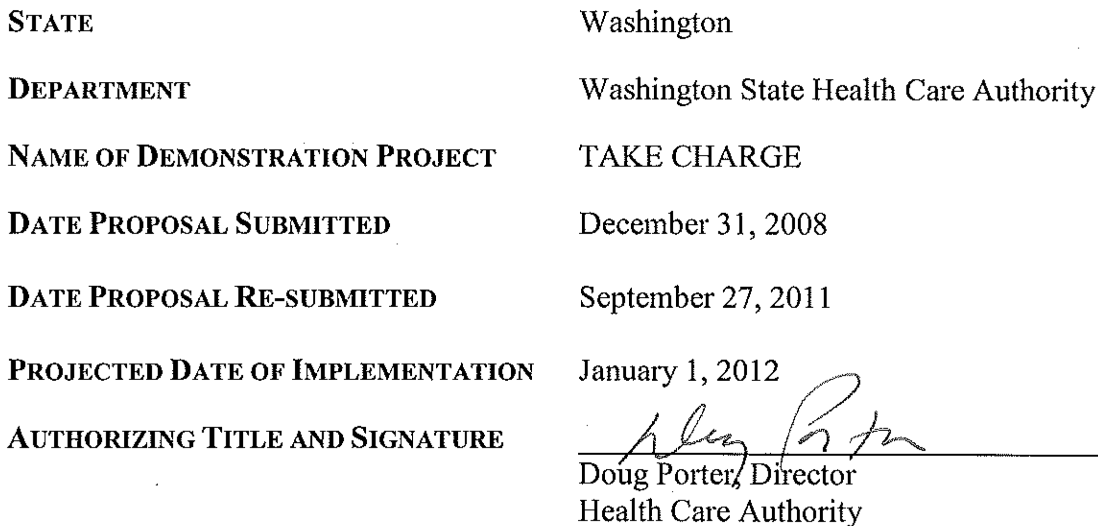
Application Template for Family Planning § 1115 Demonstration



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

PRIMARY FAMILY PLANNING CONTACT:

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

Date Proposal Submitted: December 31, 2008
Date Proposal Re-submitted: September 27, 2011
Projected Date of Implementation: January 1, 2012

I. Enrollment Projections and Goals

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

Demonstration Year 11: 125,000
Demonstration Year 12: 138,000

Please describe the goals of the demonstration.

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

II. Family Planning Demonstration Standard Features

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

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

☒ The Agency has utilized a public process to allow interested stakeholders to comment on its proposed family planning demonstration.

☒ Family planning demonstrations are intended to provide family planning services to low-income men and women who would not otherwise have access to services for averting pregnancy. Eligible individuals are those who are:

- Uninsured, or those whose insurance does not completely cover their contraceptive needs
- Not enrolled in Medicare, Medicaid or the Children's Health Insurance Program (SCHIP)

Signature: ______________________

Title: Director

III. ELIGIBILITY

A. Eligible Populations

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

☒ Women losing Medicaid pregnancy coverage at the conclusion of 60 days postpartum.
Period for which individuals would have coverage: **ten (10) months**

☐ Individuals losing Medicaid coverage with gross income up to and including ____% FPL

☐ Individuals losing SCHIP coverage with gross income up to and including ____% FPL

☒ Individuals eligible based solely on income, with gross income from 0% FPL up to and including 250% FPL

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

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

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

☒ Men of reproductive age

☒ Women of reproductive age

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

B. Initial Eligibility Process

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

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

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

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

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

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

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

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

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

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

The HCA eligibility worker will:

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

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

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

☒ **Yes**
☐ No

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

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

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

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

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

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

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

5. **Is the application for family planning simplified or the same as full Medicaid?**
   Please attach a copy of the application.

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

6. **Is point-of-service eligibility granted?**

   ☐ Yes
   ☒ **No**

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

7. ☒ **Please assure** *(with a checkmark)* **that the State uses gross income prior to applying any income disregards.**

8. **What income disregards does the State use? Please indicate any differences by eligibility group or age.**

   The Agency uses the following income disregards:

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

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

   ☒ **Yes**
   ☐ No

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

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

a. Proof of Income

☒ Self Declaration

☐ Documentation required

- What documents are sufficient to document income?
- When are documents required?
- Are there differences by eligibility group or age?

