

**Application: Section 1115 Family Planning Only
Demonstration Waiver**



November 30, 2022

Table of Contents

Washington State Application Certification Statement –Section 1115(a) Extension	1
Appendix A: Historical Narrative	3
History	3
Request	4
Expenditure Authorities	6
Appendix B: Historical Budget Allotment & Future Projections	7
Annual Expenditures	7
Budget Projections for 2023-2027	8
Appendix C: Interim Evaluation and Plans for Future Evaluation	9
Current Program Evaluation and Monitoring	9
Interim Evaluation of Goals and Progress, 2018-2021	9
Future Evaluation, 2023-2027	11
Appendix D: Summary of Quality Assurance Monitoring	13
Quality Monitoring Activities	13
Quality and Access to Care	14
Appendix E: Public Notice Process	16
Appendix F: Budget Neutrality Worksheet, 2017-2027	18
.....	18
Attachment A: Special Terms and Conditions	19
Attachment C: Evaluation Design, 2018-2022	54
Attachment D: Contraceptive Care Reports	60
Attachment E: Public Notices, Comments, & Responses	64

Washington State Application Certification Statement – Section 1115(a) Extension

Washington State Application Certification Statement - Section 1115(a) Extension

This document, together with the supporting documentation outlined below, constitutes **Washington State’s** application to the Centers for Medicare & Medicaid Services (CMS) to extend the **Section 1115 Family Planning Only Demonstration #11-W-00134/0-01** for a period of **5 years** pursuant to section 1115(a) of the Social Security Act.

Type of Request

 Section 1115(a) extension with no program changes

This constitutes the state's application to the Centers for Medicare & Medicaid Services (CMS) to extend its demonstration without any programmatic changes. The state is requesting to extend approval of the demonstration subject to the same Special Terms and Conditions (STCs), waivers, and expenditure authorities currently in effect for the period **July 1, 2023-June 30, 2028**.

The state is submitting the following items that are necessary to ensure that the demonstration is operating in accordance with the objectives of title XIX and/or title XXI as originally approved. The state’s application will only be considered complete for purposes of initiating federal review and federal-level public notice when the state provides the information as requested in the below appendices.

- **Appendix A:** A historical narrative summary of the demonstration project, which includes the objectives set forth at the time the demonstration was approved, evidence of how these objectives have or have not been met, and the future goals of the program.
- **Appendix B:** Budget/allotment neutrality assessment, and projections for the projected extension period. The state will present an analysis of budget/allotment neutrality for the current demonstration approval period, including status of budget/allotment neutrality to date based on the most recent expenditure and member month data, and projections through the end of the current approval that incorporate the latest data. CMS will also review the state’s Medicaid and State Children’s Health Insurance Program Budget and Expenditure System (MBES/CBES) expenditure reports to ensure that the demonstration has not exceeded the federal expenditure limits established for the demonstration. The state’s actual expenditures incurred over the period from initial approval through the current expiration date, together with the projected costs for the requested extension period, must comply with CMS budget/allotment neutrality requirements outlined in the STCs.

- **Appendix C:** Interim evaluation of the overall impact of the demonstration that includes evaluation activities and findings to date, in addition to plans for evaluation activities over the requested extension period. The interim evaluation should provide CMS with a clear analysis of the state’s achievement in obtaining the outcomes expected as a direct effect of the demonstration program. The state’s interim evaluation must meet all of the requirements outlined in the STCs.
- **Appendix D:** Summaries of External Quality Review Organization (EQRO) reports, managed care organization and state quality assurance monitoring, and any other documentation of the quality of and access to care provided under the demonstration.
- **Appendix E:** Documentation of the state’s compliance with the public notice process set forth in 42 CFR 431.408 and 431.420.

The state’s application will only be considered complete for purposes of initiating federal review and federal-level public notice when the state provides the information requested in Appendices A through E above, along with the Section 1115 Extension Template identifying the program changes being requested for the extension period. Please list all enclosures that accompany this document constituting the state’s whole submission.

1. Section 1115(a) Extension Template and Appendices
2. Centers for Medicare & Medicaid Services Special Terms and Conditions #11-W-00134/0-01
3. Centers for Medicare & Medicaid Expenditure Authority #11-W-00134/0-01
4. Attachments:
 - A: Special Terms and Conditions
 - B: Evaluation Design, 2023-2027
 - C: Quality Measuring, Monitoring and Improving Process
 - D: Public Notices, Comments, & Responses
 - E: Budget Neutrality Worksheet

The state attests that it has abided by all provisions of the approved STCs and will continuously operate the demonstration in accordance with the requirements outlined in the STCs.

Signature: Chami Fata MD, MSc

Date: November 30, 2022

Washington State Medicaid Director

Appendix A: Historical Narrative

History

Washington State's 1115 family planning demonstration waiver was initially approved by the Centers for Medicare and Medicaid Services (CMS) in 2001. The waiver consists of two programs that were implemented and overseen by the Washington State Health Care Authority (HCA).

- The Family Planning Only Pregnancy-Related (FPO-PR) extension – this program provides family planning services for 10 months to individuals who were on pregnancy Medicaid and do not qualify for other Medicaid programs. This is an automatic transition following the month after the end of the 60 days postpartum coverage.
- Take Charge - implemented in July 2001, offering family planning services to individuals with family income at or below 200% of the federal poverty level (FPL). Initially, enrollees on Take Charge could only access care through qualified Take Charge providers. The income increased to 250% FPL on October 1, 2012, and again when the Affordable Care Act (ACA) was implemented on October 1, 2013, to 260% of FPL. On July 1, 2019, the Take Charge provider network was expanded, and the program was renamed from Take Charge to Family Planning Only (FPO).

The goals of the FPO-PR and the FPO programs are to: 1) improve the health of individuals, children, and families by decreasing unintended pregnancies and lengthening intervals between births; and 2) reduce state and federal Medicaid expenditures for births from unintended pregnancies. For the first ten years, the waiver was administered by the Washington State Department of Social and Health Services (DSHS) Health and Recovery Services Administration (HRSA). On July 1, 2011, Washington State Medicaid merged with the Washington State Health Care Authority (HCA). The re-organized Health Care Authority has since administered the 1115 family planning demonstration waiver.

Total enrollees decreased over the past demonstration year by 90.2% from 15,182 in DY19 to 7,981 in DY20. During DY20, there were steady declines each quarter in enrollment in both the Family Planning Only (FPO) and the Family Planning Only-Pregnancy Related (FPO-PR) populations, see Table 4. However, in DY20, the FPO enrollment increased by 12.9% from Quarter 3 to Quarter 4. Overall participation decreased over the past demonstration years, most notably between DY19 to DY20 by 100.5% (from 3,113 in DY19 to 1,553 in DY20). The declines in enrollment and participation in DY20 coincide with Washington State's Governor Inslee's 'Stay Home, Stay Healthy' quarantine directives under the public health emergency for COVID-19.

Most recent data indicate increases in enrollment for DY21 quarter 3. Total enrollees increased by 6.0% from 3,791 in DY21 Quarter 2 to 4,019 in DY21 Quarter 3, but participation decreased by 12.4% (from 419 to 367 participants). Newly enrolled clients increased by 0.8% from 484 in DY21 Quarter 2 to 488 in DY21 Quarter 3. In DY21 Quarter 3, the most frequently provided family planning method for all participants was oral contraceptives (i.e.,

birth control pills) used by 35.4% of unduplicated participants.

Utilization of the FPO-PR benefit amongst individuals who have recently been pregnant has dramatically decreased across this most recent demonstration period. We believe that broadly this is a result of: 1) increased education and access to long-acting reversible contraception; and 2) improved access to one's preferred form of birth control before pregnancy medical coverage ends. When the federal declaration of the Public Health Emergency (PHE) occurred in January of 2020, it created an additional factor because many clients did not transition to FPO-PR and instead remained on the more comprehensive pregnancy coverage. It also may remain true that some individuals are automatically enrolled in FPO-PR even when they do not need the services of the program since they have obtained coverage through a Qualified Health Plan (QHP) or another insurance source. Most clients enrolled in FPO are teens who are seeking confidential services. They make up almost two thirds of the participants. Each quarter, around 1,000 people are enrolled in the two programs.

Request

The current waiver is set to expire June 30, 2023. Initially this renewal was due June 30, 2022, but we requested and were granted an extension on the application until September 30, 2022. At the time this renewal application is due, Washington intends to maintain coverage for the same populations currently served in FPO and FPO-PR. In June 2022, After-Pregnancy Coverage (APC) was implemented in Washington, providing 12 months of full-scope Medicaid benefits to individuals who were pregnant during the prior year. Clients who had a pregnancy less than 12 months prior were moved into APC and will continue to receive this coverage during the PHE. Clients who had a pregnancy that ended more than 12 months prior and are on FPO-PR will remain on this coverage until after the PHE ends.

There is currently no established end date for the PHE. Once the PHE is declared to be over, we anticipate the FPO-PR program will become obsolete due to availability of comprehensive coverage under APC.

We are requesting a five-year extension from July 1, 2023, through June 30, 2028. We are requesting the same waiver and expenditure authorities as those included in the current waiver.

Demonstration Population

The family planning demonstration waiver includes the following groups of clients:

- Individuals who were active on FPO-PR when the PHE went into effect in 2020. Once the PHE ends, HCA will identify these individuals and redetermine what program they are eligible for.
- Recently pregnant individuals who lose Medicaid coverage 12 months after their pregnancy ends, are seeking to prevent an unintended pregnancy and are not eligible for more comprehensive Medicaid coverage and have family income at or below 260% FPL.
- Uninsured individuals with family income at or below 260% FPL, and in need of family planning services in order to prevent an unintended pregnancy.

- Teens and domestic violence victims who need confidential family planning services, are covered under their perpetrator's or parent's health insurance and have individual incomes at or below 260% FPL.

Program Goals

- Ensure access to family planning/contraceptive care services.
- Decrease unintended pregnancies.
- Lengthen intervals between pregnancies and births.
- Reduce state and federal Medicaid expenditures for averted births from unintended pregnancies.

Program Coverage

- The family planning demonstration waiver covers every FDA-approved birth control method and a narrow range of family planning services that help clients to use their preferred contraceptive method/s safely, effectively, and successfully to avoid unintended pregnancy. The birth control methods that can be accessed are:
 - Oral Contraceptives
 - Contraceptive Ring and Patch
 - Internal and External Condoms
 - Spermicides
 - Contraceptive Injections
 - Contraceptive Implants
 - Intrauterine Devices
 - Emergency Contraception
 - Sterilizations
 - Diaphragms and Cervical Caps
 - Natural Family Planning
 - Abstinence Counseling
- Family planning-related services for an individual with a uterus and ability to become pregnant include: an annual comprehensive family planning preventive medicine visit, screening for GC/CT for clients ages 13 through 25; cervical cancer screening; HPV vaccines; and services directly related to successfully using a chosen method of contraception.
- Family planning-related services for an individual with a penis and ability to impregnate others include: an annual counseling session for reducing the risk of unintended pregnancy; how to use condoms and spermicides; HPV vaccines; and services directly related to vasectomies.

Expenditure Authorities

The Demonstration's expenditure authority falls under the State's title XIX plan and section 1115(a)(2) of the Social Security Act. Requirements not applicable to the expenditure authorities are:

1. **Methods of Administration: Transportation:** Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53. To the extent necessary to enable the State to not assure transportation to and from providers for the demonstration population.
2. **Amount, Duration, and Scope of Services (Comparability):** Section 1902(a)(10)(B). To the extent necessary to allow the State to offer the demonstration population a benefit package consisting only of family planning services and family planning-related services.
3. **Prospective Payment for Federally Qualified Health Centers and Rural Health Centers and Rural Health Clinics:** Section 1902(a) (15). To the extent necessary for the State to establish reimbursement levels to these clinics that will compensate them solely for family planning and family planning-related services.
4. **Eligibility Procedures:** Section 1902(a) (17). To the extent necessary to allow the State to not include parental income when determining a minor's (individual under age 18) eligibility for the family planning demonstration. To the extent necessary to allow the State to not require reporting of changes in income or household size for 12 months, for a person found income-eligible upon application or annual redetermination when determining eligibility for the family planning demonstration.
5. **Retroactive Coverage:** Section 1902(a) (34). To the extent necessary to enable the State to not provide medical assistance to the demonstration population for any time prior to the first of the month in which an application for the demonstration is made.
6. **Early and Periodic Screening, Diagnostic, and Treatment (EPSDT):** Section 1902(a)(43)(A). To the extent necessary to enable the State to not furnish or arrange for EPSDT services to the demonstration population.

Appendix B: Historical Budget Allotment & Future Projections

Annual Expenditures

The State is required to provide quarterly reports using the Forms CMS-64 and CMS-37 to report expenditures for services provided under the family planning waiver. The tables below show the service and administrative expenditures and the Per Member per Month (PMPM) expenditures for the demonstration from July 2017 through June 2022. Budget neutrality is presented for this same time period in Attachment F. Due to fluctuations in enrollment and expenditures related to the Public Health Emergency (PHE) and administrative expenditures the trend rate for the demonstration has also fluctuated.

Table 1: Annual Service and Administrative Expenditures July 1, 2017 – June 30, 2022*						
	Service Expenditures CMS-64		Administrative Expenditures CMS-64		Total Expenditures CMS-64	Expenditures CMS-37
	Total Computable	Federal Share	Total Computable	Federal Share		
DY17	\$1,099,389.00	\$943,334.00	\$84,639.60	\$76,175.58	\$1,184,028.60	
DY18	\$765,944.00	\$672,166.00	\$122,121.96	\$109,909.67	\$888,065.96	
DY19	\$1,196,326.00	\$1,015,890.00	\$121,819.88	\$109,637.74	\$1,318,145.88	
DY20	\$761,152.00	\$660,532.00	\$85,190.03	\$76,670.98	\$846,342.03	
DY21	\$300,814.00	\$258,404.00	\$68,000.59	\$61,200.42	\$368,814.59	
* Demonstration year expenditures reported are based on claims paid through March 31, 2022						

Table 2: Per Member Per Month (PMPM) Expenditures July 1, 2017 – June 30, 2022					
	DY17	DY18	DY19	DY20	DY21*
# Member Months	92,318	100,001	94,948	43,191	32,933
PMPM	\$11.93	\$7.66	\$12.60	\$17.62	\$9.13
Total Expenditures	\$1,100,912.00	\$765,944.00	\$1,196,326.00	\$761,152.00	\$300,814.00
Total Expenditures = Member Months multiplied by PMPM *DY21 number of member months are based on data through March 31, 2022. CMS-37 data is not prepared based on the demonstration years of waivers. The CMS-37 is informed using accounting data for federal fiscal years which is based on date of payment. The current CMS-37 contains expenditure estimates for FFY 2022, Q3 through FFY 2023, Q4.					

Budget Projections for 2023-2027

Below is the projection of enrollment and costs from July 2023 through June 2027. Baseline values were determined by averaging enrollment and costs for DY17 through DY19. The state decided not to use demonstration years that ran during the COVID-19 pandemic due to wide fluctuations in expenditures and enrollment over the course of that period.

Table 3: Demonstration Budget Projection 2023-2027								
	Demo Trend Rate	Baseline Average of DY17 – DY19	DY23	DY24	DY25	DY26	DY27	TOTAL
# Member Months		95,758	95,758	95,758	95,758	95,758	95,758	\$4,085,988.84
PMPM		\$10.15	\$6.11	\$9.73	\$7.95	\$10.69	\$8.18	
Total Expenditures			\$585,406	\$931,284	\$761,028	\$1,024,412.00	\$783,858.84	
Total Expenditures = Member Months multiplied by PMPM CMS-37 data is not prepared base on the demonstration years of waivers. The CMS-37 is informed using accounting data for federal fiscal years which is based on date of payment. The current CMS-37 contains expenditure estimates for FFY 2022, Q3 through FFY 2023, Q4. The estimate for demonstration years (DY) 22 through 26 are based on an average spend of DY 17 through DY 21 and follows a similar pattern.								

Appendix C: Interim Evaluation and Plans for Future Evaluation

Current Program Evaluation and Monitoring

Given the development and implementation of a new state program to extend postpartum care, the evaluation design will be revised for the next waiver renewal period.

Many of the program's original objectives will be retired due to their limited relevance and applicability to the current program. The proposed outcome measures can be grouped into three categories:

- (1) Process outcomes for FPO Waiver clients – will focus on the eligibility processes and if efforts to reduce administrative barriers to family planning led to increased enrollment and participation.
- (2) Intermediate outcomes for both FPO Waiver clients and the waiver's target population; - will focus on providers offering the full range of contraceptive methods, and,
- (3) Long-term outcomes for Washington's reproductive-age population as a whole – will focus on reporting whether the most recent birth was intentional or not.

