

# Application: Section 1115 Family Planning Only Demonstration Waiver

Washington State  
Health Care Authority

**October 12, 2017**

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# 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, 2012-December 31, 2017**. The STCs are in Attachment A and can be accessed on the CMS Medicaid.gov website here: <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/wa/wa-take-charge-ca.pdf>.

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: TAKE CHARGE Health Insurance Survey
  - C: Evaluation Design, 2018-2022
  - D: Quality Measuring, Monitoring and Improving Process
  - E: Public Notices, Comments, & Responses
  - F: 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: \_\_\_\_\_  
[Governor]

Date: \_\_\_\_\_

## Appendix A: Historical Narrative

### History

Washington State's 1115 waiver family planning demonstration was approved by the Centers for Medicare and Medicaid Services (CMS) in 2001 and includes two programs implemented by the Washington State Health Care Authority (HCA). The Family Planning Only (FPO) extension, which existed prior to the waiver, provides family planning only services for 10 months to those women who have recently been pregnant and do not qualify for full coverage Medicaid after their pregnancy medical coverage ends 60 days after the pregnancy ended. The TAKE CHARGE program began in July 2001 and expanded Medicaid coverage for family planning services to men and women with family incomes at or below 200% of the federal poverty level (FPL). Beginning on October 1, 2012, clients with incomes up to 250% of FPL were eligible to apply for TAKE CHARGE. With the implementation of the Affordable Care Act (ACA) and the use of MAGI for determination of income the limit was increased to 260% of FPL effective October 1, 2013. Both 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. For the first ten years of the waiver it 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 now administers the 1115 family planning demonstration waiver.

With the Affordable Care Act (ACA) Washington expanded Medicaid and offered subsidized qualified health plans on the Washington Health Benefit Exchange. This dramatically reduced the number of uninsured people in Washington to less than 6%. Increases in the number of people enrolling in Medicaid and qualified health plans continues to affect enrollment into the family planning only programs. Enrollment has declined from around 100,000 in fiscal year 2013 (DY12) to around 8,700 enrollees in fiscal year 2017 (DY16). This level of enrollment appears to have stabilized and is most likely due to having reached the saturation rate of those who are both eligible for and able to afford a qualified health plan or eligible for expanded Medicaid. Those who have become covered by Medicaid or a QHP are now receiving free contraceptive care in addition to full health coverage, so the goals of the waiver continue to be met.

Participation in the family planning only programs amongst women who have recently been pregnant has dramatically decreased. We believe this is a result of increased availability and education about long acting reversible contraception and women receiving their chosen form of birth control prior to pregnancy medical ending 60 days postpartum. Some women are automatically enrolled in the FPO extension even when they do not need the services of the program since they have obtained coverage through a QHP or other insurance source. The majority of clients enrolled in TAKE CHARGE are teens who are seeking confidential services. They make up almost two thirds of the participants. Each quarter around 1,000 people participate in the two programs. The more detailed explanation and tables below show how enrollment and participation has changed over the years the waiver has been in place.

## **Request**

The current waiver expires December 31, 2017. The current extension was received on December 21, 2016. The 1115 waiver fiscal year is July 1-June 30 to coincide with Washington State's fiscal year. Washington intends to maintain the following goals and coverage for the same populations currently served. No changes are being made except that the waiver will now be called the Family Planning Only Program to reduce confusion inherent in having two program names. We are requesting an extension through December 2022. We are requesting the same waiver and expenditure authorities as are effective in the current waiver.

## **Demonstration Population**

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

- Recently pregnant women who lose Medicaid coverage after their maternity coverage ends. (60 days postpartum)
- Uninsured women and men with family incomes at or below 260% 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 have individual incomes at or below 260% FPL.

## **Program Goals**

- Ensure access to family planning services.
- Decrease unintended pregnancies.
- Lengthen intervals between pregnancies and births.
- Reduce state and federal Medicaid expenditures for averted births from unintended pregnancies.
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## **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 contraceptive methods safely, effectively, and successfully to avoid unintended pregnancy. The types of birth control include:
- Oral Contraceptives.
  - Contraceptive Ring and Patch.
  - Male and Female Condoms.
  - Spermicides.
  - Contraceptive Injections.
  - Contraceptive Implants.
  - Intrauterine Devices.

- Emergency Contraception.
  - Male and Female Sterilizations.
  - Diaphragms and Cervical Caps.
  - Natural Family Planning.
  - Abstinence Counseling.
- Family planning-related services for women include an annual comprehensive family planning preventive medicine visit, screening for GC/CT for women ages 13 through 25, cervical cancer screening, and services directly related to successfully using a chosen method of contraception.
  - Family planning-related services for men include an annual counseling session for reducing the risk of unintended pregnancy, how to use condoms and spermicides, 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 2012 through June 2016. Budget neutrality is presented for this same time period in Attachment F. Due to fluctuations in historical enrollment and expenditures related to Affordable Care Act (ACA) implementation and administrative expenditures the trend rate for the demonstration has also fluctuated.

<b>Table 1: Annual Service and Administrative Expenditures July 1, 2012 – June 30, 2017</b>						
	<b>Service Expenditures CMS-64</b>		<b>Administrative Expenditures CMS-64</b>		<b>Total Expenditures CMS-64</b>	<b>Expenditures CMS-37</b>
	<b>Total Computable</b>	<b>Federal Share</b>	<b>Total Computable</b>	<b>Federal Share</b>		
<b>DY12</b>	\$17,459,759.00	\$15,810,175.00	\$671,480.00	\$591,716.00	\$18,131,240.00	\$15,243,618
<b>DY13</b>	\$14,292,091.00	\$12,933,646.00	\$334,514.00	\$300,824.00	\$14,626,605.00	\$16,931,739
<b>DY14</b>	\$1,776,745.69	\$1,587,085.19	\$419,234.24	\$377,200.10	\$2,195,979.93	\$2,705,681
<b>DY15</b>	\$1,439,732.01	\$1,256,326.94	\$136,305.48	\$122,582.55	\$1,576,037.49	\$1,808,000
<b>DY16</b>	\$1,331,302.00	\$1,142,321.00	\$27,622.00	\$24,770.00	\$1,358,924.00	\$2,999,157



<b>Table 2: Per Member Per Month (PMPM) Expenditures July 1, 2012 – June 30, 2017</b>					
	<b>DY12</b>	<b>DY13</b>	<b>DY14</b>	<b>DY15</b>	<b>DY16*</b>
<b># Member Months</b>	642,607	555,114	133,996	90,010	86,208
<b>PMPM</b>	\$28.22	\$26.35	\$16.39	\$17.51	\$15.76
<b>Total Expenditures</b>	\$18,131,240.00	\$14,626,605.00	\$2,195,979.93	\$1,576,037.49	\$1,358,924.00
Total Expenditures = Member Months multiplied by PMPM *DY16 number of member months are estimated based on adding each quarter's numbers in the state's quarterly reports.					

## Budget Projections for 2018-2022

The State expects that enrollment will remain stable over the next five years as long as the ACA remains in place and Washington residents have access to affordable health insurance and expanded Medicaid remains in place. It is not possible to predict the impacts if the ACA is dismantled as the details of that are not known. Below is the projection of enrollment and costs from January 2018 through December 2022. Baseline values were determined by averaging enrollment and costs for the past two demonstration years (DY 15 and DY 16) due to wide fluctuations in expenditures and enrollment over the course of the previous demonstration period.

<b>Table 3: DEMONSTRATION BUDGET PROJECTION: 2018-2022</b>								
	Demo Trend Rate	Baseline: Average of DY 15 & DY 16	Future Demonstration Years (DY) & Fiscal Years					TOTAL
			DY 17/FY 16	DY 18/FY 19	DY 19/FY 20	DY 20/FY21	DY 21/FY 22	
<b># Member Months</b>		88,109	88,109	88,109	88,109	88,109	88,109	
<b>PMPM Cost</b>	<b>6.4%</b>	\$ 16.64	\$ 17.70	\$ 18.83	\$ 20.03	\$ 21.31	\$ 22.68	
<b>Total Expenditure</b>		\$ 1,465,821	\$ 1,559,475	\$ 1,659,113	\$ 1,765,118	\$1,877,895	\$ 1,997,878	\$8,859,479
Demonstration trend rate is based on the average trend rate for DY 15 and DY 16, using the FFP service expenditures.								
Total expenditures were not used to calculate the trend rate because there was a one time FTE reduction that decreased the administrative expenditures significantly and caused a negative trend rate from DY year 15 to 16. Service expenditures are the primary expenditures of the program and represent where there will be costs in the future.								

## **Appendix C: Interim Evaluation and Plans for Future Evaluation**

### **Current Program Evaluation and Monitoring**

Through participation in various statewide meetings and as providers and clients share related concerns and updates, areas for improvement are identified. In fiscal year 2016 a thorough review of program clinical policies was completed. Provider billing guides and program rules were updated during fiscal year 2017 to incorporate feedback from providers and to reflect current national clinical standards and guidelines. The provider directory and website information was improved and updated as part of an agency wide website redesign in 2016.

Findings from the TAKE CHARGE Health Insurance Survey report, an interim evaluation report completed in May 2015, were presented to Washington State Department of Health staff in a Learning Session in August 2015. The results were used with additional input from stakeholders to inform recommendations to transition the family planning only programs to a state plan service through a State Plan Amendment (SPA). The decision was made not to pursue a family planning only SPA since the same program eligibility and policies could not be maintained. Washington State decided to pursue an extension of the current 1115 waiver in order to maintain flexibility in eligibility categories. A copy of the TAKE CHARGE Health Insurance Survey report is attached and a summary is below.

### **Interim Evaluation of Goals and Progress, 2012-2016**

#### **Goal: Increase access to family planning services**

Over this last demonstration period enrollment declined. This is due to availability of full health coverage through expanded Medicaid and qualified health plans. Although some small family planning clinics have closed, FQHCs and other health systems have expanded and filled in the gaps. Access to family planning services is still widely available across the state. The clinics that have closed were operated by public health departments that no longer offer clinical services.

#### **Goal: Reduce the number of unintended pregnancies in Washington**

Washington relies on the Pregnancy Risk Assessment Monitoring System (PRAMS) survey for unintended pregnancy rates. PRAMS survey results are not individually linked to Medicaid clients so the survey results cannot be reported specifically for the target population of our family planning waiver. The questions in the PRAMS survey were changed for the survey year of 2012. As a result unintended pregnancy rates computed from 2012 on are not directly comparable to those prior to 2012. Unintended pregnancy in Washington State decreased from 41% in 2012 to 35 % in 2014. Births among Medicaid clients as a result of unintended pregnancies have decreased from 36% in 2012 to 29 % in 2014.

## **Enrollment and Participation Trends over Life of Demonstration**

Washington's family planning only waiver has experienced many changes over the past fifteen years. Although the numbers of women losing Medicaid pregnancy coverage after the end of the postpartum period fluctuated modestly until January 2014, the caseload for uninsured and confidential women and men with incomes at or below 260% of the FPL has shown greater change.

Pregnant clients remained steady around 40,000 total enrollees until DY14 when there was a dramatic drop due to full ACA implementation. Many of these clients became eligible for expanded Medicaid after the birth of their baby. Monthly enrollment peaked at 19,230 in November 2013 and decreased by 77% to 4,307 in June 2016. Participation in the family planning only extension has dwindled due to more comprehensive coverage choices and receiving contraception prior to pregnancy medical ending. Two reimbursement changes in September 2015 may have contributed to this. Professional reimbursement for insertion of a LARC was increased and payment for inpatient postpartum insertion of LARC was allowed. Only 8% of women who were enrolled in the family planning only extension in DY15 used LARC.

The TAKE CHARGE clients peaked in May 2005 (DY5) at 90,294 clients. The number of enrollees declined and stabilized at a lower level in January 2009 (DY8). This caseload rose slightly after that and then started another downward trend. There was a peak just prior to full ACA implementation in October 2013 (DY13) at 42,021 clients. Since then monthly enrollment decreased by 93% to 2,858 in June 2016. In contrast to the recently pregnant population, the enrollees in TAKE CHARGE are more likely to need and use the services. In DY15 61% of the TAKE CHARGE enrollees used the service.

A number of TAKE CHARGE program and eligibility changes potentially contributed to this population's declining caseload:

- January 2006: New billing instructions – specified a more limited scope of services, especially for men.
- November 2006: New billing instructions – clients with health insurance became ineligible except for good cause; Social Security Number (SSN) required, documentation of citizenship (affidavit permitted for those without other documentation), and proof of identify required; sexually transmitted disease and infection (STD/STI) services limited to urogenital Neisseria gonorrhoea (GC) and Chlamydia trachomatis (CT) for women ages 13 – 25; and services for men were limited. New billing instructions were based in part on Special Terms and Conditions (STCs) effective July 2006.
- August 2008: Citizenship documentation became required. Use of a previously permitted affidavit was discontinued.
- April 2010: New Medicaid billing system (ProviderOne) implemented. This resulted in some discontinuities in data during the transition period.

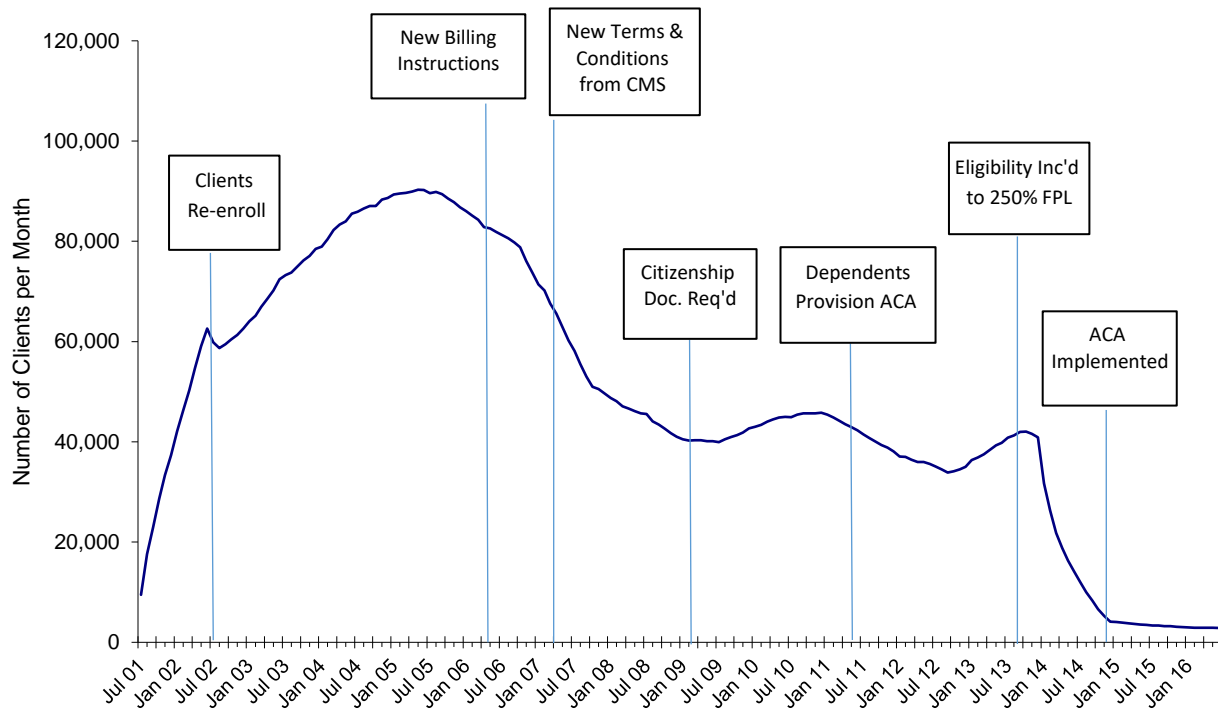
- September 2010: Dependent provision of ACA took effect. Parents allowed to cover dependents up to age 26 on their health insurance.
- October 2012: STCs of the renewal granted in July 2012 were implemented. Eligibility was changed allowing men and women up to 250% FPL (up from 200% FPL). The new STCs also allowed men and women with creditable health insurance to apply for TAKE CHARGE.
- October 2013: Medicaid expansion includes eligibility for adults up to 138% of the FPL. TAKE CHARGE eligibility increased to 260% of the FPL.
- January 2014: Health insurance available through the health benefit exchange takes effect. Clients with health insurance no longer eligible for TAKE CHARGE. Clients must first apply for Medicaid and be denied before they can enroll in TAKE CHARGE except with good cause for those under 19 and domestic violence victims.

The following graph and tables show the enrollment figures over the life of the demonstration, from DY1 (July 2001 – June 2002) through DY15 (July 2015 – June 2016).

**Figure 1. Enrollment of Clients  $\leq$  260% of FPL**

**As of September 9, 2016**

**Population 2 + Population 3 (TAKE CHARGE)**



<b>Table 4. Total Number of Enrollees</b>				
<b>July 1, 2001 – June 30, 2016</b>				
<b>Year</b>	<b>Recently Pregnant</b>	<b>TAKE CHARGE - Women</b>	<b>TAKE CHARGE- Men</b>	<b>Total Population (Unduplicated)</b>
DY1	32,897	55,525	3,454	90,159
DY2	36,682	94,501	7,441	136,178
DY3	39,038	114,222	8,880	159,231
DY4	40,031	127,818	9,725	174,859
DY5	39,805	125,261	8,218	170,759
DY6	39,881	110,586	4,454	152,649
DY7	39,054	84,117	1,333	122,696
DY8	38,628	68,908	763	106,785
DY9	38,908	70,794	924	109,054
DY10	40,663	70,577	1,042	110,731
DY11	41,689	64,374	1,013	105,688
DY12	41,692	59,398	772	100,441
DY13	35,220	53,671	695	89,204
DY14	14,715	14,590	137	29,305
DY15	10,820	5,743	57	16,600

<b>Table 5. Total Number of Participants</b>				
<b>July 1, 2001 – June 30, 2016</b>				
<b>Year</b>	<b>Recently Pregnant</b>	<b>TAKE CHARGE - Women</b>	<b>TAKE CHARGE- Men</b>	<b>Total Population (Unduplicated)</b>
DY1	10,659	52,830	3,030	65,716
DY2	14,433	75,333	4,029	92,577
DY3	15,702	92,963	5,005	112,198
DY4	17,431	124,074	8,809	148,633
DY5	14,483	94,349	3,643	111,410
DY6	15,132	99,584	3,270	116,845
DY7	13,378	57,925	382	70,948
DY8	11,719	49,128	339	60,625
DY9	11,398	55,702	440	66,903
DY10	9,837	52,534	412	62,259
DY11	8,681	40,582	325	49,245
DY12	8,283	40,946	284	49,082
DY13	5,863	32,366	214	38,340
DY14	1,214	5,796	28	7,010
DY15	861	3,512	16	4,383

## Annual Disenrollment and Retention Figures

Disenrollment is defined as having a gap in enrollment of more than four months. Retention is defined as those continuously enrolled or experiencing a gap in eligibility of no more than four months. As a result of Medicaid expansion and health care reform, the pattern of disenrollment and retention dramatically changed in DY13. Patterns appear to have returned to pre ACA patterns.

