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Perceptions and practice of state Medicaid officials regarding informed consent for female sterilization

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Abstract

Objective —To explore the attitudes, beliefs, and interpretations of individual state Medicaid office employees regarding their state's postpartum sterilization policy and its impact on patient care.

Study Design —We invited employees in all 50 state Medicaid director's offices who self- or peer-identified as best informed about the sterilization policy to participate in semi-structured qualitative interviews. Using a pilot-tested interview guide, we transcribed, coded, and analyzed each interview. We attempted to obtain supplemental data, including relevant policy details and instructions for physicians in the state, from all 50 state Medicaid office websites.

Results —We collected data from 15 telephone interviews, four written responses, and 48 states' websites for analysis. Participants had varying responses regarding the impact of the Medicaid-mandated sterilization consent form in terms of informed consent as well as the utility and ramifications of the waiting period. State policies varied in terms of the age of consent, complexity of the form, availability of translations, use of unclear terminology, and the consent-obtaining process.

Conclusion —State Medicaid employees have differences in opinions regarding the intent of the Medicaid-mandated sterilization consent form and policies. Better understanding of the variation in individual state policies that may contribute to inequitable access to sterilization is necessary.

Implications —Provision of consistent guidelines and widespread coordination of the Medicaid sterilization policies in identified areas impacting informed consent may reduce existing obstacles and provide more equitable access to contraceptive care.

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Keywords

sterilization; postpartum contraception; Medicaid; disparity; informed consent; health policy

1. Introduction

The federal Department of Health and Human Services enacted the Medicaid sterilization policy in 1976 to address a history of coerced sterilizations on women of low socioeconomic and/or racial/ethnic minority status by ensuring informed and voluntary consent [1–11]. As contemporary examples of coerced sterilization as well as ongoing bias and disparities in postpartum sterilization continue, the need for protection remains [1,9,12–23]. However, studies have also identified the mandated sterilization consent form and 30-day waiting period as a barrier to access and fulfillment of desired sterilization procedures [1–3,5,8,10,24–31]. A recent study estimated that challenges in complying with these Medicaid requirements lead to “62,000 unfulfilled requests for postpartum sterilization annually, resulting in an estimated 10,000 abortions and 19,000 unintended births in the subsequent year” [25, page 3]. Those with unintended births are more likely to have inadequate or delayed prenatal care and face poorer health outcomes such as increased infant and maternal mortality/morbidity [2,17,26,32–33].

State variation in enforcement of the Medicaid policy is another concern, potentially contributing to unequal patient protection, accessibility, and informed consent as well. Given the infrastructure of Medicaid as a federally-mandated but state-administered insurance plan, individual states may implement the sterilization policy differently. For example, a national survey of obstetrician-gynecologists demonstrated both intra- and inter-state variation regarding the gestational age used to define premature delivery and thus use a shorter 72-hour rather than standard 30-day waiting period [34]. Some states (e.g. California and Texas) also have additional state policies governing postpartum sterilization that impact clinical practice [35].

As experts in the field, state Medicaid employees should be able to clarify their state’s interpretation of the policy, identify issues with policy implementation, and explain policy differences specific to that state that may impact informed consent and patient care. Given their formal role in accomplishing these important policy functions, their opinions on the policy are also significant as they may influence individual state policy implementation and enforcement. Finally, filling this significant knowledge gap by assessing their attitudes and beliefs regarding the Medicaid sterilization policy is critical as they are key stakeholders in any future research and policy revision efforts. Therefore, our objective was to gain the perspectives and interpretations of state Medicaid employees on the sterilization policy, as no study has analyzed this important stakeholder viewpoint since the policy’s implementation.