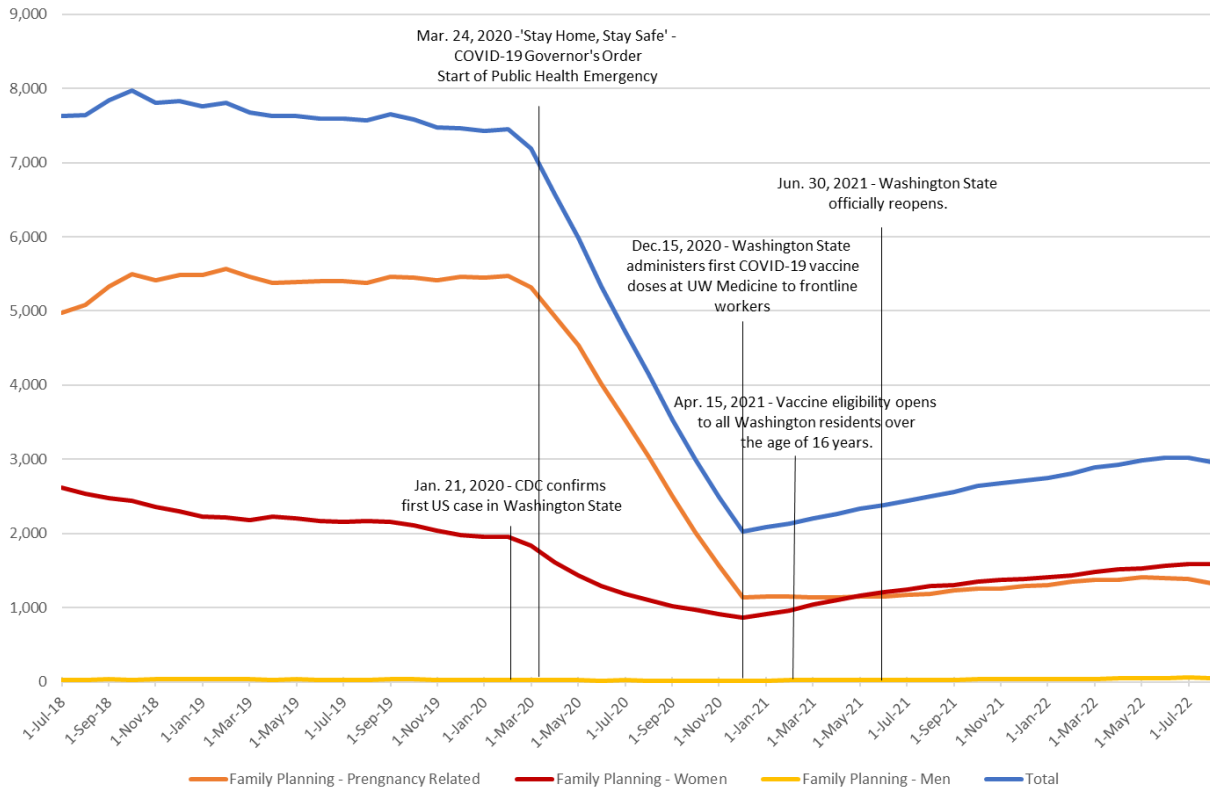
Performance targets will be developed for each outcome and will be monitored annually to measure progress toward these goals.

Interim Evaluation of Goals and Progress, 2018-2021

Key Findings

1. ***COVID-19 quarantine, associated healthcare access restrictions, and subsequent Public Health Emergency (PHE)*** eroded enrollment and participation gains from the pre-pandemic period. The PHE allowed many eligible FPO-PR clients to maintain full-scope Medicaid coverage after their pregnancy ended explaining most of the decreased enrollment of this waiver group.
2. ***FPO Waiver-Women clients*** continue to use family planning and family planning-related waiver services more than the other waiver groups (i.e., FPO-PR and FPO Waiver-Men). This waiver group highlights the fact that the waiver continues to have an important role for low-income women not eligible for Medicaid who are seeking high-quality, confidential family planning services. Family planning can be an important gateway into the healthcare system for low-income and racially/ethnically diverse clients of reproductive age.

Enrollment of Family Planning Waiver Clients by Population in Washington State (June 01, 2018 - June 30, 2022)



Enrollment and Participation Trends over Life of Demonstration

The following graph and tables show the enrollment figures over the life of the demonstration, from DY18 (July 1, 2018) through DY21 (June 30, 2022).

Table 4. Total Number of Enrollees July 1, 2018 – June 30, 2022				
Year	Family Planning Pregnancy related	Family Planning - Women	Family Planning- Men	Total Population (Unduplicated)
DY18	12,066	4,757	66	16,874
DY19	11,323	3,824	59	15,182
DY20	5,358	2,629	47	8,034
DY21	2,450	2,554	80	5,084

Table 5. Total Number of Participants				
July 1, 2018 – June 30, 2022				
Year	Family Planning Pregnancy related	Family Planning - Women	Family Planning- Men	Total Population (Unduplicated)
DY18	1,263	2,359	8	3,628
DY19	1,071	2,039	7	3,113
DY20	367	1,179	9	1,553
DY21	174	1,058	16	1,248

Annual Disenrollment and Retention Figures

Table 6. Annual Disenrollment and Retention Figures								
Demonstration Period: July 1, 2018 – June 30, 2022 (DY18-DY21)								
Reason for Disenrollment/# and % Enrollees	July 1, 2018 – June 30,2019		July 1, 2019 – June 30,2020		July 1, 2020 – June 30,2021		July 1, 2021– June 30,2022	
	n	%	n	%	n	%	n	%
Sterilization	357	3.6	287	2.9	113	2.3	47	4.7
Eligible for Full Benefits Due to Pregnancy	673	6.8	724	7.4	384	7.7	214	21.5
Eligible for Full Benefits	1,144	11.6	1,495	15.3	593	11.9	298	29.9
Re-enrolled	168	1.7	121	1.2	36	0.7	16	1.6
Did not Renew	7,210	73.3	6,865	70.1	2,960	59.6	205	20.6
Eligible for Other State- Funded Program	285	2.9	298	3.0	879	17.7	216	21.7
Total Disenrollment Number	9,837		9,790		4,965		996	

Note: the above table reflects both exits from and entries into the demonstration waiver. Clients who both exit and enter will be counted twice.

Future Evaluation, 2023-2028

(See Attachment C for full description)

Questions and Hypotheses

Draft in progress.

Evaluation Design

Draft in progress.

Data Collection and Sources

Draft in progress.

Data Analysis Strategy

Draft in progress.

Appendix D: Summary of Quality Assurance Monitoring

Quality Monitoring Activities

Washington State Medicaid engages in several quality monitoring activities, primarily for managed care services which covers and pays for 85% of Medicaid recipients. The following reports describe these activities:

- 2020 External Quality Review Report (<https://www.hca.wa.gov/assets/billers-and-providers/EQR-TechnicalReport%20-Final-01312022.pdf>)
- Washington State Medicaid Managed Care Quality Strategy (<https://www.hca.wa.gov/assets/program/13-0053-washington-state-managed-care-quality-strategy.pdf>)
- 2021 Comparative and Regional Analysis Report (<https://www.hca.wa.gov/assets/billers-and-providers/eqr-performance-measure-comparative-analysis-report-appendix%20ae.pdf>)

Since the 1115 Family Planning Only Demonstration waiver is Fee –For- Service (FFS), it is not mentioned in these reports. However, the providers that serve the clients in the waiver programs are all contracted with the Managed Care Organizations (MCOs) and therefore their quality of care is included in the monitoring done for the MCOs.

As part of CMS’s required Payment Error Rate Measurement (PERM) program Washington State Medicaid’s FFS claims and managed care organization per member per month (PMPM) payments are submitted on a quarterly basis for the Review Year (RY) Cycle. The CMS PERM Statistical Contractor (SC) pulls data samples from each quarterly data set. The CMS PERM Review Contractor (RC) requests records for the sampled claims and reviews for compliance with federal, state, and agency rules and regulations. The CMS PERM data processing contractor reviews the MMIS/ProviderOne to ensure the claim was processed and paid appropriately according to federal, state, and agency rules and regulations. The CMS PERM Eligibility Review Contractor (ERC) reviews the agency Medicaid eligibility process and systems for compliance with federal, state and agency rules and regulations. There may be samples of eligibility or claims for waiver services within the sample and if so then the specific agency rules related to the family planning only programs are applied. Any identified processing and payment errors will result in an error rate and corrective action plan.

Each PERM review cycle is three years. COVID-19 pandemic caused delays therefore RY 2017 was followed by RY2021. RY2024 has recently kicked off with first quarter data submission in October 2022.

Quality and Access to Care

Washington State's Performance Measures Coordinating Committee with the support of ad hoc technical work groups developed the initial Washington Statewide common measure set December 2014. The measures provide the foundation for health care accountability and measuring performance. Two measures related to the Family Planning Only Demonstration waiver are contraceptive care – most & moderately effective methods and unintended pregnancies.

The “contraceptive care – most & moderately effective methods” measures the percentage of individuals ages 15-44 who may be at risk of unintended pregnancy that is provided a most effective (i.e., sterilization, implants, intrauterine devices, or systems (IUD/IUS) or moderately effective (i.e., injectables, oral pills, patch, ring, or diaphragm) method of contraception. This measure uses claims data and is a statewide population health monitoring measure. The “unintended pregnancies” measure uses the Pregnancy Risk Assessment Monitoring System (PRAMS) survey to determine the percentage of pregnancies that was unintended at the time of conception. This is a statewide population health monitoring measure.

In 2020, 20.8% of postpartum people ages 15-20 were provided a long-acting reversible method of contraception (LARC) within sixty days of delivery in the Fee-for-service (FFS) population and 21.3% in the Managed care population.

Postpartum people ages 21-44 who were provided a long-acting reversible method of contraception (LARC) within sixty days of delivery, were 15.1% of the eligible FFS and managed care populations.

In 2020, 38.9% of people who identify as women ages 15-20 were provided a most or moderately effective FDA-approved method of contraception within sixty days of delivery in the eligible FFS population. For managed care enrollees, 45.1% of clients in this category were provided with a most or moderately effective method.

People who identify as women ages 21-44 who were provided a most effective or moderately effective FDA-approved method of contraception within sixty days of delivery, was 32.4% of the eligible Fee-for-service (FFS) population. In managed care, 39.7% of individuals in this category were provide with a most or moderately effective method.

Details along with additional 2016-2019 data can be found in [Attachment D](#) of this report.

Eligibility for family planning services through the demonstration waiver is determined by Washington Medicaid eligibility staff. Based on established MAGI processes, the family planning application is reviewed and, if the client meets program requirements, their enrollment starts the first day of the month they applied. To maintain quality in the Medical Eligibility Determination Unit (MEDS), each new staff is trained and has every application audited and reviewed until they reach 95% accuracy in their processing. The FPO-PR extension waiver program is an opt-out program. Prior to implementation of After Pregnancy Coverage all Medicaid clients receiving

pregnancy coverage were sent a letter before their coverage terminated letting them know they would be automatically enrolled in FPO-PR unless they applied for other broader Medicaid eligibility categories, which they were encouraged to do. As of June 2022, Washington state has implemented extended postpartum coverage from 60 days to 12 months (After Pregnancy Coverage). This change means that postpartum clients are no longer automatically enrolled in FPO-PR. Washington state has also updated their letters that FPO is an option that people can apply for on an annual basis and as many times as needed. This provides maximum access to family planning services for recently pregnant clients.

Throughout DY18, efforts were started to expand the FPO provider network as a strategy to promote and maintain access to services. Beginning in DY19, individuals on FPO coverage could see any contracted Medicaid provider for family planning services, rather than the more limited pool of qualified Take Charge providers.

Appendix E: Public Notice Process

Washington has complied with all requirements in the 42 CFR §431.408 for public notice and transparency. Public notice was initially given by posting how to comment on our application for an extension of our 1115 Family Planning Only Waiver on the HCA website and in the Washington State Register on June 13, 2022. An email with a link to the notice and draft application was sent on June 27, 2022 to a list of all Apple Health providers.

Two virtual public meetings were conducted to allow comment in person, on phone, or via webinar. These occurred on June 30, 2022 and July 29, 2022. Comments were also accepted via fax, email or in writing via post. The official comment period was from June 30, 2022 through August 26, 2022. A preliminary draft of the renewal application was posted on the HCA website on July 27, 2022.

The Washington State Federally recognized Indian tribes were requested to consult on our application for extension via a letter sent on June 30, 2022. Copies of all these notices are attached in Attachment E.

After initial submission on 9/30/22 and quick review by CMS there were a few items to be addressed by CMS before comprehensive review. Those items were: data tables in the version posted to the HCA website on July 27, 2022 were not updated, there was lack of detail on the dates of past public forum, and there was not an interim evaluation report for the current waiver cycle included as part of the renewal. The interim evaluation was resource intensive and we were given until 11/30/22 to upload this to the CMS portal. This was submitted to CMS on 11/30/22 and is summarized in Appendix C. Per 42 CFR §431.408 we will now have an additional 30-day comment period, public notice and tribal notification. Copies of these notices are included in Attachment E. The 30-day comment period will start 12/19/22 when notice goes out broadly that the revised waiver renewal application is posted to the HCA website and directing interested parties to the sections of the application that have been updated.

Post-award Public Input Process Required by 42 CFR §431.420(c)

Washington hosted a public forum via webinars to provide updates on the FPO Waiver. The dates, times, and location of the public forum were published on HCA’s website 30 days in advance of each meeting and sent via email to subscribers of HCA public notices.

The table below documents annual meetings, links to each YouTube posted webinar and webinar slides. Each Frequently Asked Questions (FAQ) PDF contains general questions and answers to the Family Planning Only Waiver and questions specific to the annual meeting content.

Meeting month/year	YouTube Recording Link	Webinar Slides	Webinar Frequently Asked Questions (FAQ) PDF
October and November 2018			Questions were answered, no concerns raised at the Washington State Perinatal Collaborative and Family Planning Network meeting
December 2019	Family Planning Only Expansion webinar - YouTube	PowerPoint Presentation (wa.gov)	Family Planning Only webinar FAQ (wa.gov)
December 2020	Family Planning Only program application update webinar - YouTube	PowerPoint Presentation (wa.gov)	fpo-dec-2020-webinar-q&a.pdf (wa.gov)
February 2021	Family Planning Only non-citizen (state-funded) application webinar - YouTube	Family Planning Only (FPO) - Non-citizen application presentation (February 2021) (wa.gov)	Family Planning Only (FPO) - Non-citizen application webinar Q&A (February 2021) (wa.gov)

Appendix F: Budget Neutrality Worksheet, 2017-2027

Family Planning Waiver Budget Neutrality Report										
July 1, 2017 through June 30, 2027										
Demonstration Year Service and Administrative Expenditures										
July 1, 2017 - June 30, 2022										
Demo Year	Service Expenditures CMS-64 (1)		Administration Expenditures CMS-64 (1)		Total Expenditures CMS-64	Service Expenditures CMS-37 (2)		Administration Expenditures CMS-37 (2)		Total Expenditures CMS-37
	Total Computable	Federal Share	Total Computable	Federal Share		Total Computable	Federal Share	Total Computable	Federal Share	
DY17	1,100,030.01	943,915.99	1,523.00	1,280.00	1,101,553.01					0.00
DY18	766,027.80	672,241.53	0.00	0.00	766,027.80					0.00
DY19	1,196,238.17	1,015,846.42	0.00	0.00	1,196,238.17					0.00
DY20	761,354.00	660,858.33	0.00	0.00	761,354.00					0.00
DY21	409,458.48	351,999.56	0.00	0.00	409,458.48					0.00
DY22						846,622.00	726,944.00	0.00	0.00	846,622.00
DY23						585,406.00	510,399.00	0.00	0.00	585,406.00
DY24						931,284.00	799,638.00	0.00	0.00	931,284.00
DY25						761,028.00	663,519.00	0.00	0.00	761,028.00
DY26						1,024,412.00	879,602.00	0.00	0.00	1,024,412.00
Calculation of Composite Federal Share			DY17	DY18	DY19	DY20	DY21	DY22	DY23	DY24
FFP Services Received by WA (CMS-64)			943,915.99	672,241.53	1,015,846.42	660,858.33	351,999.56	726,944.00	510,399.00	799,638.00
FFP Administration Received by WA (CMS-64)			1,280.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total FFP (CMS-64)			945,195.99	672,241.53	1,015,846.42	660,858.33	351,999.56	726,944.00	510,399.00	799,638.00
Total Expenditures (CMS-64)			1,100,030.01	766,027.80	1,196,238.17	761,354.00	409,458.48	846,622.00	585,406.00	931,284.00
Composite Federal Share			0.86	0.88	0.85	0.87	0.86	0.86	0.87	0.86
(1) Demonstration year expenditures reported for DY 17 through DY 21 are based on actual expenditures through June 22, 2022										
(2) CMS-37 data is not prepared base on the demonstration years of waivers. The CMS-37 is informed using accounting data for federal fiscal years which is based on date of payment. The current CMS-37 contains expenditure estimates for FFY 2022, Q3 through FFY 2023, Q4. The estimate for demonstration years (DY) 22 through 26 are based on an average spend of DY 17 through DY 21 and follows the a similar pattern.										

