Washington State Health Care Authority

Annual Report: Section 1115 Family Planning Only Demonstration Waiver
Demonstration Reporting Period: July 1, 2017-June 30, 2018
Demonstration Year: 17
Approved start and end date of the Demonstration: July 1, 2011 – June 30, 2018
Project Number: 11-W-00134/0

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EXECUTIVE SUMMARY

Washington has participated in the 1115 Family Planning Only Demonstration Waiver since July 1, 2011. Health Care Authority (HCA) administers the waiver in Washington in addition to Medicaid. The waiver extends eligibility for family planning services to uninsured women and men capable of producing children and certain groups that need confidential family planning services, all with income at or below 260 percent of the federal poverty level (FPL). The Special Terms and Conditions (STCs) for the waiver requires an annual monitoring report be submitted 90 days following the end of each demonstration year. This report provides information on enrollment, utilization, operations, and expenditures related to the waiver. Washington uses the state fiscal year (SFY) as our demonstration year (DY) period.

This report covers services provided during the period July 1, 2017 through June 30, 2018. Enrollment has remained stable over the past demonstration year, with a slight increase during the last quarter of the year. In May 2018, the 1115 waiver family planning demonstration was approved for another 5 years. In conjunction with this renewal we will make a few policy and operational changes in the next year to improve access to services and enrollment. Appendix A describes historical program and policy changes and how enrollment and participation has changed over the 17 years, the waiver has been in place in Washington. Appendix B is our Budget Neutrality Workbook.

INTRODUCTION

Washington State's 1115 waiver family planning only demonstration was originally approved by the Centers for Medicare and Medicaid Services (CMS) in 2001 and became effective July 1, 2001. The waiver includes two programs: the Family Planning Only Extension, which existed prior to the waiver and, the Take Charge program, which began with the waiver. The waiver has been consistently renewed and extended since 2001. The major changes that occurred to the waiver programs are described in Appendix A. The waiver was renewed on May 9, 2018 for five years through June 30, 2023 with only one program change; the name is now Family Planning Only Program.

Program Goals

- Improve access to family planning and family planning related services.
- Decrease unintended pregnancies.
- Lengthen intervals between pregnancies and births to positively improve birth and women's health outcomes.
- Reduce state and federal Medicaid expenditures for averted births from unintended pregnancies.

Program Eligible Population

The family planning only demonstration waiver includes two family planning only programs with three groups of clients:

- Family Planning Only Extension
    - Recently pregnant women who lose Medicaid coverage after their 60-day post pregnancy coverage ends. Coverage is for ten more months.
- Take Charge
    - Uninsured women and men with family incomes at or below 260% of the FPL, seeking to prevent an unintended pregnancy.
    - Teens and domestic violence victims who need confidential family planning services and have income at or below 260% of the FPL.

Program Coverage

The family planning only 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:
  - Sterilization (Tubal procedures and Vasectomy).
  - Emergency Contraception.
  - Intrauterine Devices.
  - Contraceptive Implant.
  - Contraceptive Injection
  - Oral Contraceptives.
  - Contraceptive Patch.
  - Vaginal Ring.
  - Diaphragms and Cervical Caps.
  - Spermicides.
  - Male and Female Condoms.
  - Natural Family Planning.

- Family planning-related services for women include an annual comprehensive family planning preventive medicine visit, screening for gonorrhea and chlamydia for women ages 13 through 25, cervical cancer screening, and services directly related to successfully using a chosen method of contraception.

- Family planning-related services for men include an annual counseling session for reducing the risk of unintended pregnancy, condoms and spermicides, and services directly related to vasectomies.

Definition of Terms:

In this report the following terms are used as defined here.

Enrollees are defined as all individuals enrolled in the demonstration for the specified demonstration year, including those newly enrolled and those still eligible from the previous demonstration year. This is also called the eligible population.

Participants are defined as all individuals who obtain one or more covered family planning services through the demonstration.

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.

Re-enroll is defined as clients who dis-enroll, then re-enroll with a gap greater than 4 months or were previously pregnant, but re-enrolled after pregnancy ended.

Full benefits includes all full eligible clients, including the new Medicaid Expansion program, and Parent/Caretaker.

Member months refer to the number of months in which persons enrolled in the demonstration are eligible for services.

PROGRAM UPDATES- Current Trends and Significant Program Activity

Administrative and Operational Activities

There have been no significant program changes in the past demonstration year. The major accomplishment this past year was the successful completion of an application to CMS for renewal of the 1115 demonstration waiver and the successful approval of a renewal period for 5 more years. Payment rates are set at and adjusted along with the Apple Health fee for service reimbursement rates. These are updated every July 1.