2. Materials and Methods

We conducted semi-structured qualitative interviews with state Medicaid employees about their state’s sterilization policy. We attempted to recruit employees from all 50 states using

contact information for the Medicaid director's office published on each state's website. After referral to the individual self- or peer-identified as best informed about their state's sterilization policy, we initiated an interview invitation via three telephone messages and/or two emails depending on the specific contact information provided by each state's Medicaid director's office. We obtained verbal consent from all participants before interviews commenced. We also gave participants the option to respond with written answers rather than via a telephone interview if they declined the interview. Additionally, we attempted to gather supplemental data from all 50 states' online published documents, which we analyzed for any differences from the standard federal guidelines (CFR Title 42, Subpart F "Sterilizations") as well as differences between individual state policies. The MetroHealth Medical Center institutional review board approved this study.

The interview guide topics included the sterilization consent form, the 30-day waiting period, unique state policy points, updates or changes to the sterilization policy since inception, and employee attitudes toward and opinions on the sterilization policy. While the policy applies to both male and female sterilization, we focused the interview on female sterilization given the literature suggesting the policy specifically serves as a barrier to care for this population [1,11,13–19]. We pilot-tested the interview guide prior to use and revised iteratively accordingly. One investigator (H.B.J) with prior qualitative interview training conducted 30–45 minute interviews via telephone between January 2018 and August 2018. We conducted interviews in a private room, audio-recorded with the participant's permission, and then transcribed verbatim. We de-identified the transcripts and written responses per our study's protocol in order to protect employees. However, we did not de-identify information from state websites given this information is available to the public.

We then coded the interview transcripts, written responses, and information from websites and analyzed within and between the domains of inquiry [28]. Two investigators (H.B.J and R.P.) developed codes deductively from topics in the interview guide and inductively from the interview transcripts. H.B.J. and R.P. then independently coded all transcripts. We then reviewed coding and resolved discrepancies in coding themes. We used Dedoose, a cloud-based program for managing qualitative data, to facilitate data analysis.

3. Results

We conducted telephone interviews with Medicaid representatives from 15 states: Florida, Kansas, Missouri, Montana, Nebraska, Nevada, New Mexico, New York, Ohio, Oregon, Texas, Vermont, Virginia, Washington, and Wisconsin. Supplemental written information was provided by Indiana, Maine, Minnesota, and South Dakota (Figure 1). Participants included seven policy analysts, four program specialists, two nurse policy managers, one assistant medical director, one clinical director for women's health, and one membership health management bureau chief. Most interviewees had focused roles concerning family planning or women's health. Reported day-to-day responsibilities for participants included consulting with stakeholders, providers, and hospitals; updating policy in coordination with new laws and regulations; reviewing complex claims, medical necessity, benefits, and prior authorizations; and administrative duties such as setting payments, coverage, and rates. Time

working for Medicaid ranged from six months to 30 years (median three years, interquartile range 3.75 years).

Of the 50 states, 48 states had information pertaining to their state's Medicaid sterilization policy accessible online. This information included Medicaid physician/provider manuals (22 states), state administrative codes/regulations (nine states), billing manuals (nine states), policy manuals (seven states), and benefits/coverage manuals (five states). Additionally, 29 states had sterilization consent form instructions and nine states had informational/FAQ sheets available which provided further insight. Twenty-two states had published guidance that differed from the federal policy and/or had additional detail regarding the logistics of implementing the policy such as proper obtainment/distribution/execution of consent forms, policies on corrections/resubmissions, ramifications of denials, and/or billing/coding guidelines (CFR Title 43, Subpart F) (Figure 2).

We organize our results around major domains of inquiry, below and in Table 1.

3.1 Intent of the Consent Form

While the published goal of the Medicaid sterilization consent form is “to ensure that individuals requesting sterilization receive information regarding the risks, benefits, and consequences, and to assure the voluntary and informed consent,” participants had varying perceptions regarding what they felt to be the purpose of the consent form [35 ,page 2].

Approximately half of the state employees interviewed did believe the purpose of the consent form is informed and voluntary consent. “The United States does have some pretty dark history with sterilizing people against or without their consent. I think it’s... appropriate that we are very cautious here and we don’t tread into that territory with vulnerable populations. That we are extra vigilant and make sure we do have full consent from people.” Some state employees reported that many providers even use the form for non-Medicaid patients to ensure informed consent is obtained.

