Director

In Collaboration with

HEALTH AND RECOVERY SERVICES ADMINISTRATION

Doug Porter, Assistant Secretary

DIVISION OF HEALTHCARE SERVICES

MaryAnne Lindeblad, B.S.N., M.P.H., Director

OFFICE OF COMMUNITY SERVICES

Todd Slettvet, M.A., Section Manager, Family Healthcare Services

Maureen Considine, A.R.N.P., TAKE CHARGE Program Manager

When ordering, please refer to
REPORT 9.92

ACKNOWLEDGMENTS

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EXECUTIVE SUMMARY

Washington State's TAKE CHARGE program, which began July 2001, expands Medicaid coverage for family planning services to men and women with family incomes at or below 200% of the federal poverty level (FPL). Program goals are to improve the health of women, children, and families in Washington by decreasing unintended pregnancies and lengthening intervals between births, and to reduce state and federal Medicaid expenditures for births from unintended pregnancies. The Department of Social and Health Services (DSHS) Health and Recovery Services Administration (HRSA) administers this program.

This report for the three-year renewal period July 1, 2006, to June 30, 2009, presents findings of a survey of 1292 women with Medicaid coverage for maternity care who gave birth in 2005. The survey explored reasons for the low family planning service use rate of recently pregnant Medicaid women and the low re-enrollment rate at the end of their automatic extension for family planning services.

The TAKE CHARGE family planning demonstration includes two groups of clients:

- Men and women with family incomes at or below 200% of the FPL, seeking to prevent unintended pregnancy (Program G); and
- Recently pregnant women who would otherwise lose Medicaid coverage after their maternity coverage ends (Program S).

Recently pregnant women who were Medicaid eligible solely because of pregnancy (S women) comprised 44.4% of total Medicaid deliveries (N=41,392) in Washington in 2007. While the proportion of births from unintended pregnancies among S women decreased from 56.3% in 2000 – 02 to 47.9% in 2003 – 05, the proportion of births from unintended pregnancies increased to 53.6% in 2006 – 07.

Compared to other Medicaid women who gave birth, S Women are higher income (with family incomes at or below 185% of the FPL) and relatively low risk for poor birth outcomes, with the highest educational attainment, and intermediate standings in smoking rates, marital status, and average age. Compared to other women enrolled in the TAKE CHARGE program, S Women had higher parity and average age, and higher rates of being married.

Key Findings

Employment History and Health Insurance Coverage. At the time of the survey, two years after the target pregnancy, the proportion of women working full-time had decreased from 41.2% to 28.9%. The proportion working part-time was essentially unchanged, and the proportion whose primary occupation was homemaker increased from 23.1% before pregnancy to 33.3% two years later.

The proportion of women without health insurance decreased from 54.1% before pregnancy to 34.0% two years later. The proportion with employer-based, military, or state-sponsored coverage increased from 33.5% to 43.6%, and Medicaid coverage increased from 12.4% to 28.4%.

For the two-year-old children, 66.7% were covered by Medicaid, 36.6% by private, state, or military health plans, and 7% were uninsured.

Knowledge of and Attitudes about Family Planning Services. The majority of survey respondents were either very aware (50.4%) or somewhat aware (25.5%) that their family planning services would be covered by Medicaid for one year after the birth of their child. Fewer women recognized the program by name. Almost half (47.1%) reported that they had not heard of the TAKE CHARGE program

Overall, 81% of women either strongly agreed or agreed that it is best to plan ahead for a pregnancy by using birth control. A very small proportion said they disagreed (1.8%) or strongly disagreed (2.0%) with the statement.

Family Planning Behavior and Pregnancy Intention. During the three months before the target pregnancy, 24.8% of women were trying to get pregnant while 16.2% were trying hard to keep from getting pregnant. Nearly 60% recalled ambivalence about pregnancy: 31% said they were not trying to get pregnant or keep from getting pregnant, and 28% were trying to keep from getting pregnant but not trying very hard.

At the time the survey respondents became pregnant with the target birth, 56.9% reported that they were not doing anything to keep from getting pregnant. The most frequently cited reasons were “I wanted to get pregnant” (42.8%) and “I didn’t mind if I got pregnant” (41.8%). Only 6.6% of the respondents reported that they were not using birth control at the time because they had problems getting it when they needed it.

S women and G women differed significantly in their future pregnancy intention. While 95.4% of G women surveyed during the first five years of the demonstration did not want or *really* did not want to get pregnant in the next twelve months, just 75.6% of S women expressed the same attitudes. More than one in ten (10.8%) S women wanted to get pregnant in the next twelve months. The proportion of married S women who wanted to get pregnant (13.3%) was more than four times greater than that for single S women (3.0%).

Effectiveness of the family planning method used at the time of the survey generally corresponded to stated pregnancy intention. The most frequent users of highly effective methods were women who did not want to get pregnant in the next twelve months (64.9%), and those who *really* did not want to get pregnant in the next twelve months (66.1%). Women who wanted to get pregnant frequently used no method (41.7%) and were infrequently abstinent (0.7%), yet 57.6% reported using some family planning method during the two months prior to the survey.

Within one year after delivery, more than half (54.4%) the survey respondents received a Medicaid-paid family planning service. Compared to women who did not receive a Medicaid family planning service, those with a family planning service were younger, had fewer years of education, had fewer prior live births, and were more frequently employed full-time. While 57.4% of single women received a family planning service, the proportion was lower among married women (52%). Among married women, receipt of family planning services decreased with increasing age while age and receipt of family planning service were unrelated among

single women. More than one-third (34.6%) of respondents who did not go to a health care provider for birth control after delivery were sterile or their partner was sterile.

After controlling for education and marital status, independent variables associated with family planning service use included: age, employment status prior to and following the target pregnancy, whether the woman was doing anything to keep from getting pregnant, not having been sterilized or having a partner who had not been sterilized, and having heard of TAKE CHARGE. Use of a TAKE CHARGE family planning service was 2.5 times higher among women who agreed that it is best to plan for pregnancy by using birth control compared to those who disagreed with that statement.

Nearly half (47.2%) the women who had no record of receiving a Medicaid-paid family planning service reported using a highly effective birth control method two years after delivery.

Subsequent Pregnancy and Birth. Within 33 months of the target pregnancy, nearly one-quarter (23.6%) of the respondents had a subsequent birth or said they were currently pregnant. Of those who reported being pregnant at the time of the survey, just over half (52.9%) were trying to get pregnant, and 47.1% said they were not trying to get pregnant.

Women who reported using highly effective methods (53.1% overall) had the lowest rate of subsequent birth or pregnancy (13.9%), and women who reported using no method (16.1%) had the highest rate of subsequent birth or pregnancy (51.2%).

In a multivariate model, the strongest risk factors for a subsequent birth or pregnancy were use of no family planning method (OR = 6.1 when compared to use of a highly effective method), excellent health status (OR = 5.0 when compared to fair or poor health status), and being a stay-at-home mom (OR = 3.2 when compared to full-time employment). Older age (mothers 30 – 34 years old at delivery) reduced the risk of a subsequent birth or pregnancy.

CONCLUSION. Survey findings highlight characteristics of potential target groups for greater use of highly effective family planning methods: single women; younger women (single or married); women who agree that it is best to plan ahead for pregnancy by using birth control methods; and women whose hopes and dreams do not include having more children.

During the time of highest enrollment in TAKE CHARGE, unintended pregnancy rates among S women declined. However, as TAKE CHARGE enrollment decreased from July 2006 through June 2009, the unintended pregnancy rates increased, to levels just below those before TAKE CHARGE. Deliveries to S women increased slightly each year from 2001 to 2005 and then began a period of more rapid increase. S women remain the single largest group of pregnant women on Medicaid, exceeding both women on TANF and Non-citizens.

Understanding the reasons for the decline in TAKE CHARGE enrollment from July 2006 through June 2009 and addressing these reasons with appropriate interventions are critical for regaining the progress that had been achieved in reducing unintended pregnancy among Medicaid women in Washington. With well-established, enhanced prenatal care services and a CSO-based family planning program, Washington is well positioned to develop targeted interventions to reach more recently pregnant women through our family planning waiver.

INTRODUCTION

Washington State's TAKE CHARGE family planning demonstration, which began in July 2001, expands Medicaid coverage for family planning services to women and men with family incomes at or below 200% of the federal poverty level (FPL). Program goals are to improve the health of women, children, and families in Washington State by reducing unintended pregnancies, lengthening the interval between births, and to decrease state and federal Medicaid expenditures for unintended births and their associated costs. TAKE CHARGE represents a change in Medicaid policy in that TAKE CHARGE provides family planning services prior to pregnancy for low-income women not otherwise Medicaid eligible and includes low-income men in its target population. The Health and Recovery Services Administration (HRSA) of the Department of Social and Health Services (DSHS) administers the program. HRSA has contracted with the DSHS Research and Data Analysis Division to conduct the evaluation.

In the first five years of the demonstration, the TAKE CHARGE program exhibited a remarkable impact on access to and provision of family planning services in Washington State. During the first few months of the program, client enrollment exceeded all expectations and continued to increase steadily until the fourth year of the demonstration. With such a large demand for program services, HRSA has invested in increasing capacity by streamlining application and billing processes and providing extensive trainings. Individual provider agencies have correspondingly increased staffing and expanded physical workspace. Furthermore, the concepts of Education, Counseling, and Risk Reduction (ECRR) are beginning to diffuse throughout the state and establish a new standard of care for family planning practice.

During its first five years, the TAKE CHARGE program increased access to family planning services and reduced unintended pregnancies among women eligible under the waiver. In particular, the program was successful in reaching younger, unmarried clients (Program G clients) who sought enrollment on their own initiative. Nearly ninety-five percent (94.9%) of these women received family planning services. However, women in the post-pregnancy extension (Program S clients), somewhat older and more likely to be married, received family planning services at a much lower rate (47.9%). (Data are based on enrollment and services during the first four years of the demonstration.) Even fewer of these women elected to re-enroll into the program after their automatic extension was complete. For the program to be more successful in achieving its goals to reduce unintended pregnancies and to lengthen the interval between births, it is important that the program effectively reach this segment of the population.

This report presents the findings of a survey of recently pregnant women (Program S clients). The survey was designed to identify the reasons for their low family planning service use rate and low re-enrollment rate in the TAKE CHARGE program after their automatic family planning extension ends.

BACKGROUND

In Washington State, in 2003 – 06, approximately 49.6 % of Medicaid deliveries represented births that were unintended at the time of conception. While unintended pregnancies are experienced by childbearing women of all ages, the majority occur to women in their twenties. For women age twenty to twenty-four, approximately 62.5% of all pregnancies are unintended.

In 2007, 47% of all deliveries to Washington State residents were funded by Medicaid. At more than \$300 million per year, maternity care is one of HRSA's largest expenses. The State Legislature and program staff recognized years ago that limiting the growth in Medicaid deliveries required interventions at multiple levels:

- Increasing access to family planning services;
- Educating communities about the benefits of avoiding unintended pregnancies; and
- Changing individual and provider behavior.

A number of programs have been initiated in Washington State over the past fifteen years to accomplish this. Each program has focused on a different population, and in combination, they have targeted as broad a population as possible.

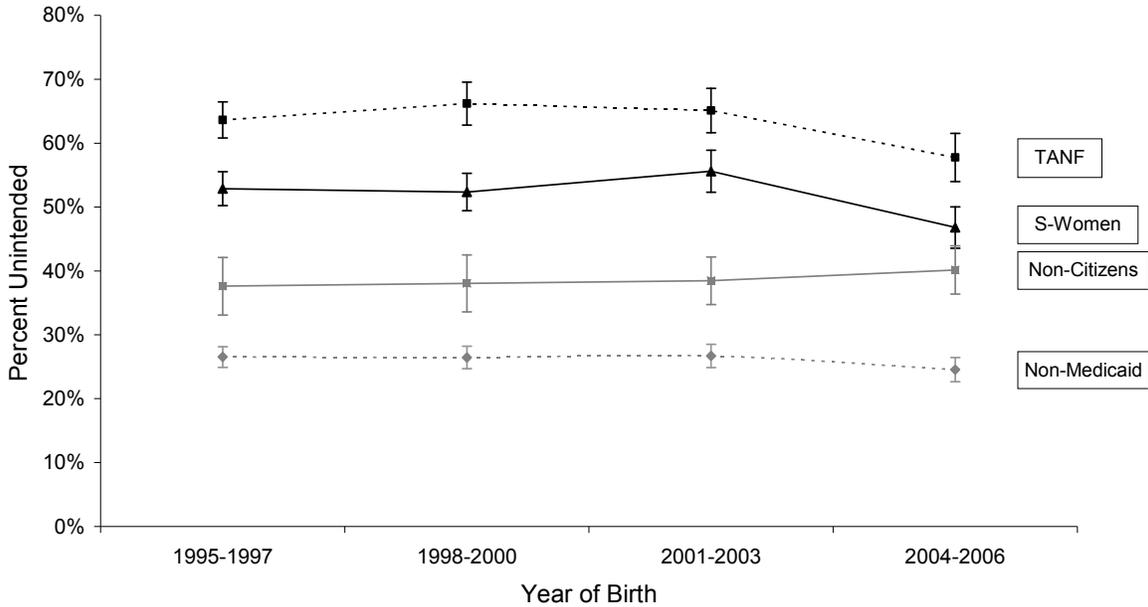
- TANF clients and potential clients receive family planning assistance and information in Community Services Offices (CSOs) across the state. In accordance with RCW 74.12.400 and 410, HRSA and the Economic Services Administration (ESA) have stationed family planning workers and nurses in most CSOs and began in the mid-1990s to co-locate clinical exam facilities in some CSOs (Campbell et al., 1999).
- Women who are Medicaid eligible solely because of pregnancy receive extended Medicaid coverage for family planning services for one full year postpartum. For these women, full-scope Medicaid coverage ends after the second postpartum month.
- All Medicaid eligible pregnant women and new mothers receive counseling about achieving their desired family size and assistance with family planning services. Since July 2000, Maternity Support Services providers have been responsible for discussing pregnancy planning with each client and documenting the initiation of a birth control method during the postpartum period. Providers continue to be responsible for completing the Family Planning Interview Guide for each client.¹

Despite all these interventions, unintended pregnancy rates in Washington State remained unchanged until 2003. For women who gave birth in 2004 – 06, the Washington State Department of Health Pregnancy Risk Assessment and Monitoring Survey (PRAMS) showed that the proportions of births from unintended pregnancy decreased significantly for Medicaid

¹ Provider forms to document required Maternity Support Services are available at <http://fortress.wa.gov/dshs/maa/firststeps/Provider%20Page/First%20Steps%20Documentation/Documentation.index.htm> (accessed February 14, 2007). Reimbursement for the Family Planning Performance Measure ended in 2009.

women on TANF and the Pregnancy Medical (S) Program (citizens) yet remained unchanged for Non-Citizens and Non-Medicaid women.

Figure 1. Washington Births from Unintended Pregnancies by Medicaid Status 1995 – 2006



S Women, eligible for Medicaid solely because of pregnancy, comprised 44.4% of total Medicaid-paid deliveries in 2007. Women on TANF and Non-Citizens accounted for the majority of the remaining deliveries, with 28.4% and 22.3%, respectively. Of the 18,367 Medicaid-funded deliveries to S Women in 2007, an estimated 59% were unintended at conception. Although the proportion of births representing unintended pregnancies among S Women is slightly lower than that for TANF women—for whom 61% of births were unintended at conception—the rate for higher-income (i.e., Non-Medicaid) women is much lower, with only 22% of births to Non-Medicaid women unintended at the time of conception.

Although the decrease in the proportion of births from unintended pregnancies is encouraging, and the timing and pattern of change point to a positive impact of the TAKE CHARGE program, the rates for regular Medicaid women (TANF and S Women citizens) remain considerably higher than those for Non-Citizens and Non-Medicaid women. S Women (citizens), who are eligible for ten months of family planning coverage after their full-scope medical coverage ends, have been modest users of family planning services through TAKE CHARGE. How TAKE CHARGE can be more effective in reaching this group is the focus of this study.

LITERATURE REVIEW

Previous research has underscored the continued need for postpartum contraception use in general, and among women eligible for Medicaid in particular. For example, based on nearly 300 prenatal interviews with Medicaid eligible women in Detroit, Miller and colleagues (2000)

reported that only 8% intended *not* to use contraception following delivery, although postpartum interviews with the same women revealed that fully 18% were not using contraception.

DePiñeres, Blumenthal, and Diener-West (2005) estimated that, in New Mexico, approximately 78% of women surveyed used postpartum contraception, compared with 64% contraceptive use among women aged 15 – 44 in the United States overall. Nevertheless, they also found racial and ethnic disparities in contraceptive use, noting that American Indians were significantly less likely than Hispanics and non-Hispanic whites to report using a method of contraception two to six months following childbirth. Their study did not address variation in the use of contraception with respect to income.

A number of factors—medical, social, and financial—contribute to the need for postpartum contraception. Short-interval pregnancies are associated with a variety of adverse medical and social outcomes for both mothers and their babies (Jacoby et al., 1999; King, 2003; Johnson and Johnson, 1980; Zhu et al., 1999). Encouraging women to use family planning services after childbirth can alleviate these problems by reducing the number of unplanned or mistimed pregnancies.

Lack of health insurance is also a growing problem in the United States. Nearly 60% of non-elderly adults with family incomes below 200% of the FPL—the eligibility threshold for TAKE CHARGE—are uninsured (SHADAC and The Urban Institute, 2006).

Lindrooth and McCullough (2007) suggested that among family planning demonstration programs implemented before 2000, both income-based expansions (n=8) and postpartum expansions (n=5) either yield financial benefits to states or, at the very least, are cost neutral. They concluded that the effect of income-based expansions is much larger than postpartum expansions, and that this is likely due to the fact that income-based expansions expand eligibility to all women, rather than only to those who are postpartum.

Bronstein et al. (2007) suggested that the broader mix of providers available under their Medicaid demonstration program in Alabama attracted a segment of service users who had not used care under the Title X clinic system. They acknowledged, however, that the demonstration program served a clientele that was more closely matched to the Title X program than the Medicaid maternity population.

STUDY GOALS

Our objective was to identify the reasons for the low family planning service use rate of recently pregnant Medicaid women and the low re-enrollment rate at the end of their automatic extension. We hypothesized that:

Hypothesis 1: Ambivalence about becoming pregnant again was common among recently pregnant women, and this ambivalence contributed to their relatively low use of family planning methods in the postpartum year.

Hypothesis 2: Women who did and did not use family planning services in the postpartum year differed in personal characteristics, attitudes, or beliefs.

PROGRAM ENROLLMENT

Table 1 shows the total number of new TAKE CHARGE clients (Program G) and clients who are automatically transferred to TAKE CHARGE for post-pregnancy family planning services (Program S). Between July 2001 and the end of the first year, total enrollment was 98,973 unduplicated clients. By the end of the eighth year, TAKE CHARGE had enrolled 425,100 clients. During this same period, 38% of clients were eligible for Program S at least once.

Table 1. TAKE CHARGE July 1, 2001 – June 30, 2009

Demonstration Year	Program G TAKE CHARGE ¹	Program S Pregnancy Extension ²	Total Unduplicated Clients
Year 1	62,657	38,066	98,973
Year 2	107,096	40,613	145,166
Year 3	125,972	41,134	164,327
Year 4	138,625	41,213	177,260
Year 5	134,660	40,901	173,057
Year 6	115,743	40,657	154,159
Year 7	85,617	39,606	123,526
Year 8	69,759	39,206	107,569
Total to Date	311,296	164,234	425,100

¹Includes some clients who transitioned to or from Program S.

²Includes some women who transitioned to or from Program G.

COVERED SERVICES

TAKE CHARGE covers most FDA-approved birth control methods and a range of family planning-related services that help clients to prevent unwanted and mistimed pregnancies. The types of birth control methods covered include abstinence counseling; birth control pills; male and female condoms; diaphragm and cervical cap; Implanon™; emergency contraception; spermicidal foam, jelly and cream; IUD; natural family planning; contraceptive injections; contraceptive ring and patch; and male and female sterilization. Most clinics refer male and female sterilization procedures, and it is not uncommon for smaller clinics to refer IUD insertions to other providers. Most clinics dispense birth control methods on site; in other cases, clients can have their prescriptions filled at a local pharmacy.

Family planning-related services generally include gynecological exams (when medically necessary) and Education, Counseling, and Risk Reduction (ECRR) for men every twelve months. Testing for and treatment of sexually-transmitted infections (STIs) are covered by TAKE CHARGE only when medically necessary for the client to use her chosen contraceptive method.

METHODS

Responses from a survey of recently pregnant women with Medicaid-paid maternity care were used to describe Program S clients automatically enrolled in the TAKE CHARGE program post-pregnancy. Surveys were individually linked to birth certificates, Medicaid claims and eligibility history.

DATA SOURCES

Office of Financial Management (OFM) Medicaid Eligibility History. Spans of eligibility for specific entitlement programs are recorded with start and end dates for each Medicaid client. Specific combinations of program and match codes identify individual programs.

First Steps Database (FSDB). All Washington birth certificates are linked at the individual level to Medicaid claims and eligibility history. FSDB begins with births in July 1988 and currently contains linked birth certificates through 2007. The annual unduplicated count of TAKE CHARGE eligible clients is linked to the FSDB by Personal Identification Code (PIC).

Medicaid Management Information System (MMIS). HRSA's claims file contains a record for every claim submitted for reimbursement. For all TAKE CHARGE eligible clients, the FSDB staff submits the annual unduplicated PICs to HRSA to obtain a service history for appropriate time periods for each client. MMIS services history data are used to describe the types of family planning services provided.

SURVEY SAMPLE SELECTION

The survey sample was selected from 2682 Washington women, age 18 – 44, who gave birth to a live born infant between March 1, 2005, and April 30, 2005, and were enrolled in the Medicaid Pregnancy Medical Program (S). The FSDB was used to determine Medicaid status. The birth months of March and April were chosen so survey mailings and respondent contacts coincided with the second birthday of the target child.

The sample was further limited by excluding women with a primary language other than English or Spanish. Women in the Washington State Department of Health Pregnancy Risk Assessment and Monitoring Survey (PRAMS) were also excluded to minimize the burden on respondents. Finally, the sample was linked to the death records from the Washington State Department of Health to exclude women from the sample who were deceased or whose infant born in March or April was deceased. The final survey sample consisted of 2504 women.

SURVEY ADMINISTRATION

The Washington State Institutional Review Board (WSIRB) approved the study on November 3, 2006. The Washington State University Institutional Review Board (WSUIRB) granted approval for the survey contractor to implement the survey. WSUIRB has a reciprocal protocol review agreement with the WSIRB.

The questionnaire was developed from existing surveys with the addition of some novel questions. Questions addressed client family planning behavior, attitudes, and knowledge. All Spanish translations of survey materials were reviewed by a DSHS-certified translator.

Research and Data Analysis (RDA) contracted with the Social & Economic Sciences Research Center (SESRC) at Washington State University in Pullman, Washington, to administer the survey. A mixed-

mode method consisting of web, mail, and phone versions of the survey maximized response rates. The SESRC's report (2007) describes survey administration in detail.

The questionnaire and contact letters were pretested with a sample of 400 Washington women, age 18 – 44, with Medicaid-paid births in November or December 2004. The questionnaire and contact letters were modified based on feedback from a focus group conducted with the phone interviewers. The final mail questionnaire is provided in Appendix A.

Full-scale data collection began February 22, 2007, and ended June 15, 2007. Initial contact was a prior notification letter introducing the survey and informing respondents they would receive a questionnaire in the mail the following week. The prior notification letter contained a website address and personal access code allowing respondents to complete the survey online if desired. A survey packet containing a questionnaire, cover letter, stamped return envelope, and five-dollar bill was mailed one week after the prior notification letter. A postcard reminder was sent one week following the questionnaire, thanking respondents for completing the survey and inviting those who had not done so to complete and return the survey as soon as possible. All non-respondents were sent a replacement questionnaire during week five. RDA attempted to find updated contact information (phone) for returned mailings. Phone contact with non-respondents, including those with updated contact information, began in week seven. During the telephone contact, respondents were given the option of completing the questionnaire by phone, on the web site, or returning the paper questionnaire.

Prior to analyses, RDA removed any duplicate surveys and applied skip patterns. To ensure all responses were included in the analysis, text answers written in response to numeric questions were recoded. Open-ended “Other” responses were reviewed and recoded if the response matched one of the choices already provided. Subcategories were created for similar open-ended “Other” responses that did not match choices already provided.

The crude survey response rate was 52.9%. We were unable to locate nearly one-quarter (22.2%) of the survey sample. This is not surprising since contact information for the survey sample was up to two years old. Of the 1570 contacted women eligible for the study, 82.3% completed the survey. The majority of respondents answered the mail version of the survey (73.3%). An additional 19.6% of respondents completed the survey over the telephone with an interviewer, and 7.1% completed the online version of the survey.