Delivery System

Access to family planning services is widely available through expanded Medicaid, qualified health plans and other commercial insurance. HCA continues to support efforts to provide Washington residents with access to comprehensive insurance coverage that surpass the coverage that the family planning only programs offer. We are invested in seeing that all women, whose pregnancies and births are paid for by Medicaid, have access to the services they need to plan and space their pregnancies. HCA also administers a state funded family planning only program for populations that do not meet the waiver criteria. There are still gaps in coverage for some Medicare enrollees, young adults covered by their parents insurance who desire confidentiality, and some immigrant populations. These groups are currently not eligible for the waiver. Further analysis would need to be done to explore changes to the current waiver that would allow these individuals access to family planning services.

Over the past year Washington State partnered with a non-profit organization called Upstream that has launched a five year project to train clinics on how to provide same day contraceptive services, incorporate pregnancy intention questions into routine primary care, provide long acting reversible contraception (LARC) services, and create referral networks for contraceptive care not offered at their clinics. Upstream is recruiting clinics to participate in their project. Providers that provide services through Washington Apple Health (Medicaid) and our Family Planning Only programs are being targeted for inclusion. Upstream will also engage in outreach activities to the public to raise awareness about the importance of considering pregnancy intention, birth control options, and where to receive family planning services. These activities will include education about HCA's family planning only programs.

Washington is currently involved with a health delivery transformation process called Healthier Washington that includes projects and strategies to improve reproductive health care in the state. Reproductive health performance measures are included in one of the domains of the Accountable Communities of Health (ACH) projects. One ACH did a pilot project to train providers in their community on providing LARCs. This was successful and well received and informed the other ACHs about what is possible. Three ACHs covering 15 counties chose projects related to reproductive health. The projects focus on:

- reducing unintended pregnancy and supporting healthy planned pregnancies
- expanding access to highly effective contraceptive methods
- aligning with group prenatal care
- supporting linkages from primary care to community-based programs that serve low-income families

Projects assessments were concluded and approved by HCA for implementation during the past year. These projects are supposed to focus on the community as a whole and will therefore impact the clients

and providers that are served by HCA's waiver family planning only programs.

Provider Participation

As of June 30 2018, the family planning only waiver had 25 provider groups serving clients at 148 sites. We have good provider distribution across the state that reflects Washington's population density. There is at least one provider in most counties (31 out of 39 counties have a provider) and more providers in the more populous counties. As expected, fewer clinics are located in sparsely populated counties of Eastern Washington requiring driving to commercial centers to access services. HCA continues to work with the Washington State Department of Health (DOH) to utilize the Title X clinics as service providers in the Take Charge program.

We realize that it is necessary to expand the provider network to include all contracted Apple Health (Medicaid) providers so that transportation is not an issue for uninsured people, especially teens. Over the past year we also have received a few requests from new providers to join the Take Charge provider network. With the renewal of the demonstration we committed to changing our rules to allow any Apple Health contracted provider to see a family planning only client. The rule change process takes about a year to complete.

Enrollment and Renewal

Enrollment has remained stable over the past demonstration year, with a slight increase during the last quarter of the year. Total enrollees increased from 15,345 in DY16 to 15,543 in DY17, a 1.3% increase over the year. This past demonstration year the Take Charge eligible population decreased by 3.9% while the Family Planning Only Extension population increased by 3.9%.

The total number of participants in the waiver increased 9.3% over the past year from 3,566 in DY16 to 3,898 in DY 17. This increase was entirely due to an increase of 88% in participants in the Family Planning Only Extension population. We currently do not have complete data of Medicaid births for the entire DY17. It is possible that if there was an increase in the number of pregnancies and births for Medicaid during the past demonstration year, that may have resulted in increased utilization of family planning services by this population. The Take Charge participants decreased by 1.7%, essentially unchanged from last year. The proportion of total program enrollees identified as participants has remained stable this year at 25.1% indicating that the 1115 waiver program continues to meet the need of those enrolled. The proportion of participants among enrollees during the past year was 60.7% for the Take Charge population versus 7.9% for the Family Planning Only Extension population.

The reason for the much lower participation rate amongst recently pregnant clients versus others is that most pregnant clients receive family planning services as part of pregnancy medical coverage during the 60 days after the pregnancy ends and before they are automatically enrolled in the Family Planning Only Extension program. They therefore are not counted as participants for the current year even though they are enrolled. Participant numbers will always not match enrollee numbers because clients who received family planning services in the prior year and remained eligible and enrolled in DY17 may not have needed or received additional services in DY17 and are therefore not counted as participants. This includes those using LARCs and those who received a 12 month supply of self-administered contraception at the end of a demonstration year.

For DY17, females 21-44 year olds had the highest enrollment (12,305), but lowest participation (17.6%) among the age groups. Females 20 years and younger had the highest participation (54.6%), followed by females over 45 years (44.7%). The total male enrollment for DY17 was 59.