In contrast, six employees thought the consent form served a purpose other than ensuring consent. Five believed the form was a legal protection for the provider and Medicaid as “a woman [could] change her mind [and] blame the provider for not giving enough time. It seems like it could be a safety net for everybody.” They also believed the form was primarily a billing requirement to receive federal funding rather than ensuring consent, making the distinction that “this form is documenting compliance with the federally required time frames that are necessary for Medicaid reimbursement. It’s not meant to be a substitution but instead a supplement to other informed consent requirements that [already] exist as part of the physician’s scope of practice.” One interviewee thought the form is an “onerous way to hold providers and members accountable” due to the complexity of the regulations and process.

Five participants questioned the efficacy of the form for obtaining informed consent stating that “the lady is getting plenty of [other] information to make an educated decision” through alternative means such as conversations with providers and provision of informational educational services offered by the health department (such as the informational brochures

provided with sterilization consent forms in three states). Four participants believed the historical context of protection from coercion is not relevant in 21st century, and eight participants acknowledged that their state's sterilization form and policy had not been updated or changed in 40 years. Another respondent called the form "antiquated" because "providers and patients aren't rushing into sterilizations." Although these participants may not have believed the form upheld its original purpose of obtaining informed consent, they often still believed the form was, at the least, a good mechanism to ensure other methods of adequate counseling were employed.

3.2 Utility of the 30 Day Waiting Period

State employees had varying perceptions about the utility of the 30-day waiting period in the context of ensuring informed consent. Eight believed the 30-day waiting period was appropriate to ensure women had sufficient time to consider a permanent surgery and prevent decisional regret. "Once you explain to them that...we're allowing you these 30 days to make sure it's what you want to do because it's a permanent sterilization, they're usually always ok," said one participant.

However, seven state employees believed the 30-day waiting period was not an appropriate mechanism or length to obtain informed consent. One respondent commented that 30 days seemed an arbitrary length of time, and "not necessarily based on decision-making research." Additionally, four state employees believed the waiting period prevented access to a desired contraceptive method. "Because of the time frame requirements for consent... some women may be choosing LARC [long-acting reversible contraception] as their second-choice method and [are not] able to access their first-choice method of sterilization." State employees also believed that the waiting period was a barrier for those who have trouble making multiple appointments or with late presentation to care. They noted the policy to be inequitable, as those on private insurance do not have a required wait for the same procedure. One respondent indicated that "Anybody else doesn't [have a waiting period]. I think members are offended in some ways, because if you had private insurance you wouldn't have to wait." All interviewees acknowledged that no other Medicaid procedure requires a waiting period between consent and implementation, regardless of its permanence or gravity, including other gynecologic procedures such as abortions and hysterectomies.

3.3 Complexity of the Consent Form

More than half of interviewees commented that the consent form was unnecessarily complex. For example, participants noted that the form has 30 total fields with different names, addresses, and dates; that it is filled out by as many as four separate people (patient, counselor, interpreter, and provider) at two different times (during counseling and again on the procedure day itself); and that parts of the form are crossed out depending on specific circumstances. One respondent acknowledged that ensuring all the "multiple moving parts" come together can be difficult. Two respondents remarked that other forms for similar reproductive health procedures are comparatively simpler. One participant shared, "I read the [sterilization] form and was like 'this is weird, why do you ask all this?' In comparison, the hysterectomy form is so much easier. It's like four boxes... so simple. Even the abortion piece is easier than sterilization." In fact, eight employees said their states had to educate

providers and claims staff on the form due to numerous errors in completion which often led to form rejection. “We were asked to work on [instructions] due to confusion, provider feedback, and error, in the effort to make sure that everyone has a full understanding of what’s required on our forms.”

