

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, Maryland 21244-1850



March 8, 2019

Beth Kidder
Deputy Secretary for Medicaid
Florida Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 8
Tallahassee, FL 32308

Dear Ms. Kidder:

The Centers for Medicare & Medicaid Services (CMS) is pleased to inform you that Florida's request to extend its section 1115 demonstration, entitled "Florida Medicaid Section 1115 Family Planning Waiver" (Project Number: 11-W-00135/4) has been approved. CMS' approval of this demonstration extension is granted under the authority of section 1115(a) of the Social Security Act (the Act) and is effective as of the date of this letter through June 30, 2023.

The demonstration extends eligibility for family planning services, for a transitional period up to 24 months, to women ages 14 through 55 with family income at or below 191 percent of the Federal Poverty Level (FPL) who have lost Medicaid State Plan eligibility and are not otherwise eligible for Medicaid or the Children's Health Insurance Program (CHIP), or enrolled in other creditable health insurance coverage that provides family planning services. Individuals who meet this criteria will be eligible for a new 24-month demonstration coverage period upon each subsequent loss of Medicaid State Plan eligibility.

Demonstration projects under section 1115 of the Act offer a way to give states more freedom to test and evaluate innovative solutions to improve quality, accessibility, and health outcomes in a budget-neutral manner, provided that, in the judgment of the Secretary, the demonstration is likely to assist with promoting the objectives of Medicaid. Consistent with federal transparency requirements, CMS also considers all public comments received during both the state and federal public input periods when evaluating whether the demonstration project as a whole will likely assist in promoting the objectives of Medicaid.

Florida received one letter during its public comment period that supported the continuation of the family planning demonstration but recommended the state amend the program to expand eligibility guidelines, implement presumptive eligibility, and remove the guideline limiting coverage to women who are not enrolled in creditable health insurance coverage that provides family planning services. The state also received a question regarding possibly adjusting the age limit for the demonstration. The state reports that it considered these requests but determined that no changes to the demonstration extension application would be made as the parameters of

the Family Planning Waiver demonstration program are defined by Florida statute and therefore cannot be adjusted. CMS did not receive any responses during the federal public comment period.

After review of all the materials submitted by the state, as well as all public comments received, CMS determined that the Florida Medicaid Section 1115 Family Planning Waiver should be extended because it is likely to assist with promoting the objectives of title XIX of the Act by improving access to high-quality, person-centered family planning services that produce positive health outcomes for individuals.

CMS' approval of this demonstration project is subject to the state's compliance with the enclosed set of STCs and associated expenditure authorities. All Medicaid title XIX requirements as expressed in law, regulation, and policy statement not expressly identified as not applicable in these approval documents shall apply to the Family Planning Waiver demonstration program. The state's authority to deviate from Medicaid requirements is limited to the expenditure authorities and requirements specifically listed as not applicable to such expenditure authorities, as described in the enclosed approval documents, and to the purpose(s) indicated.

This award is subject to your written acknowledgement of the award and acceptance of the STCs and associated expenditure authorities within 30 days of the date of this letter.

Your CMS project officer for this demonstration is Mr. Jack Nocito, who can be contacted to answer any questions concerning the implementation of this demonstration at 410-786-0199 or at Jack.Nocito@cms.hhs.gov. Official communications regarding program matters and correspondence concerning the demonstration should be submitted to him at the following address:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mail Stop: S2-25-26
7500 Security Boulevard
Baltimore, MD 21244-1850

Official communications regarding this demonstration should be sent simultaneously to Mr. Nocito and to Ms. Shantrina Roberts, Associate Regional Administrator (ARA) for the Division of Medicaid and Children's Health Operations in our Atlanta Regional Office. Ms. Roberts' contact information is as follows:

Centers for Medicare & Medicaid Services
Division of Medicaid and Children's Health Operations
Atlanta Federal Center, 4th Floor, Suite 4T20
61 Forsyth Street, South West
Atlanta, GA 30303-8909

If you have any questions regarding this approval, please contact Mrs. Judith Cash, Director, State Demonstrations Group, Center for Medicaid & CHIP Services at (410) 786-9686.

Sincerely,

/s/

Chris Traylor
Deputy Administrator and Director

cc: Shantrina Roberts, ARA, CMS Atlanta Regional Office

**CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY**

NUMBER: 11 -W-00135/4

TITLE: Florida Medicaid Family Planning Waiver

AWARDEE: Florida Agency for Health Care Administration

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by Florida for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period of this demonstration extension, be regarded as expenditures under the state's title XIX plan. All requirements of the Medicaid statute will be applicable to such expenditure authorities (including adherence to income and eligibility system verification requirements under section 1137(d) of the Act), except those specified below as not applicable to these expenditure authorities.

The following expenditure authority and the provisions specified as "not applicable" enable Florida to operate its demonstration through June 30, 2023, unless otherwise stated:

Expenditures for extending title XIX family planning services through a targeted application and enrollment process, for a transitional period up to 24 months, to women ages 14 through 55 with family income at or below 191 percent of the Federal Poverty Level (FPL) who have lost Medicaid State Plan eligibility and are not otherwise eligible for Medicaid or the Children's Health Insurance Program (CHIP), or enrolled in other creditable health insurance coverage that provides family planning services. Individuals who meet this criteria will be eligible for a new 24-month transitional period of demonstration coverage upon each subsequent loss of Medicaid State Plan eligibility.