Of the 15,543 clients enrolled in the family planning only waiver in DY17, 7,069 (45.4%) were retained. Of the total 8,474 clients whose eligibility ended in DY17 and did not re-enroll in the waiver after a gap of more than four months, 74.8% completely dis-enrolled. Twenty-three percent (23.2%) of clients who dis-enrolled from the family planning only programs returned to another Medicaid program after a gap of more than four months. These included full coverage, pregnancy medical, and state funded programs. Two percent re-enrolled in the family planning only waiver programs. Clients with a sterilization procedure (0.1%) represented the smallest group of dis-enrolled clients. See Appendix A, Table 12 for a comparison from year to year of retention and disenrollment.

The following tables show data on enrollees and participants for DY17 by age cohort. Eligibility data were used for the tables relating to enrollment. Claims data were used to produce the tables describing utilization by enrollees. Due to small numbers and the obligation of HCA to protect the privacy of its clients, data about males were not broken down by age and the age cohorts for participants has been combined into broader groups than recommended in this waiver's STCs. Additional enrollment data can be found in Appendix A.

Table 1: Unduplicated Number of Enrollees by Quarter in Demonstration Year 17						
Number of Female Enrollees by Age and Quarter						
	14 years old and under	**15-20 years old**	**21-44 years old**	**Over 45 years old**	**Total Unduplicated Female Enrollment**	**Total Unduplicated Male* Enrollment**
Quarter 1	29	2,083	6,329	62	8,503	33
Quarter 2	31	1,977	6,298	61	8,367	33
Quarter 3	28	1,947	6,582	73	8,630	33
Quarter 4	18	1,899	7,020	77	9,014	34
Year End **	13	3,034	12,305	132	15,484	59

*Due to HCA policy regarding the release of small numbers only total male enrollment is reported.

**Ages for Quarters are calculated based on the last day in the quarter while Age for "Year End Total" is based on the last day of the Demonstration Year. Given that a client may age into an older age cohort throughout their 12-month program eligibility period, "Year End Total" is not a sum of each age cohort.

Table 2: Unduplicated Number of Participants* with any Claim by Age Group and Quarter in Demonstration Year 17					
Number of Females who Utilized Services by Age and Quarter					
	20 years old and under	21-44 years old	Over 45 years old	Total Female Users	Percentage of total Unduplicated Female Enrollment
Quarter 1	705	728	24	1,457	17.1
Quarter 2	657	719	24	1,400	16.7
Quarter 3	692	759	27	1,478	17.1
Quarter 4	563	760	17	1,343	14.9
Year End Total	1,665	2,166	59	3,890	25.1

*Male participants were less than 11. Due to HCA policy regarding the release of small numbers, we cannot report male participation by quarter or age cohort.

POLICY ISSUES AND CHALLENGES

There have been no policy issues or challenges over the past year.

As a result of the five-year waiver renewal received in May 2018 there are several action items that impact policy, eligibility, and application processes for the new demonstration period. These require changes to Washington Administrative Code (WAC - rules) and application accessibility and processing. These WAC changes will allow two policy changes that should expand provider accessibility to clients; 1) Applications will no longer need to be submitted from specific providers and 2) waiver clients will be able to see the provider of their choice for services.

In June 2018 HCA started the one year process to change our rules to allow a waiver application to be submitted directly by a client. Current rule states that the application must come from a Take Charge provider. In conjunction with this change HCA will change the procedure of application submission to include mail or fax directly from a client, fax from any provider or In Person Assister (IPA), or on the phone with an HCA representative. The application will also be updated to include address and fax number for submission and a revised attestation to clarify informed choice to apply for family planning only coverage.

HCA has also started the process to change approval and denial letters per agreement with CMS. Apple Health denial letters will include information about the Family Planning Only programs and how to apply. Take Charge and Family Planning Only Extension approval letters will clearly state the length of coverage and end date and note that the client will need to reapply at the end of the coverage period.

The challenge of these changes is that they take approximately a year to achieve to allow stakeholder input and comment and accommodate internal review processes and external contractor work flows. HCA hopes to have all policy and procedure changes implemented by the beginning of DY19 (July 1, 2019).

Action plan for Demonstration Year 18 (July 1, 2018 – June 30, 2019)

Washington State's plan for DY18 includes items specifically outlined in the renewal STCs and ongoing activities from last year:

- Ongoing activities:
  - HCA continues to evaluate the need to expand eligibility to underinsured people as changes occur in requirements for insurance coverage related to family planning needs on a national level.
  - HCA continues to evaluate the impact of proposed changes to other federal and state programs that provide family planning services to underinsured and uninsured populations.
  - HCA continues to work with Upstream to identify providers and regions that will benefit from their training and serves on the Steering Committee for their five year project in Washington.
  - HCA continues to communicate with family planning providers and will reinstitute regular stakeholder meetings and public forums.