Over this demonstration period annual retention of enrolled clients decreased from 52% in DY12 to 29% in DY14 and rose to 40% in DY15. The proportion of dis-enrolled clients who did not renew their eligibility without a specific reason has fluctuated from close to three-fourths in DY12 down to one half in DY13 and back up to close to the pre-ACA level at 70.1% in DY15. These dis-enrollments could be due to obtaining commercial coverage or increases in use of LARCs. There were similar fluctuations in the rate of those who dis-enrolled and then became eligible for full Medicaid benefits either through expanded Medicaid or pregnancy or another state funded program (20.4% in DY12 to 48.5% in DY13 to 27.7% in DY15). These fluctuations show the impact that health reform has had on the family planning waiver program and that more of those dis-enrolling are obtaining complete health coverage through Medicaid expansion.

Table 6. Annual Disenrollment and Retention Figures								
Demonstration Period: July 1, 2012 – June 30, 2016 (DY12-DY15)								
Reason for Disenrollment/# and % Enrollees	July 1, 2012 – June 30, 2013		July 1, 2013 – June 30, 2014		July 1, 2014 – June 30, 2015		July 1, 2015 – June 30, 2016	
	n	%	n	%	n	%	n	%
<b>Sterilization</b>	221	0.4%	139	0.2%	44	0.2%	18	0.2%
<b>Eligible for Full Benefits Due to Pregnancy</b>	5,378	10.5%	3,315	4.8%	874	4.0%	683	6.9%
<b>Eligible for Full Benefits</b>	4,693	9.2%	29,227	42.6%	5,203	24.0%	1,807	18.2%
<b>Re-enrolled</b>	2,788	5.4%	602	0.9%	251	1.2%	202	2.0%
<b>Did not Renew</b>	37,840	73.8%	34,646	50.4%	14,849	68.4%	6,952	70.1%
<b>Eligible for Other State- Funded Program</b>	354	0.7%	747	1.1%	472	1.2%	256	2.6%
<b>Total Disenrollment Number</b>	51,274		68,676		21,693		9,918	

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

## Service Utilization

The most frequently provided family planning method for female clients is birth control pills, with 41.1% of the recently pregnant population and 54.3% of TAKE CHARGE having received birth control pills during DY15. In DY15 both groups frequently received emergency contraception pills as well: 14.4% and 54.6% respectively. Use of contraceptive implants decreased in DY15, notably among the recently pregnant population at 3.4% compared to 5.1% in DY14 and 4.1% in DY13. This is still a higher usage than in DY12 at 2.4%. IUD insertion rates have remained relatively stable for this population at 14-16% since DY12. The TAKE CHARGE population had a decline in IUD insertions from DY 12 to DY 14, but has increased to 8.5% in DY 15 the same rate as seen in DY12.

During DY15 use of hormone injections was greater in the TAKE CHARGE population at 18.1% than those recently pregnant at 9.2%. The use of hormone injections has varied from year to year, but not by much. Female sterilization has a low rate of use among the waiver populations, mostly because many women get sterilized immediately after a delivery while they are still covered under pregnancy medical. Those recently pregnant in the waiver have a higher use of female sterilization than TAKE CHARGE clients (2.8% and 0.1% respectively). The use of sterilization increased in DY15 from previous years amongst this population. The difference between the two populations may be explained by the different characteristics of these two groups of women. Recently pregnant women may be more desirous of a non-reversible family planning method than the TAKE CHARGE clients who are younger, often single women, the majority of whom have not had children.

In DY 15 all male participants used vasectomy as their form of contraception. This is the reason that men enroll in TAKE CHARGE. Since ACA men have had increased access to health care coverage through expanded Medicaid and affordable qualified health plans so the number of vasectomies has decreased by 93% since DY12.

Table 6: Use of Family Planning Methods							
July 1, 2015 - June 30, 2016 (DY15)							
Family Planning Method	Recently Pregnant		TAKE CHARGE - Women		TAKE CHARGE- Men		Total Clients (unduplicated)
	n	%	n	%	n	%	
Birth Control Pills	354	41.1%	1,906	54.3%	0	0.0%	2,257
Emergency Contraception	124	14.4%	1,884	53.6%	0	0.0%	1,862
Male Condom	41	4.8%	612	17.4%	2	12.5%	655
Hormone Injection	79	9.2%	635	18.1%	0	0.0%	713
Vaginal Ring	37	4.3%	181	5.2%	0	0.0%	218
IUD Insertion	138	16.0%	299	8.5%	0	0.0%	320
Transdermal Patch	29	3.4%	107	3.0%	0	0.0%	136
Spermicide/Topical CC	4	0.5%	89	2.5%	0	0.0%	93
Contraceptive Implant	29	3.4%	129	3.7%	0	0.0%	158
Female Sterilization	24	2.8%	3	0.1%	0	0.0%	25
Female Condom	0	0.0%	1	0.0%	0	0.0%	1
Male Sterilization	0	0.0%	0	0.0%	13	81.3%	13
Diaphragm/Cap	0	0.0%	1	0.0%	0	0.0%	1
Natural Family Planning	2	0.2%	6	0.2%	0	0.0%	8
<b>Total Participants</b>	<b>861</b>		<b>3,512</b>		<b>16</b>		<b>4,389</b>

**TAKE CHARGE Health Insurance Survey** (<https://www.dshs.wa.gov/sesa/rda/research-reports/take-charge-health-insurance-survey>)

Despite opportunities to buy health insurance through the Washington State Health Benefit Exchange (HBE), some Washington women continued to be enrolled in the TAKE CHARGE program and receive Medicaid-funded family planning services. This interim evaluation studied



and described the reasons that women remained on TAKE CHARGE instead of obtaining insurance through another source, such as the HBE.

The main data source was a brief survey mailed to women enrolled in TAKE CHARGE between February and July 2014. Responses were received from 338 women, resulting in a response rate of 18%.

Key Findings included:

- The majority (66%) of women who remained on the TAKE CHARGE program were working but did not have employer-sponsored health insurance, for a variety of reasons.
- Washington's HBE, known as HealthPlanFinder, was the most frequent source of information about health insurance; however, two-thirds of women who tried to get information from the website found it "somewhat difficult" or "very difficult" (58%), or "impossible" (9%) to get the help they needed there.
- The most frequent reason respondents did not buy or enroll in an insurance plan through the HBE was cost: 45% responded that the main reason was that the costs are too high.
- Nearly half (49%) of the respondents indicated they were unable to pay for health insurance because of bills they had to pay. One-third (35%) were unable to pay for basic necessities like food, heat, or rent, and one-third (35%) had credit card debt. Nearly half had used up all their savings (48%) or had problems paying for medical bills (44%).
- More than half the respondents indicated that it would be very difficult (46%) or impossible (14%) for them to pay the personal costs for health insurance in the future.

The evaluation concluded that a small number of women in Washington continue to have clear needs for family planning coverage that are not being met, except through the TAKE CHARGE family planning program. Limited assets and high debts are common problems in the United States that influence affordability of health insurance. Many women least able to afford health insurance are the same women with the greatest need to prevent unintended pregnancy. As a result of this evaluation Washington determined that it would benefit the citizens of Washington to transition the family planning only program into our SPA.

## **Future Evaluation, 2018-2022**

(See Attachment C for full description)

### **Questions and Hypotheses**

Washington will evaluate two objectives of the 1115 family planning only demonstration a) ensure access to family planning and/or family planning-related services and b) improve or maintain health outcomes for the target population as a result of access to family planning and/or family planning-related services by testing the following hypotheses:

1. Enrollees will utilize family planning services and/or family planning related services.
2. Beneficiaries will maintain coverage for one or more 12 month enrollment period.
3. Health outcomes will improve as a result of the demonstration.
4. Beneficiaries will have a higher rate of using more effective contraceptive methods compared to other members of Medicaid beneficiaries.

Health Care Authority has contracted with the DSHS Research and Data Analysis Division to conduct the 1115 Family Planning Only demonstration waiver evaluation. Research and Data Analysis (RDA) is a division within Planning, Performance, and Accountability (PPA) of the DSHS. RDA provides valid, rigorous, and policy-relevant analyses of government-funded social and health services in the State of Washington.

Since RDA staff have performed past evaluations of the 1115 Family Planning Only waiver, along with other maternity and family-planning-related studies, they are very knowledgeable about Medicaid programs in general and the specific family planning only program of 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.

### **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.

### **Data Collection and Sources**

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

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.

### **Data Analysis Strategy**

The table in Attachment C describes the measures, sources and analytic approach for each question and hypothesis. Only quantitative data analyses will be applied.

We will apply descriptive methods of frequency and proportions to demonstrate service utilization of the demonstration beneficiaries for all the service utilization measures. For health outcomes, the data analyses will be descriptive utilizing 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.

The last hypothesis 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.

## 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. Several reports describe these activities:

- 2015 External Quality Review Annual Report ([https://www.hca.wa.gov/assets/billers-and-providers/2015technicalreport\\_final.pdf](https://www.hca.wa.gov/assets/billers-and-providers/2015technicalreport_final.pdf))
- Washington State Medicaid Managed Care Quality Strategy (<https://www.hca.wa.gov/assets/free-or-low-cost/draft-medicaid-mc-quality-strategy.pdf>)
- 2016 Comparative Analysis Report (<https://www.hca.wa.gov/assets/program/eqr-comparative-analysis-report-2016.pdf>)
- 2016 Regional Analysis Report (<https://www.hca.wa.gov/assets/program/eqr-regional-analysis-report-2016.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.

Washington recognizes the model for quality monitoring applied to the MCOs should be applied to the FFS programs and services. HCA implemented the Quality Measuring, Monitoring and Improving (QMMI) process early in 2017 and a proposal is included in the MITA chapter Performance and Plan Management Self-Assessment. The proposed initiative is to use the existing QMMI process (see attached) to develop comprehensive FFS quality performance measuring and monitoring. HCA has a common measure set that is used to assess performance of the MCOs and that will be used to assess performance in FFS. Over the next year contraceptive measures will be recommended to be added to this common measure set.

As part of CMS's required Payment Error Rate Measurement (PERM) program Washington State Medicaid's FFS claims and managed care encounters are submitted on a quarterly basis for the Review Cycle Year. The federal statistical contractor pulls samples from each quarterly data set. The federal PERM medical review contractor requests records for the sampled claims and reviews for compliance with federal, state, and agency rules and regulations. The federal 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. There may be samples of 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. The most recent corrective action plan from February 2017 identifies what HCA will do to meet the FFS target error rate of 3.6%. The state will increase provider education, provide advance notification to providers regarding the PERM review and any

error findings, and improve monitoring of policy, provider guides and system edits to ensure compliance. By updating the Apple Health PERM website and adding educational tools provider knowledge of and response to the PERM review will increase.

## Quality and Access to Care:

Washington State participates in the CMCS Maternal and Infant Health Initiative on Contraceptive Care Measures and uses the Office of Population Affairs, National Quality Forum Contraceptive Care Measures to monitor access to contraception across all of our Medicaid programs including the 1115 Family Planning Only Demonstration waiver. The FFS population consistently has a higher usage of most and moderately effective methods of contraception (sterilization, pills, patches, rings, implants, IUDs, injection, diaphragm). In 2015 41.3% received a most or moderately effective method in FFS versus 30.1% in managed care. Appendix C summarizes outcomes for the 1115 demonstration over the most recent extension period from 2012-2016 and shows the contraceptive method choices for DY15.

In July 2015 a report titled Use of Long-Acting Reversible Contraception by Washington Women on Medicaid was published which summarized use of Long-Acting Reversible Contraception (LARC) among Washington women and teens on Medicaid, including yearly numbers of LARC insertions from 2010-2014, and described the medical specialty and licensure of practitioners who performed LARC insertions for Medicaid clients and the clinical settings in which LARCs were inserted. The data for this report included claims and clients from the waiver programs. (<https://www.dshs.wa.gov/sesa/rda/research-reports/use-long-acting-reversible-contraception-washington-women-medicaid>)

Key findings included:

- With the 2014 expansion of Medicaid eligibility through the ACA, the TAKE CHARGE family planning waiver of fifteen years' duration, and a state-funded program for postpartum family planning coverage for undocumented women, a variety of Medicaid programs provide coverage for contraceptive products and counseling.
- Some groups including undocumented women and women who decline to apply for Medicaid have limited access to Medicaid coverage for family planning services.
- More than 100,000 women and teens on Medicaid received LARCs in the five years, 2010-2014. In 2013 more than one-fifth (20.6%) of Medicaid women used a LARC and with full implementation of ACA in 2014 the number increased by 16%. These rates are higher than the rates achieved by other states implementing new strategies.
- In 2014 more than 2,000 medical providers performed LARC insertions for Medicaid clients in 2014. The types of providers ranged from women's health specialists - obstetrician gynecologists (33%) and nurse midwives (30%) to primary care providers - family practice physicians (22%) and physician assistant and nurse practitioners (11%).
- In 2014 women on Medicaid received LARCs in a wide range of clinical practice settings. 42% of women received LARCs in general and specialty medical practices. Another 28% of women received LARCs in family planning clinics.

Access to family planning services through the demonstration waiver is determined by eligibility. Applications for one of the waiver programs called TAKE CHARGE are first screened for completeness by the health care providers offering the services before being sent to HCA for processing and determination of eligibility by a dedicated special eligibility unit at HCA. There is no point-of-service eligibility option for this program. . Based on MAGI processes the 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 extension waiver program is an opt-out program. All Medicaid clients receiving pregnancy coverage are sent a letter before eligibility ends letting them know they will be automatically enrolled in FPO unless they apply for other Medicaid eligibility categories, which they are encouraged to do. This provides maximum access to family planning services for recently pregnant clients.

A wide provider network is the second aspect to maintaining access. HCA has a large number of providers that provide women's health services. The LARC report described above details the wide range of provider types and sites that offer family planning services to Medicaid clients and where clients in the FPO extension program can receive services. The TAKE CHARGE program is based on a limited network of providers who have agreed to specifically see TAKE CHARGE clients and agree to assist with applications, being the client's point of contact for confidentiality, and assist with referrals to other healthcare and social services as needed, particularly for those who are uninsured. Currently there are 146 clinic sites across the state where TAKE CHARGE enrollees can obtain services. These include school based clinics, FQHCs, public health departments, all the Title X clinics, hospital based clinics, and a few private practices. The HCA's Clinical Director for Women's Health maintains direct communication with these providers and attends the statewide Family Planning Provider Task Force meetings lead by the state's Department of Health (DOH) where quality and clinical practice topics are discussed. This is also an opportunity for the HCA to receive feedback which is used as part of the interim evaluation process described in Appendix C.

## 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 September 6, 2017. This notice was changed when we realized that the application required more details prior to posting. A revised public notice was posted on the HCA website on October 2, 2017 and the official version was published in the Washington State Register on October 18, 2017. In addition an email with the notice and a copy of the draft application was sent on October xx, 2017 to a list of stakeholders that includes the family planning clinics in Washington State and providers who are contracted with HCA to provide services under the waiver. Two public meetings were conducted to allow comment in person, on phone, or via webinar. These occurred on October 25 and November 3, 2017. Comments were also accepted via fax, email or in writing via post. The official comment period was from October 18-November 17, 2017. A preliminary draft of the renewal application was posted on the HCA website on September 6, 2017. A final draft of the application was posted on the HCA website on October xx, 2017. The Washington State Federally recognized Indian tribes were requested to consult on our application for extension via a letter sent on September 6, 2017. Copies of all these notices are attached as well as the comments received and Washington's responses.

# 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



## Center for Medicaid and CHIP Services

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Mr. Doug Porter  
Director  
Health Care Authority  
626 8<sup>th</sup> Avenue  
P.O. Box 45502  
Olympia, WA 98504

JUN 29 2012

Dear Mr. Porter:

We are pleased to inform you that Washington's request for an extension of its section 1115 family planning demonstration entitled, "TAKE CHARGE" as modified by the Special Terms and Conditions (STCs) accompanying this award letter, has been approved as project number 11-W-00134/0-01.

Under this demonstration, the State will provide family planning and family planning-related services to women losing Medicaid pregnancy coverage at the conclusion of a 60 day postpartum period and to women and men who have family incomes at or below 250 percent of the Federal poverty level (FPL), who are not otherwise eligible for Medicaid or the Children's Health Insurance Program (CHIP). Approval of the extension of this demonstration is under the authority of section 1115(a) of the Social Security Act (the Act) and is effective as of the date of this approval letter through December 31, 2013.

As indicated over the course of our discussions, CMS is not approving the State's request that CMS not apply sections 1902(a)(17) and 1902(a)(46)(B) of the Act to the expansion population, to the extent necessary to allow individuals to self-declare citizenship. Our rules at 42 CFR 435.406(a)(iii) state that citizenship documentation requirements apply to demonstrations under section 1115, including family planning demonstrations (see also 72 Fed. Reg. 38662, 38682, July 13, 2007). Additionally, CMS is not approving Washington State's requests to not apply the requirements of section 1137 of the Act in order to not require individuals to provide social security numbers at the time of application, and for the State to not conduct income verification for all applicants through available electronic data matches. In accordance with section 1137 of the Act and related regulatory guidance, the State currently has the flexibility to accept self attestation and follow-up with data matches after enrollment.

Our approval of this demonstration project is subject to the limitations specified in the enclosed approved expenditure authorities list and title XIX requirements made not applicable. The State may deviate from the Medicaid State plan requirements only to the extent those requirements have been specifically listed as granted expenditure authority or title XIX requirements not applicable. All requirements of the Medicaid program as expressed in law, regulation, and policy statement not



# Attachment A Continued

Mr. Porter – Page 2 of 3

expressly identified as not applicable in this letter, shall apply to the Washington TAKE CHARGE demonstration.

The approval is also conditioned upon continued compliance with the enclosed STCs defining the nature, character, and extent of Federal involvement in this project. This award letter is subject to our receipt of your written acceptance of the award, including the expenditure authority and STCs, within 30 days of the date of this letter.

Your contact for this demonstration is Ms. Kelly Heilman, who may be reached at (410) 786-1451 and through e-mail at [Kelly.Heilman@cms.hhs.gov](mailto:Kelly.Heilman@cms.hhs.gov). Ms. Heilman is available to answer any questions concerning the scope and implementation of the project. Communications regarding the program matters and official correspondence concerning the demonstration should be submitted to Ms. Heilman at the following address:

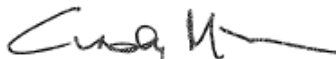
Centers for Medicare & Medicaid Services  
Center for Medicaid and CHIP Services  
7500 Security Boulevard, Mail Stop: S2-01-16  
Baltimore, MD 21244-1850

Official communication regarding program matters should be sent simultaneously to Ms. Heilman and to Ms. Carol Peverly, Associate Regional Administrator in our Seattle City Regional Office. Ms. Peverly's contact information is as follows:

Centers for Medicare & Medicaid Services  
Seattle Regional Office  
Division of Medicaid and Children's Health Operations  
Blanchard Plaza Building  
2201 Sixth Avenue  
MS/RX-43  
Seattle, WA 98121

We extend our congratulations to you on this award and look forward to working with you during the course of the demonstration extension.