Medicaid Requirements Not Applicable to the Medicaid Expenditure Authorities:

All Medicaid requirements apply, except the following:

- 1. Methods of Administration: Transportation** **Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53**

To the extent necessary to enable the state to not provide transportation to and from providers for the demonstration population.

- 2. Amount, Duration, and Scope of Services (Comparability)** **Section 1902(a)(10)(B)**

To the extent necessary to allow the state to offer the demonstration population a benefit package consisting only of family planning services and family planning-related services for up to 24 months of coverage per each loss of Medicaid State plan eligibility.

Centers for Medicare & Medicaid Services

SPECIAL TERMS AND CONDITIONS

NUMBER: 11 -W-00135/4
TITLE: Florida Medicaid Family Planning Waiver
AWARDEE: Florida Agency for Health Care Administration

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Florida Medicaid Family Planning Waiver section 1115(a) Medicaid demonstration (hereinafter “demonstration”). The parties to this agreement are the Florida Medicaid Agency and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and the state’s obligations to CMS during the life of the demonstration. The STCs are effective through June 30, 2023 unless otherwise specified. All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below and the associated expenditure and non-applicable authorities.

The STCs have been arranged into the following subject areas:

- I. Preface
 - II. Program Description and Objectives
 - III. General Program Requirements
 - IV. Eligibility and Enrollment
 - V. Benefits and Delivery Systems
 - VI. General Reporting Requirements
 - VII. General Financial Requirements
 - VIII. Monitoring Budget Neutrality
 - IX. Evaluation
 - X. Schedule of State Deliverables during the Demonstration
- Appendix A: Template for Annual Monitoring Reports
Appendix B: Template for Evaluation Design Plan

II. PROGRAM DESCRIPTION AND HISTORICAL CONTEXT

Effective through June 30, 2023, the Florida Medicaid Family Planning Waiver (“FPW”), section 1115(a) Medicaid demonstration expands the provision of family planning and family planning-related services to women ages 14 through 55 with family income at or below 191 percent of the Federal Poverty Level (FPL) who have lost or are losing Florida Medicaid State Plan eligibility and are not otherwise eligible for the Children’s Health Insurance

Program (CHIP), or enrolled in health insurance coverage that provides family planning services. Eligibility for the FPW is limited to a period of up to 24 months following the loss of Medicaid coverage, as authorized in s. 409.904(5) Florida Statutes to provide transitional coverage for those losing Medicaid eligibility. Women may become eligible for a new two-year period of transitional family planning coverage upon each subsequent loss of Medicaid eligibility.

Historical Context and Objectives

In 1997, Florida submitted the FPW application to CMS to obtain federal approval on the implementation of section 409.904(5) Florida Statutes, which authorized funding for extending the eligibility for family planning services, and provide up to 24 months of family planning coverage to postpartum women with incomes at or below 185 percent of the FPL who received pregnancy-related services paid for by Medicaid. The demonstration was approved for a 5-year period on August 23, 1998, and implemented October 1, 1998.

The demonstration was originally implemented to provide a limited Medicaid benefit package of family planning and family planning-related services to an expansion population of women of childbearing age losing Medicaid pregnancy coverage or full Medicaid coverage, that had family income at or below 185 percent of the FPL, and who were not otherwise eligible for Medicaid or CHIP, or enrolled in other health insurance coverage that provided family planning services. With the implementation of the Affordable Care Act's requirement to transition to the use of Modified Adjusted Gross Income (MAGI) for determining Medicaid income eligibility, the state's comparable income limit increased to 191 percent of the FPL effective January 1, 2014. The state has not had any other program changes. On September 27, 2017, Florida submitted a request to extend the demonstration for a five-year period with no program changes.

CMS and Florida expect this demonstration will promote Medicaid program objectives by:

- Increasing access to family planning services;
- Increasing child spacing intervals through effective contraceptive use;
- Reducing the number of unintended pregnancies in Florida; and,
- Reducing Florida's Medicaid costs by reducing the number of unintended pregnancies by women who otherwise would be eligible for Medicaid pregnancy-related services.

III. GENERAL PROGRAM REQUIREMENTS

- 1. Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited

to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

- 2. Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid programs expressed in law, regulation, and policy statement not expressly waived or identified as not applicable in the expenditure authority document (which is a part of these terms and conditions), must apply to the demonstration.
- 3. Changes in Medicaid Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, court order, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid programs that occur during this demonstration approval period, unless the provision being changed is explicitly waived or identified as not applicable.
- 4. Impact on Demonstration of Changes in Federal Law, Regulation, and Policy Statements.**
 - a) To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change.
 - b) If mandated changes in the federal law require state legislation, the changes must take effect on the day, such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.
- 5. Changes Subject to the Amendment Process.** Changes related to demonstration features such as eligibility, enrollment, benefits, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Social Security Act (the Act). The state must not implement changes to these demonstration elements without prior approval by CMS. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 6 below.
- 6. Amendment Process.** Requests to amend the demonstration must be submitted to CMS in writing for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required reports and other deliverables in a timely fashion according to the deadlines specified therein. Amendment requests must include, but are not limited to, the following:

- a) A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;
- b) A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality expenditure limit;
- c) An explanation of the public process used by the state consistent with the requirements of STC 14; and,
- d) If applicable, a description of how the evaluation design must be modified to incorporate the amendment provisions.