Table 2. Survey Sample Contacts and Response Rates

Disposition	Number of S Women	Percent of Total
Total Survey Sample	2504	100.0%
Ineligible	40	1.6%
Unable-to-Locate	555	22.2%
No Response	339	13.5%
Successfully Contacted Eligibles	1570	62.7%
Refused	278	17.7%
Completed Surveys	1292	82.3%
Mail	947	73.3%
Phone	253	19.6%
Web	92	7.1%
Response Rate		
Response Rate ¹	1292/2442	52.9%
Response Rate of Contacted Eligibles ²	1292/1570	82.3%

¹Response Rate Eligible S-Women = completed/sample size adjusted for ineligible

²Response Rate of Contacted Eligibles = $\frac{\text{completed mail} + \text{completed web} + \text{completed phone}}{\text{contacted eligibles}}$

DATA ANALYSIS

Information about TAKE CHARGE enrollment and client services was based on the entire population of TAKE CHARGE enrollees. Age and gender were the only demographic characteristics available for all TAKE CHARGE clients; these data were supplemented with information from birth certificates for the subset of female clients who had a birth certificate available for analysis. Data regarding client contraceptive use, client knowledge of Medicaid coverage for contraception, future pregnancy intention, and family planning behavior and attitudes were based on survey responses.

Study Groups

Survey Sample (n=2504). Washington women identified as enrolled in Medicaid pregnancy program S at the time of delivery in March – April 2005. Medicaid coverage for prenatal care or delivery was identified by linking Medicaid claims data to birth certificates. Women were limited to primary language equal to English or Spanish, age 18 – 44, with no identifiable fetal or infant deaths, maternal deaths, or PRAMS participation.

Survey Respondents (n=1292). Women in the survey sample who completed a mail, phone, or web version of the questionnaire.

Survey Respondents with a TAKE CHARGE Family Planning Service (n=691). Survey respondents who had at least one Medicaid-paid billing claim for a family planning service covered under TAKE CHARGE.

Survey Respondents using a highly effective family planning method (n=686). Responses to the survey question, “During the last 2 months, what kinds of birth control did you use when you had sex?” were categorized by method effectiveness. Women who reported using a highly effective method in combination with a less effective method were included in the highly effective method category. Highly effective methods included birth control pills, hormonal injection (Depo Provera®), intrauterine device, Implanon®, transdermal patch (Ortho Evra®), vaginal ring (Nuva Ring®), and female and male sterilization. Less effective methods included condoms, diaphragm, cervical cap, emergency contraceptive pills, spermicidal foam, jelly, and cream, withdrawal, rhythm, and natural family planning.

Survey Respondents with a Subsequent Birth or Pregnancy (n=301). Survey respondents who had a subsequent record of live birth in FSDB (n=163) or reported on the survey having a pregnancy since target birth in April – March 2005 (n=138).

Survey Respondents who re-enrolled in TAKE CHARGE (n=116). Survey respondents with an eligibility span in TAKE CHARGE Program G and Medicaid eligibility code P within 25 months of target birth in April – March 2005.

TAKE CHARGE Eligibles with Medicaid-Paid Births (n=133,174). All women eligible for TAKE CHARGE between July 1, 2001, and June 30, 2007, who had a Medicaid-paid birth (live birth or fetal death) between July 1, 1988, and June 30, 2007, and who were residents of Washington State at the time of delivery. This group includes only citizen women enrolled in Program S.

Statistical Analysis

Table 3 compares known characteristics of survey respondents with survey non-respondents and with S Women age 18 – 44 with a live birth in 2005. Significant differences existed between respondents

and non-respondents with respect to age, race/ethnicity, educational achievement, and region of residence. On average, respondents were half a year older than non-respondents ($p=0.02$). The race/ethnicity of most survey respondents was either white (73.3%) or Hispanic (15.6%). No significant differences existed between respondents and non-respondents regarding the average number of prior live births, primary language, or marital status. Between respondents and all S Women who gave birth in 2005, only race/ethnicity, education, and region of residence were significantly different.

Descriptive statistics were calculated for the total survey sample and for survey respondents and non-respondents. Significant differences between study groups for normally distributed continuous variables were determined using the two-sample t test. Categorical variables were constructed for continuous variables not normally distributed. The Wald chi-square test, or Fisher's exact test when appropriate, was used for categorical variables.

Logistic regression models described the relationships among demographics, socioeconomic status, and family planning knowledge, behavior, and attitudes on selected outcomes. The outcome variables in the logistic regression models were use of TAKE CHARGE family planning services following a Medicaid-paid delivery; subsequent birth or pregnancy within two years following a Medicaid-paid delivery; and highly effective birth control method use within two months of taking the survey. Only independent variables significantly associated with the outcome variable of interest were included in the logistic regression models.

In analyses using client surveys, data are presented with non-respondent sample weights applied. Non-respondent weights were calculated based on survey respondents as a proportion of all women sampled. Where survey responses are presented, weights were applied to adjust for differences in non-response for the following characteristics: region, education, race, and age. Survey variable percents are shown excluding observations with missing responses.

All analyses were conducted using SAS Version 9.1 for Windows (SAS Institute Inc., Cary, NC). Differences were considered significant at $p < 0.05$.

LIMITATIONS

Although we controlled for non-response, survey respondents and non-respondents may differ on factors we could not measure. Survey-related measures may not reflect family planning knowledge, behavior, and attitudes of clients under 18. Although survey questions asked respondents about the method they used to prevent pregnancy, it is possible that responses may have included methods they used to protect against STIs, such as condoms. Client race/ethnicity, parity, and marital status for G women were available only for those with a birth certificate available in the FSDB. It is possible clients not matched to the FSDB differ on these characteristics, which may influence their contraceptive and family planning behavior. The number of clients with a history of a birth may also be under-reported since information on births occurring before July 1988 or after June 2007 was unavailable at the time of this analysis.

Table 3. Comparison of Survey Respondents with Non-Respondents and S Women

Characteristic	Survey Respondents n=1292 (100%)	Non-Respondents n=1172 (100%)	Resp. vs Non-resp. <i>p</i> *	S Women 2005 Births n=16,352 (100%)	Resp. vs S Women <i>p</i> *
Age, mean ± SD	26.1 ± 5.5	25.6 ± 5.3	0.02	25.9 ± 5.4	0.19
18-19	115 (8.9)	123 (10.5)		1472 (9.0)	
20-24	479 (37.1)	473 (40.4)		6347 (38.8)	
25-29	370 (28.6)	305 (26.0)		4669 (28.6)	
30-34	206 (15.9)	177 (15.1)		2436 (14.9)	
35-39	100 (7.7)	82 (7.0)		1145 (7.0)	
40-44	22 (1.7)	12 (1.0)		283 (1.7)	
Race/ethnicity			<.01		<.01
White	947 (73.3)	759 (64.8)		11815 (67.0)	
Hispanic	202 (15.6)	187 (16.0)		2734 (15.5)	
African American	38 (2.9)	46 (3.9)		643 (3.6)	
Native American	13 (1.0)	28 (2.4)		446 (2.5)	
Asian/Pacific Islander	42 (3.3)	90 (7.7)		1154 (6.5)	
More than one race	39 (3.0)	47 (4.0)		628 (3.6)	
Other/Unknown	11 (0.9)	15 (1.3)		224 (1.3)	
Education			0.01		<.01
No high school diploma	209 (16.2)	212 (18.1)		2842 (17.4)	
High school diploma/GED	417 (32.3)	406 (34.6)		5888 (36.0)	
Some college or Associate's degree	510 (39.5)	439 (37.5)		6054 (37.0)	
Bachelor's degree or more	128 (9.9)	78 (6.7)		1279 (7.8)	
Unknown	28 (2.2)	37 (3.2)		289 (1.8)	
Prior Live Births			0.81		0.15
1	490 (37.9)	451 (38.5)		6999 (39.7)	
2	367 (28.4)	324 (27.6)		4725 (26.8)	
3	219 (17.0)	197 (16.8)		2884 (16.3)	
4-5	125 (9.7)	102 (8.7)		1734 (9.8)	
6 or more	23 (1.8)	27 (2.3)		444 (2.5)	
Unknown	68 (5.3)	71 (6.1)		858 (4.9)	
Primary Language			0.97		
English	1213 (93.9)	1101 (93.9)		not applicable	
Spanish	47 (2.6)	4 (2.6)		not applicable	
Unknown	32 (2.5)	28 (2.4)		not applicable	
Marital Status			0.15		0.47
Married	724 (56.0)	624 (53.2)		8990 (55.0)	
Unmarried	563 (43.6)	545 (46.5)		7294 (44.6)	
Unknown	5 (0.4)	3 (0.3)		68 (0.4)	
Region			<.01		0.02
King County	237 (18.3)	262 (22.4)		3605 (20.4)	
Western Washington	616 (47.7)	583 (49.7)		8591 (48.7)	
Eastern Washington	439 (34.0)	327 (27.9)		5448 (30.9)	

*Significant differences between respondents and non-respondents determined using chi-square test for categorical variables and two-sample t test for equal means for maternal age as a continuous variable.

FINDINGS

Recently pregnant women who were Medicaid eligible solely because of pregnancy (S Women citizens) comprised 44.4% of the total Medicaid deliveries in Washington in 2007. These women had family incomes up to and including 185% of the FPL. While the proportion of births from unintended pregnancies among S women decreased from 56.3% in 2000 – 02 to 47.9% in 2003 – 05, the proportion of births from unintended pregnancies increased to 53.6% in 2006 – 07. Similarly, for women on TANF at delivery, the proportion of births from unintended pregnancies decreased from 65.2% in 2000 – 02 to 57.5% in 2003 – 05, the proportion of births from unintended pregnancies increased to 62.0% in 2006 – 07.

Table 4. Unintended Pregnancy Rates for Washington Women

Thinking back to just before you got pregnant, how did you feel about becoming pregnant?				
<input type="checkbox"/> I wanted to be pregnant later. <input type="checkbox"/> I didn't want to be pregnant then or at any time in the future.				
Year of Births	TANF	S (Citizens)	Non-Citizens	Non-Medicaid
2000-02	65.2%	56.3%	40.2%	26.5%
2003-05	57.5%*	47.9%*	39.8%	25.3%
2006-07	62.0%	53.6%*	38.4%	23.1%

*Statistically significant difference from the previous years, p<0.05.

S women are automatically enrolled in the TAKE CHARGE program after their full-scope medical coverage ends two months after completion of their pregnancy; however, they have been modest users of family planning services through TAKE CHARGE and few of these women re-enroll in TAKE CHARGE after the end of their period of automatic eligibility. How TAKE CHARGE can be more effective in reaching this group is the focus of this study.

Survey questions will be presented by the following domains: Demographics and Economic Status, Employment and Health Insurance, and Family Planning Knowledge, Attitudes, and Behavior.

DEMOGRAPHICS AND ECONOMIC STATUS

Compared to other women with Medicaid-paid deliveries in 2005, S women had the highest educational attainment and intermediate ranks in smoking, marital status, and age. The proportion of S women having their first birth was greater than that of non-citizens and TANF women.

The proportion of survey respondents who reported being married was slightly greater at the time of the survey than on the birth certificate. An additional 21.7% of survey respondents reported that they were not married but were living with a partner at the time of the survey.

Comparable to all S women with births in 2005, 82.3% of survey respondents had a high school diploma at the target birth. At the time of the survey, the proportion of respondents with a high school diploma increased slightly to 86.6%.

Table 5. Characteristics of Washington Women with Medicaid Births in 2005

Maternal Characteristics	TANF N=12,062	S Women N=16,896	Non-citizens N=8453
Average age	24.3	25.7	26.5
Average age of mothers with first births	20.9	22.9	23.6
Mothers with first births (%)	33.3%	43.2%	33.7%
Married (%)	27.4%	53.9%	55.6%
Maternal smoking (%)	31.2%	14.5%	0.4%
At least a High School education (%)	64.2%	80.5%	35.5%
Bachelor's degree or more (%)	1.7%	7.8%	4.9%

Women with missing information were not included in the denominator.

The estimated monthly family income for respondents who reported being married or living with a partner was on average \$900 more than respondents who reported being single, divorced, or separated. Very few (4.5%) respondents reported having a monthly family income of less than \$500, and 11.9% reported having a monthly family income of more than \$3500.

As shown in Table 3, women in the survey sample were representative of other S Women who gave birth in 2005. In contrast, S Women with a known prior birth were very different from G Women enrolled in TAKE CHARGE with a known prior birth, as shown in Table 6.

Table 6. Characteristics of Program G and S Women Enrolled in TAKE CHARGE Demonstration Years 1 – 6

Characteristic	Program G	Program S	Total
Total Women Enrolled Jul 2001 - Jun 2007	236,493	112,512	349,005
Medicaid-paid Births Jul 1988 - Dec 2006	36,931	87,133	124,064
Percent with History of a Medicaid-paid Birth	15.6%	77.4%	35.5%
Age at Enrollment (mean years)			
Clients without History of a Medicaid-paid Birth	21.6	24.9	22.0
Clients with History of a Medicaid-paid Birth	23.4	26.2	25.8
Age at Most Recent Medicaid-paid Birth (mean years)			
Married	25.2	27.7	27.2
Single	22.2	24.4	23.6
Number of Prior Births (median)			
Married	1	1	1
Single	0	1	0

History of a Medicaid-paid birth, age at most recent birth, and number of prior births from FSDB.

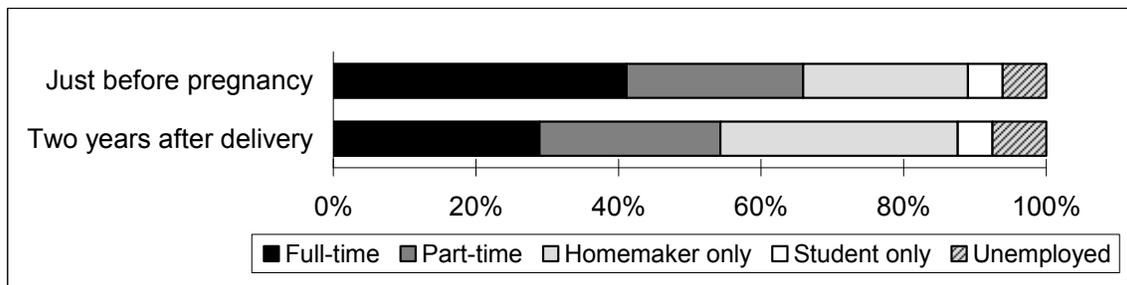
- More than three-fourths (77.4%) of S women had a prior Medicaid-paid birth recorded, compared to 15.6% of G women.

- On average, S women were 3 years older at initial enrollment than G women.
- Married women in both programs were older at their most recent birth than unmarried women.
- Among single women, S women averaged one prior birth at initial enrollment compared to none for G women.

EMPLOYMENT AND HEALTH INSURANCE COVERAGE

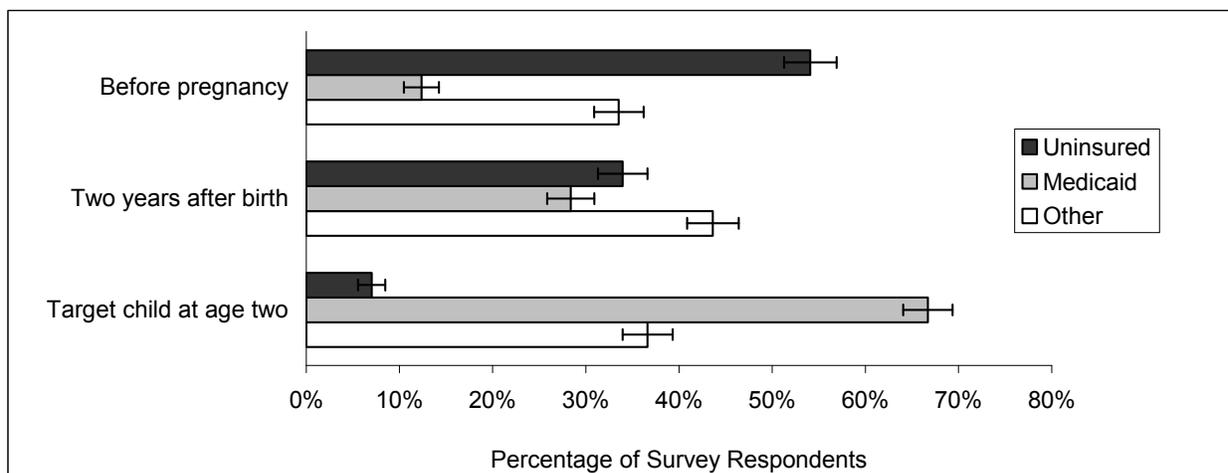
Before the pregnancy that qualified them for participation in this survey, two-thirds (65.9%) of these women were working full-time or part-time; however, more than half (54.1%) had no health insurance at that time.

Figure 2. Employment Status Before and After Birth



At the time of this survey, two years after the target pregnancy, the proportion of women working full-time had decreased from 41.2% to 28.9%. The proportion working part-time was essentially unchanged (24.8% versus 25.4%). The proportion whose primary occupation was homemaker increased from 23.1% prior to pregnancy to 33.3% two years later.

Figure 3. Type of Health Insurance Coverage Before Pregnancy and Two Years After Birth



*Respondents could select all responses that applied, so proportions will not add to 100%. Proportions weighted for non-response.

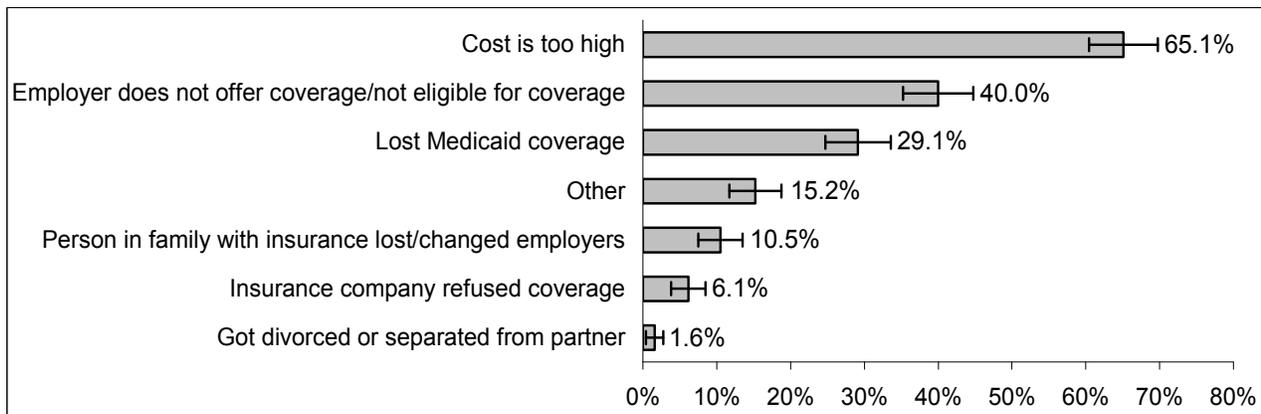
The proportion of women with no health insurance decreased from 54.1% prior to pregnancy to 34.0% two years after having a Medicaid-paid birth. During this time period, the proportion of women with employer-based, military, or state-sponsored coverage increased from 33.5% to 43.6%, and Medicaid coverage increased from 12.4% to 28.4%. Self-reported Medicaid coverage was slightly higher than Medicaid eligibility data. Matching survey respondents to Medicaid eligibility data showed that 10.3% were eligible for Medicaid (excluding TAKE CHARGE) approximately one month before pregnancy and 23.6% were eligible two years after delivery.

For target children at age two, respondents stated that 66.7% were covered by Medicaid, 36.6% were covered by private, state, or military health plans, and 7.0% were uninsured.

Over one-third (35.9%) of respondents with a child on Medicaid at age two were uninsured at the time of the survey compared to 15.2% of women with a child on employer-based, military, or state-sponsored plans. Furthermore, 83.4% of women with an uninsured child were themselves uninsured at the time of the survey.

The most frequently reported reason for lack of insurance at the time of the survey was that the cost of insurance is too high (65.1%). Other reasons were an employer not offering coverage or the client not being eligible for coverage (40%), and more than a quarter of the women reported the loss of Medicaid coverage as the reason they were uninsured (29.1%).

Figure 4. Reasons Cited for Not Having Health Insurance at the Time of the Survey

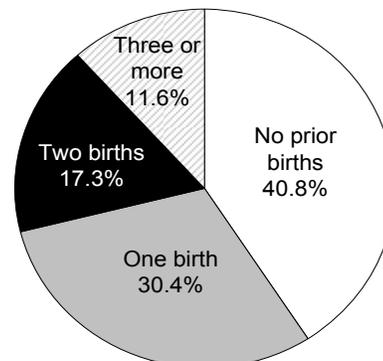


Respondents could select all responses that applied, so proportions will not add to 100%. Percents weighted for non-response.

PATTERNS OF CHILD BEARING

Birth certificate data revealed that 40.8% of survey respondents had no prior live births between July 1988 and April 2005. Nearly one-third (30.4%) of the women had one prior birth, and 17.3% had two prior births. Overall, women had an average of one live birth prior to the birth that qualified them for participation in this survey.

Figure 5. S Women: Prior Births



Percentages exclude women with missing prior birth information.

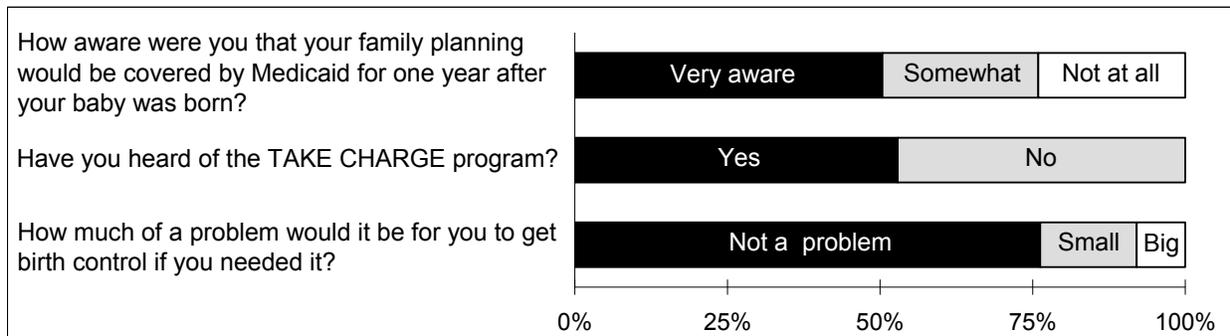
Of the 687 women with a birth in FSDB before 2005, 23.5% gave birth within 24 months of the target birth. The interval between the prior birth and the target birth ranged from 10 to 172 months, with a median of 38 months (rounded to the nearest month). Nearly one-fifth (18.4%) of respondents with a prior birth recorded had a subsequent birth identified (up to 33 months after the target birth) as well.

At the time of this survey, 11.6% of women had a subsequent birth within two years after the target pregnancy. Of these 152 women, the average interval between the target birth and the subsequent birth was 18 months (rounded to the nearest month). Only 23 respondents had both a prior birth within two years before the target birth and a subsequent birth within two years after the target birth.

KNOWLEDGE OF FAMILY PLANNING SERVICES

Women with recent Medicaid-paid births experience various opportunities to receive information about postpartum family planning services. In the few weeks before or after their baby was born, 92.0% of women said that a doctor, nurse, or other health care worker talked with them about family planning or using birth control. During this same time period, 44.8% of women said they received counseling or information about birth control, and 15.8% received counseling or information about getting sterilized.

Figure 6. Awareness of Medicaid Family Planning Services



Although some women (24.1%) were unaware of Medicaid-coverage for postpartum family planning services, the majority were either very aware (50.4%) or somewhat aware (25.5%) that their family planning services would be covered by Medicaid for one year after the birth of their infant. Fewer respondents recognized the program by name. Almost half (47.1%) reported they had not heard of the TAKE CHARGE program that provides family planning services to many women in Washington State.

Access to birth control was not a major issue from the clients' perspective. At the time of the survey, 76.2% of women reported that it would not be a problem to get birth control if they needed it. A smaller proportion of women (15.8%) reported it would be a small problem and 8.0% reported it would be a big problem.

ATTITUDES ABOUT FAMILY PLANNING

Overall, four out of five women either strongly agreed or agreed that it is best to plan ahead for a pregnancy by using birth control methods. A smaller proportion (15.4%) of the respondents neither agreed nor disagreed that it was best to plan ahead for a pregnancy by using birth control methods. Small proportions of women said they either disagreed (1.8%) or strongly disagreed (2.0%) with the statement.

Nearly two-thirds of women reported that family finances affected their decision to have a baby at least somewhat: 48.1% of women said finances had some influence on their decision and 17.0% of women said it influenced their decision a lot.

Figure 7. Do you agree with the statement: “It is best to plan ahead for a pregnancy by using birth control methods”?

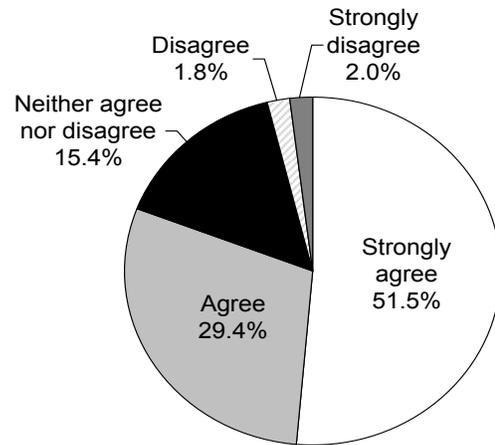
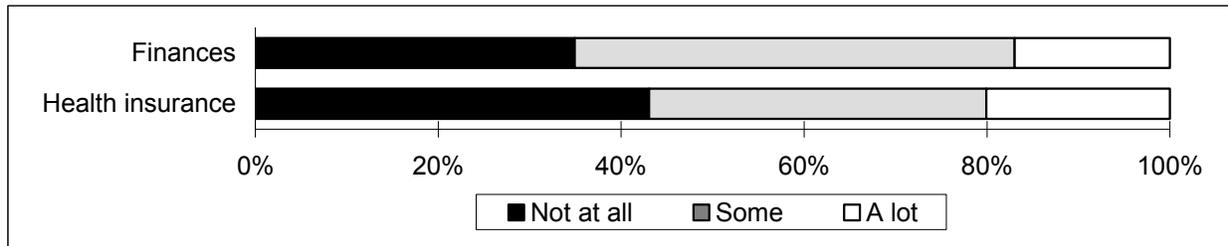


Figure 8. How much did finances and health insurance affect your decision to have a baby?