Sincerely,



Cindy Man  
Director

Enclosures

# Attachment A Continued

Mr. Porter – Page 3 of 3

cc:

Carol Peverly, ARA, Seattle Regional Office  
Janice Adams, State Representative  
Kelly Heilman, CMCS

DRAFT

# Attachment A Continued

## Centers for Medicare & Medicaid Services SPECIAL TERMS AND CONDITIONS

**NUMBER:** 11 -W-00134/0-01  
**TITLE:** TAKE CHARGE Section 1115 Family Planning Demonstration  
**AWARDEE:** Washington Health Care Authority

### I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Washington family planning section 1115(a) Medicaid demonstration, entitled "TAKE CHARGE" (hereinafter "demonstration"). The parties to this agreement are the Washington Health Care Authority (the 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 approval letter through December 31, 2013, unless otherwise specified. All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below. This demonstration is approved through December 31, 2013.

The STCs have been arranged into the following subject areas:

- I. Preface
  - II. Program Description and Objectives
  - III. General Program Requirements
  - IV. Eligibility
  - 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 Operational Reports  
Appendix B: Template for Annual Reports

### II. PROGRAM DESCRIPTION AND OBJECTIVES

The Washington family planning section 1115(a) Medicaid demonstration expands the provision of family planning and family planning-related services to women who are losing Medicaid pregnancy coverage at the conclusion of 60 days postpartum period and individuals (men and women) who have family income at or below 250 percent of the Federal poverty level (FPL), and who are not otherwise enrolled in Medicaid or the Children Health Insurance Plan (CHIP).

# Attachment A Continued

Under this demonstration, Washington expects to promote the objectives of title XIX by:

- Increasing access to family planning services;
- Reducing the number of unintended pregnancies in Washington and;
- Reducing Medicaid costs by reducing the number of unintended pregnancies by women who otherwise would be eligible for Medicaid pregnancy-related services.

### 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 waiver and expenditure authority documents (of which these terms and conditions are part), 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 programs that occur during this demonstration approval period, unless the provision being changed is explicitly waived or identified as not applicable.
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 eligibility, enrollment, benefits, delivery systems, cost sharing, sources of non-Federal share of funding, budget neutrality, and other comparable program elements in these STCs 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 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

## Attachment A Continued

process set forth in STC 6 below. The State will notify CMS of proposed demonstration changes at the quarterly monitoring call, as well as in the written quarterly report, to determine if a formal amendment is necessary.

6. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS 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) An explanation of the public process used by the State consistent with the requirements of STC 12 to reach a decision regarding the requested amendment;
  - b) A data analysis which identifies the specific impact of the proposed amendment on the current budget neutrality expenditure limit.
  - c) A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and
  - d) If applicable, a description of how the evaluation design must be modified to incorporate the amendment provisions.
7. **Demonstration Phase-Out.** The State may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.
  - a) Notification of Suspension or Termination: The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The State must submit its notification letter and a draft phase-out plan to CMS no less than 5 months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the State must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the State must conduct tribal consultation in accordance with its approved tribal consultation State Plan Amendment. Once the 30-day public comment period has ended, the State must provide a summary of each public comment received, the State's response to the comment and how the State incorporated the received comment into a revised phase-out plan.

The State must obtain CMS approval of approve the phase-out plan prior to the implementation of the phase-out activities. There must be a 14-day period between CMS approval of the phase-out plan and implementation of phase-out activities.

- b) 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

## Attachment A Continued

will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

- c) **Phase-out Procedures:** The State must comply with all notice requirements found in 42 CFR §431.206, 431.210 and 431.213. In addition, the State must assure all appeal and hearing rights 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 discussed in October 1, 2010, State Health Official Letter #10-008.
  - d) **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.
8. **CMS Right to Terminate or Suspend.** CMS may 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 suspension or termination, together with the effective date.
9. **Finding of Non-Compliance.** The State does not relinquish its rights to challenge the CMS finding that the State materially failed to comply with the terms of this agreement.
10. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers 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 withdrawal, together with the effective date, and must 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, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authorities, including services and administrative costs of disenrolling participants.
11. **Adequacy of Infrastructure.** CMS and the State acknowledge while funding is subject to appropriation from the State Legislature, 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.
12. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The State must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September

# Attachment A Continued

27, 1994). The State must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009, the implementing regulations for the Review and Approval Process for Section 1115 demonstrations at 42 C.F.R. §431.408, and the tribal consultation requirements contained in the State's approved State plan, when any program changes to the demonstration, including (but not limited to) those referenced in STC 6, are proposed by the State.

In States with Federally recognized Indian tribes consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the State's approved Medicaid State plan if that process is specifically applicable to consulting with tribal governments on waivers (42 C.F.R. §431.408(b)(2)).

In States with Federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the State is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal, amendment and/or renewal of this demonstration (42 C.F.R. §431.408(b)(3)). 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.

13. **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

14. **Eligibility Requirements.** Family planning and family planning related services are provided to eligible individuals, provided the individual is redetermined eligible for the program on an annual basis. The State must enroll only individuals meeting the eligibility criteria below into the demonstration who are not otherwise enrolled in Medicaid or the Children's Health Insurance Plan (CHIP). Additionally, the State will provide 12 month continuous eligibility, and not require reporting of changes in income or household size for this 12-month period, for an individual found to be income-eligible for this demonstration upon initial application or annual redetermination.
  - 1) Women losing Medicaid pregnancy coverage (SOBRA pregnant women) at the conclusion of 60 days postpartum period and who have a family income at or below 250 percent of the Federal poverty level (FPL) at the time of annual redetermination; or
  - 2) Women who have family income at or below 250 percent of the FPL; or
  - 3) Men who have family income at or below 250 percent of the FPL.
15. **Eligibility Determinations.** Washington utilizes designated family planning providers to assist in collecting applications for the demonstration in order to facilitate streamlined access to eligibility determination with the ultimate goal of expanded access to family planning and family planning-related care. While providers assist in collecting applications, all eligibility

# Attachment A Continued

determinations are conducted by the State in conformance with required Medicaid provisions, including Single State Agency requirements. The State must utilize a Memorandum of Understanding (MOU) with each designated family planning provider to ensure that applications are forwarded to the State agency without delay for eligibility determinations.

Under the demonstration, the State will consider the date a signed application is received by a family planning provider as the date of application, and, if determined eligible, the eligibility effective date will be the first of the month in which a signed application was received by a family planning provider.

16. **Redeterminations.** The State must ensure that redeterminations of eligibility for the demonstration are conducted at least every 12 months. At the State's option, redeterminations may be administrative in nature.
17. **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 who receive a sterilization procedure and complete all necessary follow-up procedures will be disenrolled from the demonstration.

## V. BENEFITS AND DELIVERY SYSTEMS

18. **Family Planning Benefits.** Family planning services and supplies described in section 1905(a)(4)(C) and are limited to those services and supplies whose primary purpose is family planning and which are provided in a family planning setting. Family planning services and supplies are reimbursable at the 90 percent matching rate, including:
  - a) Approved methods of contraception;
  - b) Sexually transmitted infection (STI)/sexually transmitted disease (STD) testing, Pap smears and pelvic exams;
    - i) Note: The laboratory tests done during an initial family planning visit for contraception include a Pap smear, screening tests for STIs/STDs, blood count and pregnancy test. Additional screening tests may be performed depending on the method of contraception desired and the protocol established by the clinic, program or provider. Additional laboratory tests may be needed to address a family planning problem or need during an inter-periodic family planning visit for contraception.
  - c) Drugs, supplies, or devices related to women's health services described above that are prescribed by a health care provider who meets the State's provider enrollment requirements (subject to the national drug rebate program requirements); and
  - d) Contraceptive management, patient education, and counseling.
19. **Family Planning-Related Benefits.** Family planning-related services and supplies are



## Attachment A Continued

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) Colposcopy (and procedures done with/during a colposcopy) or repeat Pap smear performed as a follow-up to an abnormal Pap smear which is done as part of a routine/periodic family planning visit.
  - b) Drugs for the treatment of STIs/STDs, except for HIV/AIDS and hepatitis, when the STI/STD is identified/ diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/drugs and subsequent follow-up visits to rescreen for STIs/STDs based on the Centers for Disease Control and Prevention guidelines may be covered.
  - c) 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.
  - d) Other medical diagnosis, treatment, and preventive services that are routinely provided pursuant to family planning services in a family planning setting. An example of a preventive service could be a vaccination to prevent cervical cancer.
  - e) 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.
20. **Primary Care Referrals.** Primary care referrals to other social service and health care providers as medically indicated are 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 participants, and must assure CMS that written materials concerning access to primary care services are distributed to demonstration participants. The written materials must explain to the participants how they can access primary care services.
21. **Services.** Services provided through this demonstration are paid fee for service (FFS).

### VI. GENERAL REPORTING REQUIREMENTS

22. **General Financial Requirements.** The State must comply with all general financial requirements under title XIX set forth in section VII.

## Attachment A Continued

23. **Reporting Requirements Relating to Budget Neutrality.** The State must comply with all reporting requirements for monitoring budget neutrality as set forth in section VIII.
24. **Monitoring Calls.** CMS and the State will participate in quarterly conference calls following the receipt of the quarterly 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, health care delivery, enrollment, quality of care, access, benefits, anticipated or proposed changes in payment rates, audits, lawsuits, financial reporting and budget neutrality issues, progress on evaluations, State legislative developments, and any demonstration amendments the State is considering submitting. The State and CMS will discuss quarterly expenditure reports submitted by the State for purposes of monitoring budget neutrality. CMS will update the State on any amendments under review as well as Federal policies and issues that may affect any aspect of the demonstration. The State and CMS will jointly develop the agenda for the calls.
25. **Quarterly Operational Reports.** The State must submit progress reports no later than 60 days following the end of each quarter for every demonstration year (DY) within the format outlined in Appendix A. The intent of these reports is to present the State's data along with an analysis of the status of the various operational areas under the demonstration. These quarterly reports must include, but are not limited to:
- a) Quarterly expenditures for the demonstration population, with administrative costs reported separately;
  - b) Quarterly enrollment reports for demonstration enrollees (enrollees include all individuals enrolled in the demonstration) that include the member months for each DY, as required to evaluate compliance with the budget neutral agreement and as specified in STC 33;
  - c) Total number of participants served monthly during the quarter for each DY (participants include all individuals who obtain one or more covered family planning services through the demonstration);
  - d) Events occurring during the quarter, or anticipated to occur in the near future that affect health care delivery, benefits, enrollment, systems, grievances, quality of care, access, payment rates, pertinent legislative activity, eligibility verification activities, eligibility redetermination processes (including the option to utilize administrative redetermination), and other operational issues;
  - e) Notification of any changes in enrollment and/or participation that fluctuate 10 percent or more in relation to the previous quarter within the same DY and the same quarter in the previous DY;
  - f) Action plans for addressing any policy, administrative or budget issues identified;

## Attachment A Continued

- g) An updated budget neutrality monitoring worksheet;
  - h) Progress updates to the transition plan as specified in STC 27; and
  - i) Evaluation activities and interim findings.
26. **Annual Report.** The annual report is due 90 days following the end of the fourth quarter of each DY within the format outlined in Appendix B. The report must include a summary of the year's preceding activity as well as the following:
- a) Total annual expenditures for the demonstration population for each DY, with administrative costs reported separately;
  - b) The average total Medicaid expenditures for a Medicaid-funded birth each DY. The cost of a birth includes prenatal services and delivery and pregnancy-related services and services to infants from birth up to age 1 (the services should be limited to the services that are available to women who are eligible for Medicaid because of their pregnancy and their infants);
  - c) The number of actual births that occur to family planning demonstration participants within the DY. (participants include all individuals who obtain one or more covered medical family planning services through the family planning program each year);
  - d) Yearly enrollment reports for demonstration enrollees for each DY (enrollees include all individuals enrolled in the demonstration) that include the member months, as required to evaluate compliance with the budget neutral agreement and as specified in STC 33;
  - e) Total number of participants for the DY (participants include all individuals who obtain one or more covered family planning services through the demonstration);
  - f) Progress updates to the transition plan as specified in STC 27;
  - g) A summary of program integrity and related audit activities for the demonstration, including an analysis of point-of-service eligibility procedures;
  - h) Evaluation activities and interim findings; and
  - i) An updated budget neutrality monitoring worksheet.
27. **Transition Plan.** The State is required to prepare and incrementally revise a transition plan consistent with the provisions of the Affordable Care Act for individuals enrolled in the family planning demonstration. The transition plan must provide details on how the State plans to coordinate the transition of these individuals to a more comprehensive coverage option available under the Affordable Care Act, including the Medicaid eligibility group described in §1902(a)(10)(A)(i)(VIII), the American Health Benefit Exchange or other coverage options available in 2014, without interruption in coverage or access to care to the

# Attachment A Continued

maximum extent possible. The State must submit a draft to CMS by November 1, 2012, with progress updates included in each quarterly and annual report thereafter. The State will revise the transition plan as needed.

28. **Final Report.** The State must submit a final demonstration report to CMS to describe the impact of the demonstration, including the extent to which the State met the goals of the demonstration. The draft report will be due to CMS 180 days after the expiration of the demonstration. CMS must provide comments within 60 days of receipt of the draft final demonstration report. The State must submit a final demonstration report within 60 days of receipt of CMS comments.

## VII. GENERAL FINANCIAL REQUIREMENTS

29. **Quarterly Expenditure Reports.** The State must provide quarterly expenditure reports using the Form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS must provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section VIII.

30. **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, Washington must report demonstration expenditures through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES); following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual. 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, including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made.
- b) **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. For any other cost settlements not attributable to this demonstration, the adjustments should be reported on lines 9 or 10C as instructed in the State Medicaid Manual.
- c) **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.

31. **Title XIX Administrative Costs.** Administrative costs will not be included in the budget neutrality agreement, but the State must separately track and report additional administrative

## Attachment A Continued

costs that are directly attributable to the demonstration. All administrative costs must be identified on the Forms CMS-64.10.

32. **Claiming Period.** All claims for expenditures subject to the budget neutrality agreement (including any cost settlements) must be made within 2 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 2 years after the conclusion or termination of the demonstration. During the latter 2-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.
33. **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 quarterly and annual reports as required under STC 25 and 26 respectively, the actual number of eligible member months for all demonstration enrollees. The State must submit a statement accompanying the quarterly and annual reports, 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, a person who is eligible for 3 months contributes three eligible member months to the total. Two individuals who are eligible for 2 months each contribute two eligible member months to the total, for a total of 4 eligible member months.
34. **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 the 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 the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the 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.
35. **Extent of Federal Financial Participation (FFP) for the Demonstration.** CMS shall provide FFP for family planning and family planning-related services and supplies at the applicable Federal matching rates described in STC 18 and 19, subject to the limits and processes described below:

## Attachment A Continued

- a) For family planning services, 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.
  - b) Allowable family planning expenditures eligible for reimbursement at the enhanced family planning match rate, as described in STC 18, should be entered in Column (D) on the Forms CMS-64.9 Waiver.
  - c) Allowable family planning-related expenditures eligible for reimbursement at the FMAP rate, as described in STC 19, should be entered in Column (B) on the Forms CMS-64.9 Waiver.
  - d) FFP will not be available for the costs of any services, items, or procedures that do not meet the requirements specified above, even if family planning clinics or providers provide them. 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 matching rate for the State. For testing or treatment not associated with a family planning visit, no FFP will be available.
  - e) 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.
36. **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 time frames 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.
37. **State Certification of Funding Conditions.** The State must certify that the following conditions for non-Federal share of demonstration expenditures are met:

## Attachment A Continued

- 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 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.
38. **Monitoring the Demonstration.** The State must provide CMS with information to effectively monitor the demonstration, upon request, in a reasonable time frame.

### VIII. MONITORING BUDGET NEUTRALITY

39. **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 selected Medicaid expenditures during the period of approval of the demonstration. The budget neutrality expenditure targets are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. Actual expenditures subject to budget neutrality expenditure limit shall be reported by the State using the procedures described in STC 30.
40. **Risk.** Washington shall be at risk for the per capita cost (as determined by the method described below in this section) for the Medicaid family planning enrollees, but not for the number of demonstration enrollees. By providing FFP for enrollees in this eligibility group, Washington shall not be at risk of changing economic conditions that impact enrollment

# Attachment A Continued

levels. However, by placing Washington 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.

41. **Budget Neutrality Annual Expenditure Limits.** For each DY, an annual budget limit will be calculated for the demonstration. For the purposes of this demonstration, the DY is based off the calendar year (SFY) of July 1 to June 30. 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 gives the PMPM (Total Computable) costs for the calculation described above by DY. The PMPM cost was constructed based on State expenditures for DY 9 and increased by the rate of growth included in the President’s Federal fiscal year 2012 budget for DYs 11, 12 and 13 as outlined below.

		SFY 2012	SFY 2013	SFY 2014
	Trend	DY 11	DY 12	DY 13
<b>Demonstration Enrollees</b>	6.2%	\$39.81	\$42.28	\$44.90

- 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 30 above, by total computable demonstration expenditures for the same period as reported on the same forms. Should the demonstration be terminated prior to the end of the approval period (see STCs 7 and 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 is structured as a “pass-through” or “hypothetical” population. Therefore, the State may not derive savings from the demonstration.
- c) Application of the Budget Limit. The budget limit calculated above will apply to demonstration expenditures, as 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.
42. **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.



# Attachment A Continued

43. **Enforcement of Budget Neutrality.** CMS will enforce budget neutrality over the life of the demonstration, rather than annually. However, no later than 6 months after the end of each DY or as soon thereafter as the data are available, the State will calculate annual expenditure targets for the completed year. This amount will be compared with the actual claimed FFP for Medicaid. Using the schedule below as a guide, if the State exceeds these targets, it will submit a corrective action plan to CMS for approval. The State will subsequently implement the approved corrective action plan.

Year	Cumulative Target Expenditures	Percentage
DY 2012	DY 11 budget limit amount	+2 percent
DY 2013	DYs 11 through 12 combined budget limit amount	+0 percent

- a) **Failure to Meet Budget Neutrality Goals.** 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 must include 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.

## IX. EVALUATION

44. **Submission of Draft Evaluation Design.** A draft evaluation design report must be submitted to CMS for approval within 120 days from the award of the demonstration extension. At a minimum, the evaluation design should include a detailed analysis plan that describes how the effects of the demonstration will be isolated from those of other initiatives occurring in the State. The report should also include an integrated presentation and discussion of the specific hypotheses (including those that focus specifically on the target population for the demonstration) that are being tested. The report will also discuss the outcome measures that will be used in evaluating the impact of the demonstration, particularly among the target population. It will also discuss the data sources and sampling methodology for assessing these outcomes. The State must implement the evaluation design and report its progress in each of the demonstration's quarterly and annual reports.

45. **Final Evaluation Plan and Implementation.** CMS shall provide comments on the draft design within 60 days of receipt, and the State must submit a final plan for the overall evaluation of the demonstration described in STC 44, within 60 days of receipt of CMS comments.