7. Extension of the Demonstration. States that intend to request a demonstration extension under sections 1115(e) or 1115(f) of the Act must submit extension applications in accordance with the timelines contained in statute. Otherwise, no later than 12 months prior to the expiration date of the demonstration, the Governor or Chief Executive Officer of Florida must submit to CMS either a demonstration extension request that meets federal requirements at 42 Code of Federal Regulations (CFR) §431.412(c) or a transition and phase-out plan consistent with the requirements of STC 8.

8. Demonstration Transition and Phase-Out. The state may suspend or terminate this demonstration, in whole or in part, at any time prior to the date of expiration.

- a) Notification of Suspension or Termination: The state must promptly notify CMS in writing of the effective date and reason(s) for the suspension or termination. At least six months before the effective date of the demonstration's suspension or termination, the state must submit to CMS its proposed transition and phase-out plan, together with intended notifications to demonstration enrollees. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with the requirements of STC 14. Once the 30-day public comment period has ended, the state must provide a summary of public comments received, the state's response to the comments received, and how the state incorporated the comments received into the transition and phase-out plan submitted to CMS.
- b) Transition and Phase-out Plan Requirements: The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for those beneficiaries whether currently enrolled or determined to be eligible individuals, as well as any community outreach activities, including community resources that are available.
- c) Phase-out Plan Approval: The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.

- d) Phase-out Procedures: The state must comply with all notice requirements found in 42 CFR §431.206, §431.210 and §431.211. In addition, the state must assure all appeal and hearing rights are afforded to demonstration participants as outlined in 42 CFR §431.220 and §431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as found in 42 CFR §435.916.
- e) Exemption from Public Notice Procedures 42 CFR §431.416(g): CMS may expedite or waive the federal and state public notice requirements in accordance with the circumstances described in 42 CFR §431.416(g).
- f) Enrollment Limitation during Demonstration Phase-Out: If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended.
- g) Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

9. CMS Right to Amend, Suspend, or Terminate. CMS may amend, suspend or terminate the demonstration, in whole or in part, at any time before the date of expiration, whenever it determines, following a hearing, that the state has materially failed to comply with the terms of the project. CMS will promptly notify the state in writing of the determination and the reasons for the amendment, suspension or termination, together with the effective date.

10. Deferral of Payment for Failure to Submit Deliverables on Time. CMS may issue deferrals in an amount up to \$1,000,000 per deliverable (federal share) when items required by these STCs (e.g., monitoring reports, evaluation design documents, required data elements and analyses, presentations, and any other deliverable specified in these STCs (hereafter singly or collectively referred to as “deliverable(s)”) are not submitted timely to CMS or found to not be consistent with the requirements approved by CMS. Specifically:

- a) Thirty days after the deliverable was due, CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverables. The deferral would be issued against the next quarterly expenditure report following the written deferral notification.
- b) For each deliverable, the state may submit a written request for an extension to submit the required deliverable. Extension requests that extend beyond the current fiscal quarter must include a Corrective Action Plan (CAP).
 - i. CMS may decline the extension request.

- ii. Should CMS agree in writing to the state's request, a corresponding extension of the deferral process described below can be provided.
 - iii. If the state's request for an extension includes a CAP, CMS may agree to or further negotiate the CAP as an interim step before applying the deferral.
- c) When the state submits the overdue deliverable(s) that are accepted by CMS, the deferral(s) will be released.
 - d) As the purpose of a section 1115 demonstration is to test new methods of operation or services, a state's failure to submit all required deliverables may preclude a state from amending (as indicated in STC 6) or extending a demonstration or obtaining a new demonstration.
 - e) CMS will consider with the state an alternative set of operational steps for implementing the deferral associated with this demonstration to align the process with any existing deferral process the state is undergoing (e.g., the quarter the deferral applies to and how the deferral is released).

11. Finding of Non-Compliance. The state does not relinquish its rights to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

12. Withdrawal of Waiver/Expenditure Authority. CMS reserves the right to withdraw waiver and/or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS must promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling participants.

13. Adequacy of Infrastructure. CMS and the state acknowledge while funding is subject to appropriation from the state legislature, the state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems applicable to the demonstration; compliance with cost sharing requirements to the extent they apply; and reporting on financial and other demonstration components.

14. Public Notice, Tribal Consultation, and Consultation with Interested Parties. The state must comply with the state notice procedures as required in 42 CFR §431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also

comply with the public notice procedures set forth in 42 CFR §447.205 for changes in statewide methods and standards for setting payment rates.

The state must also comply with tribal and Indian Health Program/Urban Indian Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR §431.408(b), State Medicaid Director Letter #01-024, or as contained in the state's approved Medicaid State Plan, when any program changes to the demonstration, either through amendment as set out in STC 6 or extension, are proposed by the state.

15. Federal Financial Participation (FFP). No federal matching funds for expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter.

16. Common Rule Exemption. The state shall ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid or CHIP program – including procedures for obtaining Medicaid or CHIP benefits or services, possible changes in or alternatives to Medicaid or CHIP programs and procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. The Secretary has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR §46.101(b)(5).

IV. ELIGIBILITY AND ENROLLMENT

17. Eligibility for the Demonstration. Transitional family planning and family planning related services are provided to eligible individuals as defined below for a 12-month period subsequent to a loss of Medicaid State Plan eligibility. As a function of the 12-month coverage period, an individual found eligible will not be required to report changes in income or household size for the 12-month period of eligibility. Individuals may reapply for coverage at the expiration of the first 12-month coverage period for an additional 12 months of coverage. Enrollees will only be provided with a maximum of two 12-month coverage periods following a loss of Medicaid State Plan eligibility for any reason.