For many women, the decision to have a baby was not influenced by having health insurance. At the time of the survey, 36.9% of women were concerned about insurance, but it only affected their decision to have a baby “some.” An additional 43.1% of women reported that health insurance did not affect their decision at all. On the other hand, 20.1% of women reported that health insurance affected their decision a lot and that they would not have a baby without it.

About 80% of women said they were mostly or totally confident that they could choose the number of children they would have in the future. The remaining women were somewhat confident (10.9%), a little confident (5.4%), or not at all confident (3.6%).

FAMILY PLANNING BEHAVIOR

During the three months before they got pregnant with the birth that qualified them for this survey, 24.8% of women were trying to get pregnant while 16.2% were trying hard to keep from getting pregnant. Nearly 60% of women expressed ambivalence about pregnancy: 31.0% were not trying to get pregnant or keep from getting pregnant, and 28.0% were trying to keep from getting pregnant but not very hard.

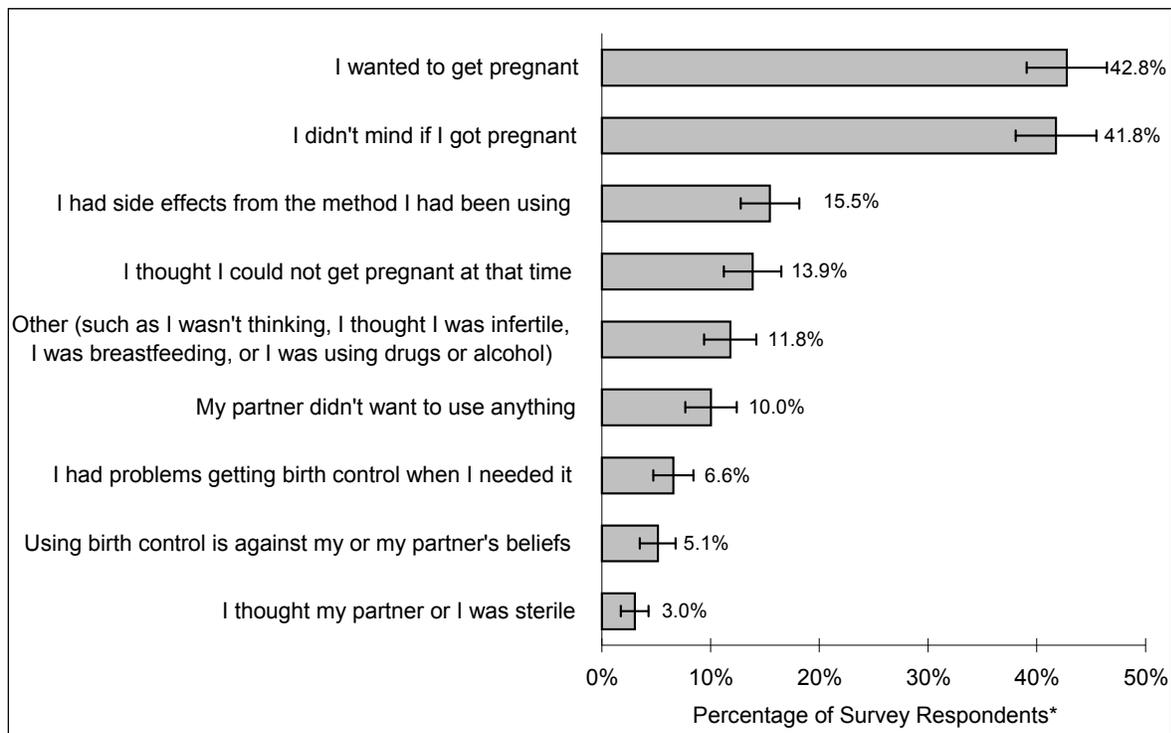
Table 7. Pregnancy Intention and Family Planning Behavior

Which of the following statements best describes you during the 3 months before you got pregnant?	n (wt. %)		Using Birth Control*
	n	(wt. %)	wt. % (95% CI)
Trying hard to keep from getting pregnant	210	16.2%	90.8% (86.8-94.8)
Trying to keep from getting pregnant but not very hard	353	28.0%	63.9% (58.8-69.1)
Wasn't trying to get pregnant or trying to keep from getting pregnant	393	31.0%	28.6% (24.0-32.2)
Trying to get pregnant	326	24.8%	5.4% (2.9-8.0)
Total	1282	100.0%	42.9% (40.1-45.7)

*Percentage of respondents who reported that they or their partner was using some sort of birth control method at the time they got pregnant (weighted for non-response).

Over 40% of women reported that they were using a birth control method at the time they got pregnant with the target birth. A woman's pregnancy intention during the three months before she became pregnant corresponded with her or her partner using birth control at the time of conception. Of the 210 women who said they were trying hard to keep from getting pregnant, 90.8% reported that they or their partner were using birth control. On the other hand, 5.4% of women who were trying to get pregnant said they or their partner were using birth control.

Figure 9. Reasons Cited for Not Using Birth Control When Becoming Pregnant with the Birth That Qualified Them for This Survey

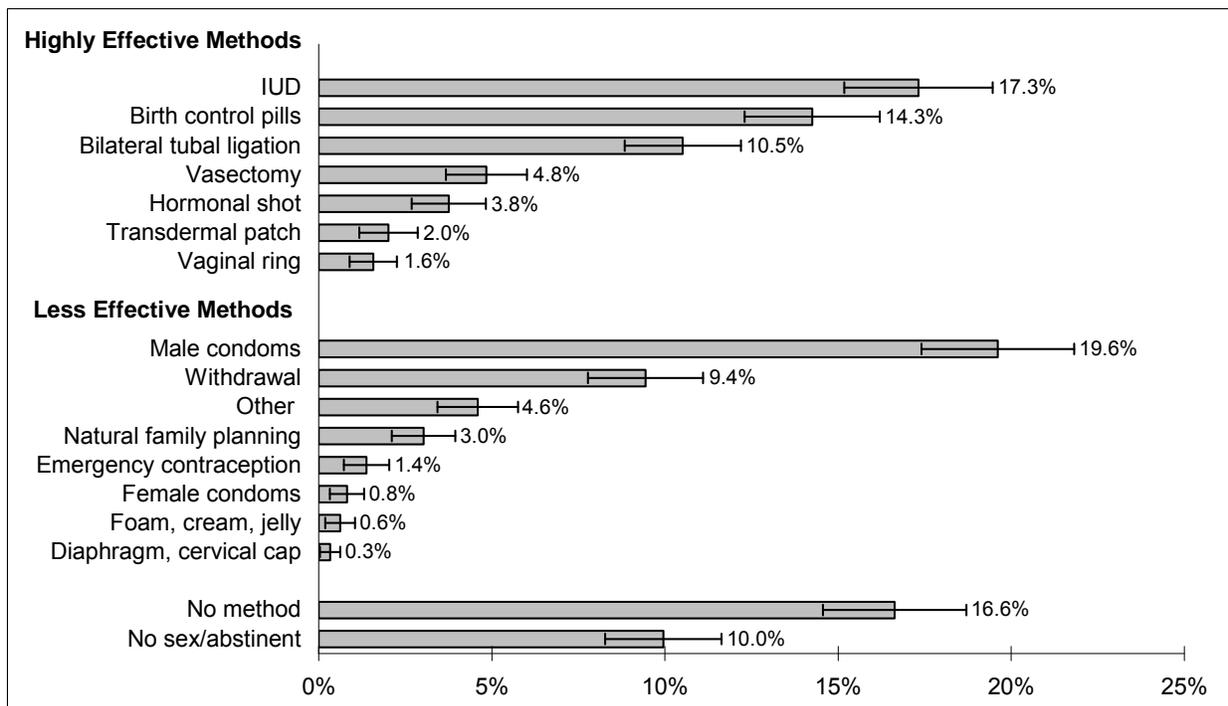


*Respondents could select all responses that applied, so proportions will not add to 100%. Proportions weighted for non-response.

At the time women became pregnant with the birth that qualified them for this survey, 56.9% reported that they were not doing anything to keep from getting pregnant. Reasons ranged from wanting to get pregnant (42.8%) and not minding if she got pregnant (41.8%) to thinking that she or her partner was sterile (3.0%).

Fewer than one in ten (6.6%) survey respondents reported they were not using birth control at the time they became pregnant because they had problems getting it when they needed it. Almost half of those women also reported having problems getting birth control at the time of the survey: 26.5% reported that if they needed birth control now, it would be a small problem, and 22.4% said it would be a big problem.

Figure 10. Types of Birth Control Methods Used During the Last Two Months



*Respondents could select all responses that applied, so proportions will not add to 100%. Proportions weighted for non-response.

Women reported on the survey the types of birth control they or their partner used when having sex during the past two months. Among highly effective methods, IUDs were most frequently reported, followed by birth control pills and sterilization. Among less effective methods, male condoms were most frequently reported, followed by withdrawal. Using no method was reported by 16.6% of women, and 10.0% reported abstinence or no sex in the past two months.

PREGNANCY INTENTION

A woman's use of family planning services may be influenced by her future childbearing goals or her ambivalence towards pregnancy. The survey collected information about pregnancy wantedness, level of trying to get pregnant (or to avoid getting pregnant), and feelings about getting pregnant to describe a respondent's past, present, and future pregnancy intentions. In the

evaluation of the first five years of TAKE CHARGE, a sample of Program G women was asked about their future pregnancy intentions at enrollment. In this survey, recently pregnant women were asked the same question.

Program G and Program S women demonstrated significant differences regarding future pregnancy intention (Table 8 below). At the time of the survey, 10.8% of Program S women reported they wanted to get pregnant in the next 12 months (excluding women with a subsequent birth or pregnancy) compared to 0.8% of Program G women. More than three-fourths (75.4%) of Program G women reported that they *really* did not want to get pregnant compared to 51.4% of Program S women. More Program S women were ambivalent about pregnancy than Program G women: 13.6% of S women said they either kind of did and kind of did not want to get pregnant or did not care one way or the other compared to 3.9% of G women.

Table 8. Future Pregnancy Intention by Program

Which of the following statements best describes what you want to happen during the next 12 months?	G-women*	S-women [†]
	n=3796 (95% CI)	n=1119 (95% CI)
I <i>want</i> to get pregnant during the next 12 months.‡	0.8% (0.5-1.2)	10.8% (9.0-12.7)
I kind of want to get pregnant and I kind of don't want to get pregnant.‡	2.8% (2.1-3.5)	6.3% (4.8-7.8)
I don't care one way or the other if I get pregnant.‡	1.1% (0.7-1.4)	7.3% (5.6-8.9)
I do not want to get pregnant.‡	20.0% (18.2-21.7)	24.2% (21.6-26.8)
I <i>really do not want</i> to get pregnant in the next 12 months.‡	75.4% (73.5-77.2)	51.4% (48.4-54.4)

*Program G client pre-survey results from the TAKE CHARGE program evaluation, years one through five.

[†]Weighted for survey non-response. Excludes women who reported being pregnant at the time of the survey and question non-respondents.

‡Significant difference between Program G and Program S survey respondents using 95% CI for difference in proportions.

Future pregnancy intention also differed significantly among S women by their living situation at the time of the survey. A larger proportion of married or partnered women wanted to get

Table 9. Future Pregnancy Intention by Marital Status Among S Women

Which of the following statements best describes what you want to happen during the next 12 months?	Program S	
	Married/Partner n=859 %* (95% CI)	Single/Divorced n=248 %* (95% CI)
I <i>want</i> to get pregnant during the next 12 months.	13.3% (11.0-15.6)	3.0% (0.9-5.0) [†]
I kind of want to get pregnant and I kind of don't want to get pregnant.	7.3% (5.5-9.1)	2.8% (0.7-5.0) [†]
I don't care one way or the other if I get pregnant.	7.2% (5.4-9.0)	7.0% (3.6-10.3)
I do not want to get pregnant.	24.8% (21.9-27.8)	22.7% (17.4-28.0)
I <i>really do not want</i> to get pregnant in the next 12 months.	47.4% (44.0-50.8)	64.6% (58.5-70.6) [†]

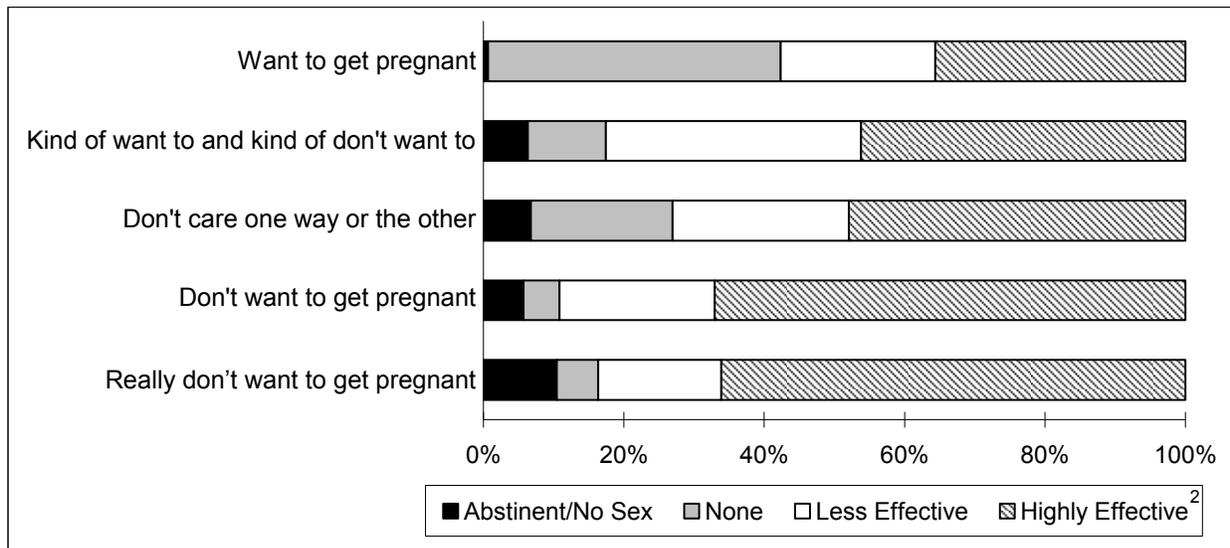
*Weighted for survey non-response. Excludes women who reported being pregnant at the time of the survey and question non-respondents.

[†]Significant difference between married/living with partner and single/divorced/separated respondents using 95% CI for difference in proportions.

pregnant or kind of wanted to get pregnant in the next 12 months compared to single, divorced, or separated women. The proportion of women who reported that they did not care one way or the other was similar for these two groups of women (married/partnered: 7.2%, single/divorced/separated: 7.0%).

In addition to future pregnancy intention, women also reported the types of family planning method they used during the last two months. The chart below combines future pregnancy intention with effectiveness of the method reported.

Figure 11. Future Pregnancy Intention and Effectiveness of Reported Family Planning Method



Excludes women who reported being pregnant at the time of the survey.

The effectiveness of the family planning method respondents reported using at the time of the survey generally corresponded to future pregnancy intention.

- Highly effective methods were used by 35.6% of women who wanted to get pregnant, 46.2% of women who kind of wanted to get pregnant, 47.9% of women who did not care if they got pregnant, 64.9% of women who did not want to get pregnant, and 66.1% of women who really did not want to get pregnant.
- Less effective methods were used by 22.0% of women who wanted to get pregnant, 36.3% of women who kind of wanted to get pregnant, 25.1% of women who did not care if they got pregnant, 21.4% of women who did not want to get pregnant, and 17.5% of women who really did not want to get pregnant.
- Over half the women who said they wanted to get pregnant in the next year used either a highly effective (35.6%) or a less effective method (22.0%) during the past two months.

² **Highly effective methods** included birth control pills, hormonal injection (Depo Provera®), intrauterine device, Implanon®, transdermal patch (Ortho Evra®), vaginal ring (Nuva Ring®), and female and male sterilization. **Less effective methods** included condoms, diaphragm, cervical cap, emergency contraceptive pills, spermicidal foam, jelly, and cream, withdrawal, rhythm, and natural family planning.

MEDICAID FAMILY PLANNING METHODS

This section describes family planning methods paid by Medicaid and the TAKE CHARGE program. Medicaid eligibility information was linked to Medicaid billing records to identify the type of family planning methods received and the corresponding program providing coverage. Table 9 shows the Medicaid-paid family planning methods received by S women who gave birth between January 1 and December 31, 2005, and by those who enrolled in TAKE CHARGE between July 1, 2005, and June 30, 2006. (S women who gave birth in 2005 would have been eligible for TAKE CHARGE Program S during year five of the demonstration.)

For S women with births in 2005, Medicaid-paid family planning services received are shown by type of reimbursement at delivery. Healthy Options, Medicaid's managed care plan, typically bills a monthly capitation rate, while fee-for-service (FFS) providers bill for each service provided. Therefore, individual (FFS) claims data permit better ascertainment of Medicaid-paid family planning services.

Table 10. Medicaid-Paid Family Planning Service Receipt of S Women with Births in 2005 and TAKE CHARGE Enrollees in Demonstration Year 5

	S Women 2005		TAKE CHARGE Year 5	
	Healthy Options	Fee-For-Service	Program S	Program G
Total Women Enrolled (n, % of program total)	10,291 (65.0%)	5,552 (35.0%)	39,748 (24.1%)	125,105 (75.9%)
Medicaid-paid Family Planning Services	<i>prior to TAKE CHARGE eligibility*</i>		<i>during TAKE CHARGE eligibility**</i>	
Participants (n, % of total enrolled)	878 (8.5%)	2,095 (37.7%)	14,075 (35.4%)	94,311 (75.4%)
Family Planning Methods (% of participants)				
Oral Contraceptives	43.5%	50.7%	49.1%	58.8%
Hormone Injection (Depo Provera®)	4.6%	10.2%	13.0%	11.6%
Transdermal Patch (Ortho Evra®)	8.3%	7.4%	13.5%	9.6%
Vaginal Ring (Nuva Ring®)	2.5%	1.3%	8.2%	12.1%
Intrauterine Device (IUD)	6.6%	9.2%	6.1%	1.4%
Bilateral Tubal Ligation (BTL)	2.3%	15.0%	1.7%	0.4%

* Medicaid-paid medical family planning services received between delivery and 60 days postpartum.

** Medicaid-paid medical family planning services received during TAKE CHARGE eligibility span in Program S or Program G.

A moderate proportion of S women received a family planning method prior to their automatic enrollment in TAKE CHARGE. For S women enrolled in FFS, 37.7% received a Medicaid-paid family planning method between delivery and 60 days postpartum. Nearly one-quarter (24.2%) of FFS S women who received a family planning method prior to TAKE CHARGE eligibility chose a long-term (IUD, 9.2%) or a non-reversible method (BTL, 15.0%).

Many women in Healthy Options may receive a family planning method through their managed care Healthy Options provider without a claim for the service being submitted to HRSA. Overall, the proportion of Healthy Options clients with an identified Medicaid-paid family planning service (8.5%) is much lower than that for fee-for-service clients (37.7%). In addition, some family planning methods, for example tubal ligation, are included in the Healthy Options benefits package, so the frequency of such claims is particularly low for managed care clients (as

per the example, 2.3% among those with a tubal ligation compared to 15% for FFS clients). For other family planning methods, managed care clients have the option of obtaining their method from a DSHS-approved Family Planning Clinic. In some cases the family planning clinic will submit a FFS claim to HRSA; however, if the managed care plan contracts with the family planning clinic, the clinic will submit their claim to the managed care plan, and our claims data will not include a record of that service.³

For both Program S and G women, oral contraceptives were used considerably more frequently than any other method. However, the use of other methods varied between the two groups, with S women being more likely to get an IUD or a sterilization procedure, and with G Women being more likely to use the vaginal ring.

Following the end of Program S eligibility, 117 (9.2%) women re-enrolled in TAKE CHARGE and 90% of those re-enrolled received a family planning service. During demonstration years one through six, the annual re-enrollment rate among Program G women averaged 36.1%. Of women surveyed, 20.5% became eligible for Program S two years postpartum with a subsequent pregnancy or birth.

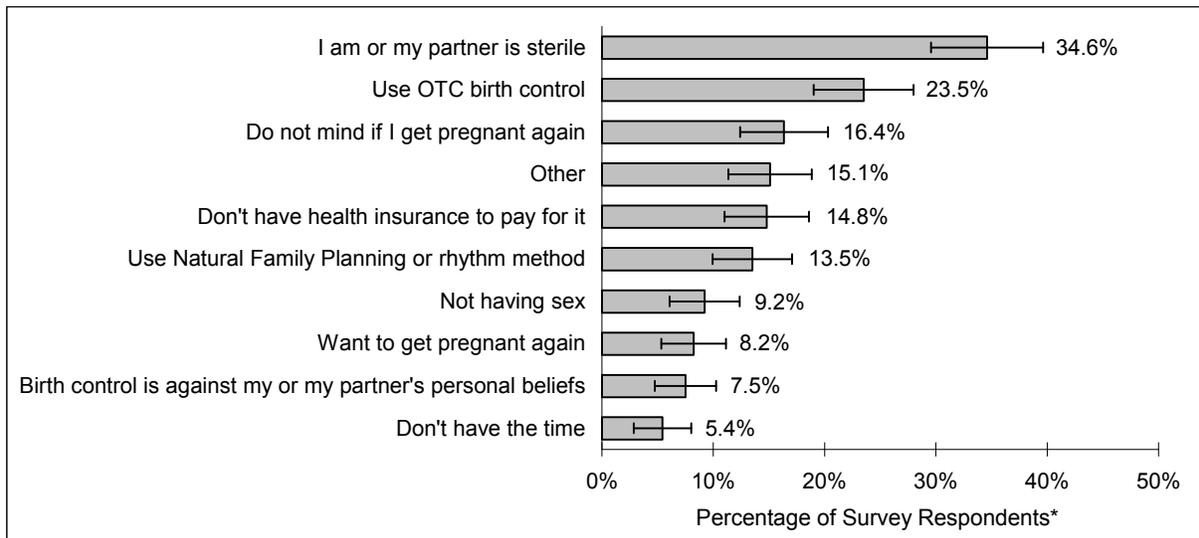
³ Generally speaking, claims data for women in FFS will more accurately reflect the use of family planning methods than will claims for women in Healthy Options. Data for S women during pregnancy and the first two postpartum months require careful interpretation as nearly two-thirds (65%) of S women were in managed care at the time of delivery. All TAKE CHARGE claims are reimbursed through fee-for-service.

Factors Associated with Medicaid Family Planning Service Use

Within one year after delivery, 54.4% of women eligible for Program S received a Medicaid-paid family planning service. Table 11 (next page) compares characteristics and responses to selected survey questions for women by receipt of family planning services. Compared to their counterparts who did not receive a Medicaid family planning service, women who received a Medicaid family planning service were younger, had fewer years of education, had fewer prior live births, and were more frequently employed full-time.

After the birth that qualified them for this study, 41.0% of women reported they had not seen a health care provider for birth control or family planning. To explore reasons why women did not use a TAKE CHARGE family planning service, we restricted responses to women who said they did not see a health care provider and also did not have a Medicaid-paid claim for a TAKE CHARGE family planning service (n=362).

Figure 12. Reasons Cited for Not Seeing a Health Care Provider for Birth Control Following Delivery



*Respondents could select all responses that applied, so proportions will not add to 100%. Proportions weighted for non-response.

The most common reason women did not go to a health care provider for birth control was that they were sterile or had a partner who was sterile (34.6%). Additional reasons included using over-the-counter (OTC) birth control methods (23.5%), not minding if they got pregnant (16.4%), not having health insurance to pay for services (14.8%), or using natural family planning methods (13.5%). A smaller proportion reported that they were not having sex (9.2%), they wanted to get pregnant again (8.2%), or birth control was against their or their partner's personal beliefs (7.5%). Of the 56 women who reported "Other" reasons, 17 commented they did not like the method's side effects, and 11 reported that they were using an IUD.