## X. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION

The State is held to all reporting requirements as outlined in the STCs; this schedule of deliverables should serve only as a tool for informational purposes only.

## Attachment A Continued

<b>Timeline</b>	<b>Deliverable</b>	<b>STC Reference</b>
Within 120 days from the award of the demonstration	Submit Draft Evaluation Design	STC 44
Within 60 days receipt of CMS comments	Submit Final Evaluation Plan	STC 45
November 1, 2012	Submit Draft Transition Plan	STC 27
Annually within 90 days following the end of the 4 <sup>th</sup> quarter for each DY	Submit Annual Report	STC 26
Quarterly within 60 days following the end of each quarter	Submit Quarterly Operational Reports	STC 25
Within 180 days after the expiration of the demonstration	Submit Draft Final Report	STC 28
60 days receipt of CMS comments	Submit Final Report	STC 28

# Attachment A Continued

## APPENDIX A: Template for Quarterly Operational Report

**State**  
**Name of Demonstration**  
**Section 1115 Quarterly Report**  
**Demonstration Year, Quarter X**  
**Fiscal Quarter**  
**Date Submitted**

### Introduction

Narrative on a brief introduction of demonstration, provide historical background from previous demonstration years and trends.

### Executive Summary

- *Brief description of Demonstration population*
- *Goal of Demonstration (list out)*
- *Program highlights (e.g. summary of benefits provided to the demonstration population)*

(Fill in chart- Indicate when each quarter begins and when it ends, see example below)

Demonstration Year (DY)	Begin Date	End Date	Quarterly Report Due Date (60 days following end of quarter)
Quarter 1	July 1 <sup>st</sup>	September 30 <sup>th</sup>	November 29 <sup>th</sup>
Quarter 2	October 1 <sup>st</sup>	December 31 <sup>st</sup>	March 1 <sup>st</sup>
Quarter 3	January 1 <sup>st</sup>	March 31 <sup>st</sup>	May 30 <sup>th</sup>
Quarter 4	April 1 <sup>st</sup>	June 30 <sup>th</sup>	August 29 <sup>th</sup>

- *Significant program changes*
  - Narrative describing any administrative and operational changes to the demonstration, such as eligibility and enrollment processes, eligibility redetermination processes (including the option to utilize administrative redetermination), systems, health care delivery, benefits, quality of care, anticipated or proposed changes in payment rates, and outreach changes; and
  - Narrative on any noteworthy demonstration changes, such as changes in enrollment, service utilization, education and outreach, and provider participation. Discussion of any action plan if applicable.
- *Policy issues and challenges*
  - Narrative providing an overview of any policy issues the State is considering, including pertinent legislative/budget activity and potential demonstration amendments;
  - Discussion of any action plans addressing any policy, administrative or budget issues identified, if applicable;
  - Narrative on progress updates to the transition plan as specified in STC 27.

# Attachment A Continued

## Enrollment

- Provide narrative on observed trends and explanation of data. As per STC 25, the State must include a narrative of any changes in enrollment and/or participation that fluctuate 10 percent or more in relation to the previous quarter with the same demonstration year (DY) and the same quarter in the previous DY.
- Enrollment figures- Please utilize the chart below to provide data on the enrollees and participants within the demonstration in addition to member months. The chart should provide information to date, over the lifetime of the demonstration extension.
  - As outlined in STCs 25 and 33,
    1. Enrollees are defined as all individuals enrolled in the demonstration,
      - The number of newly enrolled should reflect the number of individuals enrolled for the quarter reported.
      - The number of total enrollees should reflect the total number of individuals enrolled for the current DY.
    2. Participants are defined as all individuals who obtain one or more covered family planning services through the demonstration, and
    3. Member months refers to the number of months in which persons enrolled in the demonstration are eligible for services. For example, a person who is eligible for 3 months contributes to 3 eligible member months to the total.

- This demonstration has three eligible populations, as described in STC 14.

*Population 1:* Women losing Medicaid pregnancy coverage the conclusion of 60 days postpartum.

*Population 2:* Women who have an income at or below 250 percent of the FPL.

*Population 3:* Men who have family income at or below 250 percent of the FPL.

DY 11: 20XX	Quarter 4 (fill in quarter dates)			
	Population 1	Population 2	Population 3	Total Population
# of Newly enrolled				
# of Total Enrollees				
# of Participants				
# of Member Months				

# Attachment A Continued

DY 12: 20XX	Quarter 1 (fill in quarter dates)				Quarter 2 (fill in quarter dates)			
	Population 1	Population 2	Population 3	Total Population	Population 1	Population 2	Population 3	Total Population
# of Newly enrolled								
# of Total Enrollees								
# of Participants								
# of Member Months								

DY 12: 20XX	Quarter 3 (fill in quarter dates)				Quarter 4 (fill in quarter dates)			
	Population 1	Population 2	Population 3	Total Population	Population 1	Population 2	Population 3	Total Population
# of Newly enrolled								
# of Total Enrollees								
# of Participants								
# of Member Months								

DY 13: 20XX	Quarter 1 (fill in quarter dates)				Quarter 2 (fill in quarter dates)			
	Population 1	Population 2	Population 3	Total Population	Population 1	Population 2	Population 3	Total Population
# of Newly enrolled								
# of Total Enrollees								
# of Participants								
# of Member Months								

### Service and Providers

- *Service Utilization*
  - Provide a narrative on trends observed with service utilization. Please also describe any changes in service utilizations or change to the demonstration's benefit package.
  
- *Provider Participation*
  - Provide a narrative on the current provider participation in rendering services during this quarter highlighting any current or expected changes in provider participation, planned provider outreach and implications for health care delivery.

# Attachment A Continued

## Program Outreach Awareness and Notification

- *General Outreach and Awareness*
  - Provide information on the public outreach activities conducted this quarter; and
  - Provide a brief assessment on the effectiveness of outreach programs.
- *Target Outreach Campaign(s) (if applicable)*
  - Provide a narrative on who the targeted populations for these outreaches are, and reasons for targeted outreach; and
  - Provide a brief assessment on the effectiveness of the targeted outreach program(s).

## Program Evaluation, Transition Plan and Monitoring

- Identify any quality assurance and monitoring activities in current quarter. Also, please discuss program evaluation activities and interim findings;
- Provide a narrative of any feedback and grievances made by beneficiaries, providers and the public, including any public hearings or other notice procedures, with a summary of the State's response or planned response; and
- Provide progress updates to the transition plan as specified in STC 27.

## Quarterly Expenditures

- The State is required to provide quarterly expenditure reports using the Form CMS-64 to report expenditures for services provided under the demonstration in addition to administrative expenditures. Please see Section VII of the STCs for more details.
- Please utilize the chart below to include expenditure data, as reported on the Form CMS-64. Provide information to date, over the lifetime of the demonstration extension.

	<b>Demonstration Year 11</b> <b>(fill in dates)</b>			
	Service Expenditures as Reported on the CMS-64	Administrative Expenditures as Reported on the CMS-64	Total Expenditures as Reported on the CMS-64	Expenditures as requested on the CMS- 37
Quarter 4 Expenditures				
<b>Total Annual Expenditures</b>				

## Attachment A Continued

	<b>Demonstration Year 12</b> <b>(fill in dates)</b>			
	Service Expenditures as Reported on the CMS -64	Administrative Expenditures as Reported on the CMS -64	Total Expenditures as Reported on the CMS -64	Expenditures as requested on the CMS- 37
Quarter 1 Expenditures				
Quarter 2 Expenditures				
Quarter 3 Expenditures				
Quarter 4 Expenditures				
<b>Total Annual Expenditures</b>				

	<b>Demonstration Year 13</b> <b>(fill in dates)</b>			
	Service Expenditures as Reported on the CMS -64	Administrative Expenditures as Reported on the CMS -64	Total Expenditures as Reported on the CMS -64	Expenditures as requested on the CMS- 37
Quarter 1 Expenditures				
Quarter 2 Expenditures				
<b>Total Annual Expenditures</b>				

### Activities for Next Quarter

- Provide details and report on any anticipated activities for next quarter.

# Attachment A Continued

## APPENDIX B: Template for Annual Report

**State**  
**Name of Demonstration**  
**Section 1115 Annual Report**  
**Demonstration Year, Annual Report (list dates covered)**  
**Fiscal Year**  
**Date Submitted**

**\*\*Please include a cover page and a table of contents**

### Introduction

Narrative on a brief introduction of demonstration, provide historical background, such as amendment changes, extension request and dates of CMS approvals.

### Executive Summary

- *Brief description of demonstration population*
- *Goal of demonstration (list out)*
- *Program highlights (e.g. summary of benefits provided to the demonstration population)*

Demonstration Year	Begin Date	End Date	Annual Report Due Date (90 days following end of Annual date)
DY 11	July 1, 2011	June 30, 2012	September 28, 2012
DY 12	July 1, 2012	June 30, 2013	September 28, 2013
DY 13	July 1, 2013	December 31, 2013	March 31, 2014

(Fill in chart- Indicate when each annual year begins and when it ends, see example below)

- *Significant program changes from previous demonstration years*
  - Narrative describing any administrative and operational changes to the demonstration, such as eligibility and enrollment processes, eligibility redetermination processes (including the option to utilize administrative redetermination), systems, health care delivery, benefits, quality of care, anticipated or proposed changes in payment rates, and outreach changes; and
  - Narrative on any noteworthy demonstration changes, such as changes in enrollment, service utilization, education and outreach, and provider participation. Please include a description of action plan if applicable.
- *Policy issues and challenges*
  - Brief narrative on noteworthy policy issues and challenges from previous demonstration years and actions if applicable;
  - Narrative providing an overview of any policy issues the State has dealt with in the reporting year, including pertinent legislative/budget activity and potential demonstration amendments;



# Attachment A Continued

- Discussion of any action plans addressing any policy, administrative or budget issues identified, if applicable;
- Narrative on progress updates to the transition plan as specified in STC 27; and
- Narrative on any budget neutrality issues the State has identified. Please include a description of action plan if applicable.

## **Enrollment and Renewal**

- Enrollment figures- Please utilize the chart below to provide data on the enrollees and participants within the demonstration in addition to member months. The chart should provide information to date, over the lifetime of the demonstration extension.
  - As outlined in STCs 25, 26 and 33,
    1. Enrollees are defined as all individuals enrolled in the demonstration,
      - i. The number of newly enrolled should reflect the number of individuals enrolled for the quarter reported.
      - ii. The number of total enrollees should reflect the total number of individuals enrolled for the current DY.
    2. Participants are defined as all individuals who obtain one or more covered family planning services through the demonstration
    3. Member months refers to the number of months in which persons enrolled in the demonstration are eligible for services. For example, a person who is eligible for 3 months contributes to 3 eligible member months to the total.
  - This demonstration has three eligible populations, as described in STC 14.

*Population 1:* Women losing Medicaid pregnancy coverage the conclusion of 60 days postpartum.

*Population 2:* Women who have an income at or below 250 percent of the FPL.

*Population 3:* Men who have family income at or below 250 percent of the FPL

	<b>Demonstration Year 11</b>			
	<b>(fill in dates)</b>			
	Population 1	Population 2	Population 3	Total Demonstration Population
<b># of Total Enrollees</b>				
<b># of Participants</b>				
<b># of Member Months</b>				

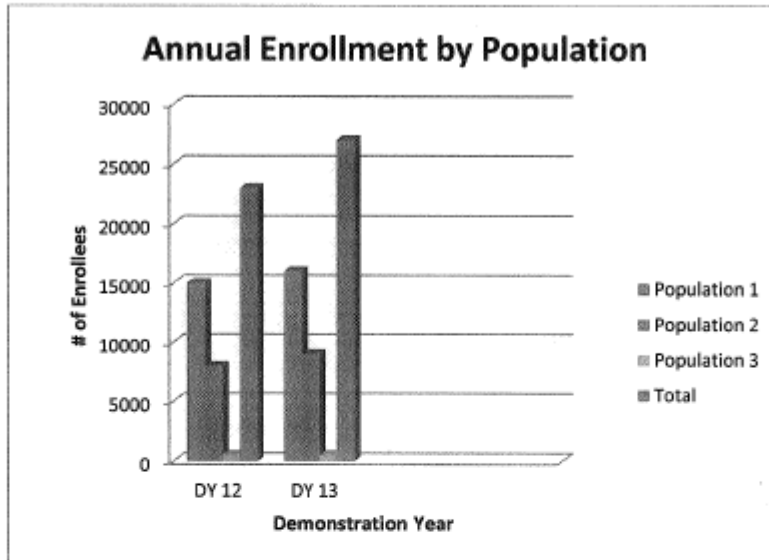
## Attachment A Continued

	<b>Demonstration Year 12</b> <b>(fill in dates)</b>			
	Population 1	Population 2	Population 3	Total Demonstration Population
<b># of Total Enrollees</b>				
<b># of Participants</b>				
<b># of Member Months</b>				

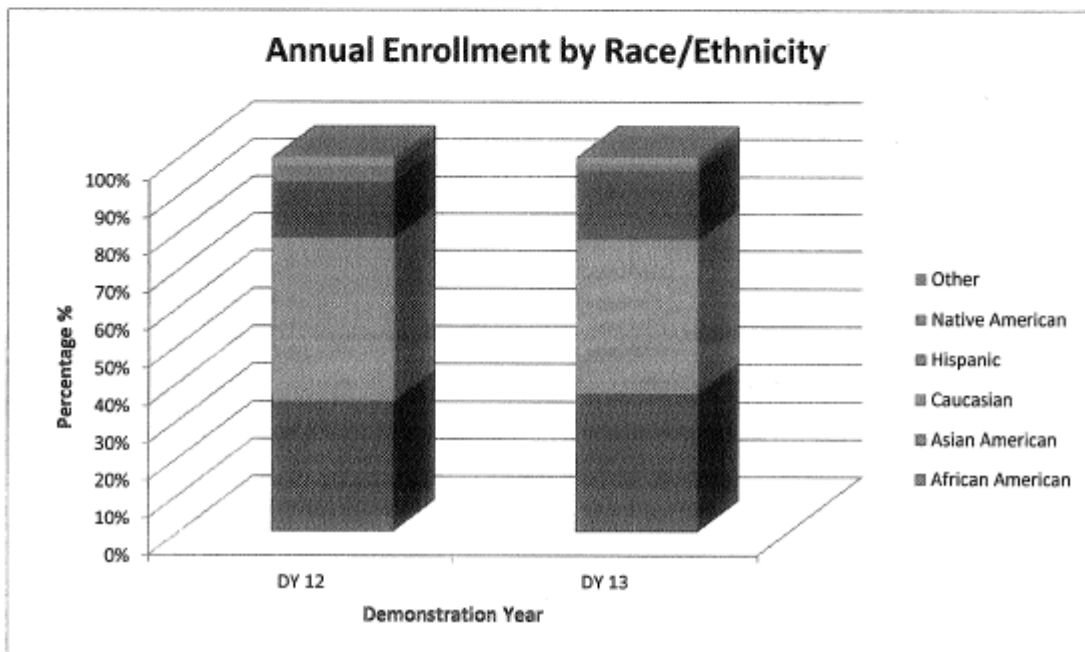
	<b>Demonstration Year 13</b> <b>(fill in dates)</b>			
	Population 1	Population 2	Population 3	Total Demonstration Population
<b># of Total Enrollees</b>				
<b># of Participants</b>				
<b># of Member Months</b>				

- Provide narrative on observed trends and analysis of data, including any proposed actions for improvement. As per STCs 25 and 26, the State must include a narrative of any changes in enrollment and/or participation that fluctuate 10 percent or more in relation to the previous demonstration year (DY). Also discuss actions identified that could improve enrollment numbers, if applicable.
- Provide graphs/ charts for the data indicated below (samples of the graph structure are included):
  - 1) Annual enrollment by population for each demonstration Year over the lifetime of the demonstration.

# Attachment A Continued



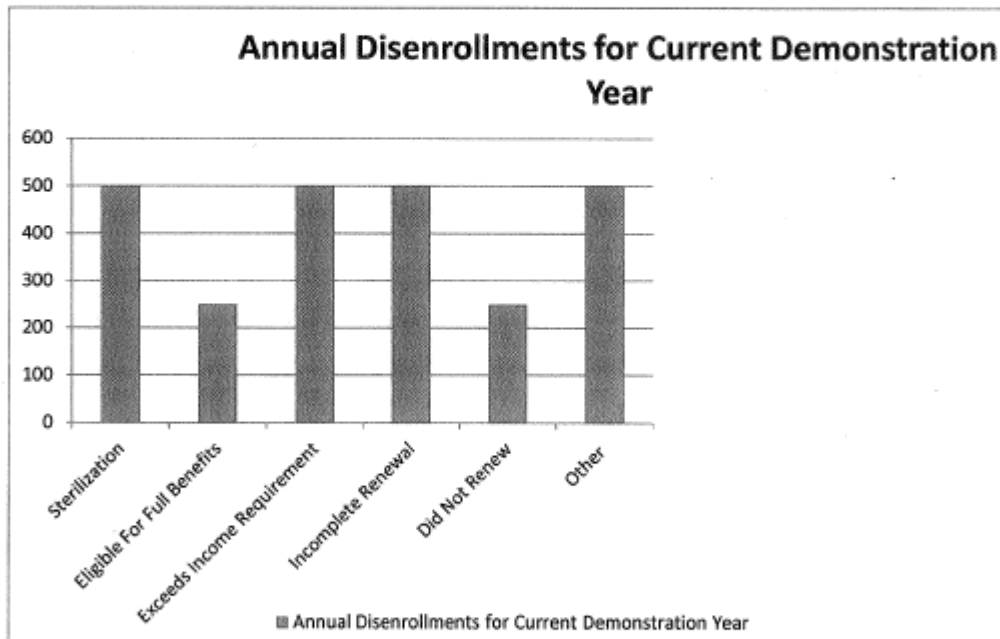
2) It is the State's option to provide graphs and analysis of annual enrollment by characteristics, such as race/ethnicity, and age. Two examples of such information is included below.



# Attachment A Continued

	African American (Enrollees/ Percentage %)	Asian American	Caucasian	Hispanic	Native American	Other	Total enrollees
DY 12	7500(32.6%)	500 (2.17%)	10000(43.4%)	3500(15.2%)	1000(4.34%)	500(2.17%)	23000
DY 13	9000(33.3%)	1000(3.70%)	11000(40.7%)	5000(18.5%)	500(1.85%)	500(1.85%)	27000

- 3) Annual Disenrollment and Retention figures
- Discuss the current demonstration year's retention and disenrollment figures, including top reasons for disenrollment, compared to last demonstration year and trends observed throughout the current demonstration year's quarters.
  - Provide charts/graphs to illustrate the data, please see examples below on disenrollment figures.