Attachment A: Special Terms and Conditions

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, Maryland 21244-1850



May 9, 2018

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

Dear Ms. Lindeblad:

The Centers for Medicare & Medicaid Services (CMS) is pleased to inform you that Washington's request to extend its section 1115 demonstration, now entitled "Washington Family Planning Only Program" (Project Number: 11-W-00134/0) has been approved. CMS' approval of this demonstration extension is granted under the authority of section 1115(a) of the Social Security Act (the "Act") and is based on the determination that the expenditure authority granted therein is likely to assist with promoting the objectives of title XIX of the Act. This approval is effective as of the date of this letter through June 30, 2023.

The Washington Family Planning Only Program section 1115 demonstration extends eligibility for family planning services to uninsured women and men capable of producing children with income at or below 260 percent of the federal poverty level (FPL); women losing Medicaid pregnancy coverage at the conclusion of the 60-day postpartum period; and teens and domestic violence victims who need confidential family planning services and have individual income at or below 260 percent of the FPL.

Demonstration projects under section 1115 of the Act offer a way to give states more freedom to test and evaluate innovative solutions to improve quality, accessibility, and health outcomes in a budget-neutral manner, provided that, in the judgment of the Secretary, the demonstration is likely to assist with promoting the objectives of Medicaid. Consistent with federal transparency requirements, CMS also considers all public comments received during both the state and federal public input periods when evaluating whether the demonstration project as a whole will likely assist in promoting the objectives of Medicaid.

Washington received several public comments during its public input period that were all in support for continuing the family planning demonstration. Several commenters commended the program for increasing access to confidential family planning services to vulnerable individuals such as teens and victims of domestic abuse; citing the demonstration program as being one of very limited resources for such vulnerable individuals. CMS received only one public comment during the federal public comment period but it was not relevant to the demonstration.

Attachment A Continued

Page 2 – Ms. MaryAnne Lindeblad

After review of all the materials submitted by the state, as well as all public comments received, CMS determined that the Washington Family Planning Only Program should be extended because it is likely to assist with promoting the objectives of title XIX of the Act by improving access to high-quality, person-centered family planning services that produce positive health outcomes for individuals.

CMS' approval of this demonstration project is subject to the state's compliance with the enclosed set of Special Terms and Conditions (STCs) and associated expenditure authorities. All Medicaid title XIX requirements as expressed in law, regulation, and policy statement not expressly identified as not applicable in these approval documents shall apply to the Washington Family Planning Only Program section 1115 demonstration. The state's authority to deviate from Medicaid requirements is limited to the expenditure authorities and requirements specifically listed as not applicable to such expenditure authorities, as described in the enclosed approval documents, and to the purpose(s) indicated. This award letter is subject to your written acknowledgement of the award and acceptance of the STCs and associated expenditure authorities within 30 days of the date of this letter.

Your project officer for this demonstration is Emmett Ruff, who can be contacted to answer any questions concerning the implementation of this demonstration at 410-786-4252 or at Emmett.Ruff@cms.hhs.gov. Official communications regarding program matters and correspondence concerning the demonstration should be submitted to him at the following address:

Mr. Emmett Ruff
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mail Stop: S2-03-17
7500 Security Boulevard
Baltimore, MD 21244-1850

Official communications regarding this demonstration should be sent simultaneously to Mr. Emmett Ruff and to Mr. David Meacham, Associate Regional Administrator (ARA) for the Division of Medicaid and Children's Health in our Seattle Regional Office. Mr. Meacham's contact information is as follows:

Ms. David Meacham
Centers for Medicare & Medicaid Services
701 Fifth Avenue, Suite 1600
Seattle, WA 98104

Attachment A Continued

Page 3 – Ms. MaryAnne Lindeblad

If you have any questions regarding this approval, please contact Mrs. Judith Cash, Director, State Demonstrations Group, Center for Medicaid & CHIP Services at (410) 786-9686.

Sincerely,

/s/

Timothy B. Hill
Acting Director

Enclosures

cc: David Meacham, ARA, CMS Seattle Region
Janice Adams, State Lead, CMS Seattle Region

Attachment A Continued

CENTERS FOR MEDICARE & MEDICAID SERVICES

EXPENDITURE AUTHORITY

NUMBER: 11 -W-00134/0

TITLE: Washington "Family Planning Only Program" Section 1115 Demonstration

AWARDEE: Washington Health Care Authority

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by Washington for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period of this demonstration extension, be regarded as expenditures under the state's title XIX plan. All requirements of the Medicaid statute will be applicable to such expenditure authorities (including adherence to income and eligibility system verification requirements under section 1137(d) of the Act), except those specified below as not applicable to these expenditure authorities.

The following expenditure authority and the provisions specified as "not applicable" enable Washington to operate its demonstration effective as of the date of the approval letter through June 30, 2023:

- Expenditures for extending Medicaid eligibility for family planning and family planning-related services through a targeted application and enrollment process to women and men capable of producing children that meet one of the following criteria:
 - a) Women losing Medicaid pregnancy-related coverage after their 60-day post maternity coverage ends;
 - b) Women and men with family income at or below 260 percent of the Federal poverty level (FPL) who are not otherwise enrolled in Medicaid or the Children's Health Insurance Program (CHIP); and,
 - c) Teens and domestic violence victims who need confidential family planning services and have individual income at or below 260 percent of the FPL.

Medicaid Requirements Not Applicable to the Medicaid Expenditure Authorities:

All Medicaid requirements apply, except the following:

1. Methods of Administration: Transportation

Section 1902(a)(4) insofar as it incorporates 42 CFR §431.53

To the extent necessary to enable the state to not assure transportation to and from providers for the demonstration population.

Attachment A Continued

2. Amount, Duration, and Scope of Services (Comparability) Section 1902(a)(10)(B)

To the extent necessary to allow the state to offer the demonstration population a benefit package consisting only of family planning services and family planning-related services.

3. Prospective Payment for Federally Qualified Health Centers and Rural Health Centers and Rural Health Clinics Section 1902(a)(15)

To the extent necessary for the state to establish reimbursement levels to these clinics that will compensate them solely for family planning and family planning-related services.

4. Eligibility Procedures Section 1902(a)(17)

To the extent necessary to allow the state to not require a person found income-eligible upon application to report changes in income or household size for the 12-month period of coverage under the family planning demonstration.

5. Retroactive Coverage Section 1902(a)(34)

To the extent necessary to enable the state to not provide medical assistance to the demonstration population for any time prior to when an application for the demonstration is made.

6. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Section 1902(a)(43)(A)

To the extent necessary to enable the state to not furnish or arrange for EPSDT services to the demonstration population.

Attachment A Continued

Centers for Medicare & Medicaid Services SPECIAL TERMS AND CONDITIONS

NUMBER: 11 -W-00134/0

TITLE: Washington "Family Planning Only Program" Section 1115 Demonstration

AWARDEE: Washington State Health Care Authority

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Washington section 1115(a) Medicaid demonstration entitled the, "Family Planning Only Program" (hereinafter "demonstration"). The parties to this agreement are the Washington State Health Care Authority (hereinafter "state") and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS during the life of the demonstration. The STCs are effective as of the date of the accompanying CMS award letter through June 30, 2023. All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below and the associated expenditure and non-applicable authorities.

The STCs have been arranged into the following subject areas:

- I. Preface
- II. Program Description and Objectives
- III. General Program Requirements
- IV. Eligibility and Enrollment
- V. Benefits and Delivery Systems
- VI. General Reporting Requirements
- VII. General Financial Requirements
- VIII. Monitoring Budget Neutrality
- IX. Evaluation
- X. Schedule of State Deliverables during the Demonstration
- Appendix A: Template for Quarterly and Annual Monitoring Reports
- Appendix B: Evaluation Design Plan (reserved)

II. PROGRAM DESCRIPTION AND HISTORICAL CONTEXT

Effective through June 30, 2023, the Washington Family Planning Only Program section 1115(a) Medicaid demonstration extends Medicaid eligibility for family planning and family planning related services to women and men capable of producing children who have family income at or below 260 percent of the federal poverty level (FPL), women losing Medicaid pregnancy coverage at the conclusion of the 60-day postpartum eligibility period, and teens and domestic violence victims who need confidential family planning services because they are covered under their perpetrators' or parents' health insurance and have individual income

Attachment A Continued

2. Amount, Duration, and Scope of Services (Comparability) Section 1902(a)(10)(B)

To the extent necessary to allow the state to offer the demonstration population a benefit package consisting only of family planning services and family planning-related services.

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To the extent necessary for the state to establish reimbursement levels to these clinics that will compensate them solely for family planning and family planning-related services.

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5. Retroactive Coverage Section 1902(a)(34)

To the extent necessary to enable the state to not provide medical assistance to the demonstration population for any time prior to when an application for the demonstration is made.

6. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Section 1902(a)(43)(A)

To the extent necessary to enable the state to not furnish or arrange for EPSDT services to the demonstration population.

Attachment A Continued

Centers for Medicare & Medicaid Services SPECIAL TERMS AND CONDITIONS

NUMBER: 11 -W-00134/0

TITLE: Washington "Family Planning Only Program" Section 1115 Demonstration

AWARDEE: Washington State Health Care Authority

I. PREFACE

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Effective through June 30, 2023, the Washington Family Planning Only Program section 1115(a) Medicaid demonstration extends Medicaid eligibility for family planning and family planning related services to women and men capable of producing children who have family income at or below 260 percent of the federal poverty level (FPL), women losing Medicaid pregnancy coverage at the conclusion of the 60-day postpartum eligibility period, and teens and domestic violence victims who need confidential family planning services because they are covered under their perpetrators' or parents' health insurance and have individual income

Attachment A Continued

at or below 260 percent of the FPL, and who are not otherwise enrolled in Medicaid or the Children's Health Insurance Program (CHIP).

Historical Context and Objectives

The Washington family planning demonstration was originally approved on March 6, 2001 with an effective date of July 1, 2001. The demonstration has been consistently extended since that date. The original Washington "TAKE CHARGE" demonstration expanded Medicaid coverage for family planning services to men and women with family income at or below 200 percent of the FPL. Beginning October 1, 2012, the state had approval to increase eligibility to individuals with income up to 250 percent of the FPL. With the implementation of the Affordable Care Act's requirement to transition to the use of Modified Adjusted Gross Income (MAGI) for determining Medicaid income eligibility, the state's comparable income limit increased to 260 percent of the FPL effective October 1, 2013. The state has not had any other program changes. On November 24, 2017, Washington submitted a request to extend the demonstration for a five-year period with the only program change being that the name of the demonstration will now be the "Family Planning Only Program."

CMS and Washington expect this demonstration program will promote Medicaid program objectives by:

- Improving access to family planning and family planning-related services;
- Decreasing unintended pregnancies;
- Reducing state and federal Medicaid expenditures by averting births from unintended pregnancies; and,
- Lengthening intervals between pregnancies and births to improve positive birth and women health outcomes.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.
2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid programs expressed in law, regulation, and policy statement not expressly waived or identified as not applicable in the expenditure authority document (which is a part of these terms and conditions), must apply to the demonstration.
3. **Changes in Medicaid Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, court order, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid program that occur during this demonstration approval period, unless the provision being changed is explicitly waived or identified as not applicable.

Attachment A Continued

4. Impact on Demonstration of Changes in Federal Law, Regulation, and Policy Statements.

- a) To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change.
- b) If mandated changes in the federal law require state legislation, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. Changes Subject to the Amendment Process. Changes related to demonstration features such as eligibility, enrollment, benefits, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Social Security Act (the Act). The state must not implement changes to these demonstration elements without prior approval by CMS. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 6 below.

6. Amendment Process. Requests to amend the demonstration must be submitted to CMS in writing for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required reports and other deliverables in a timely fashion according to the deadlines specified therein. Amendment requests must include, but are not limited to, the following:

- a) A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;
- b) A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality expenditure limit;
- c) An explanation of the public process used by the state consistent with the requirements of STC 14; and,
- d) If applicable, a description of how the evaluation design must be modified to incorporate the amendment provisions.

Attachment A Continued

7. **Extension of the Demonstration.** States that intend to request a demonstration extension under sections 1115(e) or 1115(f) of the Act must submit extension applications in accordance with the timelines contained in statute. Otherwise, no later than 12 months prior to the expiration date of the demonstration, the Governor or Chief Executive Officer of the state must submit to CMS either a demonstration extension request that meets federal requirements at 42 Code of Federal Regulations (CFR) §431.412(c) or a transition and phase-out plan consistent with the requirements of STC 8.
8. **Demonstration Transition and Phase-Out.** The state may suspend or terminate this demonstration, in whole or in part, at any time prior to the date of expiration.
 - a) Notification of Suspension or Termination: The state must promptly notify CMS in writing of the effective date and reason(s) for the suspension or termination. At least six months before the effective date of the demonstration's suspension or termination, the state must submit to CMS its proposed transition and phase-out plan, together with intended notifications to demonstration enrollees. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with the requirements of STC 14. Once the 30-day public comment period has ended, the state must provide a summary of public comments received, the state's response to the comments received, and how the state incorporated the comments received into the transition and phase-out plan submitted to CMS.
 - b) Transition and Phase-out Plan Requirements: The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for those beneficiaries whether currently enrolled or determined to be eligible individuals, as well as any community outreach activities, including community resources that are available.
 - c) Phase-out Plan Approval: The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.
 - d) Phase-out Procedures: The state must comply with all notice requirements found in 42 CFR §431.206, §431.210 and §431.211. In addition, the state must assure all appeal and hearing rights are afforded to demonstration participants as outlined in 42 CFR §431.220 and §431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as found in 42 CFR §435.916.

Attachment A Continued

- e) Exemption from Public Notice Procedures 42 CFR §431.416(g): CMS may expedite or waive the federal and state public notice requirements in the event it determines that the objectives of titles XIX or XXI would be served or under circumstances described in 42 CFR §431.416(g).
- f) Enrollment Limitation during Demonstration Phase-Out: If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended.
- g) Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

9. CMS Right to Amend, Suspend, or Terminate. CMS may amend, suspend or terminate the demonstration, in whole or in part, at any time before the date of expiration, whenever it determines, following a hearing, that the state has materially failed to comply with the terms of the project. CMS will promptly notify the state in writing of the determination and the reasons for the amendment, suspension or termination, together with the effective date.

10. Deferral for Failure to Submit Timely Demonstration Deliverables. CMS may issue deferrals in the amount of \$1,000,000 per deliverable (federal share) when items required by these STCs (e.g., monitoring reports, evaluation design documents, required data elements and analyses, presentations, and any other deliverable specified in these STCs (hereafter singly or collectively referred to as “deliverable(s)”) are not submitted timely to CMS or found to not be consistent with the requirements approved by CMS. Specifically:

- a) Thirty days after the deliverable was due, CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverables. The deferral would be issued against the next quarterly expenditure report following the written deferral notification.
- b) For each deliverable, the state may submit a written request for an extension to submit the required deliverable. Extension requests that extend beyond the current fiscal quarter must include a Corrective Action Plan (CAP).
 - i. CMS may decline the extension request.
 - ii. Should CMS agree in writing to the state’s request, a corresponding extension of the deferral process described below can be provided.
 - iii. If the state’s request for an extension includes a CAP, CMS may agree to or further negotiate the CAP as an interim step before applying the deferral.

Attachment A Continued

- c) When the state submits the overdue deliverable(s) that are accepted by CMS, the deferral(s) will be released.
- d) As the purpose of a section 1115 demonstration is to test new methods of operation or services, a state's failure to submit all required deliverables may preclude a state from extending a demonstration or obtaining a new demonstration.
- e) CMS will consider with the state an alternative set of operational steps for implementing the deferral associated with this demonstration to align the process with any existing deferral process the state is undergoing (e.g., the quarter the deferral applies to and how the deferral is released).

- 11. Finding of Non-Compliance.** The state does not relinquish its rights to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.
- 12. Withdrawal of Waiver/Expenditure Authority.** CMS reserves the right to amend or withdraw waiver and/or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS must promptly notify the state in writing of the determination and the reasons for the amendment or withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn or amended, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling participants.
- 13. Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems applicable to the demonstration; compliance with cost sharing requirements to the extent they apply; and reporting on financial and other demonstration components.
- 14. Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the state notice procedures as required in 42 CFR §431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also comply with the public notice procedures set forth in 42 CFR §447.205 for changes in statewide methods and standards for setting payment rates.

The state must also comply with tribal and Indian Health Program/Urban Indian Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR §431.408(b), State Medicaid Director Letter #01-024, or contained in the state's approved Medicaid State Plan, when any program changes to the demonstration, either through amendment as set out in STC 6 or extension, are proposed by the state.

Attachment A Continued

15. Federal Financial Participation (FFP). No federal matching funds for expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter.