Single women were more likely to receive a TAKE CHARGE family planning service than married women. Overall, 57.3% of women who were single at the time of delivery received a TAKE CHARGE family planning service compared to 52.0% of women who were married

Table 11. TAKE CHARGE S Women Family Planning Service Users vs. Non-Users

Characteristic	FP Service	No FP Service	p*
	n=691 (%) [†]	n=594 (%) [†]	
Age at delivery (years)			<.01
mean ± SD	25.0 ±17.8	27.0 ±19.7	
18-19	71 (11.2)	44 (8.6)	
20-24	301 (45.3)	176 (31.7)	
25-29	193 (26.3)	176 (28.6)	
30-34	83 (11.9)	121 (19.8)	
> 34	43 (5.3)	77 (11.2)	
Education at delivery			<.01
No high school diploma	126 (19.8)	82 (14.7)	
High school diploma/GED	237 (35.7)	180 (32.4)	
Some college or AA degree	258 (36.7)	247 (41.3)	
Bachelors degree or more	51 (6.3)	76 (10.7)	
Unknown	19 (1.5)	9 (0.8)	
Number of live births (including target birth)			<.01
median	2	2	
1	292 (43.2)	196 (33.6)	
2	198 (28.7)	168 (29.3)	
3	97 (13.7)	121 (19.7)	
≥4	61 (8.5)	86 (13.9)	
Unknown	43 (5.9)	23 (3.6)	
Marital Status at delivery			0.06
Married	368 (52.0)	352 (57.6)	
Single	319 (47.4)	241 (42.3)	
Unknown	4 (0.6)	1 (0.2)	
Employment status prior to pregnancy			<.01
Full time	320 (47.5)	197 (33.7)	
Part time	166 (24.2)	148 (25.5)	
Unemployed/laid off	36 (5.2)	41 (7.1)	
Student	33 (4.5)	30 (5.4)	
Homemaker	129 (18.5)	171 (28.4)	
Current employment status at time of survey			0.05
Full time	216 (31.8)	144 (25.1)	
Part time	164 (24.0)	157 (27.1)	
Unemployed/laid off	56 (8.3)	37 (6.5)	
Student	33 (4.5)	31 (5.3)	
Homemaker	213 (31.4)	214 (35.8)	
How aware were you that Medicaid would cover your family planning			0.08
Very aware	361 (53.3)	276 (47.0)	
Somewhat aware	170 (24.5)	155 (26.9)	
Not aware	155 (22.2)	150 (26.2)	
Have you heard of TAKE CHARGE?			<.01
Yes	396 (58.6)	272 (46.2)	
No	281 (41.4)	313 (53.8)	
Family Planning Method within two months of survey			<.01
Highly Effective	403 (58.9)	279 (47.2)	
Less Effective	147 (21.2)	157 (26.1)	
Abstinent	43 (5.9)	49 (8.5)	
None	97 (14.0)	109 (18.2)	
It's best to plan ahead for a pregnancy using birth control			<.01
Agree	565 (83.5)	447 (77.6)	
Neither agree nor disagree	97 (14.4)	92 (16.5)	
Disagree	14 (2.1)	35 (5.8)	

*Significant differences between respondents who received a family planning service and respondents who did not receive a family planning service determined using chi-square test for categorical variables and two sample t-test for equal means for maternal age as a continuous variable.

[†]Percentage weighted for survey non-response.

($p < 0.01$, chi-square test). In addition, the relationship between family planning service use and marital status was influenced by age.

Table 12. TAKE CHARGE Family Planning Service Utilization by Marital Status and Age at Delivery

Age at Delivery	Single			Married		
	Total n	Received FP Service %*	OR (95% CI)	Total n	Received FP Service %*	OR (95% CI)
18-19	88	54.6%	0.96 (0.56, 1.64)	27	81.5%	4.47 (1.62, 12.32) [†]
20-24	231	61.8%	1.29 (0.85, 1.97)	242	64.1%	1.80 (1.23, 2.65) [†]
25-29	153	55.6%	ref.	215	49.7%	ref.
30-34	50	52.7%	0.89 (0.46, 1.72)	154	37.8%	0.61 (0.40, 0.95) [†]
> 34	38	45.8%	0.67 (0.32, 1.40)	82	32.3%	0.48 (0.27, 0.85) [†]
Total	560	57.3%		720	52.0%	

*Percentage of S Women who received a TAKE CHARGE Medical FP service weighted for survey non-response.

[†]Significant difference in the odds of receiving a TAKE CHARGE medical FP service compared to the odds of the reference group receiving a FP service.

As shown in Table 12, the odds of receiving a TAKE CHARGE family planning service were significantly higher for younger, married women compared to older, married women.

- For single women, the rate of Medicaid-paid family planning service use had no significant trend related to age.
- For married women age 18 – 19, the rate of Medicaid-paid family planning service use was 4.5 times greater than that of married women age 25 – 29. For women age 20 – 24, the rate was 1.8 times greater than that of women age 25 – 29.
- For older married women, age 30 – 34, the rate of Medicaid-paid family planning service was almost two-thirds (0.61 times) that of married women age 25 – 29. For women age 35 and older, the rate was about half (0.48 times) that of women age 25 – 29.

Logistic regression was used to describe factors associated with TAKE CHARGE family planning service utilization. After controlling for education and marital status, independent variables associated with family planning service use included: age, employment status prior to and following pregnancy, whether a woman was doing something to keep from getting pregnant at the time she became pregnant with the target birth, not having been sterilized or having a partner who has not been sterilized, and having heard of TAKE CHARGE.

Use of family planning services was strongly associated with a woman’s attitude towards contraception and pregnancy planning. After controlling for age, education, and marital status, women who agreed that it is best to plan for pregnancy by using birth control used a TAKE CHARGE family planning service 2.5 times more often than women who disagreed with the statement.

Table 13. Factors Associated with Receiving a Medicaid-Paid Family Planning Service

Independent Factor	OR* (95% CI)
Married age 18-20 vs. married age 25-29	3.97 (1.35, 11.68)
Agree it is best to plan ahead for pregnancy by using birth control methods vs. disagree	2.49 (1.20, 5.15)
No high school diploma at delivery vs. BA degree or more	2.01 (1.16, 3.48)
Employed full-time prior to pregnancy vs. homemaker only	1.82 (1.29, 2.58)
Married age 20-24 vs. married age 25-29	1.74 (1.15, 1.65)
Heard of TAKE CHARGE vs. had not heard	1.64 (1.27, 2.10)
Respondent or partner has not been sterilized vs. sterilized	1.55 (1.02, 2.34)
Using birth control when getting pregnant vs. not using birth control	1.30 (1.00, 1.68)

*Odds ratio adjusted for all variables listed in the model.

FAMILY PLANNING METHODS BEYOND TAKE CHARGE

Medicaid billing records from the first five years of the waiver evaluation showed that S women are modest users of TAKE CHARGE family planning services. However, survey responses from this phase of the evaluation indicate that many women used a family planning method in the two months before the survey even though they did not receive a TAKE CHARGE family planning service.

Table 14. Postpartum Medicaid Family Planning Service Use by Effectiveness of Reported Method Used in the Past Two Months

FP Method	Medicaid FP Service n=690 (100%)*	No Medicaid FP Service n=594 (100%)*	Total n=1284 (100%)*
Highly Effective	403 (58.9)	279 (47.2)	682 (53.5)
Less Effective	147 (21.2)	157 (26.1)	304 (23.4)
None	98 (14.0)	109 (18.2)	207 (16.0)
Abstinent/No Sex	43 (5.9)	49 (8.5)	92 (7.1)

*Percentage weighted for survey non-response. Excludes seven respondents not eligible for Program S.

- Nearly one-half (47.2%) of women who did not receive a TAKE CHARGE family planning service used a highly effective method compared to 58.9% of women who received a TAKE CHARGE family planning (FP) service.
- A larger proportion (26.1%) of women who did not receive a TAKE CHARGE FP service used less effective methods two years after delivery than women who received a TAKE CHARGE family planning service (21.2%).

Women may have obtained FP methods through mechanisms other than TAKE CHARGE by paying out-of-pocket, by having health coverage (private or public) for family planning services apart from TAKE CHARGE, or by receiving a long-acting method at the time of delivery.

Table 15. S Women: Highly Effective Method Users vs. Nonusers

Variable	Highly Effective		No Highly Effective		p*
	n = 686	(%) [†]	n = 606	(%) [†]	
Desired number of future children					<.01
median	0		1		
No more	375	(53.6)	169	(27.4)	
One more	184	(27.1)	218	(36.2)	
Two more	66	(9.6)	103	(17.4)	
Three more	28	(4.5)	34	(5.7)	
Four or five more	5	(0.7)	13	(2.1)	
Don't know / as many as God allows	28	(4.4)	69	(11.3)	
Confidence in choosing the number of children you will have in the future					<.01
Not at all / a little / somewhat confident	98	(14.9)	145	(25.8)	
Mostly confident	164	(23.9)	154	(25.6)	
Total confident	421	(61.2)	283	(48.5)	
Future pregnancy wantedness in the next 12 months					<.01
Want to get pregnant	68	(10.0)	98	(16.3)	
Ambivalent	33	(4.9)	33	(5.7)	
Don't want to get pregnant	483	(71.1)	248	(42.1)	
Subsequent birth or pregnancy	94	(14.0)	207	(36.0)	
Seen a health care worker for birth control since target birth					<.01
Yes	488	(72.9)	251	(42.8)	
No	192	(27.1)	345	(57.2)	
Age at delivery (years)					0.04
mean ± standard deviation	26.1	±5.4	26.1	±5.6	
18-19	73	(11.7)	42	(8.0)	
20-24	236	(36.2)	243	(42.4)	
25-29	199	(27.2)	171	(27.4)	
30-34	118	(17.1)	88	(13.8)	
>34	60	(7.8)	62	(8.4)	
Counseling or information about getting sterilized					<.01
Yes	153	(22.1)	53	(8.4)	
No	527	(77.9)	542	(91.6)	
Problem getting birth control if needed					<.01
Big Problem/Small Problem	139	(20.7)	154	(27.4)	
Not a problem	533	(79.3)	428	(72.6)	
Living situation at time of survey					0.04
Married / living with partner	541	(79.0)	464	(78.0)	
Single / divorced / separated	141	(21.0)	129	(22.0)	
It is best to plan ahead for a pregnancy by using birth control					<.01
Agree	593	(87.7)	425	(72.7)	
Neither	67	(10.0)	123	(21.7)	
Disagree	16	(2.3)	33	(5.5)	
Job status at time of survey					<.01
Working full-time	210	(31.1)	154	(26.4)	
Working part-time	190	(27.8)	132	(22.5)	
Unemployed	42	(6.2)	52	(9.2)	
Student only	31	(4.5)	33	(5.3)	
Homemaker only	209	(30.5)	219	(36.6)	
Target pregnancy intention					<.01
Trying to get pregnant	169	(24.4)	157	(25.4)	
Ambivalent	185	(27.8)	208	(34.7)	
Trying to keep from getting pregnant	327	(47.9)	236	(39.9)	

* Significant differences were determined using the chi-square test for categorical variables.

†Percentage weighted for survey non-response and exclude missing observations for survey variables.

Highly Effective Family Planning Methods

Many women use family planning methods, including highly effective methods, independent of TAKE CHARGE eligibility status. We identified factors associated with a recently pregnant woman's use of a highly effective family planning method. Table 15 compares characteristics of women who used a highly effective method two years after giving birth to those of women who did not use a highly effective method.

Women using highly effective methods wanted to prevent pregnancy and were confident they could control the number of children they had in the future. Among highly effective method users, 71.1% did not want to get pregnant in the next twelve months. Moreover, 53.6% said they did not want to have *any* more children. The majority (61.2%) of women using a highly effective method were totally confident they could choose the number of children they had in the future compared to 48.5% of women not using a highly effective method.

Other independent variables associated with using a highly effective method during the last two months included using birth control when becoming pregnant with the target birth, working full-time or part-time at the time of the survey, having one or more prior births, seeing a health care provider for birth control, and receiving counseling or information about sterilization near the time of the target birth.

Table 16. Factors associated with using a Highly Effective FP Method

Independent Factor	OR* (95% CI)
Seen a health care worker for birth control since birth	5.92 (4.30, 8.14)
Received counseling or information about sterilization	2.79 (1.77, 4.41)
Age 18-19 vs. 25-29	2.78 (1.53, 5.03)
Desire no more children in the future vs. more children	2.39 (1.70, 3.37)
Don't want to get pregnant in the next 12 months vs. want to get pregnant	2.36 (1.50, 3.70)
Totally confident in choosing future number of children vs. somewhat to not at all confident	1.90 (1.27, 2.83)
Married/partner vs. single	1.86 (1.29, 2.69)
Not a problem getting birth control if needed vs. problem getting birth control	1.67 (1.19, 2.35)

*Odds ratio adjusted for all variables listed in the model.

Highly effective method use was most strongly associated with seeing a health care worker for birth control (OR=5.9 after adjusting for age, desire for more children, living situation, employment status, and agreeing that it is best to plan ahead for pregnancy by using birth control). This association may be significant because women must see a health care worker to receive highly effective methods since those methods are available by prescription only.

Table 17. Effectiveness of Reported Family Planning Method Used in the Past Two Months and Subsequent Pregnancy

FP Method Past Two Months	Subsequent Pregnancy/Birth			
	n	%*	n	%*
Highly Effective	686	53.1%	94	13.9%
Less Effective	304	23.5%	83	28.3%
None	208	16.1%	106	51.2%
Abstinent/No Sex	94	7.3%	18	19.4%
Total	1292	100.0%	301	26.0%

*Percentage weighted for survey non-response.

More than half (51.2%) the women using no method in the past two months had a subsequent birth or pregnancy since the birth that qualified them for this study. Women without a subsequent birth or pregnancy were 3.3 times more likely to use a highly effective method during the last two months than women with a subsequent birth or pregnancy. The next section explores additional factors associated with a subsequent birth or pregnancy.

SUBSEQUENT PREGNANCY AND BIRTH

Since 1995, S women have demonstrated higher subsequent birth rates within two years of delivery than Non-Medicaid and Non-Citizen women. TANF women have the highest subsequent birth rate; of TANF women who gave birth in 2003, 16.4% had another birth within two years of the initial birth. During this same time period, S Women had a slightly lower rate (12.8%), followed by Non-Medicaid (11.8%) and Non-Citizen (11.0%).

Within 33 months after delivery (prior to March 2008), 23.6% of respondents had a subsequent birth record in FSDB or were pregnant at the time of the survey. Women who had a subsequent birth or pregnancy differed from those who did not in several areas: age, parity, pregnancy intention for target birth, use of birth control at the time of target pregnancy, effect of health insurance on their decision to have the baby born in 2005, and agreement that it is best to plan ahead for pregnancy using birth control. Characteristics present at the time of the survey, such as wanting more children, living situation, employment status, effectiveness of birth control method during the past two months, and health status, differed between these two groups (Table 17).

- A larger proportion (29.8%) of women under age 25 at the time of the target birth had a subsequent birth or pregnancy than women older than age 25 (17.6%).
- At the time of the survey, over half (50.2%) the women with a subsequent birth or pregnancy reported that they were homemakers exclusively.
- The majority of women who had a subsequent birth or pregnancy were either married or living with a partner (87.3%). Among women without a subsequent birth, 74.4% were married or living with a partner, and 24.7% were single (divorced, separated, or never married).

Table 18. Subsequent Pregnancy/Birth versus No Subsequent Pregnancy/Birth

Characteristic	Sub. Preg/Birth		No Sub. Preg/Birth		p*
	n=301	(%) [†]	n=991	(%) [†]	
Age at delivery (years)					<.01
mean ± SD	24.1	±16.1	26.3	±19.5	
18-19	34	(12.6)	81	(9.1)	
20-24	143	(49.3)	336	(35.9)	
25-29	82	(25.5)	288	(27.8)	
30-34	28	(8.7)	178	(17.7)	
> 34	14	(3.8)	108	(9.4)	
Number of live births at time of survey					<.01
median	1		2		
One	139	(47.5)	351	(36.0)	
Two	76	(25.4)	291	(30.0)	
Three	39	(11.9)	180	(17.8)	
Four or more	29	(9.3)	119	(11.5)	
Unknown	18	(5.9)	50	(4.7)	
Pregnancy Intention 3 months before getting pregnant with target birth					0.04
Trying to get pregnant	85	(27.6)	241	(23.8)	
Wasn't trying to get pregnant or trying to keep from getting pregnant	102	(34.0)	291	(29.8)	
Trying to keep from getting pregnant, but not trying very hard	78	(26.3)	275	(28.3)	
Trying hard to keep from getting pregnant	35	(11.6)	175	(17.4)	
Did having health insurance affect your decision to have target baby?					<.01
A lot	48	(15.7)	214	(21.4)	
Some	98	(32.9)	371	(38.1)	
Not at all	150	(51.4)	396	(40.5)	
Current Living Situation at time of survey					<.01
Married/Living with Partner	264	(87.3)	741	(74.4)	
Single/Divorced/Separated	32	(10.9)	238	(24.4)	
Current employment status at time of survey					<.01
Full time	49	(17.2)	315	(32.5)	
Part time	56	(19.9)	266	(27.0)	
Unemployed/laid off	23	(8.0)	71	(7.4)	
Student	15	(4.7)	49	(4.9)	
Homemaker	150	(50.2)	278	(28.1)	
It's best to plan ahead for a pregnancy by using birth control					<.01
Agree	209	(70.6)	809	(84.1)	
Neither agree nor disagree	70	(24.2)	120	(12.6)	
Disagree	16	(5.2)	33	(3.3)	
Doing something to keep from getting pregnant with target birth?					0.01
Yes	106	(36.1)	442	(45.2)	
No	193	(63.9)	534	(54.8)	
Desire more children in the future at time of survey?					<.01
Yes	193	(71.9)	458	(50.2)	
No	78	(28.1)	466	(49.8)	
Overall health status at time of survey					<.01
Excellent	86	(28.7)	184	(18.8)	
Very good	117	(39.7)	333	(34.1)	
Good	77	(25.7)	330	(34.2)	
Fair/Poor	18	(5.9)	124	(12.9)	
Birth Control Method within 2 months of survey					<.01
Abstinent/No Sex	18	(5.9)	76	(7.6)	
None	106	(34.7)	101	(10.1)	
Less Effective Method	83	(28.0)	221	(21.9)	
Highly Effective Method	94	(31.4)	592	(60.4)	
If you needed birth control, would getting it be a problem?					0.01
Big Problem/Small Problem	52	(18.2)	241	(25.5)	
Not a problem	242	(81.8)	719	(74.5)	

*Significant differences between respondents who had a subsequent birth/pregnancy and those who did not have a subsequent birth/pregnancy determined using chi-square test for categorical variables or two sample t-test for equal means for maternal age as a continuous variable.

[†]Percentage weighted for survey non-response.

Table 19. Factors Associated with Subsequent Birth/Pregnancy

Independent Factor	OR* (95% CI)
<i>Family Planning Method Used During Past Two Months</i>	
None vs. highly effective	6.13 (3.84, 9.77)
Abstinent/no sex vs. highly effective method	3.24 (1.52, 6.90)
Less effective method vs. highly effective method	2.60 (1.70, 3.98)
<i>Overall Health</i>	
Excellent vs. fair/poor	4.98 (2.19, 11.33)
Very good vs. fair/poor	3.73 (1.72, 8.11)
Good vs. fair/poor	2.43 (1.11, 5.36)
Homemaker only vs. employed full-time	3.15 (1.94, 5.13)
<i>Education at Delivery</i>	
No HS diploma vs. BA degree or more	2.44 (1.13, 5.29)
Some college vs. BA degree or more	2.18 (1.16, 4.12)
Married/living with partner vs. single	2.20 (1.26, 3.85)
Decision to have baby not at all influenced by health insurance vs. a lot	1.90 (1.17, 3.06)
Desire having more children in the future vs. having no more children	1.64 (1.09, 2.48)
Age 30-34 at delivery vs. 25-29	0.46 (0.24, 0.89)

*Odds ratio adjusted for all variables in the model.

The strongest risk factors for a subsequent birth were use of no family planning method, excellent health status, and being a stay-at-home mom. Older age (mothers 30 – 34 years old at delivery) reduced the risk of a subsequent birth.

- The rate of subsequent birth or pregnancy was 6.13 times greater for women using no birth control, 2.60 times greater for women using a less effective method, and 3.24 times greater for women who were abstinent during the past two months compared to women using a highly effective method, after adjusting for all other variables in the model.
- The rate of subsequent birth or pregnancy was 4.98 times greater for women reporting excellent overall health status, 3.73 times greater for women reporting very good overall health status, and 2.43 times greater for women reporting good overall health status compared to women reporting fair or poor health status, after adjusting for all other variables.
- The rate of subsequent birth or pregnancy was 3.15 times higher among women who were exclusively homemakers compared to women who were employed full-time, after adjusting for all other variables.

DISCUSSION

Survey findings provide great detail about the characteristics of S women who did and did not use family planning services. In addition, the surveys inform us about broader issues, including lack of health insurance and the role of stay-at-home moms.

The Washington State Population Survey (SPS) conducted by the Office of Financial Management estimates that 21.6% of women age 18 – 44 with family incomes between 100 and 200% of the FPL were uninsured, with 59.6% having employer-based, individual, military, or other private insurance and 18.8% having publicly-funded health insurance. More than half (54%) our respondents were uninsured prior to pregnancy and only 33.5% had private insurance. Two years later, more than one-third of S Women (35%) were uninsured. These large differences are consistent with characteristics of our survey sample: by surveying women who became Medicaid-eligible because of pregnancy, women who were uninsured prior to pregnancy are over-represented. It is also possible that women who become Medicaid-eligible because of pregnancy differ in other ways from the statewide sample in the SPS. While few (7%) children whose birth qualified our respondents to be in our survey were uninsured at age two, their mothers expressed special concerns about their own lack of health insurance. In open-ended comments, numerous mothers addressed this issue: *“So is there hope for single mothers like myself to get Health Insurance that we can afford or get assistance?”* and *“After my children are both in school and I start working again, then I will hopefully have medical again. For now, I’m living on the edge.”*

Our survey also highlights characteristics of women whose primary occupation was homemaker (stay-at-home moms). The proportion of respondents whose primary occupation was homemaker increased from 23.1% prior to pregnancy to 33.3% two years later. The most frequent reason cited in the SPS for respondents not working in the previous two weeks was taking care of family and home. The need to stay at home to care for family members thus contributes to the lack of health insurance in this group, since employer-based coverage is the most frequent source of health insurance in this age group. Women who reported their pre-pregnancy work status as homemaker were less likely to receive subsequent Medicaid-paid family planning services, and women whose work status two years after delivery was homemaker accounted for half (50.2%) of the women with a subsequent birth or pregnancy. In a multivariate model, women whose work status was homemaker were more than three times (OR=3.15) more likely to have a subsequent birth or pregnancy compared to women who were employed full-time. In the same model, using no birth control method during the past two months was most strongly associated with a subsequent birth or pregnancy (OR=6.13).

While more single women received Medicaid-paid family planning services (57.3% of single women compared to 52% of married women), the proportion who received family planning services was much higher for younger married women than for older married women (81.5% for 18 – 19 year olds compared to 32.3% for women older than 34). The use of family planning services among single women did not vary by age. The striking differences among married women remained significant in a multivariate model that controlled for educational attainment, employment, and other variables. The significance of age *per se* could be related to other factors not measured by our survey. The differences might reflect generational changes in values or

attitudes about child-bearing. Older women might be less likely to receive family planning methods because they seek to complete their families by having additional children without delay. It is also possible that younger women are more likely to receive Medicaid-paid family planning services because their incomes are lower and so they depend on publicly-financed family planning to a greater extent than older women.

On the other hand, the use of a highly effective family planning method was only modestly greater among those women who received Medicaid-paid family planning services (58.9%) compared to women who did not (47.2%). This suggests that some women who desire highly effective family planning methods will acquire them, whether or not they have coverage through Medicaid or TAKE CHARGE. The survey did not ask women where they had received their family planning method if it was not through Medicaid or TAKE CHARGE.

Ambivalence about pregnancy intention was more frequent among married women and those living with a partner than among single or divorced women. Nearly 90% of single or divorced women either did not want to get pregnant or *really* did not want to get pregnant in the next year; less than 10% were ambivalent (kind of wanted to get pregnant and kind of didn't want to get pregnant, or didn't care one way or the other if she got pregnant). Among married women and those living with a partner, 72% either did not want to get pregnant or *really* did not want to get pregnant, and 14.5% were ambivalent.

While future pregnancy intention corresponded in a general way to the effectiveness of the family planning method used at the time of the survey, more than half (57.6%) of the women who wanted to get pregnant in the next year reported using some family planning method. This apparent inconsistency could be related to timing; the respondent might want to get pregnant within the next year but not at the time of the survey. It is also possible that these differences reflect the incongruity between desires and behavior; although the respondents may desire to get pregnant (in the future), they may nevertheless take action to prevent pregnancy.

The survey findings also highlight more general characteristics of potential target groups for greater use of highly effective family planning methods: single women; younger women (single or married); women who agree that it is best to plan ahead for pregnancy by using birth control methods; and women whose hopes and dreams do not include having more children. With well established enhanced prenatal care services including Maternity Support Services and a CSO-based family planning program, Washington is well positioned to develop targeted interventions to reach more recently pregnant women through our family planning waiver.

CONCLUSION

Recently pregnant women who responded to our survey informed us of the wide range of circumstances they experience and the diversity of their attitudes and beliefs. Generally speaking, these women expressed gratitude for the maternity services they received with Medicaid coverage and the family planning services that some of them received through TAKE CHARGE. A small minority disapproved of family planning services in general and for single women in particular. Nevertheless, the majority of respondents (80.9%) agreed or strongly agreed that “It is best to plan ahead for a pregnancy by using birth control methods.” Just 3.8% of respondents disagreed or strongly disagreed with that statement, and an additional 15.4% neither agreed nor disagreed.