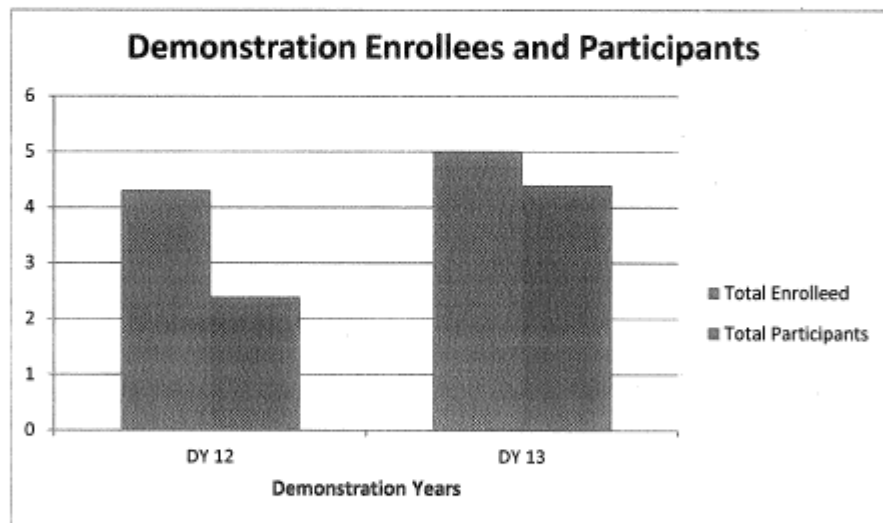


# Attachment A Continued

	Sterilization (Enrollees/ Percentage %)	Eligible for Full Benefits	Exceeds income requirement	Incomplete Renewal	Did not Renew	Other	Total Disenrollment Numbers
DY 12	500(20.0%)	250(10.0%)	500(20.0%)	500(20.0%)	250(10.0%)	500(20.0%)	2500
DY 13	500(16.67%)	750(25%)	500(16.67%)	250(8.33%)	500(16.7%)	500(16.7%)	3000

### Service and Providers

- *Service Utilization*
  - Provide a narrative on trends observed with family planning and family planning-related services and supplies utilization. Please also describe any changes in service utilizations or change to the demonstration's benefit package. Provide any relevant charts/graphs illustrating data found.
  - Provide a cumulative graph highlighting the enrollees and participants over the lifetime of the demonstration.



- *Provider Participation*
  - Provide a narrative on the current provider participation in rendering services during this demonstration year highlighting any current or expected changes in provider participation, planned provider outreach and implications for health care delivery.

### Program Outreach Awareness and Notification

- *General Outreach and Awareness*
  - Provide information on the public outreach activities conducted this demonstration year, and

# Attachment A Continued

- Provide a brief assessment on the effectiveness of outreach programs throughout the demonstration Year.
- *Target Outreach Campaign(s) (if applicable)*
  - Provide a narrative on who the targeted populations for these outreaches are, and reasons for targeted outreach,
  - Provide a brief assessment on the effectiveness of the targeted outreach program(s); and
  - Describe any trends observed and any identified actions that could improve the outreach programs.

## **Program Evaluation, Transition Plan and Monitoring**

- A summary of program integrity and related audit activities for the demonstration, including an analysis of point-of-service eligibility procedures;
- Identify any quality assurance and monitoring activities in current quarter. Also, please discuss program evaluation activities and interim findings;
- Provide a narrative of any feedback and grievances made by beneficiaries, providers and the public, including any public hearings or other notice procedures, with a summary of the State's response or planned response;
- Provide progress updates to the transition plan as specified in STC 27.

## **Provide an Interim Evaluation of Goals and Progress**

### **Goal 1:**

**Progress Update:**

### **Goal 2:**

**Progress Update:**

### **Goal 3:**

**Progress Update:**

## **Annual Expenditures**

- The State is required to provide quarterly expenditure reports using the Form CMS-64 to report expenditures for services provided under the demonstration in addition to administrative expenditures. Please see Section VII of the STCs for more details.
- Please utilize the chart below to include this expenditure data, as reported on the Form CMS-64. The chart should provide information to date, over the lifetime of the demonstration extension.

# Attachment A Continued

	Service Expenditures as reported on the CMS-64		Administrative Expenditures as reported on the CMS-64		Expenditures as requested on the CMS-37	Total Expenditures as reported on the CMS-64
	Total Computable	Federal Share	Total Computable	Federal Share		
Demonstration Year 11						
Demonstration Year 12						
Demonstration Year 13						

	<b>Demonstration Year 11 (fill in dates)</b>
	Total Demonstration Population
<b># Member Months</b>	
<b>PMPM</b>	
<b>Total Expenditures</b> <i>(Member months multiplied by PMPM)</i>	

	<b>Demonstration Year 12 (fill in dates)</b>
	Total Demonstration Population
<b># Member Months</b>	
<b>PMPM</b>	
<b>Total Expenditures</b> <i>(Member months multiplied by PMPM)</i>	

	<b>Demonstration Year 13 (fill in dates)</b>
	Total Demonstration Population
<b># Member Months</b>	
<b>PMPM</b>	
<b>Total Expenditures</b> <i>(Member months multiplied by PMPM)</i>	

# Attachment A Continued

## Actual Number of Births to Demonstration Population

- Provide the number of actual births that occur to family planning demonstration participants within the DY over the lifetime of the demonstration (participants include all individuals who obtain one or more covered family planning services each year).

	# of Births to Demonstration Participants
Demonstration Year 11	
Demonstration Year 12	
Demonstration Year 13	

## Cost of Medicaid Funded Births

- For each demonstration year, provide the average total Medicaid expenditures for a Medicaid-funded birth. The cost of a birth includes prenatal services and delivery and pregnancy-related services and services to infants from birth up to age 1 (the services should be limited to the services that are available to women who are eligible for Medicaid because of their pregnancy and their infants);

## Activities for Next Year

- Report on any anticipated activities for next year.



# Attachment A Continued

## CENTERS FOR MEDICARE & MEDICAID SERVICES EXPENDITURE AUTHORITY

**NUMBER:** 11 -W-00134/0-01  
**TITLE:** TAKE CHARGE Section 1115 Family Planning 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 authorities and the provisions specified as "not applicable" enable Washington to operate its section 1115 Medicaid family planning demonstration, entitled "TAKE CHARGE" effective as of the date of the approval letter through December 31, 2013, unless otherwise stated.

Expenditures for extending Medicaid eligibility for family planning and family planning-related services, subject to an annual redetermination, to individuals who are not otherwise enrolled in Medicaid or the Children's Health Insurance Program (CHIP), and are:

- a) Women losing Medicaid pregnancy coverage (SOBRA pregnant women) at the conclusion of 60 days postpartum and who have a family income at or below 250 percent of the Federal poverty level (FPL) at the time of annual redetermination; or
- b) Men and women who have family income at or below 250 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 B: Take Charge Health Insurance Survey

# TAKE CHARGE

Health Insurance Survey



*Washington State Department of Social and Health Services  
Services and Enterprise Support Administration  
Research and Data Analysis Division*

# Attachment B Continued

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

*Kevin Quigley, Secretary*

SERVICES AND ENTERPRISE SUPPORT ADMINISTRATION

*Patricia Lashway, Assistant Secretary*

RESEARCH AND DATA ANALYSIS DIVISION

*David Mancuso, Ph.D., Director*

*Alice Huber, Ph.D., Deputy Director*

*In Collaboration with*

HEALTH CARE AUTHORITY

*Dorothy Frost Teeter, M.H.A., Director*

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

HEALTH CARE SERVICES

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OFFICE OF COMMUNITY SERVICES

*Todd Slettvet, M.A., Section Manager*

*Stacey Bushaw, M.S., Family Health Care Services Unit Manager*

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

When ordering, please refer to  
REPORT 9.107

# Attachment B Continued

## TAKE CHARGE Health Insurance Survey

Laurie Cawthon, M.D., M.P.H.

May 2015

Department of Social and Health Services  
Services and Enterprise Support Administration  
Research and Data Analysis Division  
Olympia, WA 98504-5204

# Attachment B Continued

## ACKNOWLEDGMENTS

This report was prepared for and funded by the Washington State Health Care Authority.

We are deeply grateful to all survey respondents for sharing their personal information with us.

Special thanks go to the members of the Research and Data Analysis Management Information and Survey Research team who conducted the survey: Monica Stanley, Debbie Macy, Linda Marvel, Kevin White, Kimberly Hixon, Jessica Weaver, and Angelica (Stevenson) Eldridge. We would also like to recognize RDA staff who assisted in development of the survey questionnaire: Nancy Raiha, Barb Lucenko, Monica Stanley, and John Rogers.

Thank you to members of the First Steps Database team: Dorothy Lyons analyzed the survey results and provided comments on report drafts, and Peter Woodcox extracted the survey sample.

Thanks to Alice Huber, Ph.D., Deputy Director of Research and Data Analysis Division, for oversight and overall project management, and to MaryAnne Lindeblad, Deputy Director Washington Health Care Authority, for helpful guidance.

We would like to recognize and thank the HCA Community Services Section staff, Todd Slettvet, Stacey Bushaw, and Maureen Considine, for reviewing the survey and the report and offering insightful suggestions.

# Attachment B Continued

## EXECUTIVE SUMMARY

Washington State's TAKE CHARGE program, which began July 2001, expanded Medicaid coverage for family planning services to men and women with family income at or below 200% of the federal poverty level (FPL). Over the fourteen years of the program, enrollment has fluctuated dramatically in response to numerous state and federal policy changes. No change, however, has had a greater impact than implementation of the Affordable Care Act. With expanded Medicaid eligibility and a robust state-sponsored health benefit exchange, Washington State has achieved a significant increase in insurance coverage among its citizens. Despite opportunities to buy health insurance through the health benefit exchange, some Washington women continue to be enrolled in the TAKE CHARGE program and receive Medicaid-funded family planning services.

This report describes the reasons that women remained on TAKE CHARGE instead of obtaining insurance through another source, such as the Health Benefit Exchange. The main data source was a brief survey mailed to women enrolled in TAKE CHARGE between February and July 2014. We received responses from 338 women, resulting in a response rate of 18%.

### Key Findings

- The majority (66%) of women who remained on the TAKE CHARGE program were working but did not have employer-sponsored health insurance, for a variety of reasons.
- Washington's Health Benefit Exchange website, known as HealthPlanFinder, was the most frequent source of information about health insurance; however, two-thirds of women who tried to get information from the website found it "somewhat difficult" or "very difficult" (58%), or "impossible" (9%) to get the help they needed there.
- The most frequent reason respondents did not buy or enroll in an insurance plan through the Health Benefit Exchange was cost: 45% responded that the main reason was that the costs are too high.
- Nearly half (49%) of the respondents indicated they were unable to pay for health insurance because of bills they had to pay. One-third (35%) were unable to pay for basic necessities like food, heat, or rent, and one-third (35%) had credit card debt. Nearly half had used up all their savings (48%) or had problems paying for medical bills (44%).
- More than half the respondents indicated that it would be very difficult (46%) or impossible (14%) for them to pay the personal costs for health insurance in the future.

**CONCLUSION.** A small number of women in Washington continue to have clear needs for family planning coverage that are not being met, except through the TAKE CHARGE family planning program. Limited assets and high debts are common problems in the United States that influence affordability of health insurance. Many women least able to afford health insurance are the same women with the greatest need to prevent unintended pregnancy.

# Attachment B Continued

## INTRODUCTION

Washington's TAKE CHARGE family planning waiver program was implemented in July 2001. This §1115 Centers for Medicare and Medicaid Services (CMS) waiver project expanded Medicaid coverage for family planning services to women and men with family income at or below 200% of the Federal Poverty Level (FPL). In October 2012, eligibility was further expanded to 250% of the FPL (equivalent to 260% of the FPL as of October 1, 2013).

Initial client enrollment exceeded all expectations and continued to increase steadily until the fourth year of the program. In its first five years, the TAKE CHARGE program increased access to family planning services and, during the time of highest enrollment, reduced unintended pregnancies among women eligible through the waiver.<sup>1</sup> In addition, the cornerstone of Washington Medicaid's family planning services has been client-centered education and counseling for risk reduction (ECRR). ECRR is designed to strengthen decision-making skills and support the client's safe and effective use of the chosen contraceptive method. ECRR has been a component of the TAKE CHARGE program since its inception, and is now part of the comprehensive prevention visit for family planning for women. The concepts of ECRR have diffused throughout the state and established a new standard of care for family planning practice.<sup>2</sup>

While TAKE CHARGE had long-lasting impacts on Washington State's delivery system for family planning services, the landscape of health insurance coverage has rapidly evolved in recent years. Over the fourteen years of the demonstration, enrollment fluctuated dramatically in response to numerous state and federal policy changes. No change has had a greater impact than implementation of the Affordable Care Act (ACA). Just as many policy makers questioned whether a need for the Title X program—the federal family planning program—would persist after the ACA, the extent of ongoing need for family planning waivers has also been uncertain. This report will describe findings from a survey of clients who enrolled in TAKE CHARGE *after* implementation of the ACA to understand the reasons they remained on the program instead of enrolling in Medicaid or obtaining insurance through the Health Benefit Exchange.

Washington State implemented expansion of its Medicaid program known as Apple Health to 138% of the FPL October 1, 2013. Washington's HealthPlanFinder became operational on the same day and was reported to be among the most successful of the state health benefit exchanges.<sup>3</sup> From October 1, 2013, to March 31, 2014, Apple Health (Medicaid) enrolled 423,205 new clients, including 137,930 who would have qualified under previous Medicaid eligibility guidelines prior to the ACA and 285,275 who were newly eligible because of the ACA.<sup>4</sup> On January 1, 2014, a new requirement for TAKE CHARGE eligibility took effect: to be determined eligible for the waiver program, each client at or below 150% of the FPL must provide documentation that she (or he) had applied for Medicaid and been denied coverage.

With a robust state-sponsored exchange and substantial enrollment in its Medicaid expansion, Washington State may serve as an example of the best-case scenario for implementation of the ACA. Our survey of clients with incomes between 138% and 260% of the FPL who enrolled in the TAKE CHARGE family planning program after January 2014 offers a unique opportunity to describe gaps in health insurance coverage for family planning services.

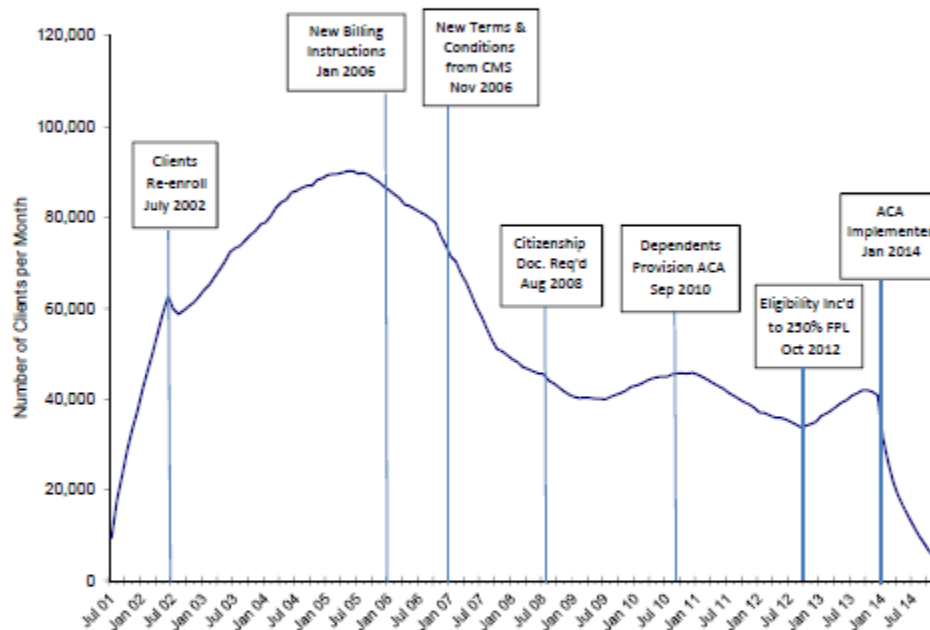


# Attachment B Continued

## BACKGROUND

The graph below shows monthly caseload client counts for the TAKE CHARGE family planning program since its inception in July 2001 through November 2014. After the caseload peaked in July 2005, the number of enrollees declined and stabilized at a lower level until implementation of the ACA. After January 2014, the number of enrolled clients plummeted: since the most recent peak in monthly enrollment of 42,021 clients in October 2013, monthly enrollment has decreased by nearly 90% (87.6%) to 5,210 in November 2014.

Figure 1. TAKE CHARGE Clients: Monthly Caseload July 2001 – November 2014



The program changes referenced in the graph above will be described briefly:

- **July 2002:** At the end of the program's first year, the automatic twelve months of eligibility ended for the first enrollees, and clients were required to re-enroll. For some clients, re-enrollment lagged by a few months.
- **January 2006:** New billing instructions that specified a more limited scope of services, especially for men, took effect.
- **November 2006:** New billing instructions, based in part on new Special Terms and Conditions (STCs) for the waiver, took effect. Clients with health insurance became ineligible except for good cause. Social Security Number (SSN), documentation of citizenship (with an affidavit permitted for those without other

# Attachment B Continued

documentation), and proof of identify were required. Routine STD/STI services were limited to Chlamydia and Gonorrhea testing and treatment for women ages 13 – 25. Services for men were further limited.

- **August 2008:** Citizenship documentation was required. The previous affidavit (personal attestation) was no longer permitted.
- **September 2010:** The dependents provision of ACA took effect. Parents were allowed to cover their dependents up to age 26 on their health insurance.
- **October 2012:** Special Terms and Conditions (STCs) of the waiver renewal approved by CMS were implemented in July 2012. Eligibility was expanded to include men and women with incomes up to 250% of the FPL (previously 200% of the FPL). The new STCs also permitted TAKE CHARGE eligibility for men and women with creditable health insurance.
- **October 2013:** Medicaid expansion includes eligibility for adults up to 138% of the FPL. TAKE CHARGE eligibility increased to 260% of the FPL.
- **January 2014:** Health insurance available through the health benefit exchange takes effect. Clients with health insurance are no longer eligible for TAKE CHARGE. With few exceptions, clients with incomes at or below 150% of the FPL must first apply for Medicaid and be denied before they can enroll in TAKE CHARGE.

Analyses conducted for the Annual Report to CMS provide additional perspectives on enrollment and disenrollment over the past three years of the program. During the most recent complete twelve-month period, July 1, 2013 – June 30, 2014, retention of enrolled clients decreased to one quarter (24%) from one half (48% and 52% in the prior two years, respectively): of the 89,204 clients enrolled in TAKE CHARGE July 2013 – June 2014, less than one quarter (24%) were enrolled at the end of that year.

More than forty percent (42.6%) of clients who did not re-enroll became Medicaid eligible with full benefits. The proportion of dis-enrolled clients who did not renew their eligibility without an identified reason, such as pregnancy, decreased to one half (50.4%) in the same year from three fourths in the previous two years.

The majority of clients who gained full Medicaid coverage after not re-enrolling in TAKE CHARGE did so through expanded Medicaid eligibility (up to 138% of the FPL) or through eligibility of parents/ caretakers based on their child's Medicaid eligibility.