☒ Income Verification and Eligibility System

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

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

b. Proof of Resources

☐ Self declaration

☐ Documentation required

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

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

c. Social Security Number

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

☐ Documentation required

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

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

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

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

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

d. **Citizenship Status**

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

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

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

☒ **State Agency**
☐ County Agency

C. Eligibility Redetermination Process

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

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

IV. Program Integrity

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

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

1. **Eligibility Determination:** Eligibility for TAKE CHARGE clients is determined by eligibility workers whose sole responsibility is processing TAKE CHARGE applications. The program has had a Medical Eligibility Quality Control (MEQC) review during the first five years of the Waiver and during the first renewal period.

2. **ProviderOne System Audits and Edits:** There are multiple audits and edits built into the new ProviderOne system to assure that only services related to Family Planning are paid. The following are examples of system edits and audits:

   - Any claim that does not have a family planning diagnosis is denied.
   - There are system edits that put limits on the number of services and supplies provided in a specific time frame.
   - The system will deny any claim that is not delivered in an outpatient setting.
   - The system also only allows payments for TAKE CHARGE services provided for enrolled clients by designated TAKE CHARGE providers. The three exceptions are pharmacies, laboratories, and sterilization providers. These three providers can serve TAKE CHARGE clients using their regular Medicaid billing number.

3. **Surveillance and Utilization Reviews (SURS) and Audits:** Our program has a close and collaborative relationship with the SURS and Audit sections within HCA. We have used algorithms to look for anomalous billing patterns and irregularities. With this method of monitoring and analysis we have

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

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

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

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

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

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

☐ Medicaid Eligibility Quality Check (MEQC)
☒ Other *(Please specify)*

1. **Medicaid Eligibility Quality Check:**

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

a. **MEQC Review October 2002 Project 32**

The project goal was to determine:

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

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

b. **MEQC Review May 2007 Project 53**

The audit objectives were to determine whether:

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

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

2. **Payment Error Rate Measurement Program**

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

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

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

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

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

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

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

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

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

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

V. SERVICE CODES:

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

A. **STD Testing and Treatment:** The Agency is being required by legislation to request coverage for STD testing and diagnosis under the Waiver renewal. While the Agency recognizes the important relationship between family planning and STD treatment and diagnosis there is an enormous unmet need for STD services in Washington State. The Agency is concerned that by opening up this coverage we will become the default STD program in the State. We want to continue to cover Gonorrhea and Chlamydia testing for women between the ages of 13 and 25 at the time of their annual family planning preventative exam. We will also continue to cover STD services that are directly related to the safe and effective use of a clients chosen contraceptive method. An example of this would be GC and CT testing prior to an IUD insertion. The state cannot afford at this time to expand STD testing and treatment any further.

B. **Request to change federal match:** The Agency is requesting coverage for pelvic ultrasounds when the placement/location of an intrauterine device (IUD) is in question. This procedure will not be used as part of a routine IUD insertion. The CPT codes that we would like to add to the service at a 90/10 match are 76830, 76856 and 76857.

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

VI. DELIVERY SYSTEM

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

☒ **Fee for Service**
☐ Primary Care Case management
☐ Other

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

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

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

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

☐ Managed Care Organizations	**Estimated Percentage of Patients: 0%**
☐ All Medicaid Providers	**Estimated Percentage of Patients: 0%**
☒ Health Department FP Clinics	**Estimated Percentage of Patients: 11.8%**
☒ Other Family Planning Clinics	**Estimated Percentage of Patients: 83%**
☒ FQHCs/RHCs	**Estimated Percentage of Patients: 2.5%**
☒ Private Providers	**Estimated Percentage of Patients: 3.2%**

Note: All TAKE CHARGE providers are Medicaid providers.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