In addition to the complexity of the form itself, five participants acknowledged that the reading level of the form is an issue which should be addressed to ensure understanding for patients with low health literacy. Respondents said that reading level analysis done on other state Medicaid forms was not done on sterilization consent forms because they felt bound to specific federal wording. “Everything else we do has to meet a certain reading level... [but this is a] tricky situation where the Feds give us this content [and] specific language to use. If it were something that we wrote, we would run those checks.” Lack of changes stemmed both from fear of losing federal funding as well as the view that the purpose of the form was not truly for consent. Therefore, comprehensibility didn’t matter as consent would be obtained in “other ways...with [communication] at a health literacy level that would be [more] applicable to them.”

3.4 State Policy Variation Impacting Informed Consent

Based on published policy and/or interviewee clarification, 22 states had differences in state Medicaid sterilization policy or further guidance compared to the federal guidelines (Figure 2). Four states’ policies had different ages of consent, two states had updated their policies concerning tele-interpreters, 11 states had different definitions for extenuating circumstances, and one state had a different process for obtaining consent than stipulated in federal policy. Respondents who believed the form’s purpose was for obtaining informed consent versus those who believed the forms served a strictly billing purpose were more likely to work in states that made state-specific changes to federal policy (average 2.5 versus 1.3 changes). Regardless, the complexity of the form/process was a theme noted in most interviews.

3.4.1 Age of Informed Consent—Federal Medicaid guidelines set the age of informed consent for sterilization at 21 years, even though the age of consent is traditionally 18 years for medical procedures. Respondents from three states following federal guidelines of 21 as the minimum age for sterilization identified issues with women younger than 21 desiring sterilization, but unable to legally obtain one through Medicaid. “We’ve had women who are crying at 20, ‘I’m having my third baby and I don’t want any more,’ but we can’t do it, we can’t pay for it. And she can’t be sterilized, even though she wants it, because she’s not 21 yet. At the time of her third baby...she has to wait and possibly risk getting pregnant again.” Other participants discussed not being able to sterilize young women for medical reasons, such as severe genetic diseases, that the patient wanted to ensure were not inherited.

Some states, including Oregon (15), Massachusetts (18), and Washington (18), have lowered the age of consent for sterilization, typically to match the age of consent for all other medical procedures in the state. However, sterilizations performed on women younger than 21 years in these states are usually financed through separate state funds to remain aligned with federal guidelines. No participant could provide an example of another Medicaid

procedure with an age of consent of 21 instead of 18. In New Hampshire, “if the individual is 57 or older... the claim may be filed electronically, and no consent form is required.”

3.4.2 Availability of interpreters/translations—Availability of translations of the sterilization consent form varied between states. Ten state employees believed form translations were not in their purview, and followed the federal example from the 1970s when the policy was enacted which only offered English and Spanish versions. In contrast, four state employees did acknowledge translation availability as part of their role. Additional translations were either based off the most common languages for that state’s population (i.e. if five percent of the total population spoke the language) or based on specific provider requests from the state or vendor. One state offered at least five different translations, including Spanish, Hmong, Russian, Somali, and Vietnamese while one state had English as the only available written option. One employee believed that no additional translations were necessary at all, as “Medicaid covers the cost of interpreters in the room.”

However, other issues with interpreters were noted. With the advent of remote tele-interpreters, the required interpreter signature on the pertinent section of the consent form was often not possible (and thus sterilization coverage was rejected). Several employees believed that “given the increase in the use of remote language services, it would be good to find a way to accommodate this [new] electronic business practice,” suggesting alternatives such as a unique call code or a faxed/mailed attestation in lieu of an actual signature. Two states had updated their published policies to allow for alternatives to a wet signature for remote interpreters.

3.4.3 Definitions of extenuating circumstances—While the federal policy allows for the standard 30-day waiting period to be decreased to 72 hours in the “extenuating circumstances” of “premature delivery” or “emergency abdominal surgery,” it does not define these terms. In their published guidance on their website, only 11 states provided additional clarification regarding these terms. As such, states have developed individual definitions, rarely published in written policy and often enforced differently between states.