Prior studies, such as the Commonwealth Fund's study of Why Young Adults Lack Health Insurance,<sup>5</sup> described barriers to obtaining health insurance faced by young adults age 19 to 29. The barriers they identified helped guide development of our survey. They reported the following reasons that young adults lacked health insurance in 2011:

- Lack of employer-based coverage (due to lack of permanent employment; higher unemployment rates among young adults compared to older adults; entry-level and part-time jobs that may not include health benefits; and coverage offered by employer was too expensive);
- Unable to be covered by parents' health plan (because parents do not have health insurance plans that young adults (up to age 26) can join or young adult passed 26th birthday);
- Financial consequences of medical bills and debt (such as all savings used to pay bills, credit card debt, unable to meet other obligations like school loans or tuition payments, delayed education or career plans, unable to pay for basic necessities like food or rent).

# Attachment B Continued

## STUDY GOALS

Our objective was to understand the reasons that account for the lack of health insurance (other than family planning coverage) among women who continued to enroll in the TAKE CHARGE program, instead of enrolling in Medicaid or obtaining insurance through the Health Benefit Exchange. Understanding these reasons may help reduce barriers to getting health insurance and contribute to efforts to achieve nearly universal coverage in the future.



# Attachment B Continued

## METHODS

Responses from a mail-only survey of women enrolled in the TAKE CHARGE family planning waiver program were used to describe the reasons that these women continued to enroll in TAKE CHARGE after health insurance became available through the Health Benefit Exchange.

### SURVEY SAMPLE SELECTION

The survey sample included female TAKE CHARGE clients, age 18-49, who enrolled in the program from February through July 2014. The sample included only women because of the very low numbers of men enrolled during this time period. Inclusion criteria included primary language identified as English (or missing) and a complete mailing address. Clients enrolled in TAKE CHARGE during the four months prior to February 2014 were excluded. After exclusions, 1,894 women remained in the survey sample.

The questionnaire, *TAKE CHARGE 2014 Health Insurance Survey*, was developed from existing surveys with the addition of a small number of new or revised questions. The survey included questions about health insurance enrollment, experiences with HealthPlanFinder, the client's financial situation, and plans for health insurance in the future. The final questionnaire is provided in the Appendix.

### SURVEY ADMINISTRATION

DSHS Research and Data Analysis Division began administration of the client survey on September 16, 2014, with the mailing of the notification letter introducing the survey and informing respondents they would receive a questionnaire in the mail the following week. A survey packet containing a questionnaire, cover letter, and stamped return envelope, was mailed one week after the notification letter. A reminder letter was sent one week following the questionnaire, thanking respondents for completing the survey and inviting those who had not to complete and return the survey. All non-respondents were sent a final replacement questionnaire four weeks after the initial letter was sent.

A total of 348 surveys were returned, resulting in a response rate of 18.4%. One client did not have a valid mailing address and was excluded from the mailings. Six clients refused participation in the survey. Ten returned surveys were excluded from final analyses because the respondents thought they were not enrolled in TAKE CHARGE during the specified time period. Of the total 1,894 clients in the survey sample, 133 (7%) could not be located.

### ANALYSIS

The analysis of the TAKE CHARGE Health Insurance Survey was designed to (1) compare basic demographics of survey respondents and non-respondents, (2) compare survey responses for younger women (up to age 26) and older women (age 26 and older), and (3) describe response frequencies for survey questions.

#### *Respondents Compared to Non-Respondents*

Survey respondents and non-respondents were compared across age and race/ethnicity. The two groups did not differ significantly in the proportion of white, non-Hispanic women. Age distribution, however, did differ significantly ( $p < .05$ ). Non-respondents included a higher proportion of women who were younger. Since children may be able to obtain health insurance from a parent's policy until age 26, we chose to look more closely at differences in survey responses between women who were younger than 26 and those who were 26 or older.

#### *Younger Respondents Compared to Older Respondents*

Response frequencies with significant differences between younger and older respondents are presented in the Appendix. The narrative findings describe these differences for relevant survey questions when the differences were statistically significant.

# Attachment B Continued

## *Response Frequencies*

Simple univariate analyses without adjustment for non-response are presented. The goals of our study do not include generalizing quantitative findings to larger groups of women; therefore adjustment for non-response is not needed. We compare demographic characteristics of our respondents to the general population of Washington women using the American Community Survey and to other Washington women who participated in our previous surveys.



# Attachment B Continued

## Demographic Characteristics of Washington Women

This section describes key demographic characteristics of women in the survey sample pool, survey respondents, and women in other surveys. While our 338 respondents may not be representative of the broader population of Washington women, comparing their demographic characteristics to all Washington women in the same age range reveals important similarities and differences.

Results from three surveys were available for comparison to the TAKE CHARGE Health Insurance Survey:

1. The American Community Survey (ACS) conducted by the U.S. Census Bureau is an ongoing survey that provides yearly data about population demographics, income, health insurance, employment and other factors. Washington relies on the ACS for population data for the state and communities across Washington. For comparison to our survey sample, we selected females age 18-49 from the total Washington population data.<sup>6</sup>
2. The TAKE CHARGE Primary Care Survey (2008) conducted by DSHS Research and Data Analysis as part of the evaluation of the TAKE CHARGE waiver assessed primary care needs, referrals, and recommendations received from TAKE CHARGE providers and receipt of primary care services among female clients enrolled in TAKE CHARGE.<sup>7</sup>
3. The Survey of Recently Pregnant Women (2007) also conducted by DSHS Research and Data Analysis as part of the evaluation of the TAKE CHARGE waiver explored reasons for the low family planning service use rate of recently pregnant Medicaid women and their low rate of re-enrollment at the end of their automatic extension for family planning services.<sup>8</sup>

## AGE

Survey respondents' ages ranged from 18 to 48 years old. Due to challenges in obtaining parental consent for younger teens to participate in this study, teens less than 18 years old were excluded from the survey sample pool.

	ACS WA Women (n=12,239)	Survey Pool (N=1,894)	Survey Respondents (n=338)
18-25 years	25.4%	53.4%	37.0%
26-34 years	28.5%	34.6%	43.2%
35-49 years	46.1%	11.9%	19.8%

The survey pool included a higher proportion of younger women, compared to the Washington population overall (per the ACS): 53.4% of women in the survey pool were 18-25 years old, compared to 25.4% of Washington women overall. This is not unexpected since need for family planning and reproductive health services is high among younger women, and health insurance is typically more affordable for older women as personal income tends to rise with increasing age.

# Attachment B Continued

On the other hand, response rates for our survey were highest for women age 35-49 years, with a response rate of 30%; intermediate for women 26-34 years old, with a response rate of 22.3%; and lowest for the youngest women in the sample age 18-25 years, with a response rate of 12.4%.

Respondents to the TAKE CHARGE Health Insurance Survey were older than respondents to the Recently Pregnant Women Survey: the proportion of respondents to the Health Insurance Survey who were 35-49 years old (19.8%) was more than double that for the survey of Recently Pregnant Women (9.4%). Respondents to the Primary Care Survey were younger still, with more than half (56%) less than 25 years old.

## INCOME

All clients newly enrolled in the TAKE CHARGE program in 2015 and eligible for this survey had incomes in the range of 138% to 260% of the FPL. Those with family incomes up to 138% of the FPL are eligible for Medicaid and thus ineligible for TAKE CHARGE.

Statewide, an estimated 237,913 women, approximately 18% of the total population of Washington women age 18 to 49, have incomes ranging from 138% to 250% of the FPL.

## EDUCATIONAL ATTAINMENT

The level of education attained by respondents to both the TAKE CHARGE Health Insurance Survey and the previous Primary Care Survey was somewhat higher than that for Washington women overall in the same age range. Educational attainment among respondents to the Recently Pregnant Women Survey was considerably lower than that for the other three groups. Respondents to the Recently Pregnant Women Survey were also younger, with nearly half (46%) less than 26 years old.

	ACS WA Women (n=12,239)	Survey Respondents (n=338)	TAKE CHARGE Primary Care Survey (n=999)	TAKE CHARGE Recently Pregnant Women Survey (n=1292)
High School Graduate/GED or less	28.2%	23.1%	27.4%	42.4%
At least some college, or two-year degree	71.8%	77.0%	74.0%	57.6%

## OVERALL HEALTH (SELF ASSESSMENT)

Two recent national surveys included questions about self-assessment of health status. Responses to our survey were consistent with both. The Kaiser Family Foundation described characteristics of uninsured poor adults with incomes up to 138% of the FPL in states that did not expand Medicaid.<sup>9</sup> They found that while nearly half (47%) of people in the coverage gap reported that their health was excellent or very good, nearly one-fifth (18%) reported that they were in fair or poor health. Respondents to the TAKE CHARGE Health Insurance Survey reported slightly better health, with 50.3% reporting excellent or very good health and just 12.6% reporting fair or poor health.

# Attachment B Continued

Since TAKE CHARGE clients had higher incomes than people in the coverage gap, it is not unexpected that they would report better health status.

A second Kaiser Family Foundation Survey about women and health care describes a notable difference in health status between women of different poverty levels: for women with incomes at less than 200% of the FPL, 25% rated their health as fair or poor, compared to 9% of higher income women. For the 18-44 year old age group, 12% rated their health as fair or poor.<sup>30</sup> This rate for 18-44 year olds in the Kaiser women and health care survey is quite similar to the rate measured for respondents to our Health Insurance Survey (12.6%).

Two prior TAKE CHARGE surveys asked clients the same question about how they rate their overall health. These surveys are of interest since the numbers of respondents were considerably higher than that for the Health Insurance Survey. The Primary Care Survey focused on female TAKE CHARGE enrollees at a time when enrollment was much higher and the Recently Pregnant Women Survey focused on women who had a Medicaid-paid birth in the prior two years.

	Survey Respondents (n=338)	TAKE CHARGE Primary Care Survey (n=999)	TAKE CHARGE Recently Pregnant Women Survey (n=1292)
Excellent/Very Good	50.3%	48%	57%
Good	37.1%	38%	32%
Fair/Poor	12.6%	14%	11%

Recently Pregnant Women reported somewhat higher rates of excellent or very good health (57%), compared to women enrolled in the TAKE CHARGE family planning program; however, rates for all three groups of Washington women were very similar.

## SUMMARY

Based on these comparisons, we can reasonably conclude that respondents to the TAKE CHARGE Health Insurance Survey are, with few exceptions, generally representative of Washington women without health insurance and in need of family planning services. The following groups are somewhat over-represented among respondents compared with non-respondents: older women, especially those 35-49 years old; more highly educated women; and possibly women with poorer health status.

Relationships between age, income, education, and health status are complex. All four factors impact affordability of health insurance and the need for health care services. In addition, these four factors are likely to impact survey response rates: while we can definitively demonstrate clear differences in response rates only related to age, the strong relationships between age and income, education, and health status imply that response rates would also differ by these factors if we were able to measure them.

Patterns of child-bearing add further complexity: younger women may wish to delay pregnancy until they complete their education and achieve adequate personal income; older women may have completed child-bearing and wish to avoid subsequent pregnancies.



# Attachment B Continued

## 1 Most women who remained on the TAKE CHARGE program were working but did not have employer-sponsored health insurance, for a variety of reasons.

The majority of women in Washington (62.3% of women 18-49 years old, 2013 ACS) are covered by employer-sponsored health insurance, based on either their own employment or their status as a dependent of a spouse/partner or parent. Even among women with jobs where their employer offers health insurance, not all women are covered. Some workers are not eligible to enroll as a result of waiting periods, or minimum work-hour rules; others choose not to enroll; and some are employed in industries, such as agriculture and service industries, with historically low insurance rates.<sup>11</sup>

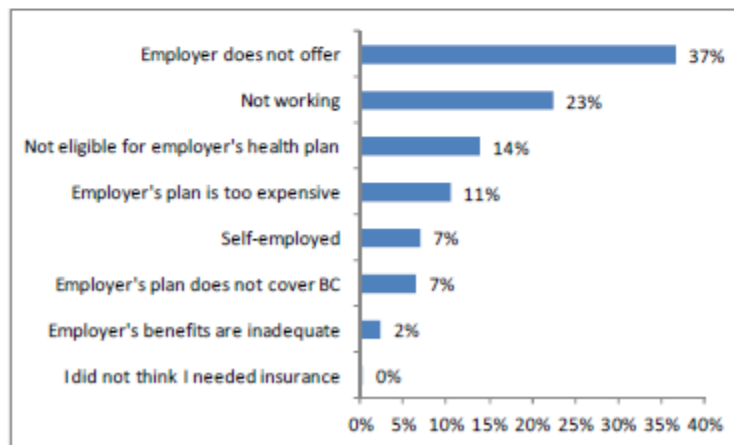
The ACA includes provisions that require new health insurance plans to provide coverage for prescription FDA-approved contraceptive services and supplies for women. This provision only applies to new (non-grandfathered) plans. Among the findings from the 2013 Kaiser Women's Health Survey, Salganicoff et al. noted that nearly two years after the ACA contraceptive coverage rule took effect, insurance covered the full cost for just one-third (35%) of women with private insurance, and about one in ten (13%) women with private insurance reported they did not have any coverage for birth control.<sup>12</sup>

A recent report, *Contraceptive Coverage in Washington State's Qualified Health Plans* (April 2015), highlights inconsistent information from health plan representatives about coverage of FDA-approved contraceptive methods.<sup>13</sup> This study included "secret shopper" calls to the eight insurance carriers that offered qualified health plans in 2014 in Washington and provides insight into the extent of confusing and inconsistent information that women might receive from health plan representatives.

The TAKE CHARGE Health Insurance Survey asked about clients' experiences, if any, with different sources of health insurance. Specifically, the survey asked about possible sources of insurance other than TAKE CHARGE family planning coverage.

### FINDINGS

Figure 2. Reasons Cited for Not Having Health Insurance from an Employer or Union



## Attachment B Continued

The most frequent reason cited for not having employer-based health insurance was that the employer did not offer health insurance (37%). Fourteen percent (14%) were ineligible for the employer's plan for reasons such as part-time work, probationary status, or missed deadlines. Eleven percent (11%) found the employer's plan too expensive, and 7% stated that the employer's plan did not cover their preferred method of birth control.

Two-thirds (66%) of respondents reported that, although they were working, they did not have employer-based health insurance. Just 23% of respondents were not working, and an additional 7% were self-employed. Only 2% of younger respondents (<26) reported being self-employed as a reason for not having employer-sponsored health insurance, compared to 10% of older respondents (>=26).

Some respondents identified issues likely to be resolved in the future that had prevented them from obtaining employer-sponsored health insurance. In particular, respondents listed timing issues such as missed deadlines, or missed open enrollment period, or probationary period after new hire as reasons for not having health insurance from their employer. In other cases, the characteristics of their employment—seasonal and part-time work and jobs in service industry—suggest that lack of employer-sponsored insurance may persist for many women.

Respondents also expressed concerns about the adequacy of insurance coverage for contraceptive services and supplies, mentioning co-pays for birth control, lack of coverage for their preferred birth control method, and inadequate coverage.

Clients provided additional insights about their eligibility (or lack thereof) for employer-sponsored coverage and the implications in their own circumstances:

*"They cut our hours so we would not be eligible."*

*"Wasn't eligible for health insurance through employer until open enrollment. I needed birth control immediately. I am now covered."*

*"TAKE CHARGE is still a much better program than my insurance."*

Other survey questions about health insurance addressed prior experience with purchasing health insurance and dependents' coverage.

Respondents had limited prior experience with purchasing health insurance: more than three-fourths (84%) of respondents had not tried to buy health insurance on their own since January 2011. For 76% of these clients, the main reason that they had not purchased a health insurance plan on their own was that the costs were too high. Twelve percent (12%) got a plan through another source, and for 6%, the reason was that the benefits they wanted were not covered.

More than two-thirds (69%) of respondents were aware that children up to age 26 can stay on or enroll in their parents' health plans if the plan includes dependent coverage; however, just 29% of clients younger than 26 had stayed on or enrolled in their parents' health plan in the past twelve months.

# Attachment B Continued

## 2 HealthPlanFinder was the most frequent source of information about health insurance but two-thirds of women found it difficult or impossible to get the help they needed there.

Washington's Health Benefit Exchange, known as Washington HealthPlanFinder, became operational on October 1, 2013. Although Washington was noted to be among a small numbers of states whose sites ran "especially smoothly," its operation was not without glitches.<sup>14</sup> Nevertheless, by December 2013, Washington was second only to California in the number of Medicaid and insurance enrollees,<sup>15</sup> and by March 31, 2014, 164,062 Washingtonians had enrolled in private insurance through Washington HealthPlanFinder.<sup>16</sup>

Staff of the Washington Health Benefit Exchange was aware of the frustration that some visitors experienced at the HealthPlanFinder website. Michael Marchand, spokesperson for the Health Benefit Exchange, commented about the website's technical difficulties: "It's disappointing because we don't want people's first engagement of our website to be anything short of a great consumer experience."<sup>17</sup>

The TAKE CHARGE Health Insurance survey included questions about awareness of HealthPlanFinder, whether or not clients considered buying health insurance through the marketplace, how easy (or difficult) it was for clients to get information and the help they needed from various sources, and their reasons for not buying health insurance through the exchange.

### FINDINGS

The level of awareness about the health benefit exchange among survey respondents was high: 70% of clients had heard about Washington's HealthPlanFinder, among whom 75% had considered buying health insurance through the Health Benefit Exchange. Similarly, just 2% of respondents cited lack of awareness of the exchange as the main reason they did not enroll in or purchase health insurance.

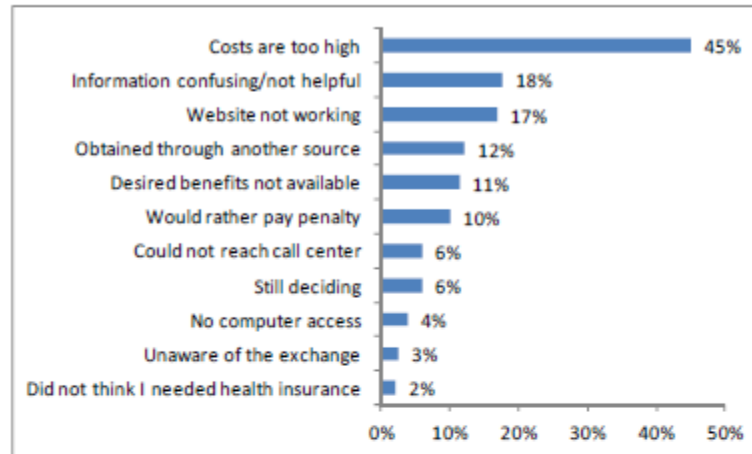
When asked how difficult it was to get information and the help they needed from a variety of sources, the majority of respondents (83%) indicated that they had tried to get health insurance information from HealthPlanFinder; however, more than half (58%) of those found it somewhat difficult or very difficult to get the help they needed. An additional 9% found it "impossible" to get the help they needed. Clients tried to get information about health insurance from other sources much less often: one-fourth to one-third of clients tried to get information from an insurance agent or broker (17%), navigators or application assisters (25%), family or friends (28%), a website other than [www.wahealthplanfinder.org](http://www.wahealthplanfinder.org) (30%), and the call center (34%).