Within 33 months of the pregnancy that qualified the respondents for this study, nearly one-quarter (23.6%) had a subsequent birth or said they were currently pregnant at the time of the survey. Of those who reported being pregnant at the time of the survey, just over half (52.9%) were trying to get pregnant, and 47.1% said they were not trying to get pregnant.

More than three-fourths (75.6%) of the women without a subsequent birth or pregnancy stated that either they did not want to get pregnant or really did not want to get pregnant during the next twelve months. However, only 66.1% of these women were using a highly effective birth control method. Over ten percent (10.5%) were abstinent, and nearly one-fourth (23.4%) were using no birth control method or a less effective method. These women, who did not want or really did not want to get pregnant and were using no birth control method or a less effective method, represent a critical target group for the TAKE CHARGE program.

Despite numerous mailings from HRSA, postpartum medical appointments, and counseling about family planning and/or birth control, nearly half (47.1%) of the respondents were unfamiliar with the name of Washington’s family planning waiver (TAKE CHARGE), and almost one-quarter (24.1%) were unaware that their family planning would be covered by Medicaid for one year after the birth of their baby. Although nearly half of the S women overall received one or more medical family planning service or services through the TAKE CHARGE program according to claims data, 47.2% of survey respondents who had no paid claims for family planning services reported using a highly effective birth control method. While it is reassuring that these women reported using highly effective birth control methods, and some were certainly using long-acting methods that did not require medical follow-up to remain effective (tubal ligation and IUD), as many as 44.3% were using less effective methods or no birth control at all. In addition to those women, 35.2% of the women who had paid claims for family planning services were also using less effective methods or no birth control at all.

These data underscore the challenges in informing and educating clients about the services covered by Medicaid and the family planning waiver. Maternity Support Services providers serve more than 70% of pregnant Medicaid clients and are responsible for counseling clients about family planning services before and after delivery. Although Washington has stationed family planning nurses in the majority of welfare offices (CSOs) across the state, S women may have no need to visit their CSO around the time of delivery.

Opportunities exist to present a stronger and more consistent message to pregnant women about the importance and availability of birth control methods to plan the timing of their next pregnancy if they seek to have more children or to prevent pregnancy, if that is their desire.

During the time of highest enrollment in TAKE CHARGE, unintended pregnancy rates among S women declined. However, as TAKE CHARGE enrollment decreased from July 2006 through June 2009, the unintended pregnancy rates increased, to levels just below those before TAKE CHARGE. Deliveries to S women increased slightly each year from 2001 to 2005 and then began a period of more rapid increase. S women remain the single largest group of pregnant women on Medicaid, exceeding both women on TANF and Non-citizens.

Understanding the reasons for the decline in TAKE CHARGE enrollment from July 2006 through June 2009 and addressing these reasons with appropriate interventions are critical for regaining the progress that had been achieved in reducing unintended pregnancy among Medicaid women in Washington.

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APPENDICES

APPENDIX A: SURVEY QUESTIONNAIRE

PLEASE PROMPTLY RETURN THIS SURVEY IN THE ATTACHED POSTAGE-PAID ENVELOPE

TAKE CHARGE Evaluation:
A Survey of Recently Pregnant Women



Your comments on this program are important to us. Please help us by answering the following questions. Your answers will be kept strictly confidential.

Sponsored by:

Department of Social & Health Services
Research and Data Analysis
PO Box 45204
Olympia, WA 98504

Conducted by:

Social & Economic Sciences Research Center
Washington State University
PO Box 641801
Pullman, WA 99164-1801

1. We would like to confirm the information we have. You had a baby in March or April 2005. Is that correct?

- Yes
- No → If no, you do not have to complete the rest of this survey. Please mail the survey back to us in the postage-paid envelope and we will remove your name from our survey list. Thank you for your time.

2. What is your baby's date of birth?

_____ / _____ / 2005 (Month/Day/Year)

We have some questions for you about your experiences before, during, and after your pregnancy. Please answer these questions only for your pregnancy in 2005.

First, we would like to know more about you during the month or so *before* you got pregnant in 2005.

3. Just before you got pregnant, what was your job status? (Check all that apply.)

- Working part time (less than 40 hours per week)
- Working full time (40 hours per week or more)
- Unemployed, not looking for work
- Unemployed but looking for work
- Temporarily laid off, on sick or other leave
- Homemaker or stay-at-home mom
- Full-time student
- Other

4. Just before you got pregnant, did you have health insurance other than Medicaid?

- Yes → Go to Question 7
- No

5. Just before you got pregnant, were you on Medicaid, Healthy Options, or medical coupon?

- Yes → Go to Question 7
- No

6. How long did you go without health insurance before you became pregnant?

- Less than one month
- _____ months

7. Which of the following statements best describes you during the 3 months before you got pregnant?

- I was trying to get pregnant.
- I wasn't trying to get pregnant or trying to keep from getting pregnant.
- I was trying to keep from getting pregnant but was not trying very hard.
- I was trying hard to keep from getting pregnant.

8. How much did having or not having health insurance affect your decision to have a baby?

- A lot. (For example, I would not have had a baby without health insurance.)
- Some. (For example, I was concerned about insurance but it didn't affect my/our decision.)
- Not at all. (For example, I didn't really think about it.)

9. How much did your (or your family's) finances affect your decision to have a baby?

- A lot. (For example, I would not have had a baby if I/we couldn't afford it.)
- Some. (For example, I was concerned about money but I/we really wanted this baby.)
- Not at all. (For example, I didn't really think about it.)

10. When you got pregnant, were you, your husband, or partner doing anything to keep from getting pregnant? (Some things people do to keep from getting pregnant include not having sex at certain times or withdrawal, and using birth control methods such as the pill, condoms, cervical ring, IUD, having their tubes tied, or their partner having a vasectomy.)

- Yes → Go to Question 12
- No

11. What were your reasons for not using any birth control? (Check all that apply.)

- I wanted to get pregnant.
- I didn't mind if I got pregnant.
- I thought I could not get pregnant at that time.
- I had side effects from the birth control method I had been using.
- I had problems getting birth control when I needed it.
- I thought my husband, partner, or I was sterile (vasectomy or tubes tied).
- My husband or partner didn't want to use anything.
- Using birth control is against my (or my partner's) personal beliefs.
- Other. (Please tell us): _____

The following questions are about the time *during* and *just after* your pregnancy in 2005.

12. How long did you go without health insurance during your pregnancy?

- I was insured the *entire* time I was pregnant → Go to Question 14
- Less than one month
- _____ months

13. Why weren't you covered by health insurance? (Check all that apply.)

- Person in family with health insurance lost job or changed employers
- Got divorced or separated from husband or partner
- Death of husband or partner
- Employer does not offer coverage/not eligible for coverage
- Cost is too high
- Insurance company refused coverage
- Other. (Please tell us): _____

14. Did you lose a job while you were pregnant?

- Yes
- No
- Not applicable (I didn't work during my pregnancy)

15. Did your partner lose a job while you were pregnant?

- Yes
- No
- Not applicable (I didn't have a partner or he didn't have a job)

16. Did you ever breastfeed or pump breast milk to feed your baby?

- Yes
- No → Go to Question 18

17. How old was your baby when you started feeding [him/her] something other than breast milk? (It may help to look at a calendar.)

_____ months

18. After your baby was born, did you have a postpartum checkup for yourself? (A postpartum checkup is the regular checkup a woman has after she gives birth.)

- Yes
- No

19. In the few weeks before or after your baby was born, did a doctor, nurse, or other health care worker talk with you about family planning or using birth control?

- Yes
- No

20. In the few weeks before or after your baby was born, did you receive any of the following? (Check all that apply.)

- An over-the-counter (non-prescription) birth control method
- A prescription for a birth control method
- A check-up or medical test related to using birth control
- Counseling or information about birth control
- Counseling or information about getting sterilized
- Emergency contraception ("morning after pill")
- A pregnancy test
- An abortion

21. In the few weeks before or after your baby was born, how aware were you that your family planning and birth control would be covered by Medicaid for one year after your baby was born?

- Very aware
- Somewhat aware
- Not aware

22. Since your baby was born, have you ever gone to a doctor, nurse, or other health care worker for birth control?

- Yes → Go to Question 24
- No

23. What are the reasons you have not seen a health care provider for birth control or other family planning services since your baby was born? (Check all that apply.)

- I am not having sex.
- I use over-the-counter birth control (such as condoms).
- I use natural family planning methods (for example, rhythm method).
- I want to get pregnant again.
- I do not mind if I get pregnant.
- I am or my husband or partner is sterile (vasectomy or tubes tied).
- I don't have health insurance to pay for it.
- I don't have the time.
- Using birth control is against my (or my partner's) personal beliefs.
- Other (Please tell us): _____

The following questions ask about your situation in the recent past, now, and in the future.

24. What is your current living situation?

- Married
- Not married but living with a partner
- Divorced
- Widowed
- Separated from spouse
- Never married and not living with a partner

25. What is your current job status? (Check all that apply.)

- Working now, part time (less than 40 hours per week)
- Working now, full time (40 hours or more per week)
- Unemployed, not looking for work
- Unemployed but looking for work
- Temporarily laid off, on sick or other leave
- Homemaker or stay-at-home mom
- Full-time student
- Other (Please tell us): _____

Go to
Question 27

26. How long have you been working at your current job(s)?

- Less than 6 months
- Between 6 months and 1 year
- More than 1 year

27. What is your husband's or partner's current job status? (Check all that apply.)

- Working now, part time (less than 40 hours per week)
- Working now, full time (40 hours or more per week)
- Unemployed, not looking for work
- Unemployed but looking for work
- Temporarily laid off, on sick or other leave
- Homemaker or stay-at-home dad
- Full-time student
- Not applicable (no husband or partner)
- Other (Please tell us): _____

28. What type of health insurance do you have now? (Check all that apply.)

- I don't currently have insurance
- Medicaid, Healthy Options, or medical coupon
- A private insurance plan from an employer
- A private insurance plan *not* from an employer
- State-sponsored health plan (such as Basic Health Plan)
- Military health care
- Other (Please tell us): _____

Go to
Question 31

29. How long have you been uninsured?

_____ months

30. Why aren't you covered by health insurance? (Check all that apply.)

- Person in family with health insurance lost job or changed employers
- Got divorced or separated from husband or partner
- Death of husband or partner
- Employer does not offer coverage/not eligible for coverage
- Cost is too high
- Insurance company refused coverage
- Lost Medicaid insurance coverage
- Other (Please tell us): _____

31. What type of health insurance do you have for your baby born in 2005?
(Check all that apply.)

- My baby doesn't currently have insurance
- Medicaid, Healthy Options, or medical coupon
- A private insurance plan from an employer
- A private insurance plan *not* from an employer
- State-sponsored health plan (such as Basic Health Plan)
- Military health care
- Other (Please tell us): _____

32. How many children do you have now living full-time in your household?

_____ children

33. How many children do you hope to have some day, including your baby born in 2005?

_____ children

34. Is your husband or partner supportive of your goals for having (or not having) children?

- Yes
- No
- Not applicable (No husband or partner)

35. How confident are you that you can choose the number of children you will have *in the future*, including not having any more children?

- Not at all confident
- A little confident
- Somewhat confident
- Mostly confident
- Totally confident

36. Which of the following statements best describes what you want to happen during the next 12 months? (Check only one.)

- I want to get pregnant during the next 12 months.
- I kind of want to get pregnant.
- I don't care one way or the other if I get pregnant.
- I do not want to get pregnant.
- I really do not want to get pregnant during the next 12 months.

37. Are you pregnant now?

- Yes
- No → Go to Question 39
- Unsure → Go to Question 39

38. Were you trying to get pregnant?

- Yes
- No

39. ***During the last 2 months, what kinds of birth control did you and your partner(s) use when you had sex?*** (Check all that apply.)

- No sex during the last 2 months (abstinent)
- Note: we did not use *any* method
- Birth control pills
- Condoms, female
- Condoms, male
- Diaphragm, cervical cap
- Emergency contraception ("morning after") pills
- Foam, cream, jelly
- IUD (intrauterine device)
- Norplant[®] implant
- Patch—Ortho Evra[®]
- Natural family planning (for example, rhythm method)
- Ring—NuvaRing[®]
- Shot—Depo Provera[®] or Lunelle[®]
- Sterilization, female (tubes tied)
- Sterilization, male (vasectomy)
- Withdrawal ("pulling out")
- Other (Please tell us): _____

40. **How much of a problem would it be for you to get birth control if you needed it?**

- A big problem
- A small problem
- Not a problem

41. **Have you heard about the TAKE CHARGE program that provides family planning services and birth control at no cost to many women in Washington State?**

- Yes → Go to Question 42
- No

If you would like information on TAKE CHARGE, a program that provides birth control at no cost to many Washington women, call the Family Planning Hotline toll-free at 1-800-770-4334

Now we would like to know more about your opinions. Please tell us how much you strongly agree, agree, neither agree nor disagree, disagree, or strongly disagree with the following statement about family life.

42. **It is best to plan ahead for a pregnancy by using birth control methods.**

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

For each situation listed below, please tell us whether you would be very upset, a little upset, a little pleased, very pleased, or that you wouldn't care.

43. **How would you feel if you got pregnant in the next year?**

- Very upset
- A little upset
- A little pleased
- Very pleased
- I wouldn't care

44. **How would you feel if you got pregnant now? (If you are already pregnant or have had another baby since 2005, how do you feel about it?)**

- Very upset
- A little upset
- A little pleased
- Very pleased
- I wouldn't care

45. **How would you feel if you did not have any more children?**

- Very upset
- A little upset
- A little pleased
- Very pleased
- I wouldn't care

Finally, we'd like to know a little bit more about you.

46. **What is your date of birth?**

____ / ____ / 19 ____ (Month/Day/Year)

47. **What is the highest grade or level of school that you have completed?**

- 8th grade or less
- Some high school, but did not graduate
- High school graduate or GED
- Some college, 2-year degree, or technical school
- 4-year college graduate
- More than 4-year college degree

48. **Are you of Hispanic or Latina origin or descent?**

- Yes
- No

49. What is your race? (Check all that apply.)

- White
- Black or African American
- Asian American
- Native Hawaiian or other Pacific Islander
- American Indian or Alaska Native
- Other (Please tell us): _____

50. Including your pregnancy in 2005, how many times have you been pregnant in your life? _____ times

51. Including the birth of your baby in 2005, how many times have you given birth in your life? _____ times

52. How would you rate your overall health now?

- Excellent
- Very Good
- Good
- Fair
- Poor

53. What is your monthly total family income from all sources? Include money from jobs and government assistance for all family members who live with you. Please tell us your best guess.

- \$500 or less
- \$501-999
- \$1,000-1,499
- \$1,500-1,999
- \$2,000-2,499
- \$2,500-2,999
- \$3,000-3,499
- \$3,500 or more

Thank you for taking the time to complete our survey!
If you have any additional comments or questions, please note them in the box below.

If you would like information about the TAKE CHARGE program that provides family planning services and birth control at no cost to many Washington women, call the Family Planning Hotline toll-free at 1-800-770-4334

Please return your questionnaire in the postage-paid envelope provided to:

Social & Economic Sciences Research Center
Washington State University
PO Box 641801
Pullman, WA 99164-1801

APPENDIX B: STUDY OUTCOMES: ODDS RATIO ESTIMATES

Table 1. Factors Associated with Medicaid-paid Family Planning Service Utilization

Independent Variables	Crude OR (95% CI)	Adjusted OR[†] (95% CI)
Age		
18-19	1.42 * (0.92 , 2.19)	
20-24	1.56 * (1.18 , 2.06)	
25-29	0.65 * (0.46 , 0.93)	
30-34	0.52 (0.34 , 0.81)	
≥ 35	1.00	
Age at delivery among married women		
18-19	4.47 * (1.62 , 12.32)	3.97 * (1.35 , 11.68)
20-24	1.80 * (1.23 , 2.65)	1.74 * (1.15 , 2.65)
25-29	1.00	1.00
30-34	0.61 * (0.40 , 0.95)	0.66 (0.41 , 1.06)
≥ 35	0.48 * (0.27 , 0.85)	0.54 (0.29 , 1.00)
Education at time of delivery		
No HS diploma	2.30 * (1.45 , 3.66)	2.01 * (1.16 , 3.48)
HS diploma/GED	1.88 * (1.24 , 2.86)	1.57 (0.96 , 2.56)
Some college or AA degree	1.52 * (1.01 , 2.28)	1.29 (0.81 , 2.06)
Bachelor's degree or more	1.00	1.00
Employment status prior to pregnancy		
Full time	2.16 * (1.61 , 2.91)	1.82 * (1.29 , 2.58)
Part time	1.46 * (1.05 , 2.02)	1.24 (0.86 , 1.78)
Unemployed/laid off	1.12 (0.67 , 1.87)	0.96 (0.53 , 1.76)
Student	1.28 (0.73 , 2.25)	0.86 (0.46 , 1.62)
Homemaker only	1.00	1.00
Current employment status at time of survey		
Full time	1.45 * (1.08 , 1.93)	
Part time	1.01 (0.75 , 1.36)	
Unemployed/laid off	1.45 (0.91 , 2.32)	
Student	0.97 (0.57 , 1.65)	
Homemaker	1.00	
Number of live births		
One	2.08 * (1.42 , 3.05)	
Two	1.58 * (1.06 , 2.34)	
Three	1.13 (0.73 , 1.74)	
Four or more	1.00	
It's best to plan ahead for a pregnancy using birth control		
Agree	2.93 * (1.54 , 5.58)	2.49 * (1.20 , 5.15)
Neither agree nor disagree	2.37 * (1.18 , 4.75)	1.77 (0.81 , 3.86)
Disagree	1.00	1.00
Level of "trying" 3 months prior to getting pregnant with target birth		
Trying hard to keep from getting pregnant	1.44 * (1.01 , 2.06)	
Trying to keep from getting pregnant, but not very hard	1.37 * (1.00 , 1.87)	
Wasn't trying to or trying to keep from getting pregnant	1.13 (0.83 , 1.52)	
Trying to get pregnant	1.00	
Doing something to keep from getting pregnant at target birth?		
Yes	1.27 * (1.01 , 1.59)	1.30 * (1.00 , 1.68)
No	1.00	1.00
Heard of TAKE CHARGE?		
Yes	1.65 * (1.31 , 2.07)	1.64 * (1.27 , 2.10)
No	1.00	1.00
How aware were you that Medicaid would cover your family planning		
Very aware	1.34 * (1.01 , 1.77)	
Somewhat aware	1.08 (0.78 , 1.48)	
Not aware	1.00	
Family planning method used at time of survey		
Highly effective	1.62 * (1.18 , 2.23)	
Less effective	1.05 (0.73 , 1.51)	
Abstinent	0.90 (0.54 , 1.49)	
None	1.00	
Respondent or partner has been sterilized		
No	1.72 * (1.21 , 2.45)	1.55 * (1.02 , 2.34)
Yes	1.00	1.00

*Significant difference in the odds of receiving a Medicaid-paid Program S family planning service compared to the odds of the reference group receiving a family planning service.

[†]Adjusted OR for all variables in the model and interaction between age and marital status. Final model R²=0.73 and Hosmer-Lemeshow=0.051.

Table 2. Factors Associated with Highly Effective Method Use in the Past Two Months

Independent Variables	Crude OR	(95% CI)	Adjusted OR*	(95% CI)
Desired number of future children				
No more	2.86	(2.24 , 3.65)	2.39	(1.70 , 3.37)
More	1.00		1.00	
Confidence in choosing future number of children				
Totally	2.18	(1.61 , 2.96)	1.90	(1.27 , 2.83)
Mostly	1.61	(1.14 , 2.28)	1.35	(0.87 , 2.09)
Somewhat / a little / not at all	1.00		1.00	
Future pregnancy wantedness				
Want to get pregnant	1.00		1.00	
Ambivalent	1.41	(0.78 , 2.56)	1.25	(0.61 , 2.55)
Don't want to get pregnant	2.76	(1.93 , 3.93)	2.36	(1.50 , 3.70)
Subsequent birth or pregnancy	0.63	(0.42 , 0.95)	0.48	(0.30 , 0.79)
Seen health care worker for birth control since target birth				
Yes	3.59	(2.83 , 4.56)	5.92	(4.30 , 8.14)
No	1.00		1.00	
Maternal age at target birth				
18-19	1.47	(0.95 , 2.28)	2.78	(1.53 , 5.03)
20-24	0.86	(0.65 , 1.13)	1.23	(0.85 , 1.78)
25-29	1.00		1.00	
30-34	1.24	(0.87 , 1.76)	1.31	(0.86 , 2.00)
≥ 35	0.93	(0.61 , 1.41)	0.96	(0.55 , 1.66)
Counseling or information about sterilization				
Yes	3.11	(2.22 , 4.37)	2.79	(1.77 , 4.41)
No	1.00		1.00	
Problem getting birth control if needed				
Yes	1.00		1.00	
No	1.44	(1.10 , 1.88)	1.67	(1.19 , 2.35)
Living situation at time of survey				
Married / living with partner	1.06	(0.81 , 1.40)	1.86	(1.29 , 2.69)
Single / divorced / separated	1.00		1.00	
Using birth control before target pregnancy				
Yes	1.59	(1.26 , 2.00)		
No	1.00			
Received a prescription for a birth control method				
Yes	1.32	(1.05 , 1.66)		
No	1.00			
Prior live births (recored in FSDB)				
No prior births	1.00			
One or more prior births	1.58	(1.26 , 1.98)		
Subsequent birth or pregnancy				
Yes	1.00			
No	3.32	(2.51 , 4.39)		
Post pregnancy extension				
Yes	1.60	(1.27 , 2.00)		
No	1.00			
Number of children living in household				
One child	1.00			
More than one child	1.48	(1.17 , 1.87)		
Job status at time of survey				
Working full-time	1.41	(1.06 , 1.88)		
Working part-time	1.48	(1.10 , 1.99)		
Unemployed	0.81	(0.51 , 1.28)		
Student only	1.01	(0.59 , 1.72)		
Homemaker only	1.00			

*Odds ratios adjusted for all variables in the final model. Final Model R²=0.98 and Hosmer-Lemeshow=0.23.

Table 3. Factors Associated with Subsequent Birth or Pregnancy

Independent Variable	Crude OR	95% CI (L, U)	Adjusted OR*	95% CI (L, U)
Age at delivery (years)				
18-19	1.41	(0.87 , 2.29)	1.33	(0.64 , 2.76)
20-24	1.41	(1.01 , 1.96)	1.53	(0.99 , 2.35)
25-29	1.00		1.00	
30-34	0.57	(0.35 , 0.95)	0.46	(0.24 , 0.89)
35 and older	0.51	(0.27 , 0.98)	0.52	(0.22 , 1.20)
Education at delivery				
Less than high school diploma	1.77	(1.00 , 3.16)	2.44	(1.13 , 5.29)
High school diploma / GED	1.30	(0.76 , 2.22)	1.50	(0.74 , 3.02)
Some college / AA degree	1.47	(0.87 , 2.48)	2.18	(1.16 , 4.12)
BA degree or more	1.00		1.00	
Number of live births at time of survey				
One	1.54	(1.01 , 2.37)		
Two	1.08	(0.68 , 1.72)		
Three	1.00			
Four or more	1.26	(0.70 , 2.26)		
Marital Status at time of the survey				
Married	1.46	(1.10 , 1.94)		
Single	1.00			
Current Living Situation				
Married/Living with partner	2.70	(1.78 , 4.09)	2.20	(1.26 , 3.85)
Single/Divorced/Separated	1.00		1.00	
Current employment status at time of survey				
Working full-time	1.00		1.00	
Working part-time	1.37	(0.89 , 2.12)	1.52	(0.90 , 2.56)
Unemployed	1.90	(1.05 , 3.46)	1.66	(0.74 , 3.73)
Student only	1.42	(0.67 , 2.99)	1.42	(0.67 , 2.99)
Homemaker only	3.54	(2.41 , 5.19)	3.15	(1.94 , 5.13)
Pregnancy Intention 3 months before getting pregnant				
Trying to get pregnant	1.71	(1.07 , 2.72)		
Wasn't trying or trying to keep from getting pregnant	1.65	(1.05 , 2.60)		
Trying to keep but not very hard	1.25	(0.78 , 2.00)		
Trying hard to keep from getting pregnant	1.00			
How much did having health insurance affect your decision to have a baby?				
A lot	1.00		1.00	
Some	1.22	(0.81 , 1.84)	1.03	(0.62 , 1.70)
Not at all	1.86	(1.26 , 2.74)	1.90	(1.17 , 3.06)
It is best to plan ahead for a pregnancy by using birth control				
Agree	1.00			
Neither	2.30	(1.61 , 3.28)		
Disagree	1.92	(1.01 , 3.63)		
Desire more children in the future?				
More	2.50	(1.81 , 3.46)	1.64	(1.09 , 2.48)
No more	1.00		1.00	
Doing something to keep from getting pregnant with target birth?				
Yes	1.00			
No	1.52	(1.14 , 2.03)		
Birth Control Method within 2 months of survey				
Abstinent/No Sex	1.43	(0.80 , 2.54)	3.24	(1.52 , 6.90)
No method	6.29	(4.33 , 9.12)	6.13	(3.84 , 9.77)
Less effective method	2.35	(1.64 , 3.36)	2.60	(1.70 , 3.98)
Highly effective method	1.00		1.00	
Overall health status at time of survey				
Excellent	3.41	(1.87 , 6.23)	4.98	(2.19 , 11.33)
Very good	2.47	(1.38 , 4.42)	3.73	(1.72 , 8.11)
Good	1.67	(0.92 , 3.04)	2.43	(1.11 , 5.36)
Fair / poor	1.00		1.00	
If you needed birth control, would getting it be a problem?				
Problem	0.63	(0.44 , 0.89)		
Not a problem	1.00			

*Adjusted OR for all variables in the model. Final model R²=94.6.