IV. ELIGIBILITY AND ENROLLMENT

16. Eligibility for the Demonstration. Family planning and family planning related services are provided to eligible individuals as defined below for a 12-month period. As a function of the 12-month coverage period, an individual found eligible will not be required to report changes in income or household size for the 12-month period of eligibility. Individuals will reapply for coverage at the expiration of the 12-month coverage period and are not limited in how many times they can reapply for coverage. Eligible individuals are as follows:

- a) Recently pregnant women who lose Medicaid coverage after their 60-day post maternity coverage ends;
- b) Uninsured women and men with family income at or below 260 percent of the FPL; and,
- c) Teens and domestic violence victims who need confidential family planning services and have individual income at or below 260 percent of the FPL.

17. Eligibility Determination Process. The state will develop and implement enrollment procedures in accordance with the following processes:

- a) Application. In addition to providing the single streamlined application to beneficiaries who wish to apply for full Medicaid or CHIP benefits, the state will use a separate application to determine eligibility for the Family Planning Only Program. The Family Planning Only Program application will be available online for fax submission, by phone submission, by mail submission, and available at designated provider sites for submission in person.
- b) Notices: In addition to complying with content requirements at 42 CFR §435.917, the state will provide the following information on the beneficiary eligibility determination notice:
 - i. Eligibility will be for a 12-month period without a requirement to report a change in income or household size.
 - ii. The eligibility determination notice will also serve as advance notification of termination of family planning coverage after the 12-month period of eligibility.
 - iii. Individuals will need to re-apply for family planning coverage at the expiration of the 12-month period of eligibility. Individuals are not limited in how many times they can reapply for coverage.
 - iv. How individuals will receive program notices in accordance with 42 CFR §435.918. Teens and domestic violence victims who need confidential family planning services will receive notices at the clinic of their choice. Applicants that opt for a clinic to receive notices regarding their eligibility

Attachment A Continued

are expected to make arrangements with the clinic as to when and how to get notices at the provider site.

- c) Coordination with other Insurance Affordability Programs. Individuals applying through the family planning only application must be provided information about potential eligibility for full-scope Medicaid or CHIP coverage and be provided facilitated access to apply for full-scope Medicaid or CHIP coverage. If individuals indicate they have not applied, but wish to apply for more comprehensive coverage, individuals must be directed to or assisted with applying through the single streamlined application. The state must receive written attestation on the family planning only application from individuals indicating they have recently been denied full-scope Medicaid/CHIP coverage or are making an informed choice to not apply for full-scope Medicaid/CHIP coverage and are only seeking family planning only coverage.

Individuals applying through the Washington Health Benefit Exchange who are determined ineligible for full-scope Medicaid or CHIP coverage must be provided information on the written notice about potential eligibility for family planning only coverage and how to apply for such coverage.

Any changes to the state's applications, notices, program outreach materials, administrative procedures, or any other associated operational processes for full-scope Medicaid/CHIP coverage or family planning only coverage necessary to comply with the requirements in this STC shall be provided to CMS for review and concurrence at least 15 days prior to the state's intended implementation of such changes. The state must submit revised drafts addressing any CMS comments received on such materials for final CMS review and approval prior to implementation.

- 18. Demonstration Disenrollment.** If a woman becomes pregnant while enrolled in the demonstration, she may be determined eligible for Medicaid under the State Plan. The state must not submit claims under the demonstration for any woman who is found to be eligible under the Medicaid State Plan. In addition, women and men who receive a sterilization procedure and complete all necessary follow-up procedures will subsequently be disenrolled from the demonstration.

V. BENEFITS AND DELIVERY SYSTEMS

- 19. Family Planning Benefits.** Individuals eligible under this demonstration will receive family planning services and supplies as described in section 1905(a)(4)(C) of the Act, which are reimbursable at the 90 percent Federal matching rate. The specific family planning services provided under this demonstration are as follows:

- a) One comprehensive family planning preventive visit per year (once every 12 months) based on nationally recognized clinical guidelines which must have a primary focus and diagnosis of family planning which includes counseling, education, and initiation or management of contraceptive methods.

Attachment A Continued

- b) The following services if they occur during a visit focused on family planning:
 - i. Pregnancy testing;
 - ii. Cervical cancer screening according to schedules established by nationally recognized clinical guidelines;
 - iii. Gonorrhea and chlamydia screening according to nationally recognized clinical guidelines based on age (only covered for women 13-25);
 - iv. Assessment and management of family planning or contraceptive problems, when medically necessary; and,
 - v. STI and STD testing and treatment when medically indicated by symptoms or report of exposure and medically necessary for the client's safe and effective use of the client's chosen contraceptive method.

- c) Contraceptives including:
 - i. FDA-approved methods of prescription and nonprescription contraceptives;
 - ii. Over-the-counter (OTC) family planning drugs, devices, and drug-related supplies; and,
 - iii. Education and supplies for FDA-approved contraceptives, natural family planning and abstinence.

- d) Sterilization procedures, the office visits or physical exams related to and necessary for sterilization, laboratory testing necessary to complete a sterilization, and approved prescription medication to treat anxiety and pain in relation to the sterilization procedure.

- e) Additional screening tests may be performed depending on the method of contraception desired based on nationally recognized guidelines. Additional laboratory tests may be needed to address a family planning problem or need during an inter-periodic family planning visit for contraception;

20. Family Planning-Related Benefits. Individuals eligible under this demonstration will also receive family planning-related services and supplies defined as those services provided as part of or as follow-up to a family planning visit and are reimbursable at the state's regular Federal Medical Assistance Percentage (FMAP) rate. Such services are provided because a "family planning-related" problem was identified and/or diagnosed during a routine or periodic family planning visit. Examples of family planning-related services and supplies include:

- a) Drugs for the treatment of STIs/STDs, except for HIV/AIDS and all forms of hepatitis, when the STI/STD is identified/diagnosed during a routine/periodic family planning visit and is not medically necessary for the client's safe and effective use of the client's chosen contraceptive method. A follow-up visit/encounter for the treatment/drugs and subsequent follow-up visits to rescreen for STIs/STDs based on

Attachment A Continued

the Centers for Disease Control and Prevention guidelines may be covered. Drugs/treatment for vaginal infections/disorders, other lower genital tract and genital skin infections/disorders, and urinary tract infections, where these conditions are identified/diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/ drugs may also be covered.

- b) Other medical diagnosis, treatment, and preventive services that are routinely provided pursuant to family planning services in a family planning setting.
- c) Treatment of major complications arising from a family planning procedure such as:
 - i. Treatment of a perforated uterus due to an intrauterine device insertion;
 - ii. Treatment of severe menstrual bleeding caused by a Depo-Provera injection requiring a dilation and curettage; or,
 - iii. Treatment of surgical or anesthesia-related complications during a sterilization procedure.

21. Minimum Essential Coverage (MEC). The Washington family planning demonstration is limited to the provision of services as described in STCs 19 and 20. Consequently, this demonstration is not recognized as Minimum Essential Coverage (MEC) as indicated by CMS in its February 12, 2016 correspondence from Vikki Wachino to MaryAnne Lindeblad, Washington State Medicaid Director, regarding the designation of MEC for the state's section 1115 demonstration.

22. Primary Care Referrals. Primary care referrals to other social service and health care providers as medically indicated will be provided; however, the costs of those primary care services are not covered for enrollees of this demonstration. The state must facilitate access to primary care services for enrollees, and must assure CMS that written materials concerning access to primary care services are distributed to demonstration enrollees. The written materials must explain to enrollees how they can access primary care services.

23. Delivery of Services. Enrollees will receive family planning demonstration services on a fee-for-service (FFS) basis. Beneficiary freedom of choice of which provider to see for family planning services shall not be restricted.

VI. GENERAL REPORTING REQUIREMENTS

24. General Financial Requirements. The state must comply with all general financial requirements under title XIX and as set forth in section VII.

25. Reporting Requirements Relating to Budget Neutrality. The state must comply with all reporting requirements for monitoring budget neutrality as set forth in section VII.

26. Submission of Post-approval Deliverables. The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs.

Attachment A Continued

27. Compliance with Federal Systems Updates. As federal systems continue to evolve and incorporate additional 1115 demonstration reporting and analytics functions, the state will work with CMS to:

- a) Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;
- b) Ensure all 1115, Transformed Medicaid Statistical Information System (T-MSIS), and other data elements that have been agreed to for reporting and analytics are provided by the state; and,
- c) Submit deliverables to the appropriate system as directed by CMS.

28. Quarterly Monitoring Reports. The state must submit three quarterly monitoring reports and one combined fourth quarter/annual monitoring report for each demonstration year according to the scheduled listed below. The quarterly monitoring reports are due no later than 60 days following the end of each demonstration quarter. The combined fourth quarter/annual monitoring report is due no later than 90 days following the end of the demonstration year as described in STC 30. The combined fourth quarter/annual report monitoring should distinctly describe the information associated with the fourth quarter of the demonstration year. The state's demonstration quarterly reporting cycle is outlined below:

Demonstration Quarter	Begin Date	End Date	Quarterly Report Due Date
Q1	July 1 st	September 30th	November 29 th
Q2	October 1st	December 31st	March 1 st
Q3	January 1st	March 31st	May 30 th
Q4 & Annual Monitoring Report	April 1st	June 30th	September 30 th

The state must submit quarterly monitoring reports through CMS' designated system using the framework incorporated in these STCs as "Attachment A." The intent of these reports is to present the state's data along with an analysis of the status of key operational areas under the demonstration. The quarterly monitoring report must include all required elements outlined below and in the format provided in Attachment A. The quarterly monitoring report should not direct readers to links outside the report, except if listed in a reference/bibliography section. Quarterly monitoring reports must include, but are not limited to:

- a) A summary of current notable program activity during the quarter. This includes highlights of the state's progress with implementation of STC 17 with supporting documentation, progress of addressing MBES/CBES Schedule C reporting adjustments on the CMS-64 as outlined in STC 34(c), and key operational milestones anticipated to occur in the near future. Notable program activity

Attachment A Continued

includes, but is not limited to, program operations such as provider participation and education, health care delivery, benefits, eligibility, enrollment, beneficiary complaints, quality of care, access, state share of financing and pertinent legislative activity;

- b) Quarterly unduplicated enrollment for demonstration enrollees (defined as any individual who obtains a covered family planning service through the demonstration) as required to evaluate compliance with the budget neutral agreement;
- c) Program outreach and education activities conducted and an assessment of the effectiveness of these outreach and education activities;
- d) Program integrity and related audit activities, including an analysis of point-of-service eligibility procedures; and,
- e) Grievances and appeals made by beneficiaries, providers, or the public and actions being taken to address any significant issues.

29. Quarterly Monitoring Calls. CMS and Washington will participate in quarterly conference calls following receipt of the quarterly/annual monitoring reports, unless CMS determines that more frequent calls are necessary to adequately monitor the demonstration. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Areas to be addressed include, but are not limited to, the state's progress with implementation of STC 17; the state's progress with completing MBES/CBES Schedule C reporting adjustments on the CMS-64; and significant program issues or changes related to health care delivery, enrollment, quality of care, access, benefits, anticipated or proposed changes in payment rates, audits, lawsuits, changes in state sources of funding for financing this demonstration, evaluation of the demonstration, state legislative developments, and any demonstration amendments the state is considering submitting. CMS will update the state on any Washington Family Planning Only Program actions under review as well as federal policies and issues that may affect any aspect of the demonstration. Washington and CMS will jointly develop the agenda for the calls.

30. Annual Monitoring Report. No later than 90 days following the end of each demonstration year, the state must submit an annual monitoring report that represents the status of the demonstration's various operational areas and any state analysis of program data collected for the demonstration year. As specified in STC 28, the state may combine its fourth quarter monitoring update with the annual monitoring report for each demonstration year. The combined fourth quarter/annual monitoring report will serve as the state's annual report that include an end of year summary of the program elements as reported in each quarterly report. The annual monitoring report will include all elements required by 42 CFR §431.428, and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a reference/bibliography section. The state must submit the annual monitoring report through CMS' designated

Attachment A Continued

system using the framework incorporated in these STCs as "Attachment A," which is subject to change as monitoring systems are developed and/or evolve, and will be provided in a structured manner that supports federal tracking and analysis. Each annual monitoring report must minimally include the following:

- a) Operational Updates - Per 42 CFR §431.428, the annual monitoring report must document any policy or administrative difficulties in operating the demonstration. The reports shall provide sufficient information to document key challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; descriptions of any public forums held, and a summary of program integrity and related audit activities for the demonstration. The annual monitoring report should also include a summary of all public comments received through the post-award public forum required per 42 CFR §431.420(c) regarding the progress of the demonstration.
- b) Performance Metrics – Per 42 CFR §431.428, the annual monitoring report must document the impact of the demonstration in providing insurance coverage to beneficiaries and the uninsured population, as well as outcomes of care, quality and cost of care, and access to care. This may also include the results of beneficiary satisfaction surveys (if conducted) and grievances and appeals. The required monitoring and performance metrics must be included in writing in the annual monitoring report, and will follow the framework provided by CMS to support federal tracking and analysis.
- c) Budget Neutrality and Financial Reporting Requirements – Per 42 CFR §431.428, the annual monitoring report must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every annual monitoring report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including a total annual member month count for the demonstration population, total annual expenditures for the demonstration population, and the resulting "per member, per month" calculation. The annual monitoring report must also include the submission of corrected budget neutrality data upon request.
- d) Evaluation Activities and Interim Findings. Per 42 CFR 431.428, the annual monitoring reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

31. Program Integrity. The state must have processes in place to ensure that there is no duplication of federal funding for any aspect of the demonstration. The state must

Attachment A Continued

confirm its process for ensuring there is no duplication of federal funding in each annual monitoring report as specified in STC 30(a).

32. Draft and Final Close-out Report. Within 120 days after the expiration of the demonstration, the state must submit a draft Close-out Report to CMS for comments.

- a) The draft report must comply with the most current guidance from CMS.
- b) The state will present to and participate in a discussion with CMS on the close-out report.
- c) The state must take into consideration CMS' comments for incorporation into the final close-out report.
- d) The final close-out report is due to CMS no later than 30 days after receipt of CMS' comments.
- e) A delay in submitting the draft or final version of the close-out report may subject the state to penalties described in STC 10.

VII. GENERAL FINANCIAL REQUIREMENTS

This project is approved for title XIX expenditures applicable to services rendered during the demonstration period. This section describes the general financial requirements for these expenditures.

33. Quarterly Expenditure Reports. The state must provide quarterly expenditure reports to report total expenditures for services provided under this Medicaid section 1115(a) demonstration following routine CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. CMS must provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined cost limits specified in STC 43.

34. Reporting Expenditures Subject to the title XIX Budget Neutrality Agreement. The following describes the reporting of expenditures subject to the budget neutrality limit:

- a) Tracking Expenditures. In order to track expenditures under this demonstration, the state must report demonstration expenditures through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES). All demonstration expenditures claimed under the authority of title XIX of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS and the two digit project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made (e.g., For reporting expenditures with dates of services made in demonstration year 17 (7/1/2017 – 6/30/2018), the state would use "17" as the project number extension).
- b) Use of Waiver Forms. The state must report demonstration expenditures on separate forms CMS-64.9 Waiver and/or 64.9P Waiver each quarter to report title XIX expenditures for demonstration services. The state will continue to use the waiver

Attachment A Continued

name "Family Planning (Take Charge)" to report expenditures in the MBES/CBES and in the budget neutrality workbook required to be submitted with the Annual Monitoring Report per STC 30.

- c) MBES/CBES Schedule C Reporting Adjustments. The state must submit prior period adjustments subsequent to the routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual to report actual expenditures incurred for demonstration services in DY12 (7/2012 – 6/2013) through DY17 (7/2017 – 6/2018). The state must complete similar adjustments to separately report administrative costs that are directly attributable to the demonstration for DY12 through DY17. The state shall complete these reporting adjustments within 12 months of the date of CMS' approval of this extension and provide written certification of the accuracy of the adjusted expenditures upon completion. The state must provide an update on the progress of these adjustments during the CMS monitoring calls described in STC 29 and the quarterly and annual monitoring reports described in STC 28 and 30.
- d) Cost Settlements. For monitoring purposes, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C.

35. Title XIX Administrative Costs. Administrative costs will not be included in the budget neutrality agreement, but the state must separately track and report administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on Form CMS-64.10.

36. Claiming Period. All claims for expenditures subject to the budget neutrality agreement (including any cost settlements) must be made within two years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

37. Reporting Member Months. The following describes the reporting of member months for the demonstration:

- a) For the purpose of calculating the budget neutrality expenditure limit, the state must provide to CMS, as part of the Annual Monitoring Report required per STC 30, the actual number of eligible member months for all demonstration enrollees. The state must submit a statement accompanying the annual report certifying the accuracy of this information.
- b) The term "eligible member months" refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example,

Attachment A Continued

a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are each eligible for two months, each contribute two eligible member months, for a total of four eligible member months.