- Activities related to implementing the new STCs:
  - HCA has started the process to revise the Washington Administrative Code (WAC) that governs the family planning only programs administered by HCA. In particular, the WAC needs to be revised to update for current clinical practice and allowance that a client be able to self-submit a Take Charge application. This will take approximately a year.
  - HCA plans to expand the provider network for the waiver program to include all Apple Health contracted providers that have family planning within their scope of practice.

- HCA has started the process to revise Medicaid denial letters to include information about how to apply for family planning only services. This will take approximately a year.
- HCA has started the process to revise the family planning only programs' approval letters to assure that it is clear that clients must reapply at the end of the eligibility period. This will take approximately a year.
- HCA will revise the client application process for Take Charge to include mail in and phone options for clients. The application itself will be revised to include an attestation per the requirements in STC 17. This will be implemented once the WAC change is complete.
- HCA will work with Upstream as they begin training clinics and disseminating information to the public in 2019. Information about HCA's family planning only programs will be incorporated into their provider training and public education.

QUALITY ASSURANCE AND MONITORING

Service Utilization

Table 3 shows utilization by birth control method and age group for DY17. The most frequently provided family planning method for all participants is birth control pills, used by 33.6%. This is followed by emergency contraception pills at 19.9% and contraceptive injections at 13.0%. There were differences in birth control method utilization between the two age groups identified in Table 3. Participants 21 years and older utilized more sterilization methods (100.0%), vaginal contraceptive ring (72.4%), intrauterine devices (71.5%), and contraceptive injections (56.5%) than participants 20 years and younger. Participants 20 years and younger used more spermicides (65.5%), condoms (64.6%), and emergency contraceptives (61.4%) than the older age group. The differences between the two age groups may indicate the majority of clients 20 years and younger were more concerned with immediate needs than long term planning, whereas older participants may already have children and are more concerned about the spacing of future pregnancies or no longer desire to have children.

Table 3: Utilization by Birth Control Method and Age Group in Demonstration Year 17

Method	Total Users			
	20 years old and younger	21 years and older	Total Participants** (unduplicated)	Percent of all Methods
Oral Contraceptive	849	933	1,782	33.6
Emergency Contraception	648	408	1,056	19.9
Contraceptive Injection	299	389	688	13.0
Intrauterine Device (IUD)	173	434	607	11.5
Condom (male and female)	266	146	412	7.8
Contraceptive Implant	173	175	348	6.6
Vaginal Contraceptive Ring	54	142	196	3.7
Contraceptive Patch	61	67	128	2.4
Spermicide*	36	19	55	1.0
Sterilization- Tubal Procedure & Vasectomy	0	25	25	0.5
Diaphragm / Cervical Cap	0	0	0	0.0
Total Participants*** (unduplicated)	10	2,042	3,665	

*Includes all topical preparations (i.e. creams, foams, and gels), films, suppositories, and sponges

**A participant may choose more than one birth control method during the demonstration year and will be recorded for each. The numbers for each method or age cohort do not add up to the totals.

***Due to HCA policy regarding the release of small numbers, the Natural Family Planning method was suppressed from the table and total unduplicated participants were recalculated to avoid deriving utilization for this method.

Tables 4 and 5 show utilization of specific family planning related services for DY17. The waiver program provides screening for sexually transmitted disease and infection (STD/STI) services limited to urogenital Neisseria gonorrhea (GC) and Chlamydia trachomatis (CT) for women ages 13 – 25 and when symptoms or exposure is reported. Services for men are limited to exposure and symptoms. The unduplicated number of waiver participants who received a GC/CT test was 1,438 or 9.3% of waiver enrollees in DY17. Less than one percent of total enrolled females received cervical cancer screening in DY17. This is not surprising since the screening guidelines for cervical cancer start at age 21 and are every 3 or 5 years depending on the type of

screen used. Forty-two percent of female clients are under 21.

Table 4: Number of Participants Tested for Gonorrhea (GC)/Chlamydia (CT)* in Demonstration year 17		
	Number	% of total Enrolled
Unduplicated number of participants who obtained an STD test	1,438	9.3

*The waiver programs only cover GC and CT screening for ages 13-25. STD testing is also covered if an exposure to a STI increases client's risk to infertility.

Table 5: Total Number of Participants who obtained a Cervical Cancer Screening* in Demonstration Year 17		
Screening Activity	Number	% of total Females Enrolled
Unduplicated number of participants who obtained a cervical cancer screening	125	0.8

*USPSTF guidelines recommend cervical cytology only every 3 years for those 21-29 years old. USPSTF recommends for those 30-65 years old choosing either every 3 year cervical cytology or every 5 years with high risk human papillomavirus testing, or every 5 years with a combination of HPV testing and cytology.

Stakeholder Engagement

Areas for improvement are identified throughout the year as providers and clients ask questions. Over the past year provider billing guides were updated regularly. These updates incorporate feedback from providers and changes in clinical practice as needed.