Excludes 153 women with sterilization.

TAKE CHARGE Final Evaluation
Three-Year Renewal: July 2006 – June 2009
Primary Care Referral

Trisha Keenan-Wilkie, M.A.
Laurie Cawthon, M.D., M.P.H.

September 2009

Department of Social and Health Services
Planning, Performance, and Accountability
Research and Data Analysis Division
Olympia, WA 98504-5204

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

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PLANNING, PERFORMANCE, AND ACCOUNTABILITY

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Elizabeth Kohlenberg, Ph.D., Director

In Collaboration with

HEALTH AND RECOVERY SERVICES ADMINISTRATION

Doug Porter, Assistant Secretary

DIVISION OF HEALTHCARE SERVICES

MaryAnne Lindeblad, B.S.N., M.P.H., Director

OFFICE OF COMMUNITY SERVICES

Todd Slettvet, M.A., Section Manager, Family Healthcare Services

Maureen Considine, A.R.N.P., TAKE CHARGE Program Manager

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EXECUTIVE SUMMARY

Washington State's TAKE CHARGE program, which began July 2001, expands Medicaid coverage for family planning services to men and women with family incomes at or below 200% of the federal poverty level (FPL). Program goals are to improve the health of women, children, and families in Washington by decreasing unintended pregnancies and lengthening intervals between births, and to reduce state and federal Medicaid expenditures for births from unintended pregnancies. The Department of Social and Health Services (DSHS) Health and Recovery Services Administration (HRSA) administers this program. The Centers for Medicare and Medicaid Services (CMS) approved the TAKE CHARGE program as a family planning demonstration program (§1115 waiver).

This report describes the primary care referral evaluation performed during the first three-year waiver renewal period (July 2006 – June 2009). Data sources include provider surveys, primary care referral forms completed by providers, and client surveys.

Key Findings

REFERRAL PRACTICES

- All providers at the ten research sites referred their TAKE CHARGE clients to primary care. Providers completed 482 primary care referral forms during the ten-month data collection period. Client survey responses show 12% of the survey respondents received a referral or recommendation from their TAKE CHARGE provider to see a doctor or specialist because of their health.
- Among survey clients who received a referral or recommendation, 56% reported receiving the name or a list of doctors, specialists, or clinics from their providers.
- Of all survey clients who reported health problems and asked their TAKE CHARGE provider to help them find a doctor or clinic to go to for medical care, 80% reported receiving the help they requested.

MEDICAL CONDITIONS AND SERVICES

- Among the medical conditions recorded on the primary care referral forms, abnormalities of cervix/neoplasm (36.7%) were the most frequent, followed by sexually transmitted diseases (STDs)/vaginitis/pelvic inflammatory disease (PID) (20.7%). Similarly, client survey responses show abnormal pap (33%) was the most frequent health condition of clients who received a referral or recommendation.
- Colposcopy was the most frequently requested primary care service on the primary care referral forms (30.7%).
- According to the primary care referral forms, almost half of the clients (47.6%) received services. Similarly, according to client survey responses, 50% of the clients who received a referral or recommendation received services.

- While primary care services are not covered by TAKE CHARGE, providers offered to provide primary care services on-site for 41.1% of clients, with clients covering the cost of care, according to the primary care referral forms. In addition, as indicated by client survey responses, 24% of survey respondents with a referral or recommendation reported being offered primary care services on-site with clients covering care costs.

BARRIERS TO RECEIVING RECOMMENDED PRIMARY CARE SERVICES

Data from the provider surveys, primary care referral forms, and client surveys all point to the cost of medical care as being one of the main limiting factors to clients receiving needed primary care services.

- 7 out of 10 research sites expressed concern about clients' lack of follow-up and reported the cost of referral care as the main causal factor.
- Among the 42 clients who providers knew did not receive the needed primary care services, the reason reported for 35.7% of the clients was cost of care.
- Among survey respondents, 712 (71%) clients reported needing to see a doctor within the past six months but did not because of cost.

CONCLUSION: Overall, TAKE CHARGE providers are assisting clients with primary care needs by making referrals and engaging in referral practices that facilitate those referrals. However, community resources available for primary care services at low cost or no cost to clients are limited, and many clients express concern about the lack of affordable health insurance and simply go without needed services because of the high cost of medical care.

INTRODUCTION

Washington State's TAKE CHARGE program, which began July 2001, expands Medicaid coverage for family planning services to men and women with family incomes at or below 200% of the federal poverty level (FPL). Program goals are to improve the health of women, children, and families in Washington by decreasing unintended pregnancies and lengthening intervals between births, and to reduce state and federal Medicaid expenditures for births from unintended pregnancies. The Department of Social and Health Services (DSHS) Health and Recovery Services Administration (HRSA) administers this program. The Centers for Medicare and Medicaid Services (CMS) approved the TAKE CHARGE program as a family planning demonstration program (§1115 waiver).

In 2001, CMS required that family planning waiver programs facilitate access to primary care services. Specifically, states are required to establish arrangements with community health centers to provide primary care services to clients enrolled in the family planning program and to provide information to the enrollees about access to primary care. During the first five years of Washington's waiver, primary care referrals should have been occurring among TAKE CHARGE providers. Many Title X clinics serve TAKE CHARGE clients, and all Title X clinics are mandated under Title X guidelines to coordinate referrals for women who require primary health care services. In addition, many Community Health Centers and Rural Health Care Centers in Washington are TAKE CHARGE providers, so referrals and follow-up for primary care services should in many cases occur automatically within the same clinic/provider setting.

For the first waiver renewal period (July 2006 – June 2009), the TAKE CHARGE program has added new activities to strengthen the primary care referral process:

- development and distribution of a culturally appropriate brochure informing TAKE CHARGE clients of ways to access primary care;
- revision of Washington Administrative Code (WAC) and Billing Instructions to require that providers refer clients to available and affordable non-family planning care services as needed; and
- use of a telephone hotline provided through a contract with WithinReach (formerly Healthy Mothers, Healthy Babies) as a resource for primary care referrals.

The objective of our evaluation of primary care referrals was to describe activities during the renewal period. Specifically, the evaluation addressed the following questions:

- Were clients provided information about access to primary care?
- Did clients receive help from the TAKE CHARGE providers/staff in locating and accessing primary care if needed?
- Did providers adhere to the program's standards relating to the primary care referral process?
- What is the level and nature of collaboration between the TAKE CHARGE providers and other community health centers in facilitating primary care services for the clients?

- What impact does the primary care referral process have on clients' access to primary care and on the providers?

Given the foundation for improvements to the primary care referral process during the first waiver period (July 2001 – June 2006), we hypothesized that:

Hypothesis: Providers will make appropriate primary care referrals consistent with community-specific resources.

The primary care evaluation, designed by Research and Data Analysis (RDA) and approved by CMS, consisted of three components: the provider survey, the primary care referral form, and the client survey. The methods and findings for each of the study components will be described separately.

Evaluation of the primary care referral process collected baseline data on providers' referral practices, possible barriers to the referral process, and some success factors reported by providers.

Primary care referral forms, completed by providers at the ten research sites, identified primary care needs and medical conditions prevalent in the TAKE CHARGE population, the types of referral providers, and clients' receipt of services.

The client survey assessed primary care needs, referrals and recommendations received from their TAKE CHARGE provider, information on access to primary care received from HRSA program staff and providers, and receipt of primary care services.

Provider Survey

METHODS

The same ten clinic sites that participated in the initial five-year research activities provided data for the provider survey and the primary care referral forms. These ten sites were randomly selected from a pool of Medicaid-approved TAKE CHARGE providers in 2001 after stratifying by provider location. (See *TAKE CHARGE Process Evaluation* (Ritualo, 2003) for description of sites and selection process.)

Research Sites

Public Health Seattle & King County White Center Public Health Center	Public Health Seattle & King County Renton Public Health Center
Planned Parenthood of Western Washington University District Health Center	Planned Parenthood of Western Washington Seattle Health Center
Skagit County Health Department	Clark County Health Department Stevenson Clinic
Mount Baker Planned Parenthood Mount Vernon Clinic	Planned Parenthood of Western Washington Everett Health Center
Planned Parenthood of Central Washington Sunnyside Clinic	Planned Parenthood of the Inland Northwest Pullman Health Center

Written referral protocols were collected from the sites and reflected in the design of the provider survey. Surveys were e-mailed to one or more designated providers at each site. The survey asked about provision of information and assistance to primary care, follow-up of identified medical condition(s), barriers to care, and collaboration with community health partners. Questions asked about both referrals for urgent, potentially life-threatening, or serious health problems, and recommendations for routine primary care services, including routine screenings, vaccinations, or treatment of common conditions such as ear, throat, or chest infections or rashes.

Analyses of the clinics' primary care referral processes for their TAKE CHARGE clients were based on responses to the provider survey, site-specific referral forms and protocols, and printed materials with contact information for local primary care resources. The findings present the survey responses from the ten sites as average (mean) scores.

FINDINGS

Referral Practices

All providers at the ten sites made primary care referrals and recommendations for their TAKE CHARGE clients. Among the different sites, 100% documented a referral in patient charts, transferred records to referral providers, gave clients a printed list with the contact information of local primary care providers/resources, and followed up with clients; 9 out of 10 sites completed

referral forms; 7 out of 10 gave clients directions to referral providers; and 5 out of 10 called to make appointments for clients.

All providers also made recommendations for routine primary care services including screenings (screening mammograms, screening cholesterol), immunizations, and treatment of common conditions such as skin problems or urinary tract infections. All providers reported that their clinic protocols did not require completing a referral form for a recommendation. On the other hand, all providers documented recommendations in patient charts; 9 out of 10 sites gave clients a list of local primary care providers; 8 out of 10 followed up with clients on the next contact; 6 out of 10 gave directions; and 1 out of 10 called to make appointments.

All but one of the ten research sites have their own referral forms in place. Of the ten sites, six have detailed, written protocols for follow-up on referrals made for urgent, potentially life-threatening, or serious health problems, and 6 out of 10 clinics have a designated person(s) responsible for organizing referrals, including sending referrals and transferring records. At Mt. Baker Planned Parenthood (MBPP) - Mount Vernon Clinic, medical records have been electronic for two years, and their primary care referral system is in the process of becoming centralized.

Providers' Perception of Efficacy of Referral Process

When asked "How well do you think your primary care referral process helps TAKE CHARGE clients receive primary care?" providers reported *some of the time* to *most of the time* (3.4 on a 5-point rating scale where "1" represents *none of the time* and "5" *all of the time*).

Providers identified the following factors as contributing to the success of their clinics' primary care referral process: availability of community resources, printed materials with referral listings, and sound referral protocol. All sites had printed materials with either contact information of local primary care providers/resources or information about access to primary care services.

Factors Contributing to Success of Primary Care Referral Process

- Having community health clinics that meet the needs of low-income clients available (n=3)
- Sound referral protocol (n=3)
- Accessible primary care around Seattle both public and private clinic/facility (n=2)
- Hand-out of Referral Listings including providers with sliding scales, updated yearly (n=2)
- Collaborative relationship with Harborview Women's Clinic for gynecology follow-up, and the Breast and Cervical Health Program for women 40 years and older for mammograms and pap smears (n=1)
- Ease of patients getting in quickly to see a primary care provider (n=1)
- Educating clients on why they need additional care and the importance of follow-up on abnormal test results, also the value of preventive care (immunizations, mammograms, etc.) (n=1)
- Providers with knowledge regarding community referrals (n=1)
- "Sometimes making the appointment for the client works." (n=1)

Challenges to Providing Primary Care Referrals

Using a 5-point rating scale where “1” represents *none of the time* and “5” represents *all of the time*, providers were asked to rate how often clients follow through and obtain care. Providers reported that after receiving a referral for a medical problem that may have serious medical consequences, clients follow through and obtain care *some of the time to most of the time* (3.5), and for recommended primary care services, they reported that clients obtain follow-up care *some of the time* (3).

Among providers who added comments about factors contributing to the lack of success of their clinic’s primary care referral process, 7 out of 10 listed the cost of referral care as the main factor for clients’ lack of follow-up. Specifically, some providers that addressed this issue stated: “*Patients can’t afford referral care. The biggest problem for patients is the out-of-pocket cost of needed care. As a result many of our patients don’t follow-up at all!*” and “*Our clients have difficulty affording health care. Because of cost, many women do not follow-up with a recommended colposcopy after an abnormal pap smear nor do many women follow-up on abnormal breast findings.*”

Providers were asked to rate the extent to which various potential barriers are a problem when providing primary care referrals or recommendations for their TAKE CHARGE clients. The table on the next page shows providers' responses using a 5-point scale, where “1” represents *not a problem* and “5” *always a problem*.

- Providers reported finding primary care providers that would serve uninsured or low-income clients as *somewhat of a problem* (3 on a 5-point scale).
- Providers reported long wait times, client resistance to going to another facility, transportation issues, inadequate time to discuss referrals with clients, and inadequate time to complete paperwork and/or track referrals as *a little problem to somewhat of a problem* (2.1 – 2.7 on a 5-point scale).

Collaboration with Community Health Care Providers

All clinics have an informal network of community health care providers where they refer their TAKE CHARGE clients for primary care. Many of these community providers such as the Community Health Centers (CHCs) and specialty programs at area hospitals offer sliding scale fees. Of family planning clinics located in a large urban setting, three have comprehensive lists including referral sources for general medicine, obstetrician/gynecologists (OB/GYNs), oncology, ultrasound, colposcopy, and breast specialists/mammograms. The two public health departments in White Center and Renton refer their clients to their site in Seattle with primary care services, to specialty programs in Seattle hospitals, and to local CHCs. The three sites situated in small urban counties, along with one in a rural county, predominantly refer to CHCs and private Family Medicine clinics. The other site in a rural area does not have a CHC available and typically refers to private Family Medicine clinics and student health services.

**Barriers Experienced by Providers in Making Referrals
and Recommendations for Primary Care**

When you refer or recommend TAKE CHARGE clients to primary care, how much of a problem are the following issues?	REFERRAL (Average Score)	RECOMMENDATION (Average Score)
Finding primary care providers or resources to serve low income, uninsured clients	3	3
Unwillingness of local primary care providers to take on new clients	2.2	2.3
Long wait times for clients to see primary care providers	2.5	2.1
Client resistance to going to another facility	2.5	2.5
Transportation issues for clients	2.6	2.5
Finding providers to accommodate client's language need	2.0	2.0
Clinic's staff unfamiliarity with services offered by other local health agencies	1.6	1.6
Inadequate length of client visits to provide/discuss referrals or recommendations	2.6	2.5
Inadequate staff time to complete paperwork and/or track referrals	2.7	NA

Response choices include: 1=Not a problem, 2=A little problem, 3=Somewhat of a problem, 4=Mostly a problem, 5=Always a problem.

Collaboration with Community Health Care Providers (continued)

The majority (7 out of 10) of clinics maintained linkages with their community-based organizations through phone calls, e-mails, or meetings.

Among the types of providers listed on the survey question about where clinics send their clients for primary care services, respondents reported sending clients *most of the time* to community health clinics for both referrals and recommendations (3.9). Providers reported sending clients *a little of the time* down the hall to programs in their own clinic or to another clinic within their affiliate system. Among the six clinics that were not health departments, providers reported sending clients to the local health department for a referral *a little of the time* (2.2) and more often for a recommendation (2.7). Clients were sent to the emergency room *a little of the time* for a referral (2.2) and from *none of the time* to *a little of the time* for a recommendation (1.6).

Primary Care Referral and Recommendation Form

METHODS

Providers at the ten sites completed a Primary Care Referral and Recommendation Form whenever they made a referral or recommendation for medical health care services not covered by TAKE CHARGE for TAKE CHARGE clients, 18 years of age or older, during the planned six-month data collection period. Each site was responsible for completing a specified number of primary care referral forms based on the volume of TAKE CHARGE clients at the clinic. Staff from Department of Social and Health Services (DSHS) Research and Data Analysis Division (RDA) presented training to the ten sites in the fall of 2007. The data collection period was extended to ten months to allow all clinics to reach their goal for total forms completed.

The primary care referral form, designed by evaluation staff, is a duplicate form for recording TAKE CHARGE clients' medical conditions, the referral providers and specialty, services requested, any activities providers did to enhance the efficacy of the referral, and follow-up information. The first page of the form was completed at the time of the initial referral or recommendation; the second page includes a section for follow-up information.

Analysis of the primary care referral forms addressed (1) the number of TAKE CHARGE clients who needed primary care referrals during the data collection period, (2) the number and types of medical conditions TAKE CHARGE clients typically experienced, (3) to what providers they were referred for primary care, and (4) whether or not they received the needed primary care services.

FINDINGS

During the ten-month data collection period, providers made 341 referrals for urgent, potentially life-threatening, or serious health problems, and 141 recommendations for routine primary care services including routine screenings, vaccinations, or treatment of common conditions such as ear, throat, or chest infections or rashes. Referrals and recommendations were reported only for female clients; no male clients were reported to have received referrals or recommendations. Referrals or recommendations to primary care could be made in-house or to outside primary care providers.

The table on the next page shows the numbers and types of medical problems that TAKE CHARGE clients experienced, based on referrals and recommendations made by the providers at the ten sites.

- Among the medical conditions recorded on the primary care referral forms, Abnormalities of Cervix/Neoplasm (36.7%) were most frequent, followed by Sexually Transmitted Diseases (STDs)/Vaginitis/Pelvic Inflammatory Disease (PID) (20.7%).

Primary Care Needs of TAKE CHARGE Clients

MEDICAL PROBLEM	INITIAL REFERRAL FORMS N	FOLLOW-UP FORMS N	CLIENT RECEIVED SERVICES	CLIENT DID NOT RECEIVE SERVICES	UNKNOWN IF SERVICES RECEIVED
Cardiovascular: Hypertension	17	16	43.8%	12.5%	43.8%
Cardiovascular: Other	2	2	0%	0%	100%
Gastrointestinal	11	7	28.6%	42.9%	28.6%
Ear, Nose, and Throat	3	2	0%	0%	100%
Endocrine/Metabolic	26	23	69.6%	4.3%	26.1%
Female: Genital and Breast					
Breast Abnormality	24	23	34.8%	8.7%	56.5%
Menstrual Abnormality	7	6	66.7%	0%	33.3%
Abnormality of Cervix/Neoplasm	177	158	23.4%	8.2%	68.4%
STDs/Vaginitis/PID	100	96	78.1%	4.2%	17.7%
Other	13	12	50.0%	33.3%	16.7%
Musculoskeletal	4	4	25.0%	0%	75.0%
Neurological	4	3	33.3%	33.3%	33.3%
Risk Factors and Other Medical Problems	63	57	54.4%	14.0%	31.6%
Skin	12	11	63.6%	9.1%	27.3%
Tobacco Abuse	1	1	100%	0%	0%
Urological	18	18	72.2%	16.7%	11.1%
Total	482	439	47.6%	9.6%	42.8%

- Of the 439 total follow-up forms received, 47.6% of the clients received services, and 9.6% of the clients did not receive services; for 42.8% of the clients, it was unknown whether or not services had been received. For 15 (35.7%) of the 42 clients who did not receive care, the reason reported was cost of care.
- Of the 148 clients who needed colposcopy, 143 had follow-up forms documenting that 23 (16.1%) received the service and 13 (9.1%) did not receive the service. For 107 (74.8%) clients it was unknown whether the services were received. For 4 (35.7%) of the 13 women who did not receive colposcopy, the reason reported was cost of care.
- More than three-fourths (78.1%) of clients with STDs/Vaginitis/PID received the needed primary care. The most frequently requested service for this condition was evaluation and treatment with a prescription medicine (47%). In the majority of cases, evaluation and treatment were provided on-site with the client paying for the cost of care.

- Other primary care services provided on-site included treatment of urinary tract and skin infections; screening for STDs, HIV, and HPV for at risk clients; support for weight management; tobacco cessation; and diabetes screening.

Referral Providers

Of the 482 initial referral forms, in-house referrals were most frequent (41.1%). In addition, clients were provided a referral list (23.6%), and other referrals were made to specialists (13.3%), private medical doctors (6.8%), and Community Health Centers (6.0%). Referrals to hospital clinics (4.8%), primary care providers (2.9%), providers of the patients' choosing (0.4%), emergency departments/urgent care centers (0.4%), and student health services (0.4%) were less frequent.

Types of Referral Providers

TYPE OF PROVIDER	REFERRALS N	IN-HOUSE REFERRALS N
Community Health Clinic	29	0
Emergency Room/Urgent Care	2	0
Family Planning Clinic	145	139
Hospital	23	0
Patient Choice	2	0
Public Health Dept	47	40
Primary Care Provider	14	0
Private MD	33	12
Referral List	114	1
Specialist Breast Care	15	0
Specialist GYN/Colposcopy	44	6
Specialist Radiology Ultrasound	2	0
Specialist Urology, Neurology, or Dermatology	3	0
Student Health Services	2	0
Missing	7	0
Total	482	198

- While primary care services are not covered by TAKE CHARGE, providers offered to provide services on-site for 41.1% of clients, with clients paying for the cost of care.

TAKE CHARGE providers were the most frequent referral providers for various primary care services including:

- Endocervical Sampling (100%);
- HPV testing (100%);

- Evaluation and Treatment-Rx for STDs/Vaginitis/PID (89.4%);
- Repeat Pap for Abnormality of Cervix/Neoplasm (76.5%);
- Evaluation and Management of STDs/Vaginitis/PID (69.2%).

**Most Frequent Medical Conditions, Primary Care Service Needed,
and Type of Referral Provider**

Medical Problem and Primary Care Service Needed	REF N	REC N	Client Received Services	Referral Provider by Type								
				PP	PUB	CHC	Specialist	PMD	Hospital	List	Other	
Abnormality of Cervix/Neoplasm												
Colposcopy	128	0	21	6	0	3	31	2	5	81	0	
Colposcopy with Biopsy	3	0	1	1	0	0	2	0	0	0	0	
Colposcopy with ECC	1	0	0	0	0	0	0	0	0	1	0	
Endocervical Sampling	2	0	2	2	0	0	0	0	0	0	0	
Evaluation and Management	1	0	1	0	0	0	1	0	0	0	0	
Evaluation and Treatment	1	0	1	0	0	0	0	0	1	0	0	
HPV Testing	4	1	4	4	0	0	0	0	0	0	0	
Repeat Pap	19	15	6	24	2	0	2	0	0	1	1	
Ultrasound	2	0	1	0	0	0	0	0	1	1	0	
STDs/Vaginitis/PID												
Colposcopy	15	0	1	2	0	0	7	0	2	4	0	
Colposcopy with ECC	1	0	0	0	0	1	0	0	0	0	0	
Cryotherapy	0	2	0	0	1	0	0	1	0	0	0	
Evaluation and Management	8	5	10	7	2	1	1	0	1	1	0	
Evaluation and Treatment	3	1	2	2	0	0	0	2	0	0	0	
Evaluation/Treatment – Rx	39	8	47	18	24	0	0	4	0	0	1	

Referral Provider Types are: Planned Parenthood (PP); Public Health Department (PUB); Community Health Clinic (CHC); Specialist in Breast Care, GYN/Colposcopy, Radiology/Ultrasound, Urology, Neurology, or Dermatology (Specialist); Personal Medical Doctor (PMD); Hospital (same); Referral List (List); Emergency Room/Urgent Care, Patient's Choice, or Student Health Services (Other).

- Colposcopy was the most frequent primary care service requested on the referral forms. Of the 177 women with Abnormalities of the Cervix/Neoplasm, 128 were referred for colposcopy, 3 for colposcopy biopsy, and 1 for colposcopy with endocervical curettage (ECC). Of the 100 women with STDs/Vaginitis/PID, 15 were referred for colposcopy and 1 for colposcopy with ECC.
- All clients referred to TAKE CHARGE providers for Evaluation and Treatment-Rx, Endocervical Sampling, and HPV testing received the primary care services needed.
- Clients needing colposcopy for Abnormality of Cervix/Neoplasm were most frequently given a list of referral providers (63.3%) or referred to individual specialists (24.2%).

Client Survey

METHODS

Survey Sample Selection: A random sample (n=3000) of Program G women, newly enrolled in TAKE CHARGE in December 2007 or January 2008, age 18 and older, was selected from HRSA's quarterly TAKE CHARGE client files. Only women were included in the sample because we did not receive any primary care referral and recommendation forms for men. Inclusion criteria included primary language identified as English (or missing) and complete mailing address.

The questionnaire, *A Survey of Health Care Needs Not Covered by TAKE CHARGE*, was developed from existing surveys with the addition of some novel questions. The survey asks enrollees questions concerning primary care information they received from HRSA and providers, primary care needs, referrals and recommendations received from TAKE CHARGE providers, and receipt of needed primary care services. The term "recommendation" was used in survey questions, with no distinction between recommendations and referrals.