In interviews, respondents expressed a wide range of definitions for “premature delivery.” Nine states counted “any day before the expected delivery” as a premature delivery – as long as the form was originally signed 30 days before the expected delivery date. They recognized that “even though premature from a clinical perspective [would be considered] differently, for the purposes of the form... you’re timing the 30 days around...the expected due date.” Five states considered premature delivery to be in the purview of the doctor, basing the coverage “solely on the physician’s certification.” One state had a gestational age cutoff, using the American College of Obstetricians and Gynecologists’ “preterm labor” definition of 37 weeks gestation. Two states made determinations on a case-by-case basis in order to take individual circumstances into account, but did not have any specific definitional guidelines in place. In published policy, two additional states used a gestational cutoff of 37 weeks, while three other states used any day before the expected delivery date with one state specifying, “This does not refer to the clinical definition of prematurity.”

The definition and enforcement of “emergency abdominal surgery” as an extenuating circumstance also varied by state. Eight states stated the procedure must be unplanned and medically necessary. Eight states had a case-by-case review of written explanations on the consent form. Two states followed the purview of the doctor, as long as there was an explanation written on the form. Examples of emergency abdominal surgeries covered as an extenuating circumstance in the past included: appendectomy, cholecystectomy, ovarian cystectomy for a ruptured cyst, removal of ectopic pregnancy, cesarean delivery for placenta accreta with severe hemorrhage, removal of metastatic abdominal cancer, and splenectomy in the case of a ruptured spleen. Respondents reported that most instances of rejection were simply due to a lack of any written explanation on the form, rather than a specific procedure that didn’t meet guidelines. One state had a list of procedures that were covered and not covered, while another state covered any procedure “if the abdomen [was] open and access [was] visualized.” Many had no explicit definition, and commented that this extenuating circumstance was rarely seen. One state claimed that they had never taken this circumstance into account “because if it was an emergency, they [didn’t] even think about [sterilization]. They just [went] in and [did] what they [needed] to do.”

Eight states specifically defined cesarean deliveries as not being emergency abdominal surgery, seven states defined cesarean deliveries as emergency abdominal surgeries, two states required an individual review of the situation, and one state used the physician’s purview. One state had additional extenuating circumstances beyond the federal policy in which the 30-day waiting period was waived completely. These situations included patients who became eligible for Medicaid insurance during the last month of pregnancy; patients who did not obtain medical care until the last month of pregnancy; or patients who had substance use disorder, but were not impaired by alcohol or illicit substances at the time of delivery.

3.4.4 Process of Obtaining Consent—In New York City, it was stipulated that consent may not be taken by the operating surgeon or person counseling regarding sterilization. This same restriction is not in place for the remainder of the state of New York, other states in our study, or for other medical procedures covered by Medicaid in New York City.

3.5 Attitudes Toward Policy Changes

Participants had different views about their role in policy change and implementation. Of those who believed the policy’s purpose was to improve informed consent, more than half supported policy changes to improve the process while only a minority of those interviewed who felt the form served primarily a billing/legal purpose felt policy changes were necessary. When asked if they would change anything about their state’s Medicaid sterilization policy, six interviewees hoped for change and had active suggestions for policy improvement, including updating the policy to more current practice, simplification/clarification of ambiguous points, and giving more definitive directions for filling out the form. A few of these interviewees had in fact advocated for policy change in their state, including one who ensured that salpingectomy was a covered procedure after hearing about “a movement among OBGYNs to do salpingectomy for sterilization as a preventative

measure, to prevent ovarian cancer.” Others, after noticing an increase in sterilization consent form rejections, “published line by line instructions to those who review[ed] the form clarifying which form discrepancies are truly issues and which are not.”

However, nine employees did not feel it was their role to advocate for change and did not want anything changed in their state’s Medicaid sterilization policy. These employees saw themselves solely as enforcers of the law stating that policy change “has never been the base priority. It’s making sure we make the federal requirements to actually pay for them” and minimizing “any reasons to come back and take money away from the state.” These nine interviewees felt reform was unnecessary because “there wouldn’t be any reason to” or because the federal guidelines didn’t give them “any room to do so.” One interviewee believed that the “best use of limited resources...[was] to improve instructions” rather than the policy itself. Another stated that any change was irrelevant because, “The questions and queries as to whether it should be approved or not come to me and I’m pretty straightforward about it.”