Quarterly reports include program data that monitors the effects of the waiver program. Monthly reports are shared with the program manager and were posted on the HCA website for stakeholders to review. Over the past year HCA developed and implemented a small numbers policy. The reports that were consistently posted on our website are in the process of being revised to meet the new policy and therefore we have not maintained the monthly posting since November 2017. The new small numbers policy was finalized in August 2018. Moving forward we will post reports on a quarterly basis to align with our reporting to CMS and to show aggregate numbers large enough that do not require suppression.

Feedback from stakeholders was formerly obtained at quarterly statewide Family Planning Provider Task Force meetings conducted by DOH. They have not had the resources to host these due to work on submitting their Title X grant renewal application. Moving forward HCA is working to develop a way to host regular stakeholder meetings during the year.

Annual Post Award Public Forum

The annual post award public forum will occur on November 16, 2018.

Program Integrity

There is no point-of-service eligibility option in the 1115 Family Planning Only waiver. All applications are processed by a dedicated special eligibility unit at HCA.

HCA continues to work with the ProviderOne billing system to strengthen and build edits and audits to ensure unusual and incorrect claims are identified and that claims are processed efficiently.

Grievances and Appeals

There were no grievances made and no public hearings during this year.

PROGRAM OUTREACH AND EDUCATION

General Outreach and Awareness

No public outreach activities were conducted in the past demonstration year. The major outreach of the agency has been focused on connecting clients to full scope coverage through Apple Health or a referral to a qualified health plan.

Target Outreach Campaign(s)

No public outreach activities were conducted in the past demonstration year. HCA continued to update stakeholders on the progress toward renewal of the waiver and informed them of the approval of a five year renewal.

BUDGET NEUTRALITY

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 only waiver. Tables 6 and 7 show the service and administrative expenditures and the Per Member Per Month (PMPM) expenditures for the demonstration by year since July 2012. Also shown in Table 8 is CMS-64 expenditures by quarter based on date of payment. We are working on a way to meet the requirement to report based on date of service in the CMS 64 as outlined in STCs 29 and 34. Current HCA accounting tools do not accommodate this requirement. HCA progress towards this goal will be updated during our quarterly monitoring calls with CMS. Our Budget Neutrality Workbook is in Appendix B.

Table 6: Annual Service and Administrative Expenditures
July 1, 2012 – June 30, 2018

	Service Expenditures		Administrative Expenditures			
	CMS-64		CMS-64		Total Computable	Expenditures
	Total Computable	Federal Share	Total Computable	Federal Share	CMS-64	CMS-37
DY12	$17,459,759	$15,810,175	$671,480	$591,716	$18,131,239	$15,243,618
DY13	$14,292,091	$12,933,646	$334,514	$300,824	$14,626,605	$16,931,739
DY14	$1,776,746	$1,587,085	$419,234	$377,200	$2,195,980	$2,705,681
DY15	$1,439,732	$1,256,327	$136,305	$122,583	$1,576,037	$1,808,000
DY16	$1,331,302	$1,142,321	$27,622	$24,770	$1,358,924	$299,157
DY17	$1,223,712	$1,054,571	$1,525	$1,276	$1,225,237	$1,261,940

Table 7: Annual Per Member Per Month Expenditures July 1, 2012 - June 30, 2018			
Demonstration Year	**Total Expenditures**	**Member Months***	**PMPM**
DY12	$18,131,239	642,607	$28.22
DY13	$14,626,605	555,114	$26.35
DY14	$ 2,195,980	133,996	$16.39
DY15	$1,576,037	90,010	$17.51
DY16	$1,358,924	86,073	$15.79
DY17	$1,225,237	85,083	$14.40

*Washington State Department of Social and Health Services, Research and Data Analysis division certifies that the Member Months calculation is accurate, per STC 37.

Table 8: Annual Service and Administration Expenditures Demonstration Year 17 (SFY 2018) (July 1, 2017 – June 30, 2018)				
	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	$424,086	$1,357	$425,443	$315,485
Quarter 2	$246,296	$56	$246,352	$315,485
Quarter 3	$217,123	$92	$217,215	$315,485
Quarter 4	$336,207	$20	$336,227	$315,485
Total Annual Expenditures	$1,223,712	$1,525	$1,225,237	$1,261,940

DEMONSTRATION EVALUATION ACTIVITIES AND INTERIM FINDINGS

This year efforts were focused on submitting the Evaluation Design for the next waiver period of July 1, 2018 – June 30, 2023 by our contracted evaluator DSHS, RDA in conjunction with our renewal application. This coming year will focus on completing the evaluation for the demonstration period just ended with DY17 (July 1, 2011 - June 30, 2018) and is scheduled to be submitted in October 2019.