The survey was pre-tested with a focus group of 11 young women and refined based on recommended changes. The final questionnaire is provided in Appendix C.

Survey Administration: Research and Data Analysis (RDA) contracted with The Gilmore Research Group in Seattle, Washington, to administer the survey. Before the mailing, the list of TAKE CHARGE clients was processed through the National Change of Address (NCOA) verification process. NCOA returned 2812 records with verified or corrected addresses.

The contractor began administration of the client survey on July 1, 2008, with the mailing of the notification letter introducing the survey and informing respondents they would receive a questionnaire in the mail along with \$2 the following week. A survey packet containing a questionnaire, cover letter, stamped return envelope, and two-dollar bill was mailed one week after the prior notification letter. A reminder letter was sent one week following the questionnaire, thanking respondents for completing the survey and inviting those who had not to complete and return the survey. All non-respondents were sent a replacement questionnaire during week five.

A total of 1001 surveys were received, resulting in a response rate of 39.6%. One survey was excluded from further analysis because the client answered only one survey question. This exclusion resulted in 1000 completed surveys available for analysis. Of the total 2812 clients in the survey sample, 10.1% could not be located.

Analysis: The analysis of the client survey was designed to (1) describe the proportion of clients who reported receiving information from HRSA program staff and TAKE CHARGE providers, (2) compare the number of clients who reported a need for primary care and the number who got a referral/received assistance from the providers, and (3) determine the proportion of clients who received the needed primary care services. The findings from these analyses are described in the next section.

FINDINGS

The majority of the TAKE CHARGE women who completed the client survey were 18–24 years of age (56%) or 25–34 years old (35%). Survey participants rated their overall health as *very good* to *excellent* (48%), *good* (38%), and *fair* to *poor* (14%). Almost half the clients (49%) had some college, two-year degree, or technical school, and 24% had a four-year college degree or more.

Among the 1000 survey respondents, almost half (48%) reported having been sick or having had health problems, other than birth control, during the past six months.

Provider Referral Practices

Among clients reporting health problems, 19% (n=89) asked their TAKE CHARGE provider for help in finding a doctor or clinic for medical care, while 81% (n=388) did not ask their TAKE CHARGE provider for such help. Of those 89 clients with a health problem who asked their TAKE CHARGE provider for help in finding a doctor or clinic, 71 (80%) reported receiving the help they requested.

For 12% of survey respondents (n=121), TAKE CHARGE providers made recommendations to see a doctor or specialist. The most frequent health conditions reported by these clients who received recommendations were abnormal pap (33%), followed by breast abnormality (10%), and HPV (4%). For 23% of clients who received recommendations, TAKE CHARGE providers offered to provide the treatment or health services at their clinics. Among these clients who received a recommendation, 56% reported receiving the name or a list of doctors, specialists, or clinics from their TAKE CHARGE provider. Of the clients who reported not being given a name or list, 24% had been offered primary care services on-site.

Barriers to Receiving Recommended Primary Care Services

Of the 121 clients who received a recommendation to see a doctor or specialist because of their health, 60 clients (50%) went to the doctor or specialist.

When the clients who received a recommendation and did not go to see a doctor or specialist were asked the reason for not going, 83% listed the reason as “Didn’t have enough money to pay.” When all clients were asked if there was a time in the past six months when they needed to see a doctor but did not because of cost, 712 clients (71%) answered “Yes.”

Clients also identified the cost of care as the limiting factor in getting needed primary care services in “Other” responses to Question 13. The table referring to Question 13, at the bottom of the page, shows 20.9% of the “Other” responses cited abstaining from medical attention due to cost. Additional comments responding to Question 13 included:

Clients that abstained from medical care due to cost commented:

- "Don't go, no insurance." (**similar comments, total n = 30**)
- "I can't afford care. I have even given myself stitches when needed."
- "Don't go to the hospital because I do not have insurance. I just try to tough it out or buy medicine at the store."
- "I only go see a doctor if I need birth control pills. I never go when I'm sick. I can't afford to."
- "I can't afford medical visits so I normally don't go. But if it's an emergency I'll go to the walk-in clinic/ER."

Types of Health Providers

Of clients surveyed, 37% reported they had at least one person they think of as their personal doctor or health care provider; 63% reported having no personal doctor or health care provider.

The following table shows the types of health care providers where TAKE CHARGE clients typically go when needing medical care.

Question 13: When you are sick or need medical care, where do you <i>usually</i> go?	N	%
Doctor's office	366	36.6%
Public health clinic or community health center	351	35.1%
School's student health center	97	9.7%
TAKE CHARGE provider	187	18.7%
Emergency room	240	24.0%
Look on the internet	146	14.6%
No usual place	147	14.7%
Other	163	16.3%
Abstained from medical attention due to cost	34	20.9%
Abstained from medical attention (unspecified reason)	30	18.4%
Went to a free, low-cost, or walk-in clinic	20	12.3%
Urgent Care	17	10.4%
Saw a doctor other than their Take Charge provider or general practitioner	13	8.0%
Alternative medicine	12	7.4%
Sought counsel from a family member in the medical field	12	7.4%
Self-care	9	5.5%
Generally does not need medical attention/usually healthy	9	5.5%
Other	7	4.3%
Total	1,000	100%

- The proportions of TAKE CHARGE clients who *usually* go to a doctor's office, or to a public health clinic or community health center, when they are sick or need medical care were similar (36.6% and 35.1%, respectively).
- Almost one quarter (24.0%) of the respondents reported they *usually* go to an emergency department when they need medical care.

Client Receipt of Help or Information on Access to Primary Care

Clients were asked three questions (Questions 3, 10, and 8b) about whether they received information or help about how to access primary care. Unduplicated responses to these survey questions show that 189 clients (18.9%) received assistance from their TAKE CHARGE provider. Assistance included a brochure with a phone number, a list of clinics, or other type of help. A small proportion (4%) of clients reported receiving information on access to primary care from Health and Recovery Services Administration (HRSA).

The table below shows the level of confidence clients had in their ability to get help from their TAKE CHARGE provider if needed.

How confident are you that...	Percentage of clients				
	Not at all confident	A little confident	Somewhat confident	Mostly confident	Totally confident
You can get help from your TAKE CHARGE provider to find a doctor or clinic if you need one?	9.7%	17.0%	27.2%	31.1%	15.1%

- Almost half (46.2%) the survey participants felt *mostly* or *totally confident* they could get help from their TAKE CHARGE provider to find a doctor or clinic if they needed one.

Additional Comments

Finally, survey participants were invited to write in additional comments if they wished. The table below lists these responses by category.

Question 18: "Is there anything we may have overlooked? If you have any additional comments you would like to make about your health care or family planning needs, please note them in the box below."		
	N	%
Many clients expressed gratitude for Take Charge.	119	40.3%
Some clients had specific concerns or suggestions regarding Take Charge.	77	26.1%
Some clients expressed general concern about the lack of health insurance.	32	10.8%
Some clients had personal concerns about their lack of health insurance.	23	7.8%
A few clients requested more information.	17	5.8%
Some clients gave miscellaneous comments that did not fall under any of the preceding categories.	27	9.2%
Total	295	100.0%

CONCLUSION

The findings show that providers are making primary care referrals for their TAKE CHARGE clients and that they are adhering to the program standards relating to the primary care referral process. Analysis of provider surveys showed that providers are completing referral forms, documenting the referral in the client's medical chart, transferring records to referral providers, and providing information to clients about local primary care providers/resources.

Providers are well informed about local resources and maintain connections with the providers they use for primary care referrals. While some research sites have comprehensive lists of referral sources ranging from general medicine to specialists in colposcopy and breast abnormalities, other sites refer to primary care services at affiliated clinics. All clinics have informal referral networks with local primary care providers. While the majority (7 out of 10) of clinics maintain linkages with their community-based organizations through e-mails, phone calls, or meetings, some clinics reported extra activities are not needed due to their long-standing relationships with local providers.

Providers are concerned about the primary care needs of their clients and the cost of medical care for the uninsured. Although providers believe their primary care referral process is reasonably successful (3.4 on the 5-point scale), the majority of the sites (7 out of 10) expressed concern about clients' lack of follow-up and reported the cost of referral care as the main reason.

Medical conditions of TAKE CHARGE clients, as recorded by providers on the primary care referral forms, show abnormalities of cervix/neoplasm were most frequent (36.7%), followed by STDs/vaginitis/PID (20.7%). Client survey responses also show abnormal pap (33%) as the most frequent health condition of clients who received a referral or recommendation.

According to the primary care referral forms, of the 439 total follow-ups received, 47.6% of the clients received services, 9.6% did not receive services, and for 42.8% of the clients, it was unknown whether or not services had been received. For 15 (35.7%) of the 42 clients who did not receive care, the reason reported was cost of care. Client survey responses show a similar picture. Of the 121 clients who received a referral or recommendation, 50% went to the doctor or specialist. Of the 50% who did not go to see a doctor or specialist, 83% reported the reason was not having enough money to pay.

Almost half of all survey participants (46.2%) had confidence they could get help from their TAKE CHARGE provider in finding a doctor or clinic if they needed one. Of clients surveyed, 12% received a referral or recommendation to see a doctor or specialist because of their health; more than half (56%) reported receiving the name or a list of referral sources, while 24% were offered the needed primary care services on-site.

Some clients express great need for health insurance and access to medical care; 18.6% of the clients who wrote in comments about their health care reported either general or personal concerns about the lack of health insurance. Many simply do without regular medical care. One client reported giving herself stitches. The majority of survey respondents (71%) reported they needed to see a doctor in the past six months but could not because of the cost.

Overall, TAKE CHARGE providers are assisting clients with primary care needs by making referrals and engaging in referral practices that facilitate those referrals. However, community resources available for primary care services at low cost or no cost to clients are limited, and many clients express concern about the lack of affordable health insurance, at times simply going without needed services because of the high cost of medical care.

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APPENDICES

APPENDIX A: PROVIDER SURVEY



DEPARTMENT OF SOCIAL AND HEALTH SERVICES

Research and Data Analysis

PO Box 45204

Olympia, WA 98504-5204

PRIMARY CARE REFERRAL PROCESS SURVEY TAKE CHARGE EVALUATION

We want to learn about your clinic's primary care referral process for TAKE CHARGE clients. One of the Centers for Medicare and Medicaid Services' (CMS) approval conditions for the TAKE CHARGE waiver renewal in 2006 was an evaluation of the primary care referral process. This survey is one part of our primary care evaluation.

We are interested in both **referrals** for urgent or potentially life-threatening or serious health problems and **recommendations** for routine primary care services including routine screenings, vaccinations, or treatment of common conditions such as ear, throat, or chest infections or rashes. Referrals or recommendations to primary care may be within your clinic or to outside primary care providers.

More than one individual may complete a survey. Appropriate respondents to this survey include:

- A clinician who sees patients, evaluates medical problems and determines what kind of referral the patient needs AND has knowledge of community partners.
- A clinician who sees patients, evaluates medical problems and determines what kind of referral the patient needs.
- A staff member who facilitates linkages with community organizations for primary care referral purposes.

Definition of Primary Care: For this survey we define primary care as medical health care services that TAKE CHARGE doesn't cover such as:

Follow-up on abnormal pap smears

Mammogram, ultrasound, biopsy

STD treatment

Colposcopy

Other medical services such as:

Treatment for common conditions like ear, throat or chest infections or rashes

Management of serious conditions like diabetes or high blood pressure

Preventive care like immunizations, dental and vision screenings

Thank you so much for your help with this important evaluation. We look forward to hearing from you soon. If you have any questions, please contact Trisha Keenan-Wilkie at 360.902.0763 or keenata@dshs.wa.gov.

Name:

Date:

Staff Position:

Clinic:



DEPARTMENT OF SOCIAL AND HEALTH SERVICES

Research and Data Analysis

PO Box 45204

Olympia, WA 98504-5204

PROVIDER SURVEY

Primary Care Referral Procedures and Policies

1. Which of the following activities do your staff typically do for a TAKE CHARGE client if a problem is identified or suspected that may have serious medical consequences (e.g. breast mass, abnormal Pap test, diabetes, high blood pressure)? (*Check all that apply.*)
 - Complete a referral form to obtain a consultation, diagnostic test, or management of medical condition
 - Document referrals to providers in client's medical chart
 - Have the client sign a release of medical information form
 - Transfer records to the referral providers (fax, mail, or give copies to client)
 - Give client directions to referral providers
 - Call to make appointment for client
 - Follow-up with client (on next visit ask if client followed through on referral, ask about medical problem, etc.)
2. Which of the following activities do your staff typically do when suggesting a TAKE CHARGE client obtain routine primary care services, including routine screenings (screening mammograms, screening cholesterol), vaccinations, or for treatment of common conditions such as ear, throat, or chest infections or rashes? (*Check all that apply.*)
 - This is considered a recommendation and a referral form is completed
 - This is considered a recommendation and a referral form is not required by our clinic protocol
 - Document recommendation to see a primary care provider in client's medical chart
 - Give client a printed list of local primary care providers/resources
 - Give client directions to primary care providers
 - Call to make appointment for client
 - Follow-up with client (on next visit ask if client followed through on recommendation, etc.)
3. Does your clinic have a designated person(s) who is responsible for organizing referrals, including sending referrals and transferring records to referral providers? Yes No

Barriers to Primary Care Referral Process

4. How often would you say clients for whom you have completed a **referral** for a medical problem that may have serious medical consequences follow through and obtain care?
 - All of the time
 - Most of the time
 - Some of the time
 - A little of the time
 - None of the time

5. How often would you say clients follow through and obtain their **recommended** primary care services?

- All of the time
- Most of the time
- Some of the time
- A little of the time
- None of the time

6. When you refer or recommend TAKE CHARGE clients to primary care, how much of a problem are the following issues?

a. Finding primary care providers/resources to serve low income, uninsured clients

FOR A REFERRAL

- Not a problem
- A little problem
- Somewhat of a problem
- Mostly a problem
- Always a problem

FOR A RECOMMENDATION

- Not a problem
- A little problem
- Somewhat of a problem
- Mostly a problem
- Always a problem

b. Unwillingness of local primary care providers to take on new clients

FOR A REFERRAL

- Not a problem
- A little problem
- Somewhat of a problem
- Mostly a problem
- Always a problem

FOR A RECOMMENDATION

- Not a problem
- A little problem
- Somewhat of a problem
- Mostly a problem
- Always a problem

c. Long wait times for clients to see primary care providers

FOR A REFERRAL

- Not a problem
- A little problem
- Somewhat of a problem
- Mostly a problem
- Always a problem

FOR A RECOMMENDATION

- Not a problem
- A little problem
- Somewhat of a problem
- Mostly a problem
- Always a problem

d. Client resistance to going to another facility

FOR A REFERRAL

- Not a problem
- A little problem
- Somewhat of a problem
- Mostly a problem
- Always a problem

FOR A RECOMMENDATION

- Not a problem
- A little problem
- Somewhat of a problem
- Mostly a problem
- Always a problem

e. Transportation issues for clients

FOR A REFERRAL

- Not a problem
- A little problem
- Somewhat of a problem
- Mostly a problem
- Always a problem

FOR A RECOMMENDATION

- Not a problem
- A little problem
- Somewhat of a problem
- Mostly a problem
- Always a problem

f. Finding providers to accommodate client's language need

FOR A REFERRAL

- Not a problem
- A little problem
- Somewhat of a problem
- Mostly a problem
- Always a problem

FOR A RECOMMENDATION

- Not a problem
- A little problem
- Somewhat of a problem
- Mostly a problem
- Always a problem

g. Clinic staff's unfamiliarity with services offered by other local health agencies

FOR A REFERRAL

- Not a problem
- A little problem
- Somewhat of a problem
- Mostly a problem
- Always a problem

FOR A RECOMMENDATION

- Not a problem
- A little problem
- Somewhat of a problem
- Mostly a problem
- Always a problem

h. Inadequate length of client visits to provide/discuss referrals or recommendations

FOR A REFERRAL

- Not a problem
- A little problem
- Somewhat of a problem
- Mostly a problem
- Always a problem

FOR A RECOMMENDATION

- Not a problem
- A little problem
- Somewhat of a problem
- Mostly a problem
- Always a problem

i. Inadequate staff time to complete paperwork and/or track referrals

FOR A REFERRAL

- Not a problem
- A little problem
- Somewhat of a problem
- Mostly a problem
- Always a problem

j. Other problems for your clients or staff (*Please tell us.*) _____

7. Do you have printed materials that you give to TAKE CHARGE clients that have information about access to primary care services? Yes No
8. Do you have printed materials with the contact information of local primary care providers/resources that you can give clients? Yes No

Collaboration with Community Health Care Organizations

9. How often do you typically send your clients to the following locations for primary care services?

a. Down the hall to programs in your own clinic

FOR A REFERRAL

- All of the time
- Most of the time
- Some of the time
- A little of the time
- None of the time

FOR A RECOMMENDATION

- All of the time
- Most of the time
- Some of the time
- A little of the time
- None of the time

b. Another clinic within your affiliate system

FOR A REFERRAL

- All of the time
- Most of the time
- Some of the time
- A little of the time
- None of the time

FOR A RECOMMENDATION

- All of the time
- Most of the time
- Some of the time
- A little of the time
- None of the time

c. Community Health Clinic

FOR A REFERRAL

- All of the time
- Most of the time
- Some of the time
- A little of the time
- None of the time

FOR A RECOMMENDATION

- All of the time
- Most of the time
- Some of the time
- A little of the time
- None of the time

d. Local Health Jurisdiction

FOR A REFERRAL

- All of the time
- Most of the time
- Some of the time
- A little of the time
- None of the time

FOR A RECOMMENDATION

- All of the time
- Most of the time
- Some of the time
- A little of the time
- None of the time

e. Emergency room

FOR A REFERRAL

- All of the time
- Most of the time
- Some of the time
- A little of the time
- None of the time

FOR A RECOMMENDATION

- All of the time
- Most of the time
- Some of the time
- A little of the time
- None of the time

f. Other locations or facilities (*Please tell us.*) _____

10. Who are the community based organizations with whom your clinic collaborates for giving primary care services to your TAKE CHARGE clients?

11. What do you do to maintain linkages with these community based organizations? (*Check all that apply.*)

- See them everyday (down the hall or across the street)
- Talk with them on the phone or email them twice a month or more
- Talk with them on the phone or email them less often than twice a month
- See them at meetings once every three months or more
- See them at meetings less often than once every three months
- Do not do any activities to maintain linkages
- Not necessary due to long standing association
- Other (*Please tell us.*) _____

12. Do you do more collaborative activities with some community partners than others?

- Yes
 - No
- If yes, please explain.

Final Comments

13. Has your clinic's primary care referral process for TAKE CHARGE clients changed since July 2006? Yes No If Yes, how?

14. How well do you think your primary care referral process helps TAKE CHARGE clients receive primary care?

- All clients get the primary care they need
- Most clients get the primary care they need
- Some clients get the primary care they need
- A few clients get the primary care they need
- None of the clients get the primary care they need

15. What factors have contributed to the success of your clinic's primary care referral process for TAKE CHARGE clients?

16. What factors have contributed to the lack of success of your clinic's primary care referral process for TAKE CHARGE clients?

17. What changes, if any, would you like to see incorporated into your clinic's primary care referral process?

What challenges does your clinic face in being able to make these changes?

If you have any additional comments, please note them here.

Thank you for your time and participation!

Please return your completed survey and cover page to Trisha Keenan-Wilkie at keenata@dshs.wa.gov or to DSHS Research and Data Analysis, PO Box 45204, Olympia, WA 98504-5204.

APPENDIX B: PRIMARY CARE REFERRAL FORM

**PRIMARY CARE REFERRAL AND RECOMMENDATION FORM
FOR TAKE CHARGE PATIENTS**

Directions: Complete page one (white copy) at time of INITIAL referral or recommendation and put in TAKE CHARGE box. Complete the follow-up (manila copy) during a subsequent patient visit or contact AFTER referral or recommendation has been made and put in TAKE CHARGE box.

Patient Name _____	Visit Date _____
Medicaid Patient ID Code (PIC) _____	DOB _____
(Check one) <input type="checkbox"/> Referral	<input type="checkbox"/> Recommendation Date _____
Referred To: Provider _____	Specialty _____

Reason for Referral or Recommendation Medical Condition: Service Requested:
--

What did your clinic do to help this patient receive needed primary care services? (Circle all that apply.) 1 Gave patient list of primary care providers or clinics 2 Gave patient directions to provider's office 3 Called provider and made appointment for patient 4 Completed medical referral form and sent to referral provider or gave to patient 5 Sent copies of all appropriate medical records to referral provider 6 Made copies of all appropriate medical records for patient to take to referral provider 7 Had patient sign medical records release for return of records from referral provider 8 Requested copies of lab reports, biopsy reports, etc. from referral provider 9 Other _____

**PRIMARY CARE REFERRAL AND RECOMMENDATION FORM
FOR TAKE CHARGE PATIENTS**

Directions: Complete page one (white copy) at time of INITIAL referral or recommendation and put in TAKE CHARGE box. Complete the follow-up (manila copy) during a subsequent patient visit or phone contact AFTER referral or recommendation has been made and put in TAKE CHARGE box.

Patient Name _____ Visit Date _____
Medicaid Patient ID Code (PIC) _____ DOB _____
(Check one) <input type="checkbox"/> Referral <input type="checkbox"/> Recommendation Date _____
Referred To: Provider _____ Specialty _____

Reason for Referral or Recommendation Medical Condition: Service Requested:
--

What did your clinic do to help this patient receive needed primary care services? (Circle all that apply.) <ol style="list-style-type: none">1 Gave patient list of primary care providers or clinics2 Gave patient directions to provider's office3 Called provider and made appointment for patient4 Completed medical referral form and sent to referral provider or gave to patient5 Sent copies of all appropriate medical records to referral provider6 Made copies of all appropriate medical records for patient to take to referral provider7 Had patient sign medical records release for return of records from referral provider8 Requested copies of lab reports, biopsy reports, etc. from referral provider9 Other _____

PRIMARY CARE REFERRAL AND RECOMMENDATION FOLLOW-UP

Please complete the follow-up (manila copy) during a subsequent patient visit or contact AFTER referral or recommendation has been made and put in TAKE CHARGE box.

Outcomes/Interventions Received
Did patient receive needed primary care services? Yes No Don't Know
If "No," what is the reason?

APPENDIX C: CLIENT SURVEY

PLEASE PROMPTLY RETURN THIS SURVEY IN THE ATTACHED POSTAGE-PAID ENVELOPE

A Survey of Health Care Needs Not Covered by TAKE CHARGE

**Your comments on this program are important to us.
Your answers will be kept strictly confidential.**



Sponsored by:

Department of Social & Health Services
Research and Data Analysis
PO Box 45204
Olympia, WA 98504

Conducted by:

The Gilmore Research Group
2324 Eastlake Avenue East, Suite 300
Seattle, WA 98102



The **TAKE CHARGE program** provides free birth control to eligible women and men in Washington State. The TAKE CHARGE program does not pay for other health care services you may need. The questions in this survey ask about any health problems or medical needs you've experienced that TAKE CHARGE doesn't cover.

First we have some questions about your health and medical care experiences, other than birth control, during the last 6 months.

1. During the past 6 months, have you been sick or had any health problems? *(for example, abnormal pap smear, migraines, breast lump, bladder infection, high blood pressure, or weight problem)*

- Yes
- No

2. During the past 6 months, did you ever **ask** your TAKE CHARGE provider to help you find a doctor or clinic to go to for medical care? *(Your TAKE CHARGE provider is the clinic, health department or doctor's office where you go for birth control.)*

- Yes
- No

3. Did your TAKE CHARGE provider **help** you find a doctor or clinic?

- Yes
- No
- I did not ask my TAKE CHARGE provider to help me find a doctor or clinic.

4. During the past 6 months, did your **TAKE CHARGE provider ever recommend** that you see a doctor or specialist because of your health?

- Yes
- No —→ **If No, Go To Question 9 on Page 2**

5. Thinking back to the last time when your TAKE CHARGE provider recommended that you see a doctor or specialist, what was the reason or health condition?

Please tell us: _____

6. After your TAKE CHARGE provider's recommendation, did you go to see a doctor or specialist?

- Yes —→ **If Yes, Go to Question 8 on Page 2**
- No

7. What were the reasons you did **not** go to see a doctor or specialist? (Check ALL that apply)

- a. Didn't think I needed to see a doctor or specialist
- b. Too busy or didn't have enough time
- c. Didn't know where to go to see a doctor or specialist
- d. Problem getting or paying for child care
- e. Didn't have transportation to the doctor's office or clinic
- f. Office or clinic wasn't open when I could get there
- g. Took too long to get an appointment or there were no openings
- h. Didn't have enough money to pay
- i. Couldn't find a doctor or specialist who would accept me as a patient
- j. Health condition went away
- k. Other (please tell us): _____

8. After recommending you go to a doctor or specialist, did your TAKE CHARGE provider do any of the following:
- a. Offer to provide treatment or health services at their clinic?
 Yes
 No
 - b. Give you the name or a list of doctors, specialists, or clinics?
 Yes
 No
9. At any time during the past 6 months, did you receive a red brochure **in the mail** with information about ways to get health care that TAKE CHARGE doesn't cover?
 Yes
 No
 Don't know
10. At any time during the past 6 months, did your **TAKE CHARGE provider** give you any information on how or where to get health care that TAKE CHARGE doesn't cover? (*for example, a brochure with a phone number or a list of clinics*)
 Yes
 No
 Don't know
11. Overall, how confident are you that you can get help from your **TAKE CHARGE provider** to find a doctor or clinic if you need one?
- a. Not at all confident
 - b. A little confident
 - c. Somewhat confident
 - d. Mostly confident
 - e. Totally confident

Finally, we'd like to know a little bit more about you.