4. Discussion

In this qualitative study, state Medicaid employees had varying beliefs regarding the true goal of the Medicaid sterilization policy – as either primarily for informed consent to reduce coercion or to satisfy billing requirements. We also found significant variation between individual states on aspects of the sterilization policy implementation, including the complexity of the form, age of consent, availability of translations and interpreters, definitions of extenuating circumstances to reduce the waiting period, and process of obtaining consent.

The majority of state employees interviewed questioned the value of the policy and the necessity of the waiting period to ensure informed consent - the policy was viewed as a billing or legal requirement necessary for federal aid, and that informed consent was best obtained separately. Participants who believed the policy was integral to consent and protection of vulnerable populations tended to be more likely to have an open attitude towards policy changes, and also tended to be more likely to work in states that had made changes to their policy to mitigate aspects that may serve as a barrier. Such policy provisions included lowering the age of consent to match other medical procedures, adding additional caveats to reduce the waiting period, and providing additional translations. Those participants who believed the form served primarily as a billing or legal purpose tended to be more likely to work in states adhering to strict federal guidelines with fewer state revisions to policy. Similarly, these participants were often less open to policy change, either by not considering larger social consequences, believing changes would invalidate the legality of the policy, or because they felt their own personal fairness in enforcement could compensate for ambiguous policy details.

Given the variation in individual state Medicaid sterilization policies and enforcement, room for increased standardization between states exists. Changes to consider include reducing the age of consent to mirror that of other procedures, increasing comprehension of the forms through reducing the reading level, reducing form complexity, and increasing the number of

translated languages. Modernization of the policy, for example by making provisions for remote interpreter signatures, may additionally increase accessibility. It is also important to clarify key terminology regarding exceptions to the waiting period, as few states clearly delineate the definitions of “premature delivery,” “emergency abdominal surgery,” and state whether an unscheduled cesarean delivery is considered an emergency abdominal surgery. Doing so would likely lead both to greater transparency and understanding of the process. Addressing additional extenuating circumstances, such as late access to care and change in insurance, may also help improve access. However, one state’s exception to the waiting period specifically for women with substance use disorder is worrisome as it reinforces the exceptionalism and stigmatization of those with mental health and substance use disorders [2,36]. The impact of state modifications on informed consent, continued protection against coercion, and access to desired care has not been analyzed. Further study into these changes and the effect of their more widespread adoption is warranted.

Limitations of this study include the small sample size of only 15 interviewees. As we interviewed employees who self- or peer-designated as the best suited to answer questions regarding sterilization, responses are both subject to response bias and also may not be representative of the larger state Medicaid office. Further, the variation in employment length and specific job title is likely a result of the differences in individual state Medicaid office structures, but also may contribute to differences in our study findings. As qualitative research is hypothesis-generating rather than hypothesis-testing, a quantitative state-by-state policy analysis is warranted to further address the questions raised in this study.

This was the first study to assess the attitudes, beliefs, and interpretations of individual state Medicaid office employees regarding their sterilization policy. Given the important role of this key stakeholder in policy implementation, clarification of their viewpoint and knowledge of any differences is important to informing clinical care, future research directions, as well as potential policy revision moving forward. Working together towards consistent guidelines to obtain informed consent and widespread coordination of the Medicaid sterilization policy may reduce existing obstacles and provide increased access to contraceptive care, while maintaining the necessary framework to protect against potential coercion.

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Figure 1:
Geographic distribution of state Medicaid officials participating in telephone interviews or providing written responses

Figure 2:
Nature of modifications made to published state Medicaid sterilization policies compared to federal guidance by state

Table 1.