HCA relies on DOH to conduct and analyze the Pregnancy Risk Assessment Monitoring System (PRAMS) survey to describe unintended pregnancy rates. PRAMS survey results are individually linked to Medicaid clients so the survey results can be reported for Medicaid statewide. 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. The Perinatal Indicators Report for Washington State, 2015 Data published July 2017 (DOH 950-153) shows that the unintended pregnancy rate for Washington remained stable in 2013 and 2014 at 36% and 35% respectively, which was a drop from 2012 at 41%. Based on the PRAMS data an estimate was made of births that are a result of unintended pregnancies. In 2014

29% of Medicaid births were estimated to be from an unintended pregnancy, whereas 15% of non-Medicaid births resulted from an unintended pregnancy. Overall Washington has seen a drop in this estimate from 28% in 2012 to 22% in 2014. The waiver program contributes to the reduction in both unintended pregnancies and births from unintended pregnancies by increasing access to contraception for Washington residents.

Interim findings reported in past reports are summarized in Appendix A.

Appendix A: Historical Context and Background

History

Washington State's 1115 waiver family planning demonstration was originally approved by the Centers for Medicare and Medicaid Services (CMS) in 2001 and became effective July 1, 2001. The waiver includes two programs: the Family Planning Only Extension, which existed prior to the waiver and, the Take Charge program, which began with the waiver. The waiver has been consistently renewed and extended since 2001. For the first ten years of the waiver, the Washington State Department of Social and Health Services (DSHS) Health and Recovery Services Administration (HRSA) administered the program. On July 1, 2011, Washington State Medicaid merged with the Washington State Health Care Authority. Health Care Authority (HCA) continues to administer the 1115 family planning only demonstration waiver. The waiver was renewed on May 9, 2018 for five years through June 30, 2023 with only one program change; the name is now Family Planning Only Program.

With the Affordable Care Act (ACA) Washington expanded Medicaid and offered subsidized qualified health plans (QHPs) on the Washington Health Benefit Exchange. This dramatically reduced the number of uninsured people in Washington from 14.5% in 2012 to 5.8% in 2017. Since family planning, services are fully covered by Medicaid and the QHPs without cost-sharing, enrollment and participation into the family planning only programs have dramatically declined.

Policy and Programmatic Changes

Washington's family planning only waiver has experienced many changes over the past fifteen years. In addition to the ACA there have been a number of program and eligibility changes to the Take Charge program over the life of the waiver which have impacted the 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 gonorrhea (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 included eligibility for adults up to 138% of the FPL. TAKE CHARGE eligibility increased to 260% of the FPL.
- January 2014: Health insurance became available through the health benefit exchange. Clients with health insurance were no longer eligible for TAKE CHARGE. Clients must first apply for Medicaid and be denied before enrolling in TAKE CHARGE.

Delivery System

Provider participation was declining over the course of the demonstration; however it has stabilized since ACA implementation. The provider landscape changed in response to the ACA and continues to change as innovative payment systems are introduced that focus on quality metrics. As Washington residents obtained comprehensive health coverage and established themselves with health homes, small clinics with single purposes found their caseloads declining. This particularly affected local health jurisdictions (LHJs) in rural areas which discontinued providing direct clinical services Community health centers and other health systems expanded to fill in some of the gaps left when these and other small clinics closed. HCA has maintained access to family planning services across the state and particularly in rural areas by contracting with these larger provider systems.

Service Utilization

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 covered under pregnancy medical. The recently pregnant population has a higher use of female sterilization than the Take Charge population. The difference between these populations may be explained by the different characteristics of these two groups. A non-reversible family planning method may be more desirable and appropriate for the recently pregnant clients than for the younger, often single clients in the Take Charge population, the majority of whom have not yet had children.

Sterilization is the primary reason that men enroll in Take Charge. Since the ACA, men have had access to health care coverage through expanded Medicaid and affordable qualified health plans through which they can obtain vasectomies. This explains the decline in male participation in the waiver program.

Enrollment Trends

Combined enrollment in the waiver family planning only programs offered by HCA peaked at approximately 175,000 in fiscal year 2005 (DY4). Currently, there are approximately 15,500 enrollees in fiscal year 2018 (DY17). Since July 2012, the entire waiver enrollment has declined by 85%. This level of enrollment appears to have stabilized and most likely has 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.

Although clients losing Medicaid pregnancy coverage after the end of the postpartum period fluctuated modestly until January 2014, the caseload for women and men in Take Charge with incomes at or below 260% of the FPL showed greater change. The recently pregnant population remained steady around 40,000 total enrollees until DY1 when there was a dramatic drop due to full ACA implementation. DY17 had 10,475 total enrollees. Many of these clients become eligible for expanded Medicaid after the birth of their baby. Monthly enrollment peaked at 19,230 in November 2013 and has decreased to 4,931 in June 2017.

The Take Charge population caseload peaked in May 2005 (DY5) at 90,294 clients, the number of enrollees declined and stabilized at a lower level in January 2009 (DY8). The 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 to a low of 2,517 in December 17. There has been a slight rise to 2,668 in the last three months of the DY17.