Individuals may become eligible for a new FPW transitional coverage period up to 24 months upon another Medicaid State Plan enrollment and subsequent loss of Medicaid State Plan eligibility. There is no limitation on the number of 24-month FPW coverage periods an eligible individual may have as long as all eligibility criteria are met.

Eligible individuals are women ages 14 through 55 with family income at or below 191 percent of the FPL who are losing Medicaid State Plan coverage for any reason; including women losing Medicaid pregnancy-related coverage after 60 days postpartum and women losing Medicaid managed care coverage.

18. Eligibility Determination Process. Within three years from the date of CMS approval of

this demonstration extension, the state will integrate FPW eligibility and application processes into the eligibility system operated by the state for Medicaid State Plan coverage in accordance with section 1943 of the Act. No later than 90 days post CMS approval of this extension, the state will submit for CMS review and approval, its three-year timeline with milestones for aligning FPW eligibility and application processes with the requirements of section 1943 of the Act. (and implementing federal regulations at 42 CFR part 435).

Until integration of the FPW into the state's Medicaid State Plan eligibility system is complete, the state will conduct a targeted FPW application and eligibility determination process that meets the intent of section 1943 of the Act in accordance with the following processes:

- a) Application. The separate FPW application will be modified to collect all information needed to determine eligibility using Modified Adjusted Gross Income (MAGI) and to align with federal conditions of eligibility as specified in 42 CFR §435.907. The state will make the separate FPW application available online for download and fax submission, by mail submission, and available at the local county health department for application and submission in person.
- b) Notices: The separate FPW application and beneficiary eligibility determination notices will provide advance notification that eligibility will be for a 12-month period without a requirement to report a change in income or household size, that enrollees are subject to reapplication after termination of the 12-month coverage period, and that enrollees will only be provided with a maximum of two 12-month coverage periods per loss of Medicaid State Plan eligibility.
- c) Verifications: The state will continue to use electronic data sources to which it has system capability to verify factors of FPW eligibility. To the extent the state is not able to verify factors of FPW eligibility electronically, the state will accept self-attestation except for income and citizenship/qualified immigration status. To verify income and citizenship/qualified immigration status, the state may request applicants provide this information as part of the FPW eligibility determination. However, the state may not make a final determination of ineligibility based on lack of documentation of income and citizenship/qualified immigration status provided by the applicant until the state first utilizes an alternative process (pre or post enrollment) to verify this information through the electronic data sources utilized for Medicaid State Plan eligibility.

A delay in implementing the processes necessary to align with section 1943 of the Act (and implementing federal regulations at 42 CFR part 435) may subject the state to the penalty described in STC 10.

19. Demonstration Disenrollment. If a woman becomes pregnant while enrolled in the demonstration, she may be determined eligible for Medicaid under the State Plan. The state must not submit claims under the demonstration for any woman who is found to be eligible under the Medicaid State Plan. In addition, women who receive a sterilization procedure and complete all necessary follow-up procedures will subsequently be disenrolled from the

demonstration.

V. BENEFITS AND DELIVERY SYSTEMS

20. Family Planning Benefits. Individuals eligible under this demonstration will receive family planning services and supplies as described in section 1905(a)(4)(C) of the Act, which are reimbursable at the 90 percent Federal matching rate. The specific family planning services provided under this demonstration are as follows:

- a) FDA-approved methods of contraception;
- b) Sexually transmitted infection (STI)/sexually transmitted disease (STD) testing, Pap smears and pelvic exams. Note: The laboratory tests done during an initial family planning visit for contraception include a Pap smear, screening tests for STIs/STDs, blood count and pregnancy test. Additional screening tests may be performed depending on the method of contraception desired and the protocol established by the clinic, program or provider. Additional laboratory tests may be needed to address a family planning problem or need during an inter-periodic family planning visit for contraception;
- c) Drugs, supplies, or devices related to women's health services described above that are prescribed by a health care provider who meets the state's provider enrollment requirements (subject to the national drug rebate program requirements); and
- d) Contraceptive management, patient education, and counseling.

A complete listing of all reimbursable service codes for the FPW is available at:
http://ahca.myflorida.com/Medicaid/Family_Planning/reim_services.shtml.

21. Family Planning-Related Benefits. Individuals eligible under this demonstration will also receive family planning-related services and supplies defined as those services provided as part of or as follow-up to a family planning visit and are reimbursable at the state's regular Federal Medical Assistance Percentage (FMAP) rate. Such services are provided because a "family planning-related" problem was identified and/or diagnosed during a routine or periodic family planning visit. Examples of family planning-related services and supplies that would be provided under this demonstration include:

- a) Colposcopy (and procedures done with/during a colposcopy) or repeat Pap smear performed as a follow-up to an abnormal Pap smear which is done as part of a routine/periodic family planning visit.
- b) Drugs for the treatment of STIs/STDs, except for HIV/AIDS and hepatitis, regardless of the purpose of the visit, consistent with CMS guidance issued April 14, 2014, SMDL#14-03/ACA# 31. This includes behavioral counseling and a follow-up visit/encounter for the treatment/drugs and subsequent follow-up visits to rescreen for STIs/STDs based on the Centers for Disease Control and Prevention guidelines may be covered.

- c) Drugs/treatment for vaginal infections/disorders, other lower genital tract and genital skin infections/disorders, and urinary tract infections, where these conditions are identified/diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/drugs may also be covered.
- d) Other medical diagnosis, treatment, and preventive services that are routinely provided pursuant to family planning services in a family planning setting. An example of a preventive service could be a vaccination to prevent cervical cancer.
- e) Treatment of major complications arising from a family planning procedure.