Domains of inquiry and illustrative quotations

Domain 1: Sterilization consent form	
Sterilization form is for informed consent	
Protects vulnerable population	“That’s what I tell myself, that we’re doing all this really to hold the government accountable to make sure we don’t cross that line [of coercion]. [It’s not] that we don’t trust women.”
Ensures consent is obtained	“[The form] does a good job of making sure that providers obtain informed consent from patients, and properly.”
Medicaid form is used for informed consent even beyond federal requirements	“[Our providers] use [the form] for everybody. It’s easy because they have to have consent from everybody.”
Sterilization form is not for informed consent	
Legal protection	“I think the forms are purely for the legal part of it...I know that they get all sorts of [other] information [about sterilization] from their physicians.”
Billing requirement	“[The form] has never been the base priority. It’s making sure we make the federal requirements to actually pay for them.”
Better alternatives to obtain informed consent	“[Consent is better obtained by] a conversation that the doctor is having with the patient...what the woman’s wishes are and the potential health risks and all that stuff.”
Antiquated	“Occasionally I’ll wonder if this is a lot of effort and/or not really necessary. Providers and patients generally are reasonable and they’re not going to be rushing out to do sterilizations.” “I don’t think the federal policy has been updated in forever...I think it’s been about 50 years of something... But it needs it, I’d say.”
Onerous	“It does make me wonder if there’s a way to hold the government accountable that would be less onerous on providers and members.”
Domain 2: Waiting period	
Waiting period is appropriate	
Allows women time to consider serious/permanent decision	“I think that the 30 days is a good number. Sometimes people aren’t always in the right frame of mind when they first make a decision like that.” “Yes [the waiting period] definitely is [a good length], because it is a very serious matter and not a decision to take lightly.”
Prevents later regret	“I don’t know how often women with a shorter time period change their mind. I think some people really know what they want...and maybe don’t need time. But I think other people might...benefit from having that time to think about it.”
Waiting period is not appropriate	
No other Medicaid procedure requires wait between consent and implementation	“Other than sterilization, there is no Medicaid procedure which requires a waiting period after consent is already given.”
30 days seems arbitrary or too long	“I don’t know if [the waiting period] was founded in sound kind of behavior and decision-making research with good studies and evidence behind it or if that was completely an arbitrary number.”
Prevents equal access to full range of contraceptive options	“There’s a big focus in today’s landscape around contraception and family planning and ensuring access to the full range. Some of our providers may see [the waiting period] as a barrier or obstacle to allowing access to the full range of contraceptive options and family planning choices.”
Barrier for those who have trouble making multiple appointments or late access to care	“By having a waiting period, you lose a lot of people because they’re not able to come back for another appointment. It’s hard to get [the Medicaid population] in to see the doctor, so they might not show back up to even have the procedure done.” “There are women who seek care late in their pregnancy for the first time, and may not have enough time for the 30-day consent form period.”
Inequity: those on private insurance have no required wait	“I would mirror what we do for everyone else in society. [Having or not having a waiting period] would just be the same across the board for everybody.”
Domain 3: Policy issues impacting informed consent	

Age of informed consent	"A child who's 20 years old and has had 4 kids and wants to be sterilized. You do 'em for free if they really wanna do it, because ...the feds won't help with reimbursement if they're under 21. It's happened to me a couple of times."
Complexity of sterilization form	"You have to put the person's name in...the address, zip code, all this information in each spot. Like who provided [the procedure] versus who [consented] to them. I just think it's a little... confusing for patients... and in general."
Comprehensibility	"You try and get that language to a 6th grade language, because that's what we try to do, right? But because there is so many medical terminologies in here, there's no way to get it ...to a 6th grade reading level."
Interpreters/translations	"Providers...face challenges in obtaining the interpreter's signature when the interpreter is at a remote location. Some services send confirmation of their language services using a worker code and the date ... rather than having their interpreters sign the form. Given the increase in the use of remote language services, it would be good to find a way to accommodate this electronic business practice."
Extenuating circumstances	"That's why those 3 exceptions to the 30-day waiting period [were required] by the [state] legislature. If they don't seek prenatal care until late in their pregnancy, they wouldn't have seen a provider. If they weren't eligible for Medicaid within 30 days the provider wouldn't have had to do this consent form for Non-Medicaid. [We want] to make sure that women have access to the services they require."