38. Standard Medicaid Funding Process. The standard Medicaid funding process must be used during the demonstration. The state must estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. If applicable, subject to the payment deferral process set out in STC 10, CMS shall reconcile expenditures reported on Form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

39. Extent of Federal Financial Participation (FFP) for the Demonstration. CMS shall provide FFP for family planning and family planning related services at the applicable federal matching rates as described in STCs 19 and 20, subject to the limits and processes described below:

- a) For procedures or services clearly provided or performed for the primary purpose of family planning (i.e., contraceptive initiation, periodic or inter-periodic contraceptive management, and sterilizations), and which are provided in a family planning setting, FFP will be available at the 90 percent federal matching rate. Reimbursable procedure codes for office visits, laboratory tests, and certain other procedures must carry a primary diagnosis or a modifier that specifically identifies them as a family planning service.

Allowable family planning expenditures eligible for reimbursement at the enhanced family planning match rate of 90 percent, as described in STC 20, should be entered in Column (D) on the CMS-64.9 Waiver Form.

- b) Pursuant to 42 CFR §433.15(b)(2), FFP is available at the 90 percent administrative match rate for administrative activities associated with administering the family planning services provided under the demonstration including the offering, arranging, and furnishing of family planning services. These costs must be allocated in accordance with OMB Circular A-87 cost allocation requirements. The processing of claims is reimbursable at the 50 percent administrative match rate.
- c) FFP will not be available for the costs of any services, items, or procedures that do not meet the requirements specified above, even if provided by eligible Medicaid providers. For example, in the instance of testing for STIs as part of a family planning visit, FFP will be available at the 90 percent federal matching rate. The match rate for the subsequent treatment would be paid at the applicable federal

Attachment A Continued

matching rate for the state. For testing or treatment not associated with a family planning visit, no FFP will be available.

40. Sources of Non-Federal Share. The state must certify that matching the non-federal share of funds for the demonstration are state/local monies. The state further certifies that such funds must not be used to match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

- a) CMS shall review the sources of the non-federal share of funding for the demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS must be addressed within the timeframes set by CMS.
- b) Any amendments that impact the financial status of the program must require the state to provide information to CMS regarding all sources of the non-federal share of funding.

41. State Certification of Funding Conditions. The state must certify that the following conditions for non-federal share of demonstration expenditures are met:

- a) Units of government, including governmentally operated health care providers, may certify that state or local tax dollars have been expended as the non-federal share of funds under the demonstration.
- b) To the extent the state utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.
- c) To the extent the state utilizes CPEs as the funding mechanism to claim federal match for payments under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such tax revenue (state or local) used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match.
- d) The state may use intergovernmental transfers to the extent that such funds are derived from state or local tax revenues and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of title XIX payments. Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between health care providers and state and/or local government to

Attachment A Continued

return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, (including health care provider-related taxes), fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

VIII. MONITORING BUDGET NEUTRALITY

The following is the method by which budget neutrality will be monitored for the Washington Family Planning Only Program section 1115(a) Medicaid demonstration.

42. Limit on Title XIX Funding. The state shall be subject to a limit on the amount of federal title XIX funding it may receive on approved demonstration service expenditures incurred during the period of demonstration approval. The budget neutrality expenditure targets are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the approved demonstration period. Actual expenditures subject to budget neutrality expenditure limit shall be reported by the state using the procedures described in STC 34.

43. Budget Neutrality Annual Expenditure Limits. For each demonstration year, an annual budget limit will be calculated for the demonstration. The Washington Family Planning Only Program annual demonstration cycle is July 1 through June 30 as originally approved. The state's demonstration years are as follows:

Demonstration Year 11 = July 1, 2011 – June 30, 2012
Demonstration Year 12 = July 1, 2012 – June 30, 2013
Demonstration Year 13 = July 1, 2013 – June 30, 2014
Demonstration Year 14 = July 1, 2014 – June 30, 2015
Demonstration Year 15 = July 1, 2015 – June 30, 2016
Demonstration Year 16 = July 1, 2016 – June 30, 2017
Demonstration Year 17 = July 1, 2017 – June 30, 2018
Demonstration Year 18 = July 1, 2018 – June 30, 2019
Demonstration Year 19 = July 1, 2019 – June 30, 2020
Demonstration Year 20 = July 1, 2020 – June 30, 2021
Demonstration Year 21 = July 1, 2021 – June 30, 2022
Demonstration Year 22 = July 1, 2022 – June 30, 2023

The budget limit is calculated as the projected per member/per month (PMPM) cost times the actual number of member months for the demonstration multiplied by the Composite Federal Share.

PMPM Cost. The following table provides the approved demonstration cost trend (based on the state's historical rate of growth) and the PMPM (total computable) ceiling for each demonstration year.

Attachment A Continued

PMPM Ceilings for Family Planning Services	
DY18	\$15.57
DY19	\$15.57
DY20	\$15.57
DY21	\$15.57
DY22	\$15.57

- a) Composite Federal Share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period, as reported on the forms listed in STC 34 above, by total computable demonstration expenditures for the same period as reported on the forms. Should the demonstration be terminated prior to the end of the approval period (see STC 8), the Composite Federal Share will be determined based on actual expenditures for the period in which the demonstration was active. For the purpose of interim monitoring of budget neutrality, a reasonable Composite Federal Share may be used.
- b) Structure. The demonstration's budget neutrality model is structured as a “pass-through” or “hypothetical” expenditure population. Therefore, the state may not derive savings from the demonstration.
- c) Risk. Washington shall be at risk for the per capita cost (as determined by the method described in this section) for demonstration enrollees, but not for the number of demonstration enrollees. By providing FFP for eligible enrollees, Washington shall not be at risk of changing economic conditions that impact enrollment levels. However, by placing the state at risk for the per capita costs for enrollees in the demonstration, CMS assures that federal demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no demonstration.
- d) Application of the Budget Limit. The budget limit calculated above will apply to demonstration expenditures reported by the state on the CMS-64 forms. If at the end of the demonstration period, the costs of the demonstration services exceed the budget limit, the excess federal funds will be returned to CMS. If the costs of the demonstration services do not exceed the budget limit, the state may not derive or utilize any such savings.

44. Future Adjustments to the Budget Neutrality Expenditure Limit. CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under the demonstration.

45. Enforcement of Budget Neutrality. CMS shall enforce budget neutrality over the life of this demonstration extension approval period. No later than 90 days after the end of

Attachment A Continued

each demonstration year, the state will calculate and report to CMS an annual cumulative expenditure target for the completed year as part of the Annual Monitoring Report described in STC 30. This amount will be compared with the actual cumulative amount the state has claimed for FFP through the completed year. If cumulative spending exceeds the cumulative target by more than the indicated percentage, the state will submit a corrective action plan to CMS for approval. The state will subsequently implement the approved plan.

<u>Year</u>	<u>Cumulative Target Expenditures</u>	<u>Percentage</u>
DY18	DY18 budget limit amount plus:	2 percent
DY19	DY18 through DY19 combined budget limit amount plus:	1.5 percent
DY20	DY18 through DY20 combined budget limit amount plus:	1 percent
DY21	DY18 through DY21 combined budget limit amount plus:	0.5 percent
DY22	DY18 through DY22 combined budget limit amount plus:	0 percent

- 46. Exceeding Budget Neutrality.** The state, whenever it determines that the demonstration is not budget neutral or is informed by CMS that the demonstration is not budget neutral, must immediately collaborate with CMS on corrective actions, which includes submitting a corrective action plan to CMS within 21 days of the date the state is informed of the problem. While CMS will pursue corrective actions with the state, CMS will work with the state to set reasonable goals that will ensure that the state is in compliance.

If at the end of the demonstration approval period, the cumulative budget neutrality limit has been exceeded, the excess federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision will be based on the time elapsed through the termination date.

IX. EVALUATION

- 47. Draft Evaluation Design.** The draft evaluation design must be developed in accordance with CMS' separately provided guidance for family planning demonstrations. The state must submit, for CMS comment and approval, a draft evaluation design with an implementation timeline by no later than 120 days after the effective date of these STCs. Any modifications to an existing approved evaluation design will not affect previously established requirements and timelines for report submission for the demonstration, if applicable. The state may choose to use the expertise of an independent party in the development of the draft evaluation design.
- 48. Evaluation Budget.** A budget for the evaluation shall be provided with the draft evaluation design. It will include the total estimated cost as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design

Attachment A Continued

or if CMS finds that the design is not sufficiently developed, or if the estimates appear to be excessive.

- 49. Evaluation Design Approval and Updates.** The state must submit a revised draft evaluation design within 60 days after receipt of CMS' comments. Upon CMS approval of the final evaluation design, the document will be included as "Attachment B" to these STCs. Per 42 CFR 431.424(c), the state will publish the approved final evaluation design within 30 days of CMS approval. The state must implement the evaluation design and submit a description of its evaluation implementation progress in each Annual Monitoring Report as required by STC 30, including any required rapid cycle assessments specified in these STCs. Once CMS approves the evaluation design, if the state wishes to make changes, the state must submit a revised evaluation design to CMS for approval.
- 50. Evaluation Questions and Hypotheses.** Consistent with CMS' separately provided guidance entitled, "Developing the Evaluation Design" and "Preparing the Evaluation Report," the evaluation documents must include a discussion of the evaluation questions and hypotheses that the state intends to test. Each demonstration component should have at least one evaluation question and hypothesis. The hypothesis testing should include, where possible, assessment of both process and outcome measures. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS' Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).
- 51. Interim Evaluation Report.** The state must submit an interim evaluation report for the completed years of the demonstration, and for each subsequent extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for extension, the interim evaluation report should be posted to the state's website with the application for public comment.
- a) The interim evaluation report will discuss evaluation progress and present findings to date as per the approved evaluation design.
 - b) For demonstration authority that expires prior to the overall demonstration's expiration date, the interim evaluation report must include an evaluation of the authority as approved by CMS.
 - c) If the state is seeking to extend the demonstration, the draft interim evaluation report is due when the application for extension is submitted. If the state made changes to the demonstration in its application for extension, the research questions and hypotheses, and how the design was adapted should be included. If the state is not requesting an extension of the demonstration, the draft interim evaluation report is due one year prior to the end of the demonstration. For demonstration phase-outs prior to the expiration of the approval period, the

Attachment A Continued

draft interim evaluation report is due to CMS on the date that will be specified in the notice of termination or suspension.

- d) The state must submit the final interim evaluation report 60 days after receiving CMS comments on the draft interim evaluation report and post the document to the state's website.
- e) The interim evaluation report must comply with CMS' separately provided guidance entitled, "Preparing the Evaluation Report."

52. Cooperation with Federal Evaluators. As required under 42 CFR 431.420(f), the state shall cooperate fully and timely with CMS and its contractors' in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state shall include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they shall make such data available for the federal evaluation as is required under 42 CFR §431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 10.

53. Summative Evaluation Report. The draft summative evaluation report must be developed in accordance with CMS' separately provided guidance entitled, "Preparing the Evaluation Report." The state must submit a draft summative evaluation report for the demonstration's current approval period within 18 months of the end of the approval period represented by these STCs. The summative evaluation report must include information as outlined in the approved evaluation design.

- a) Unless otherwise agreed upon in writing by CMS, the state shall submit the final summative evaluation report within 60 days of receiving comments from CMS on the draft.
- b) The final summative evaluation report must be posted to the state's Medicaid website within 30 days of approval by CMS.

54. State Presentations for CMS. CMS reserves the right to request that the state present and participate in a discussion with CMS on the evaluation design, the state's interim evaluation, and/or the summative evaluation.

55. Public Access. The state shall post the final documents (e.g., monitoring reports, approved evaluation design, interim evaluation report, summative evaluation report, and close-out report) on the state's Medicaid website within 30 days of approval by CMS.

Attachment A Continued

56. Additional Publications and Presentations. For a period of 12 months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration over which the state has control. Prior to release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials. CMS will be given 30 days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews. This requirement does not apply to the release or presentation of these materials to state or local government officials.

X. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION

Deliverable	Timeline	STC Reference
Quarterly Monitoring Report	Within 60 days following the end of each quarter	STC 28
Annual Monitoring Report	Within 90 days following the end of each demonstration year	STC 30
Draft Evaluation Design Plan	Within 120 days after the approval of the demonstration extension	STC 47
Final Evaluation Design Plan	Within 60 days following receipt of CMS comments on Draft Evaluation Design	STC 49
Summative Evaluation Report	Within 18 months following the end of this demonstration extension period	STC 53

Attachment A Continued

56. Additional Publications and Presentations. For a period of 12 months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration over which the state has control. Prior to release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials. CMS will be given 30 days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews. This requirement does not apply to the release or presentation of these materials to state or local government officials.

X. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION

Deliverable	Timeline	STC Reference
Quarterly Monitoring Report	Within 60 days following the end of each quarter	STC 28
Annual Monitoring Report	Within 90 days following the end of each demonstration year	STC 30
Draft Evaluation Design Plan	Within 120 days after the approval of the demonstration extension	STC 47
Final Evaluation Design Plan	Within 60 days following receipt of CMS comments on Draft Evaluation Design	STC 49
Summative Evaluation Report	Within 18 months following the end of this demonstration extension period	STC 53

Attachment A Continued

health care delivery, benefits, quality of care, anticipated or proposed changes in payment rates, and outreach changes.

- ii. Narrative on any demonstration changes, such as notable changes in enrollment, service utilization, and provider participation (up or down 10 percent). Discussion of any action plan if applicable.
- iii. Narrative on the existence of or results of any audits, investigations, or lawsuits that impact the demonstration.

3. Policy Issues and Challenges

- a. Narrative of any operational challenges or issues the state has experienced.
- b. Narrative of any policy issues the state is considering, including pertinent legislative/budget activity, and potential demonstration amendments.
- c. Discussion of any action plans addressing any policy, administrative or budget issues identified, if applicable.

B. Utilization Monitoring

The state will summarize utilization through a review of claims/encounter data for the demonstration population in the subsequent tables. This includes the following:

Table 1. Utilization Monitoring Measures

Topic	Measure [reported for each month included in the report]
Utilization Monitoring	Unduplicated Number of Enrollees by Quarter
	Unduplicated Number of Beneficiaries with any Claim by Quarter (by key demographic characteristics such as age, gender, and income level)
	Utilization by Primary Method and Age Group
	Total number of beneficiaries tested for any sexually transmitted disease
	Total number of female beneficiaries who obtained a cervical cancer screening
	Total number of female beneficiaries who received a clinical breast exam

Table 2: Unduplicated Number of Enrollees by Quarter

	Number of Female Enrollees by Quarter				
	14 years old and under	15-20 years old	21-44 years old	Over 45 years old	Total Unduplicated Female Enrollment*
Quarter 1					
Quarter 2					
Quarter 3					
Quarter 4					
	Number of Males Who Utilize Services by Age and Quarter				
	14 years old and under	15-20 years old	21-44 years old	Over 45 years old	Total Unduplicated Male Enrollment*
Quarter 1					
Quarter 2					
Quarter 3					
Quarter 4					

Attachment A Continued

*Total column is calculated by summing columns 2-5.

Table 3: Unduplicated Number of Beneficiaries with any Claim by Age Group and Gender per Quarter in the Demonstration Year (to date)

	Number of Females Who Utilize Services by Age and Quarter					
	14 years old and under	15-20 years old	21-44 years old	Over 45 years old	Total Female Users *	Percentage of Total Unduplicated Female Enrollment
Quarter 1						
Quarter 2						
Quarter 3						
Quarter 4						
	Number of Males Who Utilize Services by Age and Quarter					
	14 years old and under	15-20 years old	21-44 years old	Over 45 years old	Total Male Users*	Percentage of Total Unduplicated Male Enrollment
Quarter 1						
Quarter 2						
Quarter 3						
Quarter 4						

*Total column is calculated by summing columns 2-5.

Table 4: Utilization by Primary Method and Age Group per Demonstration Year (to date)

Primary Method	Total Users					
	14 years old and under	15 – 20 years old	21 – 44 years old	45 years old and older	Total*	Percent of All Devices
Sterilization						
Emergency Contraception						
Intrauterine Device (IUD)						
Hormonal Implant						
1-Month Hormonal Injection						
3-Month Hormonal Injection						
Oral Contraceptive						
Contraceptive Patch						
Vaginal Ring						
Diaphragm						
Sponge						
Female Condom						
Male Condom						

*Total column is calculated by summing columns 2-5.

Attachment A Continued

Table 5: Number Beneficiaries Tested for any STD by Demonstration Year (to date)

Test	Female Tests		Male Tests		Total Tests	
	Number	Percent of Total	Number	Percent of Total	Number	Percent of Total
Unduplicated number of beneficiaries who obtained an STD test						

Table 6: Total Number of Female Beneficiaries who obtained a Cervical Cancer Screening (to date)

Screening Activity	Number	Percent of Total Enrolled Females
Unduplicated number of female beneficiaries who obtained a cervical cancer screening		

Table 7: Breast Cancer Screening (to date)

Screening Activity	Number	Percent of Total Enrolled Females
Unduplicated number of female beneficiaries who received a Breast Cancer Screening		

C. Program Outreach and Education

1. General Outreach and Awareness
 - a. Provide information on the public outreach and education activities conducted this demonstration quarter; and,
 - b. Provide a brief assessment on the effectiveness of these outreach and education activities.
2. Target Outreach Campaign(s) (if applicable)
 - a. Provide a narrative on the populations targeted for outreach and education campaigns and reasons for targeting; and,
 - b. Provide a brief assessment on the effectiveness of these targeted outreach and education activities.