Declines in participation were particularly striking amongst clients who were recently pregnant and enrolled in the Family Planning Only Extension program. Prior to ACA (since the beginning of the demonstration), enrollment of recently pregnant women ranged from 20-44% of the recently pregnant enrollees and has dropped to 8% in DY17. We believe this is a result of increased availability and education about long acting reversible contraception (LARC) and women receiving their chosen form of birth control prior to pregnancy medical coverage ending 60 days after the pregnancy ends. In 2015, Washington Medicaid introduced an enhanced professional fee for LARC insertion and a separate hospital payment for the device with immediate postpartum LARC insertion. Also contributing is the requirement for birth control pills to be dispensed in a 12 month supply since 2012. Prior to that clients had to go to the pharmacy every month or every three months to pick-up a refill. Another reason for low participation is that some clients are automatically enrolled in the Family Planning Only Extension even when they do not need program services since they have obtained coverage through a QHP or other insurance source, but HCA is not informed. In addition to recently pregnant women participation in Take Charge also dramatically declined from a high of 97% of enrollees in DY1 (fiscal year 2002) to 61% in DY17.

- The following graph and tables show the trends over the life of the demonstration, from DY1 (July 2001 – June 2002) through DY17 (July 2017 – June 2018). Historically we broke down the waiver enrollees into three populations which differ from the way CMS has requested enrollment and utilization information in the new Special Terms and Conditions (STCs). Previously we used the terms Population 1, 2, and 3. We have changed the headings on the tables below to reflect the terminology used in this report and defined in the introduction..

Figure 1. Enrollment of Clients <=260% of FPL
As of October 2, 2018
Population 2 + Population 3

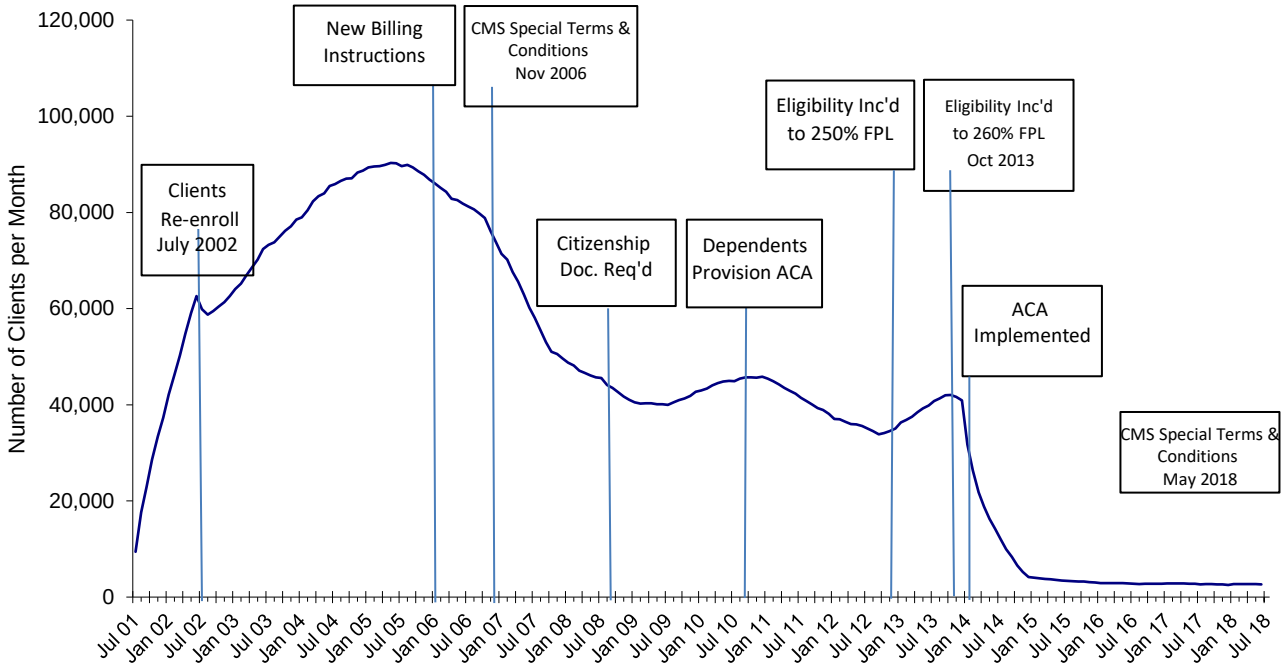

Table 9: Total Number of Enrollees July 1, 2001 – June 30, 2018				
Year	**Family Planning Only Extension**	**Take Charge - Female**	**Take Charge - Male**	**Total Population (Unduplicated)**
DY1	32,897	55,525	3,454	90,159
DY2	36,682	94,501	7,441	136,178
DY3	39,038	114,222	8,880	159,231
DY4	40,031	127,818	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
DY16	10,085	5,217	56	15,345
DY17	10,475	5,009	59	15,543