A complete listing of all reimbursable service codes for the FPW is available at:
http://ahca.myflorida.com/Medicaid/Family_Planning/reim_services.shtml.

22. Minimum Essential Coverage (MEC). The Florida family planning demonstration is limited to the provision of services as described in STCs 20 and 21. Consequently, this demonstration is not recognized as Minimum Essential Coverage (MEC) as indicated by CMS in its February 12, 2016 correspondence from Vikki Wachino to Justin Senior, Deputy Secretary of Medicaid, regarding the designation of MEC for the state's section 1115 demonstration.

23. Primary Care Referrals. Primary care referrals to other social service and health care providers as medically indicated will be provided; however, the costs of those primary care services are not covered for enrollees of this demonstration. The state must facilitate access to primary care services for enrollees, and must assure CMS that written materials concerning access to primary care services are distributed to demonstration enrollees. The written materials must explain to enrollees how they can access primary care services.

24. Delivery of Services. Enrollees will receive family planning demonstration services on a fee-for-service (FFS) basis. Beneficiary freedom of choice of which provider to see for family planning services shall not be restricted.

VI. GENERAL REPORTING REQUIREMENTS

25. General Financial Requirements. The state must comply with all general financial requirements under title XIX and as set forth in section VII.

26. Reporting Requirements Relating to Budget Neutrality. The state must comply with all reporting requirements for monitoring budget neutrality as set forth in section VIII.

27. Submission of Post-approval Deliverables. The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs.

28. Compliance with Federal Systems Updates. As federal systems continue to evolve and incorporate additional section 1115 demonstration reporting and analytics functions, the state

will work with CMS to:

- a) Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;
- b) Ensure all 1115, Transformed Medicaid Statistical Information System (T-MSIS), and other data elements that have been agreed to for reporting and analytics are provided by the state; and,
- c) Submit deliverables to the appropriate system as directed by CMS.

29. Quarterly Monitoring Reports. The state must submit three quarterly monitoring reports and one combined fourth quarter/annual monitoring report for each demonstration year according to the schedule listed below. The quarterly monitoring reports are due no later than 60 days following the end of each demonstration quarter. The combined fourth quarter/annual monitoring report is due no later than 90 days following the end of the demonstration year as described in STC 31. The combined fourth quarter/annual report monitoring should distinctly describe the information associated with the fourth quarter of the demonstration year. The state's demonstration quarterly reporting cycle is outlined below:

Demonstration Quarter	Begin Date	End Date	Report Due Date
Q1	July 1 st	September 30 th	November 29 th
Q2	October 1 st	December 31 st	March 1 st
Q3	January 1 st	March 31 st	May 30 th
Q4 & Annual Monitoring Report	April 1 st	June 30 th	September 30 th

The state must submit quarterly monitoring reports through CMS' designated system using the framework incorporated in these STCs as "Appendix A", which is subject to change as monitoring systems are developed and/or evolve, and will be provided in a structured manner that supports federal tracking and analysis. The intent of the quarterly monitoring reports is to present the state's data along with an analysis of the status of key operational areas under the demonstration. The quarterly monitoring report should not direct readers to links outside the report, except if listed in a reference/bibliography section. In addition to the data elements outlined in Appendix A, quarterly monitoring reports must include, but is not limited to, all of elements outlined below:

- a) A summary of current notable program activity during the first two quarters of the demonstration year. This includes highlights of the state's progress with implementation of STC 18 with supporting documentation and key operational milestones anticipated to occur in the near future. Notable program activity includes, but is not limited to, program operations such as provider participation

and education, health care delivery, benefits, eligibility, enrollment, beneficiary complaints, quality of care, access, state share of financing and pertinent legislative activity;

- b) Identification of metrics and a plan to address improving demonstration participation and service utilization. This includes an assessment of the program's effectiveness with outreach and education to the targeted population and identification of areas for process improvement in administering this family plan demonstration successfully in accordance with the intended goals and objectives;
- c) Quarterly unduplicated enrollment for demonstration enrollees (defined as any individual who obtains a covered family planning service through the demonstration) as required to evaluate compliance with the budget neutrality agreement;
- d) Program outreach and education activities conducted and an assessment of the effectiveness of these outreach and education activities;
- e) Program integrity and related audit activities, including an analysis of point-of-service eligibility procedures; and,
- f) Grievances and appeals made by beneficiaries, providers, or the public and actions being taken to address any significant issues.

30. Quarterly Monitoring Calls. CMS and Florida will participate in quarterly conference calls following receipt of the quarterly/annual monitoring reports, unless CMS determines that more frequent calls are necessary to adequately monitor the demonstration. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Areas to be addressed include, but are not limited to, the state's progress with implementation of STC 18; significant program issues or changes related to health care delivery, enrollment trends, quality of care, access, benefits, anticipated or proposed changes in payment rates, audits, lawsuits, changes in state sources of funding for financing this demonstration, evaluation of the demonstration, or state legislative developments; and any demonstration amendments the state is considering submitting. CMS will update the state on any Florida Family Planning Waiver actions under review as well as federal policies and issues that may affect any aspect of the demonstration. Florida and CMS will jointly develop the agenda for the calls.