D. Program Integrity

Provide a summary of program integrity and related audit activities for the demonstration.

E. Grievances and Appeals

Provide a narrative of grievances and appeals made by beneficiaries, providers, or the public, by type and highlighting any patterns. Describe actions being taken to address any significant issues evidenced by patterns of appeals.

Attachment A Continued

Table 5: Number Beneficiaries Tested for any STD by Demonstration Year (to date)

Test	Female Tests		Male Tests		Total Tests	
	Number	Percent of Total	Number	Percent of Total	Number	Percent of Total
Unduplicated number of beneficiaries who obtained an STD test						

Table 6: Total Number of Female Beneficiaries who obtained a Cervical Cancer Screening (to date)

Screening Activity	Number	Percent of Total Enrolled Females
Unduplicated number of female beneficiaries who obtained a cervical cancer screening		

Table 7: Breast Cancer Screening (to date)

Screening Activity	Number	Percent of Total Enrolled Females
Unduplicated number of female beneficiaries who received a Breast Cancer Screening		

C. Program Outreach and Education

1. General Outreach and Awareness
 - a. Provide information on the public outreach and education activities conducted this demonstration quarter; and,
 - b. Provide a brief assessment on the effectiveness of these outreach and education activities.

2. Target Outreach Campaign(s) (if applicable)
 - a. Provide a narrative on the populations targeted for outreach and education campaigns and reasons for targeting; and,
 - b. Provide a brief assessment on the effectiveness of these targeted outreach and education activities.

D. Program Integrity

Provide a summary of program integrity and related audit activities for the demonstration.

E. Grievances and Appeals

Provide a narrative of grievances and appeals made by beneficiaries, providers, or the public, by type and highlighting any patterns. Describe actions being taken to address any significant issues evidenced by patterns of appeals.

Attachment C: Evaluation Design, 2018-2022

See Appendix C for proposed changes to the Evaluation Design 2023-2027

Washington State Family Planning Only 1115 Demonstration

Evaluation Design for Extension Period 01-01-18 through 12-31-2022

A. Demonstration Objectives/Goals

The purpose of the Family Planning Only 1115 Demonstration (FPO) is to provide Medicaid coverage for family planning (FP) and/or family planning-related services for low income individuals not otherwise eligible for Medicaid. The program's goals are to improve the health of women, children, and families by decreasing unintended pregnancies and lengthening intervals between births and reducing state and federal Medicaid expenditures for births from unintended pregnancies.

The FPO 1115 Demonstration serves individuals from these three populations: 1) recently pregnant women who lose Medicaid coverage after their pregnancy coverage ends; 2) uninsured women and men with family incomes at or below 260% federal poverty level (FPL) who seek FPO services to prevent an unintended pregnancy; and 3) teens and domestic violence victims who need confidential FPO services and are covered under their perpetrator's or parent's health insurance and are at or below 260% (FPL).

The specific objectives of the Washington State FPO program that will be tested include:

- Ensure access to FP services and/or FP-related services.
- Improve or maintain health outcomes for the target population as a result of access to FP services and/or FP-related services.

B. Evaluation Questions and Hypotheses

The demonstration's core evaluation questions, hypothesis, data sources, and analytic approaches are provided in the below table.

Attachment C Continued

C. Summary of Key Evaluation Questions, Hypotheses, Data Sources, and Analytic Approaches

Evaluation Component	Evaluation Question	Evaluation Hypotheses	Measures (to be reported for each Demonstration Year)	Data Source	Analytic Approach	Time Periods
Demonstration Objective 1: Ensure access to and utilization of family planning and/or family planning-related services for individuals not otherwise eligible for Medicaid.						
Process	How did beneficiaries utilize covered health services?	Enrollees will utilize family planning services and/or family planning related services.	Number of beneficiaries who had a family planning or family planning related service encounter in each year of the demonstration/total number of beneficiaries	ProviderOne and FSDB	Descriptive statistics (frequencies and percentages)	Compute for each year of the demonstration extension and calculate annual rates for each measures specified.
			Number of family planning services utilized/total number of beneficiaries			
			Number of female beneficiaries who utilized any contraceptive in each year of the demonstration /total number of female beneficiaries			
			Number of female beneficiaries who utilized long-acting reversible contraceptives in each year of the demonstration/ total number of female beneficiaries			
			Number of beneficiaries tested for any sexually transmitted disease (by STD)/total number of beneficiaries			
			Number of female beneficiaries who obtained a cervical cancer screening/total number of female beneficiaries			
			Number of female beneficiaries who received a clinical breast exam/total number of female beneficiaries			

Attachment C Continued

Evaluation Component	Evaluation Question	Evaluation Hypotheses	Measures (to be reported for each Demonstration Year)	Data Source	Analytic Approach	Time Periods
	Do beneficiaries maintain coverage long-term (12 months or more)?	Beneficiaries will maintain coverage for one or more 12 month enrollment period.	Number of beneficiaries who completed one spell of 12 month enrollment/total number of beneficiaries Number of beneficiaries re-enrolled for at least their second spell of coverage/total number of beneficiaries	ProviderOne	Descriptive statistics (frequencies and percentages)	Available on a monthly basis approximately 1 month after the end of each quarter
Demonstration Objective 2: Improve or maintain health outcomes for the target population as a result of access to family planning and family planning-related services.						
Outcome/ Impact	Does the demonstration improve health outcomes? [Calculate for target population and similar population from Medicaid within-state]	Health outcomes will improve as a result of the demonstration.	Number of subsequent live births that occurred at an interval of 18 months or longer/ total number of subsequent live births Number of low birth weight babies born to beneficiaries /total number of babies born to beneficiaries Number of premature babies born in the beneficiaries/total number of babies born to beneficiaries	ProviderOne and FSDB	Descriptive statistics (proportions) and significance testing (chi-squared of the proportions); trend analysis when applicable.	Calculate annual and biannual rates for each measures specified and conduct a trend analysis after year three.
	Does the demonstration increase the use of more effective contraceptive methods among FPO beneficiaries?	Beneficiaries will have a higher rate of using more effective contraceptive methods compared to other members of	Compare the rates separately for most effective and moderately effective methods. Example: compare the proportion of LARC insertions among FPO beneficiaries to the proportion of other eligible Medicaid beneficiaries.	ProviderOne and FSDB	Descriptive statistics (proportions) and significance testing (Chi ² test)	Annual rates available for statistical testing.

Evaluation Component	Evaluation Question	Evaluation Hypotheses	Measures (to be reported for each Demonstration Year)	Data Source	Analytic Approach	Time Periods
		Medicaid beneficiaries.				

Attachment C Continued

D. Methodology

1. Evaluation design: The evaluation design will utilize a post-only assessment with a comparison group.

The timeframe for the post-only period will begin when the current demonstration period begins on 1/1/2018, and ends when the current demonstration period ends on 12/31/2022. There will be annual evaluations during the extension period and a final evaluation when the demonstration period ends. We will construct a comparison group when applicable for various evaluation processes.

2. Data Collection and sources: For the data sources identified in the above table, describe how the data will be collected. Additionally, identify the frequency of the data collection, and limitations of the data. Identify which data will be collected prospectively via beneficiary surveys or interviews (if applicable), or retrospectively through administrative data.

Data collection

All data for the evaluation will be administrative data collected retrospectively.

Data Sources

Data for evaluation are based on eligibility, birth certificates, and linked claims file with vital records also known as the First Steps Database (FSDB). Claims and eligibility data are available for all Medicaid clients. Even though these data are highly reliable and valid, claims data are 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 contraceptive methods provided, not the method in use by the client as clients may discontinue methods.

ProviderOne: HCA's claims file contains a record for every claim submitted for reimbursement. For all FPO eligible clients, the FSDB staff obtains a service history for appropriate time periods for each client. ProviderOne services history data are used to describe the types of FP services provided. ProviderOne is updated monthly.

First Steps Database (birth certificates linked to Medicaid clients): All Washington birth certificates are linked at the individual level to Medicaid claims and eligibility history. FSDB begins with births in August 1988 and currently contains linked birth certificates through 2016. The annual unduplicated count of FPO eligible clients is linked to the FSDB by ProviderOne ID. The First Steps Database is created biannually.

3. Data Analysis Strategy: Describe the analytic methods that will be utilized to answer the evaluation questions identified in the above table. If the design is mixed-methods (collecting both quantitative and qualitative), the state should explain how the evaluation team plans to integrate the findings from both types of assessments.

Only quantitative data analyses will be applied.

Attachment C Continued

- **Quantitative Methods:** For each evaluation question, include the statistical and analytical methods that will be employed (and are consistent with what was listed in the table above).

For objective #1, we will apply descriptive methods of frequency and proportions to demonstrate service utilization of FPO beneficiaries for all the service utilization measures as specified in the table. The monthly enrollment into Medicaid program will be the key indicator for measuring 1) whether the beneficiaries maintain coverage long term, i.e., continues enrollment of 12 months or more, and 2) whether there is a re-enrollment for at least the second spell of coverage three years prior to and three years post the current enrollment year.

For objective #2, most of the data analyses for the outcome measures specified will be descriptive that utilizes basic statistic tests of Chi-squared statistics for comparison on the differences in frequencies or proportions between groups and Cochran-Armitage test for examining the changes in proportion of the outcomes over time among FPO program beneficiaries when applicable. The comparison group will be selected from the same data source and restricted to women of reproductive ages 15-44 who were Medicaid eligible during the same evaluation period but were not participating in the FPO program. For the outcome measures of birth span, low birth weight and premature babies, the differences in proportions of the outcomes will be tested at an annual basis. We will also calculate the proportions of these outcome measures at a biannual basis and therefore, Cochran-Armitage test for trend can be conducted when applicable.

On the state added evaluation question: “Does the demonstration increase use of more effective contraceptive methods?” we are proposing the following study design and analysis.

Brief description

By allowing women access to the contraceptive services they need and want, women seeking FPO services during the year are able to achieve their childbearing goals by reducing the number of unintended pregnancies. The objective of this evaluation is to examine whether FPO services increase the proportion of women using the more effective contraceptive methods.

Methods

We will use the First Steps Database, including ProviderOne data on contraceptives dispensed, to track contraceptive methods used by FPO program beneficiaries. Contraceptive methods will be categorized as most effective, i.e., long-acting reversible contraceptives (LARC) and moderately effective methods including injectable, patch, pill, ring, and diaphragm. We will exclude sterilization due to potential small sample sizes which would lead to less power to detect statistical differences. We will also exclude less effective methods due to lack of claims data on non-prescriptive devices. Basic statistics of Chi-squared test, student’s t-test, or analysis of variance (ANOVA) will be conducted to detect statistical inferences.

Key measures

1. Describe prescribing/dispensing patterns for contraceptive methods used by FPO eligible women at the first visit, as an index month, within a calendar year and compare their contraceptive use history during the 12 month prior to the index month;

Attachment C Continued

2. Track women who received a contraceptive method longitudinally to identify LARC insertions and to describe monthly contraceptive coverage for other contraceptive dispensed.

Hypotheses:

1. Women enrolling in FPO were likely to leave their first visit with more effective contraceptive than they used before the visit.
2. Women enrolling in FPO were likely to use more effective contraceptive and more monthly coverage than their Medicaid counterpart who did not use FP services.

4. Simplified Evaluation Budget:

The required budget will consist of the following line items:

1. Computer programming (cost per hour x hours);
2. Analysis of the data (cost per hour x hours);
3. Preparation of the report (cost per hour x hours);
4. Other (specify work, cost per hour, and hours). If work is outside the requirements of the basic evaluation this should be identified in the draft evaluation design along with justification for an increased budget match.

E. Independent Contractor: Indicate and describe the process the state will follow to acquire an independent entity or entities to conduct the evaluation (either a competitive procurement or those with an existing contractual relationship with the state). Include the timeframe for the independent contractor to begin and complete the evaluation work.

HCA has contracted with the Department of Social and Health Services (DSHS) Research and Data Analysis (RDA) Division to conduct the FPO waiver extension evaluation. 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 previous 1115 Family Planning Only waiver evaluations, along with other maternity and family-planning-related studies, they are very knowledgeable about Medicaid programs in general and the family planning waiver program called TAKE CHARGE in particular. They are prepared to begin evaluation activities for the coming five-year period promptly, upon approval of the extension and the evaluation design.

Attachment D: Contraceptive Care Reports

Measure CCW: Contraceptive Care -- Women Ages 15-20
Percentage Who Were Provided a Most Effective or Moderately Effective FDA-approved Method of Contraception
By Race/Ethnicity 2016 to 2020

	2016			2017			2018			2019			2020		
	TOTAL ELIGIBLE WOMEN	More/Most Effective Contraception Age 15-20		TOTAL ELIGIBLE WOMEN	More/Most Effective Contraception Age 15-20		TOTAL ELIGIBLE WOMEN	More/Most Effective Contraception Age 15-20		TOTAL ELIGIBLE WOMEN	More/Most Effective Contraception Age 15-20		TOTAL ELIGIBLE WOMEN	More/Most Effective Contraception Age 15-20	
		N	% of Total		N	% of Total		N	% of Total		N	% of Total		N	% of Total
Hispanic	23,184	5,479	23.6%	24,160	5,884	24.4%	25,425	6,163	24.2%	26,682	6,697	25.1%	30,416	6,678	22.0%
Not Hispanic or Ethnicity Unknown															
White	36,744	13,876	37.8%	35,079	13,189	37.6%	32,882	12,261	37.3%	31,385	11,590	36.9%	33,424	11,127	33.3%
Asian	3,553	692	19.5%	3,401	692	20.3%	3,286	621	18.9%	3,139	639	20.4%	3,417	626	18.3%
Black	5,432	1,382	25.4%	5,226	1,277	24.4%	5,103	1,239	24.3%	4,996	1,144	22.9%	5,588	1,133	20.3%
American Indian/Alaska Native	2,205	758	34.4%	2,297	797	34.7%	2,446	821	33.6%	2,428	780	32.1%	2,756	830	30.1%
Hawaiian/Pacific Islander	1,915	392	20.5%	1,877	397	21.2%	1,850	340	18.4%	1,874	303	16.2%	2,169	317	14.6%
More Than One Race	1,973	716	36.3%	2,361	866	36.7%	2,745	964	35.1%	2,926	1,116	38.1%	2,930	968	33.0%
Other/Unknown	4,733	1,143	24.1%	4,667	1,150	24.6%	4,458	1,043	23.4%	4,423	1,036	23.4%	5,049	1,011	20.0%
Total	79,739	24,438	30.6%	79,068	24,252	30.7%	78,195	23,452	30.0%	77,853	23,305	29.9%	85,749	22,690	26.5%

Excludes women with eligibility for programs using state funds only; women who are eligible for both Medicaid and Medicare; women who have full third party liability; women who were infecund; women who had a live birth in the last two months of the measurement year; and women who were pregnant at the end of the measurement year. **Race/ethnicity** categories are mutually exclusive. Hispanic women may be of any race. **Most or moderately effective FDA-approved contraception methods:** female sterilization, contraceptive implants, intrauterine devices or systems, injectables, oral pills, patch, ring, or diaphragm. Continued use of some methods may not be identified in claims or encounters. **Eligible women** are women in the specified age range as of December 31 of the measurement year who were continuously enrolled in Medicaid or CHIP with medical or family planning benefits throughout the 12 months of the measurement year (one month gap allowed) and who do not meet exclusion criteria. Eligibility must include December 31 as the 'anchor' date.

Contraceptive care reports continued

Measure CCW: Contraceptive Care -- Women Ages 15-20
Percentage Who Were Provided a Long-acting Reversible Method of Contraception (LARC)
By Race/Ethnicity 2016 to 2020

	2016			2017			2018			2019			2020		
	TOTAL ELIGIBLE WOMEN	LARC Age 15-20		TOTAL ELIGIBLE WOMEN	LARC Age 15-20		TOTAL ELIGIBLE WOMEN	LARC Age 15-20		TOTAL ELIGIBLE WOMEN	LARC Age 15-20		TOTAL ELIGIBLE WOMEN	LARC Age 15-20	
		N	% of Total		N	% of Total		N	% of Total		N	% of Total		N	% of Total
Hispanic	23,184	1,177	5.1%	24,160	1,274	5.3%	25,425	1,326	5.2%	26,682	1,443	5.4%	30,416	1,400	4.6%
Not Hispanic or Ethnicity Unknown															
White	36,744	2,365	6.4%	35,079	2,417	6.9%	32,882	2,317	7.0%	31,385	2,244	7.1%	33,424	2,046	6.1%
Asian	3,553	119	3.3%	3,401	128	3.8%	3,286	99	3.0%	3,139	138	4.4%	3,417	101	3.0%
Black	5,432	297	5.5%	5,226	268	5.1%	5,103	232	4.5%	4,996	210	4.2%	5,588	161	2.9%
American Indian/Alaska Native	2,205	147	6.7%	2,297	189	8.2%	2,446	175	7.2%	2,428	175	7.2%	2,756	176	6.4%
Hawaiian/Pacific Islander	1,915	67	3.5%	1,877	90	4.8%	1,850	75	4.1%	1,874	63	3.4%	2,169	70	3.2%
More Than One Race	1,973	139	7.0%	2,361	190	8.0%	2,745	188	6.8%	2,926	217	7.4%	2,930	163	5.6%
Other/Unknown	4,733	201	4.2%	4,667	221	4.7%	4,458	174	3.9%	4,423	200	4.5%	5,049	141	2.8%
Total	79,739	4,512	5.7%	79,068	4,777	6.0%	78,195	4,586	5.9%	77,853	4,690	6.0%	85,749	4,258	5.0%

LARC=long-acting reversible method of contraception (implant or IUD). Ongoing LARC use may not be identified in claims or encounters.