Table 10: Total Number of Participants July 1, 2001 – June 30, 2018				
Year	**Family Planning Only Extension**	**Take Charge - Female**	**Take Charge - Male**	**Total Population (Unduplicated)**
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	4,389
DY16	439	3,106	21	3,566
DY17	826	3,067	8	3,898

Table 11: Total Number of Member Months July 1, 2001 – June 30, 2018				
Year	**Family Planning Only Extension**	**Take Charge - Female**	**Take Charge - Male**	**Total Population (Unduplicated)**
DY1	175,198	414,923	21,688	611,809
DY2	197,296	689,403	48,269	934,968
DY3	215,662	872,924	58,701	1,147,287
DY4	219,399	992,539	63,457	1,275,395
DY5	211,959	972,303	54,811	1,239,073
DY6	216,157	836,982	28,231	1,081,370
DY7	207,547	590,616	6,601	804,764
DY8	197,789	491,898	4,710	694,397
DY9	202,976	506,167	5,618	714,761
DY10	213,686	527,041	6,859	747,586
DY11	222,363	449,578	6,203	678,144
DY12	221,772	415,713	5,122	642,607
DY13	180,729	369,973	4,412	555,114
DY14	66,232	67,764	614	133,996
DY15	53,791	36,219	343	90,010
DY16	52,831	32,908	334	86,073
DY17	53,065	31,674	344	85,083

Annual Disenrollment and Retention

Over this demonstration period annual retention of enrolled clients decreased from 52% in DY12 to 29% in DY14 and then increased to 45% in DY17. 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 74.8% in DY17. 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 23.2% in DY17). 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 12: Annual Disenrollment and Retention*

Demonstration Period: July 1, 2012 – June 30, 2018 (DY12-DY17)

Demonstration Year	Sterilization (Enrollees/ Percentage %)	Eligible for Full Benefits Due to Pregnancy	Eligible for Full Benefits	Re-enrolled	Eligible for Other State-Funded Program	Did not Renew	Total Disenrollment Number
DY 12	221	5,378	4,693	2,788	354	37,840	51,274
	0.4%	10.5%	9.2%	5.4%	0.7%	73.8%	
DY 13	139	3,315	29,227	602	747	34,646	68,676
	0.2%	4.8%	42.6%	0.9%	1.1%	50.4%	
DY 14	44	874	5,203	251	472	14,849	21,693
	0.2%	4.0%	24.0%	1.2%	1.2%	68.4%	
DY 15	18	683	1,807	202	256	6,952	9,918
	0.2%	6.9%	18.2%	2.0%	2.6%	70.1%	
DY 16	107	589	1,238	172	269	6,134	8,509
	1.3%	6.9%	14.5%	2.0%	3.2%	72.1%	
DY 17	5	516	1,188	167	263	6,335	8,474
	0.1%	6.1%	14.0%	2.0%	3.1%	74.8%	

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

Appendix B: Budget Neutrality Workbook

BUDGET NEUTRALITY WORKSHEET - Demonstration Years 11-17 (July 1, 2011-June, 30 2018)

Budget neutrality is calculated using the methodology described in the Washington State Special Terms and Conditions #11-W-00134/0, Section VIII. **This sheet uses the expenditures reported on the CMS 64.**

President's Trend Rate			6.2%				
Demonstration Year	17	16	15	14	13	12	11
State Fiscal Year	18	17	16	15	14	13	12
Calculation of Washington's Trend Rate:							
# Member Months	85,083	86,073	90,010	133,996	555,114	642,607	678,144
PMPM Cost	$14.40	$15.79	$17.51	$16.39	$26.35	$28.22	$21.90
WA Trend Rate	-9%	-10%	7%	-38%	-7%	29%	
Calculation of Annual Budget Limit and Margin:							
Annual Budget Limit (DOP)	$1,055,847	$1,167,091	$1,378,910	$1,964,285	$13,234,470	$16,401,891	$13,521,215
Margin	$(169,390)	$(191,833)	$(197,127)	$(231,695)	$(1,392,135)	$(1,729,349)	$(1,327,000)
Calculation of Composite Federal Share:							
FFP Service Received by WA	$1,054,571	$1,142,321	$1,256,327	$1,587,085	$12,933,646	$15,810,175	$12,921,370
FFP Admin Received by WA	$1,276	$24,770	$122,583	$377,200	$300,824	$591,716	$599,845
Total FFP	$1,055,847	$1,167,091	$1,378,910	$1,964,285	$13,234,470	$16,401,891	$13,521,215
Total Computable Expenditures	$1,225,237	$1,358,924	$1,576,037	$2,195,980	$14,626,605	$18,131,240	$14,848,214
Composite Federal Share	0.86	0.86	0.87	0.89	0.90	0.90	0.91