Washington State Health Care Authority

**Quarter 2: Section 1115 Family Planning Only Demonstration Waiver**
**Demonstration Year 23: July 1, 2023 - June 30, 2024**
**Demonstration Reporting Period: October 1, 2023 - December 31, 2023**

**Demonstration Approval Period: July 1, 2018 - June 30, 2023 (extension through June 30, 2024)**
**Project Number: 11-W-00134/0**

# February 29, 2024

# Contents

## EXECUTIVE SUMMARY

Washington State's 1115 Family Planning Only (FPO) Programs demonstration waiver was originally approved by the Centers for Medicare and Medicaid Services (CMS) in 2001 and became effective July 1, 2001. In May 2018, the waiver was approved for another five years through June 30, 2023, and now includes an extension year through June 30, 2024. The Special Terms and Conditions (STCs) for the waiver require quarterly monitoring reports that must be submitted 90 days following the end of each quarter. This report provides information on enrollment, utilization, operations, and updates related to the waiver. Washington uses the state fiscal year (SFY) as our demonstration year (DY) period. This report covers services provided during quarter 2 of DY23 October 1, 2023, through December 31, 2023. Appendix B provides background and definitions of the program.

The Washington State Health Care Authority (HCA) administers the waiver in Washington in addition to Medicaid. The waiver extends eligibility for family planning services to uninsured people 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). Family Planning Only programs cover every FDA approved birth control method and a narrow range of family planning and family planning-related services that help clients use their contraceptive methods safely and effectively to avoid unintended pregnancy. FPO formerly offered FP-pregnancy related coverage, however, with the expansion of After-Pregnancy Coverage up to 12 months postpartum (implemented in July 2022) and the Redetermination process that began in April 2023 due to the end of the federal PHE (public health emergency), the FPO waiver no longer has pregnancy-related clients enrolled.

Overall enrollment has decreased from the previous quarter (DY23 Quarter 1). Total enrollees decreased by 48.9% from 1,875 in DY23 Quarter 1 to 958 in DY23 Quarter 2. Participation increased by 33.8% (from 207 to 277 participants). Moreover, newly enrolled clients increased by 36.8% from 231 in DY23 Quarter 1 to 316 in DY23 Quarter 2. Client enrollment and participation remain predominantly those who identify as female. In DY23 Quarter 2, the most frequently provided family planning method for all participants remained oral contraceptives (i.e., birth control pills) used by 36.4% of unduplicated participants.

Besides family planning and contraceptive care, waiver clients also have limited access to Neisseria gonorrhea (GC) and Chlamydia trachomatis (CT) screens and tests and cervical cancer screenings. To date, 120 unduplicated waiver participants received a GC/CT test or 5.5% of total waiver enrollees for the demonstration year. Additionally, [redacted] (or [redacted]%) of the unduplicated female identifying enrollees to date have received a cervical cancer screen while enrolled in the demonstration waiver.

## PROGRAM UPDATES

### Current Trends and Significant Program Activity

#### *Delivery System and Provider Participation*

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 surpasses the coverage that the FPO programs offer. However, FPO plays a critical role for those populations who are ineligible for comprehensive Medicaid coverage and for those seeking confidential services.

HCA also administers a state-funded look-alike FPO program for populations that do not meet the waiver criteria. This state-funded program began in January of 2020. HCA created and released a separate FPO application for the state-funded program in March 2021. There are still gaps in coverage for some Medicaid enrollees, young adults (i.e., those between 19 and 26 years of age) covered by their parents' insurance who desire confidentiality and some immigrant populations. These groups are currently not eligible for the federal waiver.

Family Planning providers and advocates are also working with HCA to ensure that the waiver population and those not eligible for the waiver continue to have access to family planning and family planning-related services to decrease unintended pregnancies, lengthen intervals between pregnancies and births, and support positive birth and health outcomes. To create conditions for the program's best outcomes, community engagement is core to potential changes.

In partnership with CMS and HCA, expansion of the covered STI services to include HIV and Viral Hepatitis testing and Hep B and A vaccinations has been confirmed. HCA updated all relevant administrative codes, billing guidance, and systems for providers to provide and be reimbursed for these services starting January 2024.