Eligible women are women in the specified age range as of December 31 of the measurement year who were continuously enrolled in Medicaid or CHIP with medical or family planning benefits throughout the 12 months of the measurement year (one month gap allowed) and who do not meet exclusion criteria. Eligibility must include December 31 as the 'anchor' date.

Excludes women with eligibility for programs using state funds only; women who are eligible for both Medicaid and Medicare; women who have full third party liability; women who were infertile; women who had a live birth in the last two months of the measurement year; and women who were pregnant at the end of the measurement year. **Race/ethnicity** categories are mutually exclusive. Hispanic women may be of any race.

Contraceptive care reports continued

Measure CCP: Contraceptive Care -- Postpartum Women Ages 15-20
Percentage Who Were Provided a Most Effective or Moderately Effective FDA-approved Method of Contraception
Within Sixty Days of Delivery
By Year and Race/Ethnicity

	2016			2017			2018			2019			2020		
	TOTAL ELIGIBLE WOMEN	Used More/Most Effective Contraception Age 15-20		TOTAL ELIGIBLE WOMEN	Used More/Most Effective Age 15-20		TOTAL ELIGIBLE WOMEN	Used More/Most Effective Age 15-20		TOTAL ELIGIBLE WOMEN	Used More/Most Effective Age 15-20		TOTAL ELIGIBLE WOMEN	Used More/Most Effective Age 15-20	
		N	% of Total		N	% of Total		N	% of Total		N	% of Total		N	% of Total
Hispanic	865	394	45.5%	777	386	49.7%	720	312	43.3%	742	363	48.9%	716	345	48.2%
Not Hispanic or Ethnicity Unknown															
White	1,141	510	44.7%	970	442	45.6%	775	348	44.9%	699	345	49.4%	592	260	43.9%
Asian	26	**	**	23	**	**	11	**	**	13	**	**	9	**	**
Black	153	51	33.3%	137	52	38.0%	114	48	42.1%	90	28	31.1%	72	26	36.1%
American Indian/Alaska Native	100	31	31.0%	105	40	38.1%	102	37	36.3%	88	33	37.5%	67	29	43.3%
Hawaiian/Pacific Islander	92	35	38.0%	52	13	25.0%	57	19	33.3%	64	12	18.8%	51	15	29.4%
More Than One Race	88	30	34.1%	86	23	26.7%	100	41	41.0%	109	52	47.7%	95	44	46.3%
Other/Unknown	91	**	**	85	**	**	77	**	**	54	**	**	46	**	**
Total	2,556	1,090	42.6%	2,235	1,003	44.9%	1,956	832	42.5%	1,859	867	46.6%	1,648	738	44.8%

Excludes women with eligibility for programs using state funds only; women who are eligible for both Medicaid and Medicare; women who have full third party liability; women with deliveries that did not end in a live birth; and women who delivered in the last two months of the year. **Race/ethnicity** categories are mutually exclusive. Hispanic women may be of any race. **Most or moderately effective FDA-approved contraception methods:** female sterilization, contraceptive implants, intrauterine devices or systems, injectables, oral pills, patch, ring, or diaphragm. **Eligible women** are women in the specified age range as of December 31 of the measurement year with a live birth who were continuously enrolled in Medicaid or CHIP with medical or family planning benefits from the date of delivery to 60 days postpartum. **Rates** calculated from small numbers may be unstable and may fluctuate widely. Caution should be used when interpreting rates based on small numbers. ** = suppressed due to small numbers.

Contraceptive care reports continued

Measure CCP: Contraceptive Care -- Postpartum Women Ages 15-20
 Percentage Who Were Provided a Long-acting Reversible Method of Contraception (LARC)
 Within Sixty Days of Delivery
 By Year and Race/Ethnicity

	2016			2017			2018			2019			2020		
	TOTAL	LARC		TOTAL	LARC		TOTAL	LARC		TOTAL	LARC		TOTAL	LARC	
	ELIGIBLE WOMEN	Age 15-20 N	% of Total	ELIGIBLE WOMEN	Age 15-20 N	% of Total	ELIGIBLE WOMEN	Age 15-20 N	% of Total	ELIGIBLE WOMEN	Age 15-20 N	% of Total	ELIGIBLE WOMEN	Age 15-20 N	% of Total
Hispanic	865	201	23.2%	777	214	27.5%	720	176	24.4%	742	202	27.2%	716	183	25.6%
Not Hispanic or Ethnicity Unknown															
White	1,141	213	18.7%	970	183	18.9%	775	140	18.1%	699	142	20.3%	592	106	17.9%
Asian	26	**	**	23	**	**	11	**	**	13	**	**	9	**	**
Black	153	26	17.0%	137	22	16.1%	114	20	17.5%	90	**	**	72	12	16.7%
American Indian/Alaska Native	100	14	14.0%	105	22	21.0%	102	19	18.6%	88	13	14.8%	67	15	22.4%
Hawaiian/Pacific Islander	92	11	12.0%	52	**	**	57	**	**	64	**	**	51	**	**
More Than One Race	88	14	15.9%	86	12	14.0%	100	16	16.0%	109	27	24.8%	95	18	18.9%
Other/Unknown	91	**	**	85	19	22.4%	77	11	14.3%	54	15	27.8%	46	**	**
Total	2,556	498	19.5%	2,235	479	21.4%	1,956	390	19.9%	1,859	416	22.4%	1,648	351	21.3%

Excludes women with eligibility for programs using state funds only; women who are eligible for both Medicaid and Medicare; women who have full third party liability; women with deliveries that did not end in a live birth; and women who delivered in the last two months of the year. **Race/ethnicity** categories are mutually exclusive. Hispanic women may be of any race. **LARC**=long-acting reversible method of contraception (implant or IUD). **Eligible women** are women in the specified age range as of December 31 of the measurement year with a live birth who were continuously enrolled in Medicaid or CHIP with medical or family planning benefits from the date of delivery to 60 days postpartum.

** = suppressed due to small numbers.

Attachment E: Public Notices, Comments, & Responses



STATE OF WASHINGTON
HEALTH CARE AUTHORITY
626 8th Avenue, SE • Olympia, Washington 98501

June 13, 2022

NOTICE

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: June 13, 2022

TIME: 3:14 PM

WSR 22-13-089

Title or Subject: Section 1115 Family Planning Only Demonstration Waiver Extension Application

Effective Date: July 1, 2023

Description: The Health Care Authority (the Agency) intends to submit an application to extend the Section 1115 Family Planning Only Demonstration Waiver for 5 years (through July 2028). The current waiver expires on June 31, 2023. It covers limited family planning and family planning-related services for people who identify as women, men, and gender fluid who are in need of contraceptive care and are enrolled in the Family Planning Only programs.

The purpose, client eligibility requirements, and benefit package will remain the same. The only potential change is the elimination of the Family Planning pregnancy-related program, due to the implementation of the After-Pregnancy Coverage program. This change will take effect when the end of the federal Public Health Emergency (PHE) is declared. There is currently no established end date for the PHE.

The purpose of the Family Planning Only program is to:

- Assure access to family planning services
- Decrease unintended pregnancies and births
- Lengthen intervals between births
- Reduce state and federal Medicaid expenditures for averted births from unintended pregnancies.

The following groups are eligible for services under the Family Planning Only program:

- Recently pregnant people who lose Medicaid coverage after their pregnancy coverage ends. These people are automatically enrolled for 10 months.¹
- Uninsured people with family incomes at or below 260% federal poverty level (FPL), seeking to prevent an unintended pregnancy
- Teens and domestic violence victims who need confidential family planning services and are covered under their perpetrator's or parent's health insurance and are at or below 260% federal poverty level (FPL).

Family Planning coverage under the waiver is for a 12-month duration starting on the first day of the month the application was signed. Applications are available on the Agency website or any Apple Health provider that offers family planning services who can assist with the completion of the application.

The Family Planning Only program provides the following services on a fee-for-service basis: FDA-approved contraceptives; natural family planning; over-the-counter contraception; emergency contraception; sterilization; contraceptive education, counseling and management; limited STD testing and treatment related to the safe and effective use of the chosen contraceptive method; cervical cancer screening according to the national clinical guidelines when associated with a family planning visit; and office visits and limited ancillary services related to the above services. There are no cost-sharing requirements to receive services under this program.

¹ This eligibility group will be eliminated once the Public Health Emergency ends and then this group will be eligible for the After-pregnancy coverage benefit which provides 12-months of full-scope Apple Health (Medicaid) benefits to people who have had a pregnancy within 12-months.

Attachment E Continued

There may be decreases in annual aggregate expenditures or enrollment due to the end of the PHE and implementation of the After-Pregnancy Coverage program. Based on Demonstration Year (DY) 2020, we expect approximately 8,000 enrollees and 1,400 participants with an expenditure of \$300,000 (DY 2021) for each year of the five-year renewal period.²

The Demonstration waiver will test the hypotheses that by maintaining the Family Planning Only program: 1) access to family planning services will remain available to people who otherwise may not have access; 2) health outcomes will improve or maintain for the waiver population; and 3) the unintended pregnancy rate in Washington State will remain stable or continue to decrease. The State expects that over the five years of the renewal period, the State will have decreased costs due to averted births from unintended pregnancy.

These hypotheses will be measured by evaluating enrollment in the Family Planning Only Program, contraceptive methods chosen, Pregnancy Risk Assessment Monitoring System (PRAMS) data, birth certificates, and claims data. Due to small sample sizes, the evaluation may be limited to descriptive analysis.

The Demonstration's expenditure authority falls under the State's Title XIX Medicaid State Plan and section 1115(a)(2) of the Social Security Act. Requirements not applicable to the expenditure authorities are:

1. Methods of Administration: Transportation: Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53. To the extent necessary to enable the State to not assure transportation to and from providers for the Demonstration population.
2. Amount, Duration, and Scope of Services (Comparability): Section 1902(a)(10)(B). To the extent necessary to allow the State to offer the Demonstration population a benefit package consisting only of family planning services and family planning-related services.
3. Prospective Payment for Federally Qualified Health Centers and Rural Health Centers and Rural Health Clinics: Section 1902(a)(15). To the extent necessary for the State to establish reimbursement levels to these clinics that will compensate them solely for family planning and family planning-related services.
4. Eligibility Procedures: Section 1902(a)(17). To the extent necessary to allow the State to not include parental income when determining a minor's (a person under age 18) eligibility for the family planning Demonstration. To the extent necessary to allow the State to not require reporting of changes in income or household size for 12 months, for a person found income-eligible upon application or annual redetermination when determining eligibility for the family planning Demonstration.
5. Retroactive Coverage: Section 1902(a)(34). To the extent necessary to enable the State to not provide medical assistance to the Demonstration population for any time prior to the first of the month in which an application for the Demonstration is made.
6. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT): Section 1902(a)(43)(A). To the extent necessary to enable the State to not furnish or arrange for EPSDT services to the Demonstration population.

A link to the full public notice for the Family Planning Only Demonstration Waiver extension application can be found at: www.hca.wa.gov/family-planning. The Agency updates this webpage regularly.

Public comment period: The public comment period for the Family Planning Only Demonstration Waiver extension application is from **June 30** through **July 29, 2022**. During this time, people can share their feedback on the waiver renewal application, the change that the program may experience, or share any other comments about the waiver renewal.

² These totals do not consider the loss of the Family Pregnancy- Related group due to the implementation of the After-Pregnancy Coverage program.

Attachment E Continued

Public comment is open to anyone who like to share feedback. HCA encourages health care and social service providers, Accountable Communities of Health, Tribal Nations, Indian health care providers, hospitals and health systems, medical associations, community-based organizations, and the public to provide feedback.

You can e-mail comments to familyplanning@hca.wa.gov or mail comments to the address below. **The deadline to provide public comment is Friday July 29, 2022 at 5 p.m. PDST.** A copy of the draft application will be available by June 30, 2022, at: www.hca.wa.gov/family-planning-by-June-30

Two public webinars are scheduled. The Agency will accept verbal and written comments at these webinars. Details of the webinars are below and can also be found at www.hca.wa.gov/family-planning.

Thursday, June 30, 2022, from 12 noon to 1 p.m. via Zoom:

<https://us02web.zoom.us/j/81274431420>

Meeting ID: 812 7443 1420

Dial by your location

- +1 253 215 8782 US (Tacoma)
- +1 346 248 7799 US (Houston)
- +1 669 900 6833 US (San Jose)
- +1 301 715 8592 US (Washington DC)
- +1 312 626 6799 US (Chicago)
- +1 929 205 6099 US (New York)

Meeting ID: 812 7443 1420

Find your local number: <https://us02web.zoom.us/u/ku0tvuGcV>

Friday, July 29, 2022, from 10 a.m. to 11 a.m. via Zoom:

<https://us02web.zoom.us/j/89782865366>

Meeting ID: 897 8286 5366

Dial by your location

- +1 253 215 8782 US (Tacoma)
- +1 346 248 7799 US (Houston)
- +1 669 900 6833 US (San Jose)
- +1 312 626 6799 US (Chicago)
- +1 929 205 6099 US (New York)
- +1 301 715 8592 US (Washington DC) Meeting ID: 897 8286 5366

Find your local number: <https://us02web.zoom.us/u/kNUO2JBDB>

For additional information, contact:

Name: Christine Quinata

Program: Family Planning Only program

Address: 626 8th Ave SE, Olympia, WA 98501

Phone: 360-725-1652

TRS/TDD/TTY:

Fax: 360-725-1152

E-mail address: FamilyPlanning@hca.wa.gov

Web site address: <https://www.hca.wa.gov/health-care-services-and-supports/apple-health-medicaid-coverage/family-planning-only>



**STATE OF WASHINGTON
HEALTH CARE AUTHORITY**
626 8th Avenue, SE PO Box 42716 Olympia, Washington 98504-2716

Date September 23, 2022

TO: Interested Persons

FROM: Beth Tinker, Clinical Nurse Consultant
Clinical Quality and Care Transformation Division

**SUBJECT: SUMMARY OF AND RESPONSES TO COMMENTS RECEIVED
REGARDING RENEWAL OF THE 1115 FAMILY PLANNING ONLY
DEMONSTRATION WAIVER**

The Health Care Authority (HCA) is submitting an application to renew the Section 1115 Family Planning Only (FPO) Demonstration waiver for five years, from July 1, 2023 through June 30, 2028. The waiver FPO programs cover limited family planning and family planning-related services for people who identify as women, men, and gender fluid who are in need of contraceptive care and are enrolled in the Family Planning Only programs.

The purpose, client eligibility requirements, and benefit package will remain the same. The only potential change during this next waiver cycle is the elimination of the Family Planning Pregnancy-Related program, due to the implementation of the After-Pregnancy Coverage program (i.e. 12 months of comprehensive post end of pregnancy coverage). This change is anticipated to take effect when the end of the federal Public Health Emergency (PHE) is declared. There is currently no established end date for the PHE.

HCA held public webinars on June 30, 2022, and July 29, 2022, to receive comments, questions, and feedback. There was a public comment period that followed and ended August 26, 2022. A summary of those comments, questions, and feedback is below, along with HCA’s responses.

We thank our partners for their comments.

SUMMARY OF COMMENTS RECEIVED	THE AGENCY CONSIDERED ALL THE COMMENTS. THE AGENCY RESPONSE TO THE COMMENTS IS BELOW.
On August 16 th Planned Parenthood Alliance Advocates – WA submitted comments. The comments indicated overall support for the HCA submitting a FPO waiver renewal and the commitment to Washingtonians in need of sexual and reproductive health care. They	HCA thanks our partners at Planned Parenthood for their comments, support and for the critical services they provide to Washingtonians.