12. Do you have one person you think of as your personal doctor or health care provider?
 Yes, I have one
 Yes, I have more than one
 No, I have no personal doctor or health care provider
13. When you are sick or need medical care, where do you **usually** go? (Check ALL that apply)
- a. Doctor's office
 - b. Public health clinic or community health center
 - c. School's student health center
 - d. TAKE CHARGE provider
 - e. Emergency room
 - f. Look on the internet
 - g. No usual place
 - h. Other (please tell us) _____
14. Was there a time in the past 6 months when you needed to see a doctor but did not because of cost?

- Yes
- No

15. In general, how would you rate your overall health *now*?

- a. Excellent
- b. Very good
- c. Good
- d. Fair
- e. Poor

16. What is your age now?

- a. under 18
- b. 18-24
- c. 25-34
- d. 35-44
- e. 45 to 54
- f. 55 and over

17. What is the highest grade or level of school that you have completed?

- a. 8th grade or less
- b. Some high school, but did not graduate
- c. High school graduate or GED
- d. Some college or 2-year degree, or technical school
- e. 4-year college degree
- f. More than 4-year college degree

THANK YOU FOR COMPLETING THIS SURVEY!

Is there anything we may have overlooked? If you have any additional comments you would like to make about your health care or family planning needs, please note them in the box below.

Please return your completed survey in the postage-paid envelope provided.



STATE OF WASHINGTON
DEPARTMENT OF HEALTH
Olympia, Washington 98504

September 15, 2011

Preston Cody, Director,
Health Care Authority / Division of Healthcare Services
Office of Community Services
PO Box 45530
Olympia, WA 98504-5530

Dear Mr. Cody:

On behalf of the Washington State Department of Health (DOH) Title X Project, I am pleased to write this letter and express overwhelming support for the continuation of the Medicaid family planning waiver known as Take Charge. For many years, the Department of Health has provided funding to local clinics to help them provide comprehensive family planning services for Washington men and women. Since 2001, Take Charge has played an enormous role in assuring their ongoing efforts.

Through Take Charge, DOH and the Health Care Authority have collaborated to assure that an increasing number of low-income Washington State Residents can access quality family planning services. The DOH Title X infrastructure gave us a base of skilled providers, and Take Charge allowed expansion of this base to include agencies that are not in the Title X provider system. The Title X agencies have, for years, provided quality family planning services without adequate funding. Local providers have produced tangible results, reaching over 200,000 men and women of reproductive age. The number of unintended pregnancies across Washington State has markedly decreased. Though funding continues to be an issue, Take Charge and Title X allow clinics to keep their doors open.

DOH has a long and successful history of working with the Take Charge program and staff. This makes us confident that continuing Take Charge would mean continuing progress toward meeting the need for comprehensive family planning services in Washington State.

Respectfully,

Sharon L. McAllister
Manager
Family Planning and Adolescent Health



August 22, 2011

Rebecca Burch-Mack Project Officer
Division of State Demonstrations and Waivers
Center for Medicaid, CHIP and Survey and Certifications
Centers for Medicaid and Medicare Services MS S2-01-16
MS S2-01-16
7500 Security Blvd.
Baltimore, MD 21244

Dear Ms. Burch-Mack Terwilliger,

I am writing this letter to express the strong support of the Community and Migrant Health Centers of Washington State for the continuation of the TAKE CHARGE Family Planning waiver. We are collaborative partners with the Washington State Health Care Authority (HCA) in our shared efforts to improve the health of women, children and families in Washington State by reducing unintended pregnancy.

We understand that the Standards of Care for the Family Planning Demonstration Projects require providers to make available appropriate referrals to healthcare not covered by the family planning waiver. We can assure you that the practice is well established.

The largest provider category for the TAKE CHARGE Program is Community Health Clinics. Given the strong network of community clinics and health centers in place in Washington, those TAKE CHARGE providers who do not routinely provide primary care services to clients enrolled in TAKE CHARGE already have access to a large referral network.

The second largest provider category, Title X Family Planning Clinics, serve the largest percentage of TAKE CHARGE clients and are required by federal guidelines to coordinate referrals for women who need primary care. This referral system has been long in place.

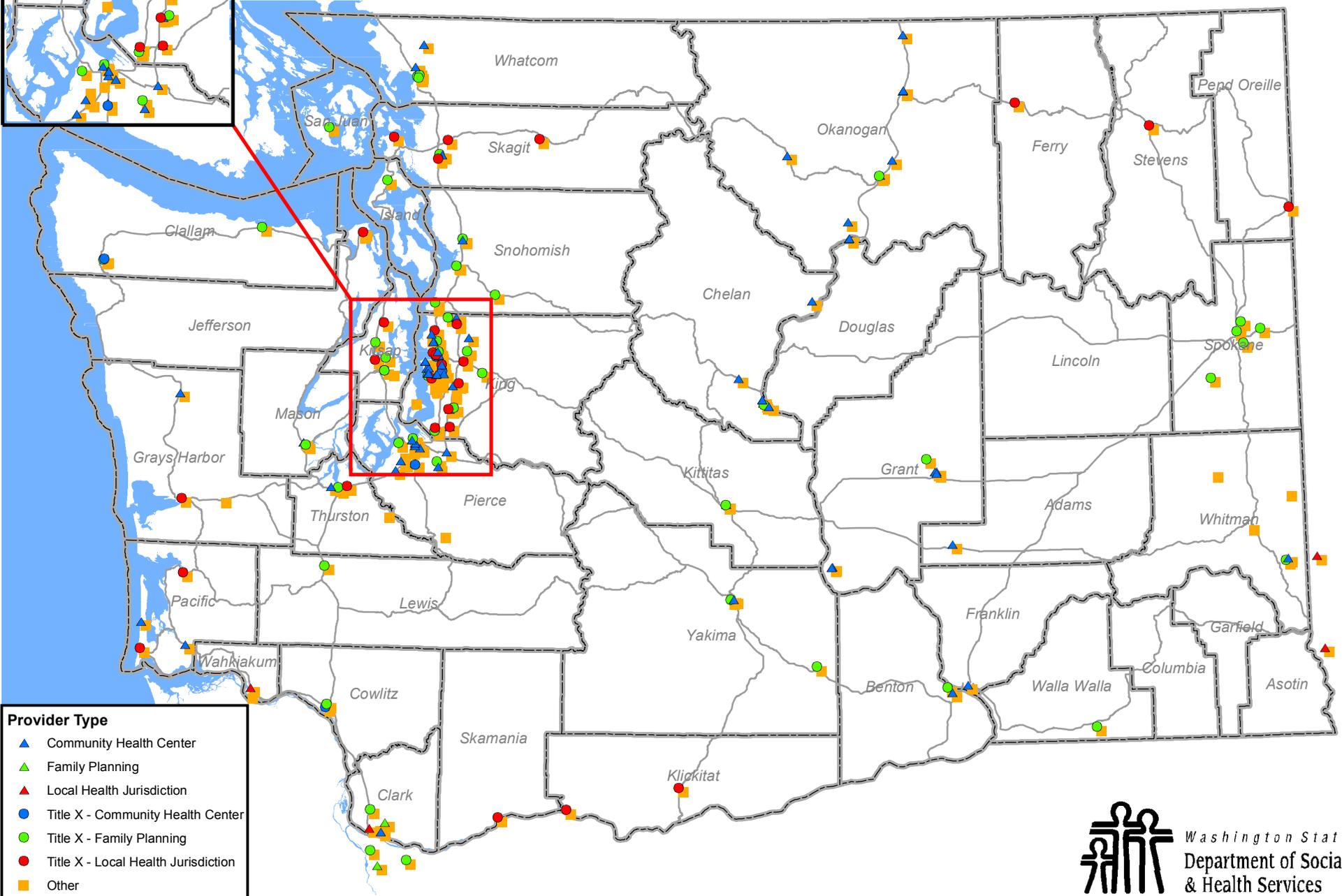
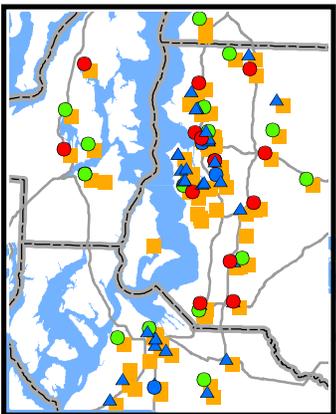
We believe that the TAKE CHARGE Program has demonstrated a very great impact on access to and the provision of family planning services in Washington State. The Community and Migrant Health Centers of Washington strongly support the continuation of this much needed public health program. We look forward to a continued partnership with The Health Care Authority as TAKE CHARGE continues to fill the gap for family planning needs for all Washingtonians.

Sincerely,

A handwritten signature in cursive script that reads "Mary C. Looker".

Mary C. Looker
Chief Executive Officer

TAKE CHARGE Provider Sites





STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES

Medication Purchasing Administration
626 8th Avenue, S.E. • P.O. Box 45502
Olympia, Washington 98504-5502

March 22, 2011

Dear Tribal Leader:

The Medicaid Purchasing Administration (MPA), a division of the Department of Social and Health Services is writing in accordance with the Health and Human Services policy requiring solicitation of advice prior to the submission of any Medicaid State Plan amendments, waiver requests, and proposals for demonstration projects likely to have a direct effect on Indians, Indian Health Programs, or Urban Indian Organizations.

It is the State's intent to renew the TAKE CHARGE Family Planning Waiver.

Name of Waiver: TAKE CHARGE

Purpose:

Washington State is submitting for renewal of the TAKE CHARGE Family Planning Waiver. This is a demonstration and research program. The purpose of the waiver is to make family planning services available to men and women with incomes at or below 200% of the Federal Poverty Level with a goal of reducing unintended pregnancy.

The objectives of TAKE CHARGE are:

- Decrease the number of unintended pregnancies;
- Increase the use of contraceptive methods;
- Increase the availability of family planning services for low-income men and women; and
- Raise the providers' awareness regarding the importance of client centered education, counseling and risk reduction to increase successful use of contraceptive methods.

Eligibility:

The TAKE CHARGE Program is for both men and women. To be eligible, an applicant must:

- Be a U.S. citizen;
- Be a resident of Washington State;
- Have income at or below 200% of the Federal Poverty Level;
- Apply voluntarily for family planning services at the office or clinic of a TAKE CHARGE provider; and
- Need family planning services but have no family planning coverage through another MPA program or health insurance plan.

Clients who are pregnant, sterilized, in the military on active duty, or incarcerated are not eligible for TAKE CHARGE.

Covered Services for Women:

- An initial or annual comprehensive family planning preventive medicine visit with some limited STD screening

- Cervical, vaginal and breast cancer screening at the time of the annual exam or as medically necessary
- Office visits directly related to a family planning problem when medically necessary
- FDA approved prescription and non-prescription contraceptives
- Sterilization

Covered Services For Men:

- FDA approved non-prescription contraceptive methods including condoms and spermicides
- Education and counseling for risk reduction for those men whose female partners are at risk for unintended pregnancy
- Vasectomy

Anticipated Impact on Tribal Members

The impact for tribal members that are eligible for Medicaid is negligible.

Contract Health Service dollars are payer of last resort to Medicaid. If a client is certified as eligible for Medicaid by the Department of Social and Health Services and receives services covered by this waiver at a participating clinic, the clinic will bill Medicaid for those services. The Department of Social and Health Services recognizes that Contract Health Service contract funds, distributed to tribes through an Indian Health Service Contract, are a very limited resource. Under federal policy ([42 CFR 36.61](#)) tribes are not allowed to use Contract Health Service dollars to pay for health services, if a client is eligible for third party reimbursement, such as Medicaid.

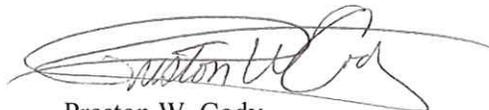
Comments and Questions

The Department of Social and Health Service's Medicaid Purchasing Administration would like to provide the opportunity for tribal representatives to give input, offer consultation or share concerns regarding this waiver renewal. If you would like to provide official written comments or would like more information, please contact Maureen Considine, ARNP, with any questions regarding the TAKE CHARGE Waiver. Please contact Deborah Sosa by June 1, 2011 if you would like to request a formal consultation or submit comments.

Maureen C. Considine, ARNP
Maureen.considine@dshs.wa.gov
626 8th Ave SE
PO Box 45530
Olympia, WA 98504-5530
360.725.1652

Deborah A. Sosa, Native Health Program Manager
sosada@dshs.wa.gov
626 8th Ave SE
PO Box 45510
Olympia, WA 98504-5510
360.725.1649

Sincerely,



Preston W. Cody
Director
Division of Healthcare Services
Medicaid Purchasing Administration

cc: Maureen Considine
Deborah Sosa

All Costs Women and Men	Base Year CY 2000	Year 1 SFY02	Year 2 SFY03	Year 3 SFY04	Year 4 SFY05	Year 5 SFY06	Year 6 SFY07	Year 7 SFY08	Year 8 SFY09	Year 9 SFY10	Year 10 SFY11
Without Waiver											
All Full Scope Medical & S women (no aliens)											
BASIC FP SERVICES											
All current participants	37,332	48,586	53,300	56,265	55,510	51,570	66,967	65,557	71,229	86,774	84,558
Per cap \$	\$135	\$149	\$153	\$167	\$173	\$246	\$216	\$213	\$254	\$215	\$230
Total \$	\$5,025,364	\$7,224,799	\$8,167,651	\$9,413,862	\$9,595,738	\$12,696,514	\$14,483,131	\$13,991,518	\$18,121,506	\$18,634,315	\$19,472,926
Federal \$		\$5,938,785	\$6,550,456	\$7,851,161	\$8,137,186	\$10,766,644	\$12,745,155	\$12,242,578	\$15,820,075	\$16,193,220	\$16,902,500
DELIVERIES											
Persons	27,074	27,759	34,052	37,339	39,332	39,972	38,986	36,753	36,304	34,763	35,111
Per cap \$		\$6,832	\$7,033	\$7,336	\$7,548	\$7,796	\$7,803	\$7,949	\$8,675	\$8,709	\$9,211
Total \$		\$189,648,176	\$239,486,591	\$273,920,371	\$296,881,559	\$311,625,080	\$304,210,317	\$292,151,314	\$314,938,866	\$302,746,996	\$323,407,863
Federal \$		\$95,677,505	\$121,731,034	\$145,287,365	\$148,440,780	\$155,906,027	\$152,378,948	\$149,581,473	\$160,933,760	\$152,281,739	\$161,703,932
FIRST YEAR INFANT MEDICAL COSTS											
Persons	27,074	27,759	34,052	37,339	39,332	39,972	38,986	36,753	36,304	34,763	35,111
Per cap \$		\$4,684	\$5,061	\$5,273	\$6,050	\$6,307	\$6,705	\$7,168	\$7,449	\$7,441	\$6,861
Total \$		\$130,022,257	\$172,336,362	\$196,889,602	\$237,961,504	\$252,106,129	\$261,403,329	\$263,447,052	\$270,429,926	\$258,668,090	\$240,896,900
Federal \$		\$65,596,228	\$87,598,573	\$104,430,245	\$118,980,752	\$126,128,696	\$130,936,928	\$134,884,891	\$138,189,692	\$130,110,049	\$120,448,450
TOTAL w/o Waiver Costs		\$326,895,232	\$419,990,604	\$480,223,835	\$544,438,801	\$576,427,722	\$580,096,778	\$569,589,884	\$603,490,298	\$580,049,401	\$583,777,689
FEDERAL w/o Waiver Costs		\$167,212,518	\$215,880,063	\$257,568,770	\$275,558,717	\$292,801,367	\$296,061,031	\$296,708,942	\$314,943,527	\$298,585,008	\$299,054,881
With Waiver											
All Full Scope Medical, S women, and TC clients (no aliens)											
BASIC FP SERVICES											
All current participants	37,332	48,586	53,300	56,265	55,510	51,570	66,967	65,557	71,229	86,774	84,558
Per cap \$	\$135	\$149	\$153	\$167	\$173	\$246	\$216	\$201	\$254	\$215	\$230
Total \$	\$5,025,364	\$7,224,799	\$8,167,651	\$9,413,862	\$9,595,738	\$12,696,514	\$14,483,131	\$13,991,518	\$18,121,506	\$18,634,315	\$19,472,926
Federal \$		\$5,938,785	\$6,550,456	\$7,851,161	\$8,137,186	\$10,766,644	\$12,745,155	\$12,242,578	\$15,820,075	\$16,193,220	\$16,902,500
DELIVERIES											
Persons		23,430	27,869	29,346	29,730	30,904	32,178	32,208	32,967	30,883	31,357
Per cap \$		\$6,832	\$7,033	\$7,336	\$7,548	\$7,796	\$7,803	\$7,949	\$8,675	\$8,709	\$9,211
Total \$		\$160,073,760	\$196,002,677	\$215,282,256	\$224,402,040	\$240,927,584	\$251,084,934	\$256,021,392	\$285,988,725	\$268,960,047	\$288,829,327
Federal \$		\$80,757,212	\$99,628,161	\$114,185,709	\$112,201,020	\$120,536,070	\$125,768,443	\$131,082,953	\$146,140,238	\$135,286,904	\$144,414,664
FIRST YEAR INFANT MEDICAL COSTS											
Persons		23,430	27,869	29,346	29,730	30,904	32,178	32,208	32,967	30,883	31,357
Per cap \$		\$4,684	\$5,061	\$5,273	\$6,050	\$6,307	\$6,705	\$7,168	\$7,449	\$7,441	\$6,861
Total \$		\$109,746,120	\$141,045,009	\$154,741,458	\$179,866,500	\$194,911,528	\$215,753,490	\$230,866,944	\$245,571,183	\$229,800,403	\$215,140,377
Federal \$		\$55,366,918	\$71,693,178	\$82,074,869	\$89,933,250	\$97,514,237	\$108,070,923	\$118,203,875	\$125,486,875	\$115,589,603	\$107,570,189
EXPANDED FP											
Persons (all)		98,973	145,166	164,327	177,260	173,057	154,159	123,526	107,569	93,540	111,232
Persons (served)		73,940	99,571	116,920	122,342	119,249	97,492	76,403	67,740	70,268	77,272
Per cap \$		\$244	\$262	\$295	\$298	\$288	\$278	\$312	\$309	\$295	\$286
Total \$		\$18,005,878	\$26,099,692	\$34,473,705	\$36,460,504	\$34,311,460	\$27,116,909	\$23,862,578	\$20,959,377	\$20,708,332	\$22,130,613
Federal \$		\$14,800,832	\$20,931,953	\$28,751,070	\$30,918,507	\$29,096,118	\$23,862,880	\$20,879,756	\$18,297,536	\$17,995,541	\$19,209,372
TOTAL w/ Waiver Costs		\$295,050,557	\$371,315,029	\$413,911,281	\$450,324,782	\$482,847,086	\$508,438,464	\$524,742,432	\$570,640,791	\$538,103,097	\$545,573,243
Federal w/ Waiver Costs		\$156,863,746	\$198,803,748	\$232,862,809	\$241,189,963	\$257,913,070	\$270,447,402	\$282,409,162	\$305,744,724	\$285,065,267	\$288,096,724

DIFFERENCE - Total Funds	\$31,844,675	\$48,675,575	\$66,312,554	\$94,114,019	\$93,580,636	\$71,658,314	\$44,847,452	\$32,849,507	\$41,946,304	\$38,204,446
DIFFERENCE - Federal Funds	\$10,348,772	\$17,076,315	\$24,705,962	\$34,368,754	\$34,888,298	\$25,613,629	\$14,299,780	\$9,198,804	\$13,519,741	\$10,958,158

Parameter Assumptions	SFY02	SFY03	SFY04	SFY05	SFY06	SFY07	SFY08	SFY09	SFY10	SFY11
Regular FMAP	50.5%	50.8%	53.0%	50.0%	50.0%	50.1%	51.2%	51.1%	50.3%	50.0%
Family Planning FMAP (based on historical claims)	82.2%	80.2%	83.4%	84.8%	84.8%	88.0%	87.5%	87.3%	86.9%	86.8%
Delivery to First Year Person Factor	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Base Year Medicaid Population Fertility Rate	128.0	128.0	128.0	128.0	128.0	128.0	128.0	128.0	128.0	128.0
Take Charge Fertility Rate (per 1,000)	64.3	62.9	55.8	41.8	41.2	50.0	61.4	68.2	65.7	58.5

Allocated admin expenses	\$ 431,416	\$ 433,885	\$ 435,991	\$ 478,934	\$ 471,588	\$ 558,567	\$ 577,582	\$ 731,995	\$ 618,289	\$ 571,877
Within Reach (Healthy Mothers Healthy Babies) FP Hotline	\$ 2,153	\$ 4,979	\$ 4,789	\$ 4,301	\$ 4,300	\$ 110,000	\$ 115,500	\$ 121,275	\$ 127,340	\$ 133,706
Evaluation	\$ 177,157	\$ 158,132	\$ 159,817	\$ 163,062	\$ 144,217	\$ 218,304	\$ 165,618	\$ 143,190	\$ 77,749	\$ 131,104

AVERTED BIRTHS EST	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
	4,329	6,183	7,993	9,602	9,068	6,808	4,545	3,337	3,880	3,754

Computation of averted births according to the new definition													
			base	dy1	dy2	dy3	dy4	dy5	dy6	dy7	dy8	dy9	dy10
Full Scope	Medicaid Births	Numerator	27,074	23,430	27,869	29,346	29,730	30,904	32,178	32,208	32,967	30,883	31,357
		Denominator	211,592	218,640	226,495	230,379	231,575	234,198	232,902	231,310	231,575	296,202	258,681
		Rate	128.0	126.3	123.0	127.4	128.4						
Take Charge	Medicaid Births	Numerator		4,367	5,965	6,186	4,658	4,310	4,363	4,184	3,807	4,085	3,160
		Denominator		67,936	94,905	110,775	111,410	104,519	87,276	68,197	55,814	62,223	54,016
		Rate		64.3	62.9	55.8	41.8	41.2	50.0	61.4	68.2	65.7	58.5
Averted Births (Medicaid only)			4,329	6,183	7,993	9,602	9,068	6,808	4,545	3,337	3,880	3,754	
Inferred Total Medicaid Births w/o Waiver			27,759	34,052	37,339	39,332	39,972	38,986	36,753	36,304	34,763	35,111	

DATA													
			base	dy1	dy2	dy3	dy4	dy5	dy6	dy7	dy8	dy9	dy10
Matched Births Count - Medicaid			27,074	23,430	27,869	29,346	29,730	30904	32178	32208	32967	30883	31357
Clients 15 to 44 Denominator			211,592	218,640	226,495	230,379	231,575	234198	232902	231310	231575	296202	258681
take charge medicaid births				4,367	5,965	6,186	4,658	4310	4363	4184	3807	4085	3160
take charge participants (denominator)				67,936	94,905	110,775	111,410	104519	87276	68197	55814	62223	54016
Take Charge Fertility Rate				64.3	62.9	55.8	41.8	41.2	50.0	61.4	68.2	65.7	58.5

current eligibles full-scope medical												
		base	dy1	dy2	dy3	dy4	dy5	dy6	dy7	dy8	dy9	dy10
Men		12	12	9	8	11	11	17	15	4	2	1
		177,633	193,153	205,022	206,587	208,700	212,115	211,507	211,769	226,527	216,455	236,442
Women		271,434	284,683	297,881	304,338	306,743	311,177	309,807	308,118	322,639	365,692	330,589
TOTAL		449,067	477,836	502,903	510,925	515,443	523,292	521,314	519,887	549,166	582,147	567,031

participating clients 15 to 44										
base	dy1	dy2	dy3	dy4	dy5	dy6	dy7	dy8	dy9	dy10
211,592	218,640	226,495	230,379	231,575	234,198	232,902	231,310	231,575	296,202	246,914

baseline fertility rate		
numer	denom	rate
27,074	211,592	128.0

total costs - women										
base	dy1	dy2	dy3	dy4	dy5	dy6	dy7	dy8	dy9	dy10
36,482	47,587	52,183	54,890	54,283	50,449	65,836	64,433	70,118	85,719	83,657
4,977,764	7,168,855	8,096,163	9,332,737	9,523,345	12,584,958	14,395,475	13,914,393	18,032,104	185,301,24	193,887,37

total costs - men										
base	dy1	dy2	dy3	dy4	dy5	dy6	dy7	dy8	dy9	dy10
850	999	1,117	1,375	1,227	1,121	1,131	1,124	1,111	1,055	901
47,600	55,944	71,488	81,125	72,393	111,556	87,656	77,125	89,402	104,190.9	84,188.96

64.3

matched births										
base	dy1	dy2	dy3	dy4	dy5	dy6	dy7	dy8	dy9	dy10
28,396	27,625	27,869	30,078	29,484	30,904	32,178	32,208	32,967	30,883	31,357