The most frequent reason that respondents did not buy or enroll in a health insurance plan through the Health Benefit Exchange was cost: 45% responded that the main reason was that the costs are too high. Nearly one in five (18%) reported that the main reason was that the information they received was too confusing or not helpful. Twenty-nine percent (29%) of respondents reported technical or logistical reasons for not buying health insurance through the exchange, including website not working (17%), could not reach call center (6%), no computer access (4%), and unaware of the exchange (3%). Some clients obtained insurance through other sources (12%), found that the benefits they desired were not available (11%), or preferred to pay the penalty for not having health insurance (10%).

Few clients (2%) reported they had not purchased or enrolled in a health insurance plan because they did not think they needed health insurance. The proportion of clients who reported they did not have health insurance through their employer and who reported that they did not think they needed health insurance (0.3%) was somewhat lower; however, for both employer-sponsored health insurance and insurance through the exchange, the perception that the client did not need health insurance was one of the least frequently cited reason for not having health insurance.

# Attachment B Continued

Figure 3. Reasons for Not Purchasing Health Insurance Through the Health Benefit Exchange



Respondents' comments about their reasons for not purchasing health insurance through the exchange highlighted both the financial issues and technical problems.

*"The health insurance plans I could afford only covered my family after we had paid in tens of thousands of dollars. It did not pay for routine exams and only paid for a few cents on prescriptions."*

*"Trying to pay off debt and all current bills. Couldn't make monthly payments even with discount. My child is covered but I cannot afford it for myself."*

Respondents had long-lasting memories of technical problems with the exchange:

*"I missed open enrollment because I couldn't access my account, the website was always down and I could never reach anyone at the call center."*

*"I tried once and website was down. No urgent health issues, life got busy, and it is low on the list of priorities. It is an expense that is not a priority as well."*

*"The website was always down and I spent hours on the phone to no avail. It was absolutely horrible."*

*"There was a 20 hour wait on the phone."*

# Attachment B Continued

### **3** Nearly half the respondents in our survey indicated that they were unable to pay for health insurance because of bills they had to pay.

A key goal of the ACA is to make health insurance affordable to low-income persons, especially those without employer-sponsored health insurance. Low-income individuals and families with incomes at 138% to 260% of the FPL including the target population for this survey are potentially eligible for tax credits to purchase coverage through the health benefit exchange. The tax credits cap what purchasers contribute to their premiums at 3% to 8% of their income.<sup>18</sup>

Prior to the ACA, the financial consequences of medical bills and debt were recognized as a barrier for young adults obtaining health insurance.<sup>19</sup> In a 2013 survey, 52% of adults with incomes between 133% and 249% of the FPL reported problems with medical bills and debts, and 75% of those suffered other financial consequences as a result, including bankruptcy, credit card debt, a lower credit rating, or inability to pay for basic necessities (food, heat, rent).<sup>20</sup>

The TAKE CHARGE Health Insurance Survey included questions about consequences of debts and bills, unmet needs for health care, and the specific types of unpaid bills or debts that respondents were paying off over time.

#### **FINDINGS**

Nearly half (49%) of respondents indicated that they were unable to pay for health insurance because of bills that they had to pay. One-third (35%) were unable to pay for basic necessities like food, heat, or rent, and one-third (35%) had taken on credit card debt. Nearly half had used up all their savings (48%) or had problems paying for medical bills (44%). Nearly 4% reported that they had declared bankruptcy. On the other hand, 20% reported that they had not experienced any of the listed consequences because of bills they had to pay.

Sixty percent of respondents stated that they had to change their way of life a lot over the previous twelve months in order to pay for bills for themselves or their families.

Based on response to this survey, the most common unmet health need was dental care: 66% of clients had needed dental care during the previous twelve months but didn't get it because they couldn't afford it. In addition, 56% needed a general doctor visit but did not get it. One-fifth to one-third needed other health services but did not get them: mental health care or counseling (21%), medical specialist visit (27%), prescription drugs (27%), other medical tests, treatment or follow-up care (31%). Sixteen percent responded that they had not needed any of the listed services. As expected, the proportion who reported that they had not needed any of the listed health services was higher for younger women less than 26 years old (21%) than for older women age 26 and over (13%).

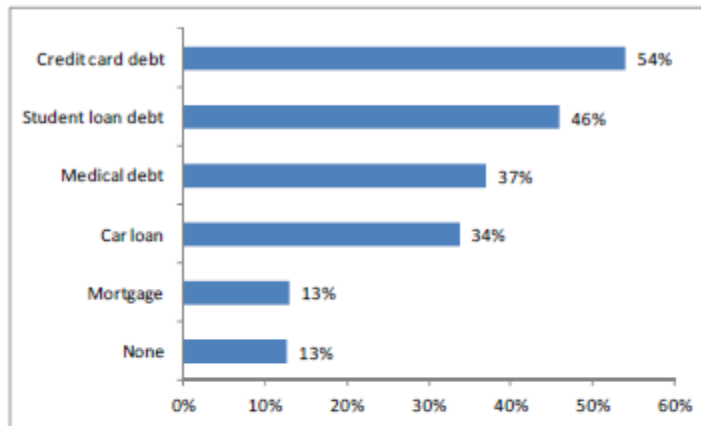
More than half (54%) the respondents reported that they had credit card debts they were paying off. Of the five different types of debt listed in this question, three or more types were reported by 30% of respondents. Thirteen percent of respondents reported that they had no unpaid bills or debts that they were paying off over time.

Just 8% of women age 26 and older reported having no unpaid bills or debts, compared to 21% of women less than 26 years old. Compared to younger women, a larger proportion of older women reported making payments for credit card debt (62% versus 41%), mortgage (18% versus 4%), car loans (39% versus 25%), and medical debt (43% versus 27%). The proportion of older women who had to change their way of life a lot in order to pay bills (64%) was higher than that for younger women (53%), and younger respondents described fewer consequences of debts.

Compared to older women, a larger proportion of younger women were unable to pay for health insurance because of bills they had to pay (43% versus 53%), had taken on credit card debt (27% versus 40%), or had declared bankruptcy (1% versus 6%).

## Attachment B Continued

Figure 4. Types of Unpaid Bills or Debts With Installment Payments



Respondents provided additional detail about specific other types of debts that they were paying off over time: traffic tickets, court fines, court costs, IRS back taxes, returning overpayment of unemployment insurance, damages for auto accident; car insurance, cell phone, furniture, wedding expenses; dentist and eye doctor, vet bills, and unspecified collections.



# Attachment B Continued

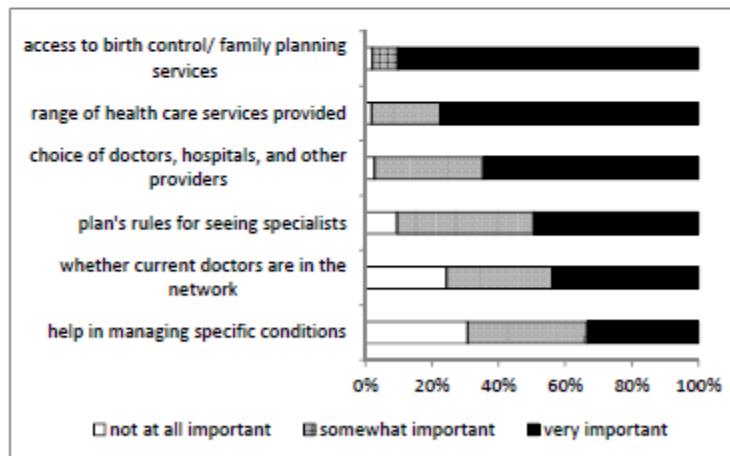
## 4 More than half the respondents indicated that it would be very difficult or impossible for them to pay the personal costs for health insurance in the future.

While the future of a number of the ACA's provisions is uncertain,<sup>21</sup> an estimated 10.3 million adults in the United States had gained health insurance coverage by the second quarter of 2014.<sup>22</sup> More time will be needed to get closer to the goal of near-universal coverage. In addition to undocumented immigrants who are not eligible for subsidized coverage, the general reasons that Americans may not obtain insurance were predicted to be that they were not aware of their eligibility, they were unable to find an affordable premium, or they choose not to enroll.<sup>23</sup> Consumers' perception that coverage, even with federal subsidies, is not affordable for them remains a serious obstacle to enrollment.<sup>24</sup>

Respondents to our survey confirmed that high costs were the most common reason for not purchasing health insurance through Washington's health benefit exchange, and nearly half indicated that they were unable to pay for health insurance because of bills they had to pay. Looking to the future, just 5% told us that it would be "not at all difficult" for them to pay the personal costs of health insurance in 2015; 35% indicated that it would be "somewhat difficult," 46% "very difficult," and 14% told us it would be "impossible" for them to pay the personal costs of health insurance.

The TAKE CHARGE Health Insurance Survey also explored non-financial factors that might play a role in clients' choosing a new health insurance plan.

Figure 5. Importance of Non-Financial Factors in Choosing a New Health Insurance Plan



Ninety-eight percent (98%) of respondents identified access to birth control/family planning services as being a very important (90%) or somewhat important (8%) factor in choosing a new health insurance plan. Similarly, 98% identified the range of health care services provided as very important (78%) or somewhat important (21%).

In contrast, nearly one-third (31%) of respondents identified help in managing specific conditions and one-quarter (24%) identified whether current doctors are in the network as being not at all important in choosing a new health insurance plan.

## Attachment B Continued

Women 26 year of age and older assigned greater importance to some factors, compared to younger women less than 26 years old. More than 80% of older women ranked the range of services as "very important," compared to 70% of younger women. More than half (56%) of older women ranked the plan's rules for seeing specialists as "very important," compared to 38% of younger women, and nearly half (48%) of older women ranked whether current doctors are in the network as "very important," compared to 37% of younger women. Five percent of younger women identified none of the listed non-financial factors as being important, compared to 0.5% of older women.

Clients' comments provided additional insights. A few clients asked for the definition of a network, and other clients noted the challenges they have faced in obtaining health insurance that met their needs:

*"After applying for WA Healthplanfinder, I had to stop paying so I could afford food and gas expenses. I live in a one bedroom apartment and they were asking me for \$200 a month for healthcare I did not use. Take Charge is the only program I use since I'm healthy and only need family planning services. went through Community College to save expenses. I work four jobs"*

*"I enrolled in the WA exchange in January and struggle every month to pay for it, usually charging it to my credit card. My kids are on Apple Health but I do not qualify because I work 2 jobs. The only reason I bought it was because of the penalties."*

*"Please continue the TAKE CHARGE program so that I can continue to get myself and my husband out of debt without the stress of not being able to afford health care. We can barely afford birth control; we couldn't imagine the debt we'd have if we had a child from an unplanned pregnancy."*





# Attachment B Continued

## CONCLUSION

Washington women enrolled in the TAKE CHARGE family planning program after implementation of health care reform informed us about their circumstances, and their attitudes and beliefs about the health insurance marketplace. Generally speaking, these women expressed gratitude for the family planning services they received through the TAKE CHARGE program and their hope that the program would continue. Access to birth control/family planning services was widely identified as being an important factor in choosing a new health insurance plan. On the other hand, respondents were not optimistic about their ability to afford health insurance in the future: just 5% told us that it would be “not at all difficult” for them to pay the personal costs of health insurance in the future; the remaining 95% indicated that it would be “somewhat difficult” (35%), “very difficult” (46%), or “impossible” (14%).

Respondents shared a broad range of insights about their own circumstances. They weighed the overall personal costs of health insurance (premiums and out-of-pocket costs) against their anticipated needs for health services, and many concluded that health insurance was too costly relative to the value it provided them. For other women, although their income was too high to qualify for Medicaid, they had incurred substantial debts that they were paying off over time, and this precluded their being able to pay health insurance premiums. Timing issues and logistics were recurrent themes: clients missed deadlines to apply for health insurance, and, if they experienced obstacles to enrollment on the HealthPlanFinder website, they did not try again or try different approaches; instead, they simply failed to buy health insurance. Timing issues were also important with respect to access to birth control: one client noted an immediate need for birth control that could not wait for open enrollment.

While 98% of respondents identified access to birth control/family planning services as being a very important or somewhat important factor in choosing a health insurance plan, a number expressed concerns about the adequacy of coverage from private insurers for contraceptive services and supplies. They mentioned co-pays for birth control, lack of coverage for their preferred birth control method, and inadequate coverage.

The recent report, *Contraceptive Coverage in Washington State’s Qualified Health Plans* (April 2015), highlights inconsistent information from health plan representatives about coverage of FDA-approved contraceptive methods. This study included “secret shopper” calls to sales and customer service representatives of the eight insurance carriers that offered qualified health plans in 2014 in Washington. They found that no carrier’s representatives consistently responded that most birth control methods were available without cost-sharing, and, on average, they indicated that more than half the methods required cost-sharing. The study compared the responses of the health plan representatives to the carriers’ filing with the Washington Office of the Insurance Commissioner and determined that the health plan representatives’ statements were largely “inaccurate.”

The extent of confusion and inconsistency on the part of the health plan representatives, as reflected in the *Contraceptive Coverage* report, validates the perceptions of our survey respondents about inadequate coverage and co-pays for birth control. Although our survey did not identify the specific health insurance plans that were problematic for our respondents, it is understandable that women will seek coverage through the TAKE CHARGE program until insurance carriers are clearly in compliance with the ACA requirement—that plans cover all FDA-approved contraceptive methods without cost-sharing for all women with reproductive capacity—and are providing accurate information about birth control coverage to consumers.

While the number of clients remaining enrolled in the TAKE CHARGE program continues to decline, some challenges that women faced in buying health insurance may increase. With shorter time periods for open enrollment, more women may miss deadlines. If requirements for employers to provide coverage for family planning methods are relaxed in the future, more working women may find themselves without family planning coverage through employer-sponsored health insurance. Without a broad and rigorous mandate for employers to provide health insurance to their employees, more working women will not have any employer-sponsored health insurance. It is important to note, as well, that women will continue to be employed in seasonal, part-time, and service jobs that traditionally have not offered health insurance. The perceived value of health insurance will

## Attachment B Continued

decrease if premiums rise; however, progressive increases in penalties for not having health insurance may persuade more women to purchase insurance. As health insurance literacy increases, women may gain more accurate information about coverage of specific family planning methods and access to birth control without cost-sharing.

Washington's implementation of health care reform has resulted in dramatic changes across the state, with very large increases in the numbers of Medicaid enrollees and significant numbers of individuals who obtained insurance through Washington's Health Benefit Exchange. Nevertheless, a small number of women continue to have clear needs for family planning coverage that are not being met, except through the TAKE CHARGE family planning program. Other groups in Washington State such as undocumented women are not eligible to purchase insurance through the Health Benefit Exchange and currently have limited access to family planning services. In states that did not expand Medicaid as provided for by the ACA, the need for family planning waivers will be even greater than in states like Washington which expanded Medicaid.

Just as the Kaiser Family Foundation reports that "medical debt can affect almost anyone," limited assets and high debts are common problems that influence affordability of health insurance in the United States. In our population of well-educated, mostly working adult women who responded to our survey, paying for medical bills in particular was a problem for nearly half (44%) the respondents in our survey, and debts of some type were reported by 9 of 10 women (87%).

Many women least able to afford health insurance are the same women with the greatest need to prevent unintended pregnancy. In the words of one survey respondent,

*"Please continue the Take Charge program so that I can continue to get myself and my husband out of debt without the stress of not being able to afford health care. We can barely afford birth control—we couldn't imagine the debt we'd have if we had a child from an unplanned pregnancy."*



# Attachment B Continued

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<sup>20</sup> Collins SR, Robertson R, Garber T, and Doty MM. (April 2013) Insuring the Future: Current Trends in Health Coverage and the Effects of Implementing the Affordable Care Act. New York: The Commonwealth Fund, April 2013.

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# Attachment B Continued

## APPENDIX


DRAFT

# Attachment B Continued

## APPENDIX A

**PLEASE PROMPTLY RETURN THIS SURVEY IN THE ENCLOSED POSTAGE-PAID ENVELOPE**

**TAKE CHARGE**  
2014 Health Insurance Survey



*Thank you for participating in the TAKE CHARGE Health Insurance Survey! Your answers will help to improve access to health insurance for women and men in the state of Washington. The survey questions ask about your experience and opinions about getting health insurance and medical care in Washington State. Your participation and responses in this survey are completely confidential and will not affect your health care. For more information about the survey, please call us toll-free at (877) 890-2635.*

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

**1. Our records show that you were enrolled in the TAKE CHARGE family planning program in 2014. Is that correct?**

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

**Health Insurance Enrollment**

*We are interested in your experiences, if any, with different sources of health insurance. The next questions ask about possible sources of health insurance other than TAKE CHARGE family planning coverage.*

**2. Many people receive health insurance offered through an employer or union. What are your reasons for not having health insurance from an employer or union? (Check all that apply)**

Not working.  
 Self-employed.  
 Employer does not offer health insurance.  
 Not eligible for my employer's health plan.  
 Employer's plan is too expensive.  
 Employer's health benefits are inadequate.  
 I did not think I needed health insurance.  
 I have health insurance through my employer but it does not cover the birth control services that I need.  
 Other (please tell us) \_\_\_\_\_

**3. Under the new health reform law, children up to the age of 26 can stay on or enroll in their parents' health plans if they include dependent coverage. Were you aware of this?**

Yes  
 No

Page 2

# Attachment B Continued

9. If you tried to get health insurance information from any of the following sources, how difficult was it to get the help you needed?

www.wahealthplanfinder.org	<input type="checkbox"/>
Other Website	<input type="checkbox"/>
Call Center	<input type="checkbox"/>
Navigators/Application Assistants	<input type="checkbox"/>
Insurance Agent or Broker	<input type="checkbox"/>
Family or Friend(s)	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>

10. What was the main reason you did not buy or enroll in a health insurance plan through the Healthplanfinder/Health Benefit Exchange?

<input type="checkbox"/>	The website was not working.
<input type="checkbox"/>	I could not get computer access.
<input type="checkbox"/>	I could not reach the telephone call center.
<input type="checkbox"/>	The information I got was too confusing or not helpful.
<input type="checkbox"/>	The costs are too high.
<input type="checkbox"/>	The plans do not cover the benefits I want.
<input type="checkbox"/>	I am still deciding, not yet ready to enroll.
<input type="checkbox"/>	I would rather pay the penalty for not having health insurance.
<input type="checkbox"/>	I got health insurance through another source.
<input type="checkbox"/>	I was not living in Washington at the time.
<input type="checkbox"/>	I did not think I needed health insurance.
<input type="checkbox"/>	I was not aware of the state healthplanfinder/health benefit exchange.
<input type="checkbox"/>	Other (please tell us) _____

4. In the past 12 months, have you stayed on or enrolled in your parents' health plan?

Yes  
 No  
 Not Applicable—I am older than 26

5. Some people buy health insurance on their own—that is, not through any employer, union, or government program. In the past three years, since January 2011, have you ever tried to buy health insurance on your own?