<p>prevent them from accessing family planning care, such as youth and those who don't have access to family car or other transport, especially in rural areas. We believe these services are and should be covered regardless of any waiver limitations. We request a follow-up discussion with FPO staff to understand this limitation further.</p>	<p>We are happy to set up a meeting to discuss further, will need to include our NEMT subject matter experts at the HCA.</p>
<p>3. On pg. 8 the draft application states that "to the extent necessary to enable the State to not provide medical assistance to the demonstration population for any time prior to the first of the month in which an application for the demonstration is made". Apple Health coverage typically allows for 3 months of retroactive coverage. Due to the high cost of some FPO covered services, aligning the including of retroactive coverage with other Medicaid programs could help address a hardship for a population vulnerable to medical debt. We ask HCA to explain why retroactive coverage is excluded for FPO.</p>	<p>The response from our eligibility team is that we are happy to meet and further explore adding 3 months of retroactive coverage to the FPO waiver STCs.</p>
<p>4. The data tables on pages 12-14 of the draft are blank. We request that HCA publicly share that data prior to submission of the waiver application.</p>	<p>The data tables have been updated. Our apologies that we didn't yet have these completed for the public comment period.</p>
<p>5. On pg. 17 the draft application states that "After pregnancy coverage means that postpartum clients are no longer automatically enrolled in FPO-PR". NOHLA fully supports the expansion of PP coverage to 12 months; additionally, we also recognize that access to family planning services after the 12mo PP period remains essential to pregnancy spacing and reproductive health. However, HCA should clarify that at the end of APC coverage, HCA will redetermine the person into any Medicaid program for</p>	<p>At the end of the certification period for all programs, HCA sends a letter 60 days prior to the end of the certification period notifying the person it is time to take action to renew their coverage (if the system cannot automatically renew it) to initiate the redetermination process to determine the suitable Medicaid program the individual is eligible for.</p>

<p>noted in particular the importance of the waiver and the FPO programs for people seeking confidential services. They also expressed support for gender inclusive language in the waiver renewal application.</p>	
<p>On August 26th Northwest Health Law Advocates submitted comments. Those are numbered and listed separately below with the corresponding agency response.</p>	
<p>1. On pg. 6 the draft application states that “Due to complicating factors related to the PHE, some pregnancy medical clients are still transitioning to FPO-PR”. Given that coverage should be continuous after the PHE end, we request that HCA specify the “complicating factors” and identify any shared characteristics of individuals who are transitioning to FPO-PR now before the end of the PHE.</p>	<p>Our eligibility team has revised this language in the waiver renewal to provide clarity. Here is the revised language, “In June 2022, After-Pregnancy Coverage (APC) was implemented in Washington, providing 12 months of full-scope Medicaid benefit to individuals who were pregnant during the prior year. Clients who had a pregnancy less than 12 months prior were moved into APC and will continue to receive this coverage during the PHE. Clients who had a pregnancy that ended more than 12 months prior and are on FPO-PR will remain on this coverage until after the PHE ends.</p> <p>Once the PHE is declared to be over, we anticipate the FPO-PR program will become obsolete due to availability of comprehensive coverage under APC.”</p>
<p>2. On pg. 7, the draft application requests to continue waiving Medicaid’s transportation requirements, seeking a waiver from federal law “To the extent necessary to enable the State to not assure transportation to and from providers for the demonstration population”. We are wondering why HCA excludes non-emergency medical transportation for this group via the waiver. There are important reasons to provide this coverage, whether through federal or state funding. Some FPO enrollees may have transportation barriers that</p>	<p>The response from our NEMT team at the HCA, “The Non-Emergency Medical Transportation (NEMT) program is administered under 42 CFR 440.170(a)(4) to cost-effectively provide non-emergency medical transportation services to individuals eligible for medical assistance under the Medicaid State Plan. It is not included in waivers as they operate outside the state plan and may include clients that are not eligible for Medicaid.”</p>

which they remain eligible, including FPO as required by law.	
6. The data tables on pages 61-63 appear identical to the data table on pg. 60. We request that HCA publicly share that data prior to submission of the waiver application.	Thank you for your careful review. These data tables have been updated.



STATE OF WASHINGTON
HEALTH CARE AUTHORITY
626 8th Avenue, SE • Olympia, Washington 98501

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: December 11, 2022

TIME: 3:40 PM

WSR 23-01-030

December 11, 2022

NOTICE

Title or Subject: Section 1115 Family Planning Only Waiver Extension Application

Effective Date: July 1, 2023

Purpose: This notice updates information previously published in a notice dated June 13, 2022, appearing in the Washington State Register under WSR# 22-13-089 on July 6, 2022, regarding extending the Section 1115 Family Planning Only Demonstration Waiver. The Agency submitted the waiver renewal application to the Centers for Medicare and Medicaid Services (CMS) on September 30, 2022, for initial review. During that review, CMS noted the following components should be included in the application prior to a formal CMS review: all data tables are updated and posted to the application posted on the HCA website; clear inclusion of dates and details of public forums; and inclusion of an interim evaluation report on the current waiver cycle. The updated application must be posted publicly on the HCA website (www.hca.wa.gov/family-planning) and an additional 30-day comment period must follow. Specifically:

- Data tables – all were updated and complete in the waiver application sent to CMS on September 30, 2022, in the version posted to the HCA website (www.hca.wa.gov/family-planning) on October 6, 2022, and in the most current version.
- Public forums – included in this current version on page 17.
- Interim evaluation report – completed and included in this current version, starting on page 9.

To review the updated waiver renewal application, please click on the link at the end of this notice.

The information under the “description” section below repeats the information in the June 13, 2022, public notice.

Description: The Health Care Authority (the Agency) intends to submit an application to extend the Section 1115 Family Planning Only Demonstration Waiver for five years (through July 2028). The current waiver expires on June 30, 2023. It covers limited family planning and family planning related services for people who identify as women, men, and gender fluid who are in need of contraceptive care and are enrolled in the Family Planning Only programs.

The purpose, client eligibility requirements, and benefit package will remain the same. The only potential change is the elimination of the Family Planning pregnancy related program due to the implementation of the After-Pregnancy Coverage program. This change will take effect when the end of the Public Health Emergency (PHE) is declared. There is currently no end date for the federal PHE.

The purpose of the Family Planning Only program is to:

- Assure access to family planning services.
- Decrease unintended pregnancies and births.

- Lengthen intervals between births.
- Reduce state and federal Medicaid expenditures for averted births from unintended pregnancies.

The following groups are eligible for services under the Family Planning Only program:

- Recently pregnancy people who lose Medicaid coverage after their pregnancy coverage ends. These women are automatically enrolled for 10 months.¹
- Uninsured people with family incomes at or below 260% federal poverty level (FPL), seeking to prevent an unintended pregnancy.
- Teens and domestic violence victims who need confidential family planning services and are covered under their perpetrator's or parent's health insurance and are at or below 260% federal poverty level (FPL).

Coverage is for 12 months starting on the first day of the month the application was signed. Applications are available on the Agency website or any Apple Health provider that offers family planning services who can assist with the completion of the application.

The Family Planning Only program provides the following services on a fee-for-service basis: FDA approved contraceptives, natural family planning, over-the-counter contraception, emergency contraception, sterilization, contraceptive education, counseling and management, limited STD testing and treatment related to the safe and effective use of the chosen contraceptive method, cervical cancer screening according to the national clinical guidelines when associated with a family planning visit; office visits and limited ancillary services related to the above services. There are no cost-sharing requirements to receive services under this program.

There may be decreases in annual aggregate expenditures or enrollment due to the end of the PHE and implementation of the After-pregnancy Coverage program. Based on Demonstration Year (DY) 2020, we expect approximately 8,000 enrollees and 1,500 participants with an expenditure of \$300,000 (Demonstration Year 2021) for each year of the five-year renewal period.²

The Demonstration will test the hypotheses that by maintaining the Family Planning Only program 1) access to family planning services will remain available to people who otherwise may not have access; 2) health outcomes will improve or maintain for the waiver population; and 3) the unintended pregnancy rate in Washington State will remain stable or continue to decrease. The State expects that over the five years of the renewal period the State will have decreased costs due to averted births from unintended pregnancy.

These hypotheses will be measured by evaluating enrollment in the Family Planning Only Program, contraceptive methods chosen, Pregnancy Risk Assessment Monitoring System (PRAMS) data, birth certificates, and claims data. Due to small sample sizes, the evaluation may be limited to descriptive analysis.

¹ This eligibility group will be eliminated once the Public Health Emergency ends and then this group will be eligible for the After-pregnancy coverage benefit which provides 12-months of full-scope Apple Health (Medicaid) benefits to people who have had a pregnancy within 12-months.

² These totals do not consider the loss of the Family Pregnancy Related group due to the implementation of the After-pregnancy Coverage program.

The Demonstration's expenditure authority falls under the State's Title XIX Medicaid State Plan and section 1115(a)(2) of the Social Security Act. Requirements not applicable to the expenditure authorities are:

1. **Methods of Administration: Transportation:** Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53. To the extent necessary to enable the State to not assure transportation to and from providers for the demonstration population.
2. **Amount, Duration, and Scope of Services (Comparability):** Section 1902(a)(10)(B). To the extent necessary to allow the State to offer the demonstration population a benefit package consisting only of family planning services and family planning-related services.
3. **Prospective Payment for Federally Qualified Health Centers and Rural Health Centers and Rural Health Clinics:** Section 1902(a)(15). To the extent necessary for the State to establish reimbursement levels to these clinics that will compensate them solely for family planning and family planning-related services.
4. **Eligibility Procedures:** Section 1902(a)(17). To the extent necessary to allow the State to not include parental income when determining a minor's (individual under age 18) eligibility for the family planning demonstration. To the extent necessary to allow the State to not require reporting of changes in income or household size for 12 months, for a person found income-eligible upon application or annual redetermination when determining eligibility for the family planning demonstration.
5. **Retroactive Coverage:** Section 1902(a)(34). To the extent necessary to enable the State to not provide medical assistance to the demonstration population for any time prior to the first of the month in which an application for the demonstration is made.
6. **Early and Periodic Screening, Diagnostic, and Treatment (EPSDT):** Section 1902(a)(43)(A). To the extent necessary to enable the State to not furnish or arrange for EPSDT services to the demonstration population.

A link to the full public notice for the Family Planning Only Waiver extension application can be found at: www.hca.wa.gov/family-planning. The Agency updates this webpage regularly. In addition, you may view all Agency public notices at <https://www.hca.wa.gov/about-hca/news/public-notices>.

Comment: The new/additional public comment period for the Family Planning Only Demonstration Waiver extension application is from **12/19/2022** through **01/19/2023 at 5:00 pm PST**. Comments may be emailed to familyplanning@hca.wa.gov, faxed to 360-725-1152, or mailed to the address below. A copy of the draft application is available at: www.hca.wa.gov/family-planning.

For additional information, contact:

Name: Beth Tinker

Program: Family Planning Only Program

Address: 626 8th Ave SE, Olympia, WA 98504

Phone: 360-972-5506

TRS/TDD/TTY: 711

Fax: 360-725-1152

E-mail address: FamilyPlanning@hca.wa.gov

Web site address: <https://www.hca.wa.gov/health-care-services-and-supports/apple-health-medicaid-coverage/family-planning-only>



STATE OF WASHINGTON
HEALTH CARE AUTHORITY

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

December 13, 2022

Dear Tribal Leader:

SUBJECT: Family Planning Only 1115 Demonstration Waiver Renewal Application

In accordance with section 1902(a)(73)(A) of the Social Security Act regarding the solicitation of advice prior to the submission of any Medicaid State Plan Amendment (SPA) or waiver likely to have a direct effect on Indians, Indian Health Programs, or Urban Indian Organizations, the Health Care Authority (HCA) hereby seeks your advice on the following matter.

Purpose: This notice is an update on this subject that was sent in June 2022. This update is necessary as upon initial review of our waiver renewal application submitted to CMS on September 30, 2022, it was noted that there were some components that needed to be included before formal review. Those components were: ensuring all data tables were updated and posted to application version on the HCA website, clear inclusion of dates and details of public forums, and inclusion of an interim evaluation report on the current waiver cycle. This updated application also needed to be posted publicly on the HCA website and an additional 30-day comment period must follow. Below is specific information on these items:

- Data tables – all were updated and complete in the waiver application sent to CMS on September 30, 2022, and in the version posted to the HCA website on October 6, 2022. Also included in the most current draft renewal application posted to www.hca.wa.gov/family-planning.
- Public forums – included in this current version (see page 17).
- Interim evaluation summary report – completed and included in this current version, starting on page 9. The complete interim evaluation report is also posted on the same HCA website.

If you would like to review the updated waiver renewal application and other waiver support documents, you will find the link to where they are posted on the HCA website at the end of this notice.

The information under the “description” section is the same information that was shared in the June 2022 public notice and added here again for clarity and context for the Family Planning Only 1115 waiver.

Description: The Health Care Authority intends to submit an application to extend the Section 1115 Family Planning Only Demonstration Waiver for five years. An approved application would extend the Family Planning Only programs from July 1, 2023, to June 30, 2028. The current waiver and demonstration period expires on June 30, 2023. It covers limited family planning and family

planning-related services for all eligible individuals who are in need of contraceptive care and are enrolled in the Family Planning Only programs.

The purpose, client eligibility requirements, and benefit package will remain the same. The only potential change is the elimination of the Family Planning Only Pregnancy-Related program, due to the implementation of the After-Pregnancy Coverage program (12 months of comprehensive coverage following the end of a pregnancy). The elimination of the Family Planning Only Pregnancy-Related program is expected to take effect following the end of the federal Public Health Emergency (PHE). There is currently no established end date for the PHE.

The purpose of the Family Planning Only program is to:

- Assure access to family planning services.
- Decrease unintended pregnancies and births.
- Lengthen intervals between births.
- Reduce state and federal Medicaid expenditures for averted pregnancies and births from unintended pregnancies.

The following groups are eligible for services under the Family Planning Only program:

- Recently pregnant individuals who lose Medicaid coverage after their pregnancy coverage ends.
- Uninsured people with family incomes at or below 260% of the federal poverty level (FPL), seeking to prevent an unintended pregnancy.
- Teens and domestic violence victims who need confidential family planning services and are covered under their perpetrator's or parent's health insurance and are at or below 260% of the federal poverty level (FPL).

Family Planning Only coverage under the waiver is for a 12-month duration starting on the first day of the month the application was approved. Applications are available on the HCA website and any Apple Health provider who offers family planning services can assist with accessing and completing the application.

The Family Planning Only program offers the following services on a fee-for-service basis: all FDA-approved contraceptives, natural family planning, over-the-counter contraceptives, emergency contraception, sterilization, contraceptive education, counseling and management, limited STD testing and treatment related to the safe and effective use of the chosen contraceptive method, cervical cancer screening according to the national clinical guidelines when associated with a family planning visit, and office visits and limited ancillary services related to the above services. There are no cost-sharing requirements to receive services under this program.

There may be decreases in annual aggregate expenditures or enrollment due to the end of the PHE and implementation of the After-Pregnancy Coverage program. Based on Demonstration Year (DY) 2020, we expect approximately 8,000 enrollees and 1,500 participants with an expenditure of \$300,000 (DY 2021) for each year of the five-year renewal period.

Anticipated Impact on Indians/Indian Health Programs/Urban Indian Organizations

The HCA is not making changes to the waiver and expects its renewal to continue to have positive impacts on the American Indian/Alaska Native Medicaid applicants or enrollees, Indian Health Programs, and/or Urban Indian Health Organizations. Those positive impacts include greater access

Dear Tribal Leader
December 13, 2022
Page 3

to contraceptive care and other covered sexual and reproductive health services. The HCA would appreciate any input or concerns that Tribal representatives wish to share, including whether this application renewal will have disproportionate impact on American Indian/Alaska Native Medicaid applicants or enrollees, Indian Health programs, or Urban Indian Health Organizations.

Copy Available on Request

An updated copy of the draft application is available at: www.hca.wa.gov/family-planning (scroll down to the sub-heading “Waiver authority for the program”).

Comments and Questions

The HCA would appreciate any input or concerns that Tribal representatives wish to share regarding the 1115 waiver renewal. Because this waiver renewal request must be submitted before the normal 60-day notification period is complete, the agency is using the approved expedited notification process. To request a copy of the draft application or return any comments, please contact HCA Family Planning at HCAfamilyplanning@hca.wa.gov by January 19, 2023.

Please contact Aren Sparck Tribal Affairs Administrator via email at aren.sparck@hca.wa.gov if you have tribal affairs-related questions.

Please forward this information to any interested party.

Sincerely,



Charissa Fotinos, MD, MSc
Medicaid and Behavioral Health Medical Director

By email and mail

cc: Beth Tinker, Maternal Child and Reproductive Health Nurse Consultant, CQCT, HCA
Aren Sparck, Tribal Affairs Administrator, HCA

Tribal Leader Letter emailed on 12/13/22, 4:10 pm. Below is a list of the blind copied recipients.

Family Planning Only 1115 Demonstration Waiver Renewal Application



Campbell, Kodi B (HCA)

To: Campbell, Kodi B (HCA)
Cc: Tinker, Elizabeth C (HCA); Sparck, Aren (HCA)

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