In September 2023, in partnership with HCA pharmacy and Office of Tribal Affairs colleagues, HCA launched a provider survey to better understand contraception access issues at the pharmacy point of sale. The survey topics included questions about barriers and solutions related to over-the-counter (OTC) contraception, dispensing and prescribing, billing Medicaid, and communications. The scope of these issues, responses, and solutions is vast and complex. For the purposes of this report, a primary interest of the FPO team's partnership is initially focused on the forthcoming OTC pill (Opill) and access to other OTC methods, i.e. emergency contraception, condoms and spermicide. In an early review of the results, likely actions include deeper engagement with the provider association networks to aid professional education (i.e. continuing education) on Apple Health policy, increasing frequency of HCA pharmacy-related communications, and partnering across the managed care system to improve billing processes. Keep in mind that FPO only applies to the fee-for-service population, not the managed care population, although providers often serve both.

We have also culminated a provider survey project, in partnership with a University of Washington Doctor of Nurse Practitioner program student, to assess provider capacity and interest toward inclusion of mental health screening in a family planning (or sexual and reproductive health) visit. A snapshot of the results demonstrates that including reimbursement for mental health screenings for FPO clients would remove a barrier to access, because of the providers (N = 22) surveyed:

- 90% agree that preconception mental health screens are important to patient health and wellbeing
- 95% of providers currently administer mental health screens in their clinical practice
- 86% of providers administer mental health screens within the family planning context

The 2023 Washington State Maternal Mortality Review panel and report determined that behavioral health conditions, including mental health and substance use, comprised the leading causes of pregnancy-related deaths. The review also elevated significant racial and ethnic inequities. Maternal mortality rates were 2.5 to 3 times higher for non-Hispanic Black people and 8.5 times higher for non-Hispanic American Indian and Alaska Native people. Inequities exist for morbidity as well. Black women and other women of color are at a higher risk for depression, anxiety, and anxiety-related disorders because of structural racism, which can impact the quality of care and increase risks for pregnancy-related medical complications, trauma, mental health conditions, chronic stress, and chronic disease. This population is often underrepresented in the data

despite the knowledge of this disproportionate burden. In terms of solutions, the review highlighted that increasing screenings, knowledge, access, treatment options, and reimbursement could have prevented 80%+ of pregnancy-related deaths. People of reproductive age often report that their family planning provider is their only healthcare provider, making depression, anxiety, and anxiety-related disorder screening imperative at preconception visits.

### *Enrollment and Participation*

Total enrollees have decreased 48.9% over the past demonstration quarter, from 1,875 in DY23 Quarter 1 to 958 in DY23 Quarter 2. Of the 958 total unduplicated enrollees in the second quarter of DY23, 95.3% enrollees were those who identify as female. Clients 21-44 years old had the highest enrollment (596 or 62.2%) and the highest participation (168 or 60.6%). As expected, and aligning with historical patterns, enrollment and participation are dominated by female identifying clients (see Table 9 for program and population descriptions).

We believe that there are major influential factors that have and continue to play a role in FPO enrollment including After-Pregnancy Coverage expansion, COVID-19, and the Redetermination process as a result of the end of the federal public health emergency. The State will continue to monitor enrollment and participation as the quarter-to-quarter trends had been stable since the implementation of the Affordable Care Act (ACA). We are actively working to both understand and shrink the gap between enrolled and participating, as there's a delta we have yet to understand. Many of the projects noted in the Program Integrity section intend to support and address this delta and its potential solutions. We are encouraged by the utilization rate increase from Q1 to Q2, see below, and will presume some of our program changes and outreach activities have played a positive role.

Tables 1 through 4 show data on enrollees and participants for DY23 by sex and age group.
**Enrollees** are all individuals in the demonstration for the specified demonstration quarter, including those newly enrolled and those still eligible from the previous demonstration quarter.
**Participants** are all individuals who obtain one or more covered family planning service through the demonstration.

Due to small numbers and the obligation of HCA to protect the privacy of its clients, cell numbers less than 11 are suppressed and noted.