31. Annual Monitoring Report. No later than 90 days following the end of each demonstration year, the state must submit an annual monitoring report that represents the status of the demonstration's various operational areas and any state analysis of program data collected for the demonstration year. As specified in STC 29, the state may combine its fourth quarter monitoring update with the annual progress summary for each demonstration year. The Annual Monitoring Report will include all elements required by 42 CFR §431.428 and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a reference/bibliography section. The state must submit the

Annual Monitoring Report through CMS' designated system using the framework incorporated in these STCs as "Appendix A", which is subject to change as monitoring systems are developed and/or evolve, and will be provided in a structured manner that supports federal tracking and analysis. Each Annual Monitoring Report must minimally include the following:

- a) Operational Updates - Per 42 CFR §431.428, the Annual Monitoring Report must document any policy or administrative difficulties in operating the demonstration. The reports shall provide sufficient information to document key challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; descriptions of any public forums held, and a summary of program integrity and related audit activities for the demonstration. The Annual Monitoring Report should also include a summary of all public comments received through the post-award public forum required per 42 CFR §431.420(c) regarding the progress of the demonstration.
- b) Performance Metrics – Per 42 CFR §431.428, the Annual Monitoring Report must document the impact of the demonstration in providing insurance coverage to beneficiaries and the uninsured population, as well as outcomes of care, quality and cost of care, and access to care. This may also include the results of beneficiary satisfaction surveys (if conducted) and grievances and appeals. The required monitoring and performance metrics will include number of enrollees, , beneficiaries with claims (including follow-up claims), contraceptive utilization, beneficiaries tested for sexually transmitted diseases, beneficiaries who obtained a cervical cancer screening, and beneficiaries who received a pelvic and/or clinical breast exam. The required monitoring and performance metrics must be included in writing in the Monitoring Reports, and will follow the framework provided by CMS to support federal tracking and analysis.
- c) Budget Neutrality and Financial Reporting Requirements – Per 42 CFR §431.428, the Annual Monitoring Report must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every Annual Monitoring Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including a total annual member month count for the demonstration population, total annual expenditures for the demonstration population, and the resulting "per member, per month" calculation. The Annual Monitoring Report must also include the submission of corrected budget neutrality data upon request.
- d) Evaluation Activities and Interim Findings. Per 42 CFR §431.428, the Annual Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses as outlined in the Evaluation Design Framework incorporated in these STCs as "Attachment B." Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

- 32. Program Integrity.** The state must have processes in place to ensure that there is no duplication of federal funding for any aspect of the demonstration. The state must confirm its process for ensuring there is no duplication of federal funding in each Annual Monitoring Report as specified in STC 31(a).
- 33. Draft and Final Close-out Report.** Within 120 days after the expiration of the demonstration, the state must submit a draft Close-out Report to CMS for comments.
- a) The draft report must comply with the most current guidance from CMS.
 - b) The state will present to and participate in a discussion with CMS on the close-out report.
 - c) The state must take into consideration CMS' comments for incorporation into the final close-out report.
 - d) The final close-out report is due to CMS no later than 30 days after receipt of CMS' comments.
 - e) A delay in submitting the draft or final version of the close-out report may subject the state to penalties described in STC 10.

VII. GENERAL FINANCIAL REQUIREMENTS

This project is approved for title XIX expenditures applicable to services rendered during the demonstration period. This section describes the general financial requirements for these expenditures.

- 34. Quarterly Expenditure Reports.** The state must provide quarterly expenditure reports to report total expenditures for services provided under this Medicaid section 1115(a) demonstration following routine CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. CMS must provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined cost limits specified in STC 44.
- 35. Reporting Expenditures Subject to the title XIX Budget Neutrality Agreement.** The following describes the reporting of expenditures subject to the budget neutrality limit:
- a) Tracking Expenditures. In order to track expenditures under this demonstration, the state must report demonstration expenditures through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES). All demonstration expenditures claimed under the authority of title XIX of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS and the two digit project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made (e.g., For reporting expenditures

with dates of services made in demonstration year 21 (7/1/2018 – 6/30/2019), the state would use "21" as the project number extension).

- b) Use of Waiver Forms. The state must report demonstration expenditures on separate forms CMS-64.9 Waiver and/or 64.9P Waiver each quarter to report title XIX expenditures for demonstration services. The state will continue to use the waiver name "Family Planning" to report expenditures in the MBES/CBES and in the budget neutrality workbooks required to be submitted with the Annual Monitoring Report per STC 31.
- c) Cost Settlements. For monitoring purposes, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C.

36. Title XIX Administrative Costs. Administrative costs will not be included in the budget neutrality agreement, but the state must separately track and report administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on Form CMS-64.10.

37. Claiming Period. All claims for expenditures subject to the budget neutrality agreement (including any cost settlements) must be made within two years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

38. Reporting Member Months. The following describes the reporting of member months for the demonstration:

- a) For the purpose of calculating the budget neutrality expenditure limit, the state must provide to CMS, as part of the Annual Monitoring Report required per STC 30, the actual number of eligible member months for all demonstration enrollees. The state must submit a statement accompanying the Annual Monitoring Report certifying the accuracy of this information.
- b) The term “eligible member months” refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are each eligible for two months, each contribute two eligible member months, for a total of four eligible member months.