Yes → If Yes, go to #7  
 No

6. What is the main reason you did not buy a health insurance plan on your own?

The costs were too high.  
 The benefits I wanted were not covered.  
 I got a plan through another source.  
 Other (please tell us) \_\_\_\_\_

---

Experiences with Healthplanfinder

From October 2013 through March 2014, people without health insurance could go to a new state insurance "exchange" or marketplace and buy a health plan or enroll in Medicaid (Apple Health). In Washington, this marketplace is called the Healthplanfinder. The next few questions ask about experiences you may have had with Washington's Healthplanfinder.

7. Have you heard about Washington's Healthplanfinder/Health Benefit Exchange?

Yes  
 No → If No, go to #11

8. Did you consider buying health insurance through Washington's Healthplanfinder/Health Benefit Exchange?

Yes  
 No



# Attachment B Continued

**Your Financial Situation**

11. During the past 12 months, have you experienced any of the following issues because of bills that you had to pay? (Check all that apply)

Unable to pay for basic necessities like food, heat, or rent

Unable to pay for health insurance

Had problems paying for medical bills (for doctors, dentists, hospitals, therapists, medication, equipment, nursing home or home care)

Used up all my savings

Taken on credit card debt

Had to declare bankruptcy

I did not experience any of these issues because of bills I had to pay.

12. During the past 12 months, did you ever need any of the following but didn't get it because you couldn't afford it? (Check all that apply)

Prescription drugs

General doctor visit

Medical specialist visit

Other medical tests, treatment, or follow-up care

Dental care

Mental health care or counseling

I did not need any of these services.

13. Over the last 12 months, have you had to change your way of life a lot in order to pay bills for yourself or your family?

Yes

No

14. What kinds of unpaid bills or debts, including student loans, are you paying off over time? (Check all that apply)

Credit card debt

Mortgage

Student loan debt

Automobile loan

Medical debt

Other (please tell us) \_\_\_\_\_

I have no unpaid bills that I am paying off over time.

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**Planning for Future Health Insurance**

15. If you were choosing a new health insurance plan today, how important would each of the following non-financial factors be in your decision?

Very Important      Somewhat Important      Not at all Important

Choice of doctors, hospitals, and other providers in the network.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Whether your current doctors are in the network.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Access to birth control/ family planning services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The plan's rules for seeing specialists, such as requiring a referral or prior authorization.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The range of health care services available.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Help in managing specific conditions, like asthma or diabetes.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

16. Next year (2015), how difficult would it be for you to pay the personal costs of health insurance, such as premiums, copays, and deductibles?

Not at all difficult

Somewhat difficult

Very difficult

Impossible

**About You**

17. In general, how would you rate your overall health?

Excellent

Very good

Good

Fair

Poor

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**Planning for Future Health Insurance**

15. If you were choosing a new health insurance plan today, how important would each of the following non-financial factors be in your decision?

Very Important      Somewhat Important      Not at all Important

Choice of doctors, hospitals, and other providers in the network.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Whether your current doctors are in the network.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Access to birth control/ family planning services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The plan's rules for seeing specialists, such as requiring a referral or prior authorization.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The range of health care services available.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Help in managing specific conditions, like asthma or diabetes.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

16. Next year (2015), how difficult would it be for you to pay the personal costs of health insurance, such as premiums, copays, and deductibles?

Not at all difficult

Somewhat difficult

Very difficult

Impossible

**About You**

17. In general, how would you rate your overall health?

Excellent

Very good

Good

Fair

Poor

Page 6



# Attachment B Continued

If you would like information about opportunities to obtain health insurance offered through Washington's Healthplanfinder or through Washington's Medicaid program known as Apple Health:

Call the Washington Health Benefit Exchange at 1-855-WAFINDER (1-855-923-4633), or

Visit the Health Benefit Exchange website at [www.wahealthplanfinder.org](http://www.wahealthplanfinder.org), or

Email your questions to [customersupport@wahealthexchange.org](mailto:customersupport@wahealthexchange.org)

**Your answers are important.**

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

ATTN: SURVEY PROJECT  
DEPARTMENT OF SOCIAL & HEALTH SVCS  
RESEARCH AND DATA ANALYSIS  
PO BOX 45204  
OLYMPIA WA 98599-9807

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18. Do you have one person you think of as your personal doctor or health care provider?

Yes, I have one  
 Yes, I have more than one  
 No, I have no personal doctor or health care provider.

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

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

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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# Attachment B Continued

## APPENDIX B

Respondents Less than Age 26 Compared to Respondents Age 26 or More  
Survey Elements of Interest with Significant Differences

Q#	Element	Response Proportions	
		Younger	Older
2	Self-employed	1.6	10.3
4	On parents' health plan		
	Yes	28.8	0.9
	Not Applicable—I am older than 26	0.8	80.2
5	In the past three years ... have you ever tried to buy health insurance on your own?	4.8	22.6
6	What is the main reason you did not buy a health insurance plan on your own?		
	The costs were too high	69.7	81.2
	I got a plan through another source	17.6	7.9
	None checked	6.4	25.8
7	Have you heard about Washington's Healthplanfinder/Health Benefit Exchange?	50.4	81.7
8	Did you consider buying health insurance through the Exchange?	65.1	78.9
9	Very difficult or impossible to get needed help from the following sources		
	Other website	8.3	18.1
	None checked	53.6	23.5
10	What was the main reason you did not buy or enroll in a health insurance plan through the ... Exchange?		
	The plans do not cover the benefits I want	6.3	13.2
	None checked	50.4	18.8
11	During the past 12 months, have you experienced any of the following issues because of bills that you had to pay?		
	Unable to pay for health insurance	43.2	53.1
	Taken on credit card debt	27.2	39.9
	Had to declare bankruptcy	0.8	5.6
12	During the past 12 months, did you ever need any of the following but didn't get it because you couldn't afford it?		
	Prescription drugs	16.8	32.9
	Mental hltl care or counseling	16.8	23.9
	I did not need any of these services	20.8	12.7
13	... had to change your way of life a lot in order to pay bills for yourself or your family?	53.2	63.6
14	What kinds of unpaid bills or debts, including student loans, are you paying off over time?		
	Credit card debt	40.8	62.4
	Mortgage	4.0	18.3
	Automobile loan	24.8	39.0
	Medical debt	27.2	42.7
	I have no unpaid bills that I am paying off over time	20.8	8.0
15	Very important non-financial factors in choosing a new health insurance plan		
	Choice of doctors, hospitals, and other providers in the network	37.4	47.6
	The plan's rules for seeing specialists	38.1	56.0
	The range of health care services available	70.3	81.7
	None checked	4.8	0.5
17	In general, how would you rate your overall health?		
	Good (note that all other categories were not significantly different)	43.4	33.5
18	Do you have one person you think of as your personal doctor or health care provider?		
	No, I have no personal doctor or health care provider	71.3	60.1
19	What is the highest grade or level of school that you have completed?		
	Some college, college, or more than college (combined)	67.2	82.5

Differences are statistically significant based on 95% confidence interval for differences between proportions.

# Attachment B Continued



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# Attachment C: Evaluation Design, 2018-2022

## 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
<b>Demonstration Objective 1: Ensure access to and utilization of family planning and/or family planning-related services for individuals not otherwise eligible for Medicaid.</b>						
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
<b>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.</b>						
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 <sup>2</sup> 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.

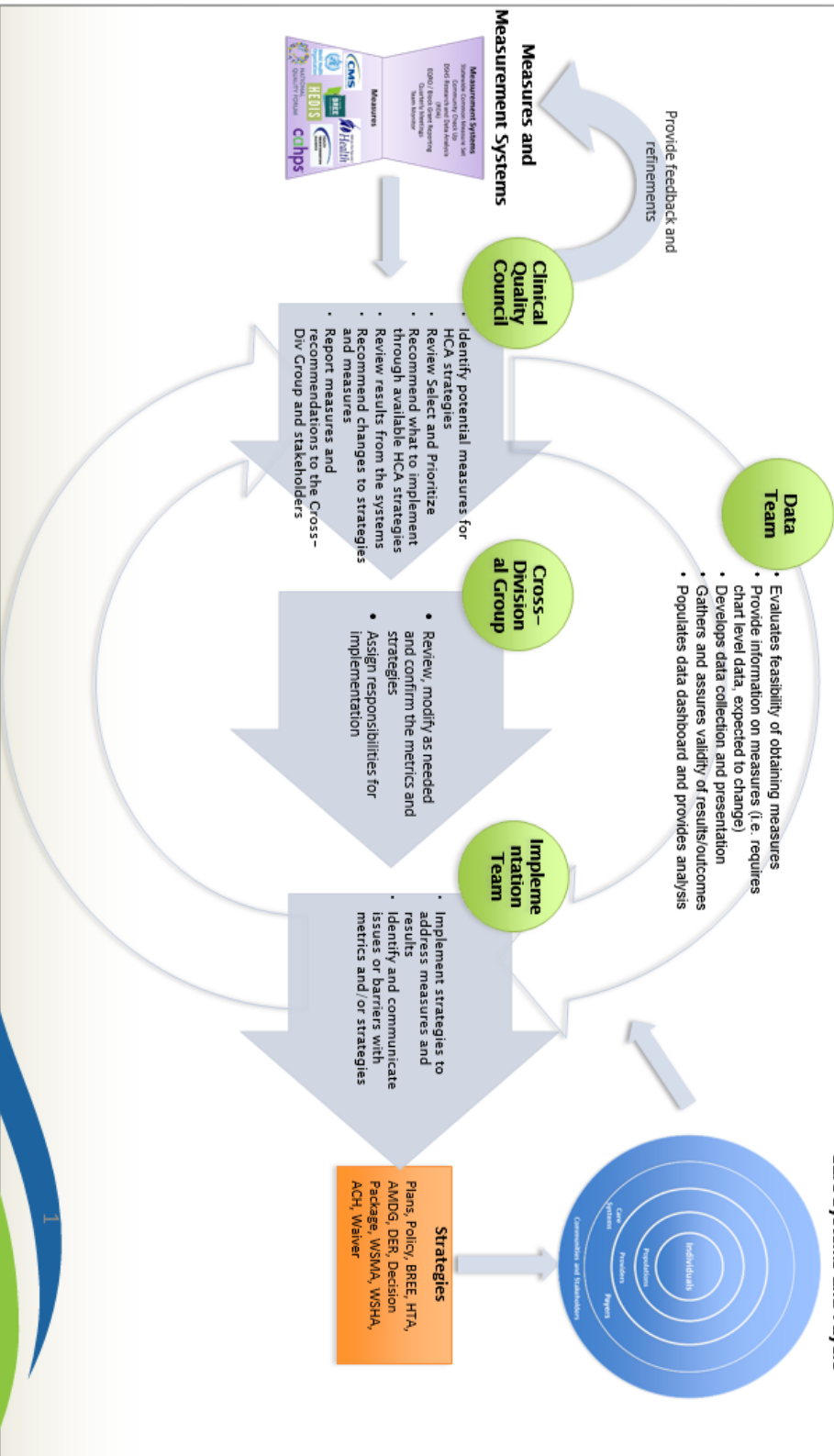
**E. Independent Contractor:** Indicate and describe the process the state will follow to acquire an independent entity or entities to conduct the evaluation (either a competitive procurement or those with an existing contractual relationship with the state). Include the timeframe for the independent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

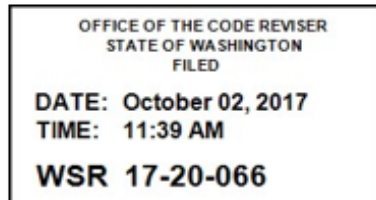


# Attachment D: Quality Measuring, Monitoring and Improving Process

*The Quality Measuring, Monitoring and Improving (QMMI) process ensures that the right quality measures are selected and prioritized, statewide actions and implementation activities are coordinated, and measures are continually refined and improved-upon.*



# Attachment E: Public Notices, Comments, & Responses



STATE OF WASHINGTON  
WASHINGTON STATE HEALTH CARE AUTHORITY

October 18, 2017

NOTICE

**Title or Subject:** Section 1115 Extension Application

**Effective Date:** January 1, 2018

**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 December 2022). The current waiver expires on December 31, 2017. It covers limited family planning and family planningrelated services for women and men who are enrolled in the Agency's two programs -- Family Planning Only Extension and Take Charge.

The purpose, client eligibility requirements, and benefit package will remain the same. The name will change to Family Planning Only to reduce confusion inherent in two program names.

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 women who lose Medicaid coverage after their pregnancy coverage ends. These women are automatically enrolled for 10 months.
- Uninsured women and men 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% (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 at specified providers who can assist with completion of the application. Services are currently provided at specified clinics across Washington State (listed on the Agency website).

The Family Planning Only program provides the following services on a fee-for-service basis: all FDAapproved contraceptives; natural family planning; over-the-counter contraception; emergency contraception; sterilization; contraceptive education, counseling, and management; limited STI/STD testing and treatment related to successful use of the chosen contraceptive method; cervical cancer screening according to national clinical guidelines when associated with a family planning visit; office

# Attachment E Continued

visits and limited ancillary services related to the above services. There are no cost-sharing requirements to receive services under this program.

Because eligibility and services will remain the same, this extension is anticipated to have no effect on annual aggregate expenditures or enrollment. Based on fiscal year 2016 experience we expect enrollment of approximately 4,000 clients with an expenditure of \$1.5 million for each year of the five year renewal period.

Washington will evaluate two goals of the 1115 family planning only demonstration, a) ensure access to family planning and/or family planning-related services and b) improve or maintain health outcomes for the target population as a result of access to family planning and/or family planning-related services by testing the following hypotheses:

1. Enrollees will utilize family planning services and/or family planning related services.
2. Beneficiaries will maintain coverage for one or more 12 month enrollment period.
3. Health outcomes will improve as a result of the demonstration.
4. Beneficiaries will have a higher rate of using more effective contraceptive methods compared to other members of Medicaid beneficiaries.

This evaluation will use comparative quantitative analysis of administrative data for two groups: the demonstration population and the general Medicaid population. Data sources include the Agency's claims files and a database that joins birth certificate data with claims data called the First Steps Database. Details of the evaluation design can be found in the extension application.

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.

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](http://www.hca.wa.gov/family-planning). The Agency updates this webpage regularly.

# Attachment E Continued

**Comment:** The public comment period for the Family Planning Only Demonstration Waiver extension application is from **Wednesday, October 18** through **Friday, November 17** at 5 p.m. PST. You can email comments to [familyplanning@hca.wa.gov](mailto:familyplanning@hca.wa.gov), fax comments to 360-725-1152, or mail comments to the address below. A copy of the draft application is available at: [www.hca.wa.gov/family-planning](http://www.hca.wa.gov/family-planning).

Two public meetings are scheduled. The Agency will accept verbal and written comments at these meetings. The meetings are:

- **Webinar**  
*Wednesday, October 25, 1:00-2 PM.*  
  
Join online:  
<https://attendee.gotowebinar.com/register/9163594174457536259>  
To use phone for audio: +1 (914) 614-3221  
Access Code: 132-623-897  
Audio PIN: Shown after joining the webinar  
In Person: 626 8<sup>th</sup> Ave. SE, Olympia WA 98501; Room 127 - Apple  
Sign in at the reception desk and get a visitor badge.
  
- **Title XIX Advisory Committee Meeting**  
*Friday, November 3, 8:30–12:00 PM.*  
Call-in: 1-888-407-5039; Participant pin: 91312278  
In person: 626 8th Ave. SE, Olympia WA 98501; Room TBA  
Sign in at the reception desk and get a visitor badge.

For additional information or a hard copy of the application, please contact:

Washington State Health Care Authority. Attn.  
Anaya Balter  
Clinical Director for Women's Health  
PO Box 45502, Olympia, WA 98504-5502  
Phone: 360-725-1652  
TDD/TTY: 1-800-848-5429  
Fax: 360-725-1152  
E-mail address: [familyplanning@hca.wa.gov](mailto:familyplanning@hca.wa.gov) Web  
site addresses:

- Take Charge page: [www.hca.wa.gov/family-planning](http://www.hca.wa.gov/family-planning)
- Public Notice page: <https://www.hca.wa.gov/about-hca/news-data-and-reports-hca/public-notice>

# Appendix F: Budget Neutrality Worksheet, 2012-2016

**WASHINGTON STATE  
TAKE CHARGE MEDICAID SECTION 1115 DEMONSTRATION WAIVER  
BUDGET NEUTRALITY WORKSHEET - Demonstration Years 11-16 (July 2011-June 2017)**

Budget neutrality is calculated using the methodology described on page 14 of the Washington State Special Terms and Conditions #11-W-00134/0-01.  
**This sheet uses the expenditures reported on the CMS 64.**

President's Trend Rate	6.2%													
Demonstration Year*	16	15	14	13	12	11	17	16	15	14	13	12	11	12
State Fiscal Year														

Calculation of Washington's Trend Rate: Using Total Expenditures													
# Member Months	86,208	90,010	133,996	555,114	642,607	678,144	88,109						
PMPM Cost	\$ 15.76	\$ 17.51	\$ 16.39	\$ 26.35	\$ 28.22	\$ 21.90	\$ 16.64						
WA Trend Rate	-10%	7%	-38%	-7%	29%		-1.6%	Avg DY16 & DY15					

Calculation of Washington's Trend Rate: Using FFP Service Expenditures only													
# Member Months	86,208	90,010	133,996	555,114	642,607	678,144	88,109						
PMPM Cost	\$ 13.25	\$ 13.96	\$ 11.84	\$ 23.30	\$ 24.60	\$ 19.05	\$ 13.60						
WA Trend Rate	-5%	18%	-49%	-5%	29%		6.4%						

Calculation of Annual Budget Limit and Margin:												
Annual Budget Limit (DOP)	\$ 1,167,091.00	\$ 1,378,910.00	\$ 1,964,285.29	\$ 13,234,470.00	\$ 16,401,891.00	\$ 13,521,214.63						
Margin	\$ (191,833.00)	\$ (197,127.00)	\$ (231,694.64)	\$ (1,392,135.00)	\$ (1,729,349.00)	\$ (1,326,999.53)						

Calculation of Composite Federal Share:												
FFP Service Received by WA (CMS 64)	\$ 1,142,321.00	\$ 1,256,327.00	\$ 1,587,085.19	\$ 12,933,646.00	\$ 15,810,175.00	\$ 12,921,369.87						
FFP Admin Received by WA (CMS 64)	\$ 24,770.00	\$ 122,583.00	\$ 377,200.10	\$ 300,824.00	\$ 591,716.00	\$ 599,844.76						
Total FFP (CMS 64)	\$ 1,167,091.00	\$ 1,378,910.00	\$ 1,964,285.29	\$ 13,234,470.00	\$ 16,401,891.00	\$ 13,521,214.63						
Total Expenditures (CMS 64)	\$ 1,358,924.00	\$ 1,576,037.00	\$ 2,195,979.93	\$ 14,626,605.00	\$ 18,131,240.00	\$ 14,848,214.16						
Composite Federal Share	0.86	0.87	0.89	0.90	0.90	0.91						

Demonstration Year 16 is reported based on claims paid through September 2017.  
DY 16 # member months is based on adding each quarters member months from the Quarter 4 Report.