**Table 1: Unduplicated Number of Female Enrollees by Age Group** and Quarter**

| | 14 years old and under | 15-20 years old | 21-44 years old | Over 45 years old | Total Unduplicated Female Enrollment* |
|---|---|---|---|---|---|
| **Quarter 1** | * | 434 | 1,290 | * | 1,796 |
| **Quarter 2** | * | 303 | 570 | * | 913 |
| **Quarter 3** | | | | | |
| **Quarter 4** | | | | | |
| **Year End** | | | | | |

**Ages for Quarters are calculated based on the last day in the quarter while Age for "Year End" is based on the last day of the DY. Given that a client may age into an older age cohort throughout

their 12-month program eligibility period, "Year End" is not a sum of each age cohort.

| Table 2: Unduplicated Number of Male Enrollees by Age Group** and Quarter | | | | | |
|---|---|---|---|---|---|
| | 14 years old and under | 15-20 years old | 21-44 years old | Over 45 years old | Total Unduplicated Male Enrollment* |
| Quarter 1 | * | 17 | 55 | * | 79 |
| Quarter 2 | * | 15 | 26 | * | 45 |
| Quarter 3 | | | | | |
| Quarter 4 | | | | | |
| Year End | | | | | |

* Due to HCA policy regarding the release of small numbers, numbers less than 11 are suppressed.
**Ages for Quarters are calculated based on the last day in the quarter while Age for "Year End" is based on the last day of the DY. Given that a client may age into an older age cohort throughout their 12-month program eligibility period, "Year End" is not a sum of each age cohort.

| Table 3: Unduplicated Number of Female Participants with any Claim by Age Group** and Quarter | | | | | | |
|---|---|---|---|---|---|---|
| | 14 years old and under | 15-20 years old | 21-44 years old | Over 45 years old | Total Female Users* | Percentage of Total Unduplicated Enrollment |
| Quarter 1 | * | 49 | 143 | * | 204 | 11.4 |
| Quarter 2 | * | 88 | 167 | * | 273 | 29.9 |
| Quarter 3 | | | | | | |
| Quarter 4 | | | | | | |
| Year End | | | | | | |

* Due to HCA policy regarding the release of small numbers, numbers less than 11 are suppressed.
**Ages for Quarters are calculated based on the last day in the quarter.

| Table 4: Unduplicated Number of Male Participants with any Claim by Age Group** and Quarter | | | | | | |
|---|---|---|---|---|---|---|
| | 14 years old and under | 15-20 years old | 21-44 years old | Over 45 years old | Total Male Users* | Percentage of Total Unduplicated Enrollment |
| Quarter 1 | * | * | * | * | * | 3.8 |
| Quarter 2 | * | * | * | * | * | 8.9 |
| Quarter 3 | | | | | | |
| Quarter 4 | | | | | | |
| Year End | | | | | | |

* Due to HCA policy regarding the release of small numbers, numbers less than 11 are suppressed.
**Ages for Quarters are calculated based on the last day in the quarter.

## POLICY ISSUES AND CHALLENGES

In April of 2021, SB 5068 was signed into Washington State law and directed the expansion of postpartum coverage from 60 days to 12 months for persons who reside in Washington state, have countable income equal to or below 193 percent of the federal poverty level, and are not otherwise eligible under Title XIX or Title XXI of the Federal Social Security Act. This extended postpartum coverage was implemented as policy in June 2022 and has affected the Family Planning Pregnancy Related (FPO-PR) clients who historically have made up over 50% of the Family Planning Only waiver programs.

## UTILIZATION MONITORING

### *Service Utilization*

Table 5 shows utilization by birth control method and age group for DY23 to date. The use of family planning methods are listed according to the most frequently used to the least frequently used. To date, the most frequently provided family planning method for all participants is oral contraceptives (i.e., birth control pills), used by 36.4% of unduplicated participants. This is followed by hormonal injections at 24.4% and emergency contraceptives at 14.0%.