39. Standard Medicaid Funding Process. The standard Medicaid funding process must be used during the demonstration. The state must estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on Form

CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. If applicable, subject to the payment deferral process set out in STC 10, CMS shall reconcile expenditures reported on Form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

40. Extent of Federal Financial Participation (FFP) for the Demonstration. CMS shall provide FFP for family planning and family planning related services at the applicable federal matching rates as described in STCs 20 and 21, subject to the limits and processes described below:

- a) For procedures or services clearly provided or performed for the primary purpose of family planning (i.e., contraceptive initiation, periodic or inter-periodic contraceptive management, and sterilizations), and which are provided in a family planning setting, FFP will be available at the 90 percent federal matching rate. Reimbursable procedure codes for office visits, laboratory tests, and certain other procedures must carry a primary diagnosis or a modifier that specifically identifies them as a family planning service.

Allowable family planning expenditures eligible for reimbursement at the enhanced family planning match rate of 90 percent, as described in STC 20, should be entered in Column (D) on the CMS-64.9 Waiver Form.

- b) Pursuant to 42 CFR §433.15(b)(2), FFP is available at the 90 percent administrative match rate for administrative activities associated with administering the family planning services provided under the demonstration including the offering, arranging, and furnishing of family planning services. These costs must be allocated in accordance with OMB Circular A-87 cost allocation requirements. The processing of claims is reimbursable at the 50 percent administrative match rate.
- c) FFP will not be available for the costs of any services, items, or procedures that do not meet the requirements specified above, even if provided by eligible Medicaid providers. For example, in the instance of testing for STIs as part of a family planning visit, FFP will be available at the 90 percent federal matching rate. The match rate for the subsequent treatment would be paid at the applicable federal matching rate for the state. For testing or treatment not associated with a family planning visit, no FFP will be available.

41. Sources of Non-Federal Share. The state must certify that matching the non-federal share of funds for the demonstration are state/local monies. The state further certifies that such funds must not be used to match any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

- a) CMS shall review the sources of the non-federal share of funding for the demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS must be addressed within the timeframes set by CMS.
- b) Any amendments that impact the financial status of the program must require the state to provide information to CMS regarding all sources of the non-federal share of funding.

42. State Certification of Funding Conditions. The state must certify that the following conditions for non-federal share of demonstration expenditures are met:

- a) Units of government, including governmentally operated health care providers, may certify that state or local tax dollars have been expended as the non-federal share of funds under the demonstration.
- b) To the extent the state utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.
- c) To the extent the state utilizes CPEs as the funding mechanism to claim federal match for payments under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such tax revenue (state or local) used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match.
- d) The state may use intergovernmental transfers to the extent that such funds are derived from state or local tax revenues and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of title XIX payments. Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between health care providers and state and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, (including health care provider-related taxes), fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

VIII. MONITORING BUDGET NEUTRALITY

The following is the method by which budget neutrality will be monitored for the Florida Family Planning Waiver section 1115(a) Medicaid demonstration.

43. Limit on Title XIX Funding. The state shall be subject to a limit on the amount of federal title XIX funding it may receive on approved demonstration service expenditures incurred during the period of demonstration approval. The budget neutrality expenditure targets are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the approved demonstration period. Actual expenditures subject to the budget neutrality expenditure limit shall be reported by the state using the procedures described in STC 35.

44. Budget Neutrality Annual Expenditure Limits. For each demonstration year, an annual budget limit will be calculated for the demonstration. The Florida Family Planning Waiver annual demonstration cycle has been realigned from the initial implementation cycle to coincide with Florida's state fiscal year as requested by the state, which is July 1 through June 30. The state's demonstration years for this demonstration approval period are as follows:

- Demonstration Year 21 = July 1, 2018 – June 30, 2019
- Demonstration Year 22 = July 1, 2019 – June 30, 2020
- Demonstration Year 23 = July 1, 2020 – June 30, 2021
- Demonstration Year 24 = July 1, 2021 – June 30, 2022
- Demonstration Year 25 = July 1, 2022 – June 30, 2023

The budget limit is calculated as the projected per member/per month (PMPM) cost times the actual number of member months for the demonstration multiplied by the Composite Federal Share.

PMPM Cost. The following table provides the approved demonstration cost trend (based on the state's historical rate of growth) and the PMPM (total computable) ceiling for each demonstration year.

	Trend Rate	DY 21 (7/18-6/19)	DY 22 (7/19-6/20)	DY 23 (7/20-6/21)	DY 24 (7/21-6/22)	DY 25 (7/22-6/23)
PMPM Ceiling Family Planning Services	0.0%	\$7.00	\$7.00	\$7.00	\$7.00	\$7.00

- a) Composite Federal Share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period, as reported on the forms listed in STC 35 above, by total computable demonstration expenditures for the same period as reported on the same forms. Should the demonstration be terminated prior to the end of the approval period (see STC 8), the Composite Federal Share will be determined based on actual expenditures for the period in which the demonstration was active. For the purpose of interim monitoring of budget neutrality, a reasonable Composite Federal Share may be used.

- b) Structure. The demonstration’s budget neutrality model is structured as a “pass-through” or “hypothetical” expenditure population. Therefore, the state may not derive savings from the demonstration.
- c) Risk. Florida shall be at risk for the per capita cost (as determined by the method described in this section) for demonstration enrollees, but not for the number of demonstration enrollees. By providing FFP for eligible enrollees, Florida shall not be at risk of changing economic conditions that impact enrollment levels. However, by placing Florida at risk for the per capita costs for enrollees in the demonstration, CMS assures that federal demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no demonstration.
- d) Application of the Budget Limit. The budget limit calculated above will apply to demonstration expenditures reported by the state on the CMS-64 forms. If at the end of the demonstration period, the costs of the demonstration services exceed the budget limit, the excess federal funds will be returned to CMS. If the costs of the demonstration services do not exceed the budget limit, the state may not derive or utilize any such savings.