VII. Program Administration and Coordination

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

☒ Primary Care Office	Relationship/Function: see below
☒ Maternal and Child Health	Relationship/Function: see below
☒ Family Planning	Relationship/Function: see below
☒ Public Health	Relationship/Function: see below
☒ Other (please specify)	Relationship/Function: see below

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

☒ **Yes**
☐ No

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

The Agency communicates with providers through:

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

VIII. EVALUATION

A. Demonstration Purpose, Aim, and Objectives

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

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

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

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

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

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

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

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

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

Objectives for January 2012 through December 2013:

During this renewal period, Washington State seeks to:

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

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

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

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

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

B. Evaluation Design

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

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

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

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

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

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

2. Performance Measures/Data Sources:

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

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

Data Sources

- **Office of Financial Management (OFM) Medicaid Eligibility History**: Spans of eligibility for specific entitlement programs are recorded with start and end dates for each Medicaid client. Specific Recipient Aid Categories (RACs) identify individual programs.

- **First Steps Database (birth certificates linked to Medicaid clients)**: All Washington birth certificates are linked at the individual level to Medicaid claims and eligibility history. FSDB begins with births in July 1988 and currently contains linked birth certificates through 2009 (with preliminary data for 2010). The annual unduplicated count of TAKE CHARGE eligible clients is linked to the FSDB by Personal Identification Code (PIC) or ProviderOne ID.

- **ProviderOne (P1, formerly MMIS)**: HCA's claims file contains a record for every claim submitted for reimbursement. For all TAKE CHARGE eligible clients, the FSDB staff obtains a service history for appropriate time periods for each client. ProviderOne services history data are used to describe the types of family planning services provided.

- **Pregnancy Risk Assessment Monitoring System (PRAMS)**: PRAMS is an annual, population-based survey sponsored by the CDC and administered in Washington by the Department of Health. PRAMS surveys women 2-4 months after delivery and provides information about pregnancy intention.

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

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

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

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

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

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

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

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

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

X. WAIVERS AND AUTHORITY REQUESTED

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

☒ **Amount, Duration and Scope 1902 9(a) (10) (B) and (C)** – The State will offer to the demonstration population a benefit package consisting only of approved family planning services.

☒ **Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) 1902(a) (43) (A)** – The State will not furnish or arrange EPSDT services to the demonstration population.

☒ **Retroactive Coverage 1902(a) (34)** – Individuals in the family planning demonstration program will not be retroactively eligible. Eligibility will begin the first day of the month that the application was signed

☒ **Eligibility Procedures 1902(a) (17)** –

- Parental income will not be included when determining a minor's *(individuals under age 18)* eligibility for the family planning demonstration.
- Income verification will not be required for minors *(individuals under age18).*
- Income verification for adult applicants will be limited to currently available data bases and any improved data bases that become available in the future.
- US citizenship may be attested to with a signature on a Citizenship and Identity Declaration form.
- Applicants will be strongly encouraged but not required to provide a Social Security Number.

☒ **Prospective Payment for Federally Qualified Health Centers and Rural Health Centers and Rural Health Clinics 1902(a) (15)** – The agency will reimburse these clinics on a fee for service basis for a very limited scope of services that include family planning and family planning related services only.

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

XI. ATTACHMENTS

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

☒ Attachment A-1: Letter of Support from State Primary Care Association
☒ Attachment A-2: Letter of Support from DOH Title X Program
☒ Attachment B: Budget Neutrality: Definitions, Assumptions and Methodology
☒ Attachment C: Budget Neutrality Worksheet
☒ Attachment D: Implementation Schedule
☒ Attachment E: Application
☒ Other Attachments *(Please indicate subject of attachment)*

- Attachment F: Population Density Map
- Attachment G: Provider Distribution Map
- Attachment H: Primary Care Referrals Report
- Attachment I: Final Evaluation Report

XII. Contact Information

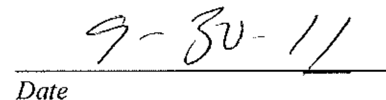
Please provide contact information for the person that CMS should contact for questions related to the family planning demonstration project.

Family Planning Contact:

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

Doug Porter, Director
Washington State Health Care Authority

Signature of Authorizing State Official



Date