**Table 5: Utilization by Birth Control Method and Age Group in Demonstration Year 23 (to date)**

| Method | Total Users | | | | | |
|---|---|---|---|---|---|---|
| | 14 years old and under | 15-20 years old | 21 – 44 years old | 45 years old and older | Total Participants** (unduplicated) | Percent of all Methods |
| Oral Contraceptive | * | 63 | 112 | * | 179 | 36.4 |
| Hormonal Injection | * | 20 | 87 | 12 | 120 | 24.4 |
| Emergency Contraception | * | 22 | 45 | * | 69 | 14.0 |
| Intrauterine Device (IUD) | * | 17 | 30 | * | 48 | 9.8 |
| Contraceptive Implant | * | 15 | 15 | * | 31 | 6.3 |
| Contraceptive Patch | | * | * | | 16 | 3.3 |
| Condom (male and female) | * | * | 12 | * | 15 | 3.0 |
| Vaginal Contraceptive Ring | * | * | * | * | * | 2.0 |
| Sterilization- Tubal Procedure & Vasectomy | * | * | * | * | * | 0.8 |
| Spermicide*** | * | * | * | * | * | * |
| Diaphragm / Cervical Cap | * | * | * | * | * | * |
| Natural Family Planning | * | * | * | * | * | * |
| Total Participants*** (unduplicated) | * | 116 | 245 | * | 382 | |

*Due to HCA policy regarding the release of small numbers, some contraceptive methods (i.e., Natural Family Planning, spermicide, sterilization, and diaphragm/cervical cap) were suppressed from the table and total unduplicated participants were recalculated to avoid deriving utilization for this method.

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

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

Table 6 shows the number of Neisseria gonorrhea (GC) and Chlamydia trachomatis (CT) screens and tests provided to Family Planning Only clients. These services are sexually transmitted infection (STI) testing specifically related to the effective and safe use of the chosen contraceptive and cervical cancer screening. To date, 120 of the unduplicated number of waiver participants received a GC/CT test or 5.5% of total waiver enrollees (2,191 to date) for the demonstration year.

| Table 6: Number of Participants Tested for GC or CT by Demonstration year (to date) | | |
|---|---|---|
| | Total Tests | |
| | Number | % of total Enrolled |
| Unduplicated number of participants who obtained a GC or CT test | 120 | 5.5 |

*The waiver programs only cover GC and CT screening for females ages 13-25. STD testing is also covered when medically indicated by symptoms or report of exposure, and medically necessary for the client's safe and effective use of their chosen contraceptive method.

Table 7 shows the number of females who have received cervical cancer screening using cervical cytology (Pap test) and/or human papilloma (HPV) testing. Seven female enrollees received cervical cancer screening in DY23 to date.

| Table 7: Total Number of Female Participants who obtained a Cervical Cancer Screening (to date) | | |
|---|---|---|
| Screening Activity | Number | % of total Females Enrolled |
| Unduplicated number of female participants who obtained a cervical cancer screening | [redacted] | [redacted] |

*The U.S. Preventive Services Task Force (USPSTF) and the American College of Obstetricians and Gynecologists (ACOG) recommend cervical cytology every 3 years for those 21-29 years old and 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.

## PROGRAM OUTREACH AND EDUCATION

### *General Outreach and Awareness*

After learning about the FPO waiver 1-year extension, HCA conducted targeted outreach and marketing to ensure all providers and clients were aware of the near-term continuation. Below reflects activity related to general outreach and awareness within this reporting period:

- GovDelivery e-Bulletins
  - Building skills in sexual health webinar series (Department of Health training)
  - CDC recommendations on perinatal hepatitis C infection
  - HCA rulemaking notice (included STI expansion announcement)
  - Help improve pharmacy contraception access with a short survey

- HCA program, enrollment, eligibility, and billing staff also hosted the second Family Planning Only Office Hours in November and had 7 providers sign-up with some in attendance. Office Hours will continue semi-annually in 2024.

### *Targeted Outreach Campaign(s)*

Below reflects targeted outreach:

- Virtual presentations
    - Washington School Based Health Alliance: 12/2023, ~25 attended

- Social Media posts were also pushed through Facebook, Instagram, and LinkedIn

### *Stakeholder Engagement*

HCA staff have a standing invitation to present at the Department of Health's Sexual and Reproductive Health statewide network meeting which convenes semi-annually. We have also engaged with DOH and other insurance and pharmacy quality assurance partners to work toward seamless systems and government agency accountability in reproductive health. The partnerships are constructive and serve as useful platforms for coordinated learning and issue mitigation.

The FPO program manager, HCA clinical pharmacy, and communications personnel have partnered to initiate a quality improvement effort to poll pharmacy staff on issues related to prescribing, dispensing, or billing for contraceptives, including a heavy focus on over-the-counter products. We want to ensure our Medicaid processes effectively support providers and clients. Thus far, we have an open survey that has been sent five times since September of 2023. Starting in the first quarter of 2024, HCA will be drafting workgroup charters and establishing priority projects and process improvements in response to the survey results.

The FPO program manager also continued to attend the Building Skills in Sexual Health Series hosted by Mountain West AIDS Education & Training Center and funded by Department of Health due to the continued increase in STIs in Washington. Two key reports, Hep C Free WA and STI & HBV Legislative Report, named concerning trends in viral Hepatitis, for example, and are calling on all health plans to ensure we are maximizing our ability to test, treat, and vaccinate (if a FDA approved vaccine is available) for the array of STIs impacting our state/community. Providers we engage with in sexual and reproductive health have signaled deep appreciation for the newly approved FPO STI coverage expansion.

As briefly mentioned previously, we have also been working on a provider survey project to understand the current delivery system and interest for inclusion of mental health screenings in family planning services. The outcomes of the project will be included in the next report as the bulk of the stakeholder engagement activity was executed in Q3.

## PROGRAM INTEGRITY

The FPO Program Manager has collaborated with HCA data specialists to design a Power Business Intelligence tool and dashboard to more readily, easily access data related to the program outputs, inputs, budget, and key policies. We completed this tool in December 2023 and are actively using it now.

Our FPO program team also finalized submission to the HCA Data Utilization Committee and Washington State Institutional Review Board the proposal and plan to implement the Person-Centered Contraceptive Counseling survey tool as a pilot in 2024. We will be executing this pilot in partnership with University of California San Fransisco as part of the evaluation plan for FPO and are excited to execute the work and learn

from its results. Typically, HCA has focused surveying on providers, thus the new approach – surveying clients and using text-based outreach – will be new in terms of practice and help inform potential policy improvements.

The FPO program team has also been collaborating with our communications colleagues to develop a communications plan focused primarily on the client audience. This plan will roll out in 2024 and intends to work in service of aiding client awareness of their coverage, addressing stigma, and improving rates of utilization.

## GRIEVANCES AND APPEALS

There were no grievances and appeals made DY23 Quarter 2.

## ANNUAL POST AWARD FORUM

There were no annual post award public forum activities DY23 Quarter 2.

## APPENDIX A: BACKGROUND AND DEFINITIONS

### *Definition of Terms*

The following terms are used in the report and 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** include 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.

| Table 8. Program Description | | |
|---|---|---|
| Program Goals | • Improve access to family planning and family planning related services.<br>• Decrease the number of unintended pregnancies.<br>• Increase the use of contraceptive methods.<br>• Increase the interval between pregnancies and births to improve positive birth and women's health outcomes.<br>• Reduce state and federal Medicaid expenditures for averted births from unintended pregnancies. | |
| Historical population name | Family Planning Only Extension | Take Charge |
| Current demonstration population name | Family Planning Only – Pregnancy Related | Family Planning Only |
| Notable Changes | After Pregnancy Care (APC) was implemented as policy in June 2022 | Added benefits as of January 1, 2024 |
| Income eligibility | Income at or below 198 percent of the federal poverty level (FPL) | Income at or below 260 percent of the federal poverty level |
| Target population | • Recently pregnant women who lose Medicaid coverage after their 60-day post pregnancy coverage ends | • Uninsured women and men seeking to prevent unintended pregnancy<br>• Teens and domestic violence victims who need confidential family planning services |
| Coverage period | Additional 10-month coverage following Medicaid 60-day post-pregnancy coverage<br>• When coverage ends must apply for Medicaid or Take Charge | 12-month coverage<br>• No limit on how many times they can reapply for coverage |
| Program coverage | • 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 women include an annual comprehensive family planning preventive 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.<br>• Family planning-related services for men include an annual comprehensive family planning preventive visit for reducing the risk of unintended pregnancy, condoms and spermicides, and services directly related to vasectomies. |