45. Future Adjustments to the Budget Neutrality Expenditure Limit. CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under the demonstration.

46. Enforcement of Budget Neutrality. CMS shall enforce budget neutrality over the life of this demonstration extension approval period. No later than 90 days after the end of each demonstration year, the state will calculate and report to CMS an annual cumulative expenditure target for the completed year as part of the Annual Monitoring Report described in STC 31. This amount will be compared with the actual cumulative amount the state has claimed for FFP through the completed year. If cumulative spending exceeds the cumulative target by more than the indicated percentage, the state will submit a corrective action plan to CMS for approval. The state will subsequently implement the approved plan.

<u>Year</u>	<u>Cumulative Target Expenditures</u>	<u>Percentage</u>
DY21	DY21 budget limit plus:	2.0 percent
DY22	DY21 and DY22 combined budget limit amount plus:	1.5 percent
DY23	DY21 through DY23 combined budget limit amount plus:	1.0 percent
DY24	DY21 through DY24 combined budget limit amount plus:	0.5 percent
DY25	DY21 through DY25 combined budget limit amount plus:	0 percent

47. Exceeding Budget Neutrality. The state, whenever it determines that the demonstration is not budget neutral or is informed by CMS that the demonstration is not budget neutral, must immediately collaborate with CMS on corrective actions, which includes submitting a corrective action plan to CMS within 21 days of the date the state is informed of the problem.

While CMS will pursue corrective actions with the state, CMS will work with the state to set reasonable goals that will ensure that the state is in compliance.

If at the end of the demonstration approval period, the cumulative budget neutrality limit has been exceeded, the excess federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision will be based on the time elapsed through the termination date.

IX. EVALUATION

- 48. Draft Evaluation Design.** The Draft Evaluation Design must be developed in accordance with the Evaluation Design Framework incorporated in these STCs as "Attachment B" and submitted by the state, for CMS comment and approval, by no later than 120 days after the effective date of these STCs. The Draft Evaluation Design must minimally include the plan for rigorous evaluation on unintended pregnancy rates within the demonstration, the number and percentage of individuals served under this demonstration, the number and percentage of individuals cycling on and off FPW coverage, and FPW service utilization (as determined by Primary Care Service Areas). Any modifications to an existing approved Evaluation Design will not affect previously established requirements and timelines for report submission for the demonstration, if applicable. The state may choose to use the expertise of an independent party in the development of the Draft Evaluation Design.
- 49. Evaluation Budget.** A budget for the evaluation shall be provided with the Draft Evaluation Design. It will include the total estimated cost as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed, or if the estimates appear to be excessive.
- 50. Evaluation Design Approval and Updates.** The state must submit a revised Draft Evaluation Design within 60 days after receipt of CMS' comments. Upon CMS approval of the final Evaluation Design, the document will be included as "Appendix C" to these STCs. Per 42 CFR §431.424(c), the state will publish the approved final Evaluation Design within 30 days of CMS approval. The state must implement the Evaluation Design and submit a description of its evaluation implementation progress in each Annual Monitoring Report as required by STC 31, including any required rapid cycle assessments specified in these STCs. Once CMS approves the Evaluation Design, if the state wishes to make changes, the state must submit a revised Evaluation Design to CMS for approval.
- 51. Evaluation Questions and Hypotheses.** Consistent with CMS' separately provided guidance entitled, "Developing the Evaluation Design" and "Preparing the Evaluation Report," the evaluation documents must include a discussion of the evaluation questions and hypotheses that the state intends to test. Each demonstration component should have at least one evaluation question and hypothesis. The hypothesis testing should include, where possible, assessment of both process and outcome measures. Proposed measures should be

selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS' Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).

52. Interim Evaluation Report. The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent extension of the demonstration, as outlined in 42 CFR §431.412(c)(2)(vi). When submitting an application for extension, the Interim Evaluation Report should be posted to the state's website with the application for public comment.

- a) The Interim Evaluation Report will discuss evaluation progress and present findings to date as per the approved evaluation design.
- b) For any demonstration authority that expires prior to the overall demonstration's expiration date, the interim evaluation report must include an evaluation of the authority as approved by CMS.
- c) If the state is seeking to extend the demonstration, the draft Interim Evaluation Report is due when the application for extension is submitted. If the state made changes to the demonstration in its application for extension, the research questions and hypotheses, and how the design was adapted should be included. If the state is not requesting an extension of the demonstration, a draft Interim Evaluation Report is due one year prior to the end of the demonstration. For demonstration phase-outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.
- d) The state must submit the final Interim Evaluation Report 60 days after receiving CMS comments on the draft Interim Evaluation Report and post the document to the state's website.
- e) The Interim Evaluation Report must comply with CMS' separately provided guidance entitled, "Preparing the Evaluation Report."

53. Cooperation with Federal Evaluators. As required under 42 CFR §431.420(f), the state shall cooperate fully and timely with CMS and its contractors' in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state shall include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they shall make such data available for the federal evaluation as is required under 42 CFR §431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC

may result in a deferral being issued as outlined in STC 10.

54. Summative Evaluation Report. The draft Summative Evaluation Report must be developed in accordance with CMS' separately provided guidance entitled, "Preparing the Evaluation Report." The state must submit a draft Summative Evaluation Report for the demonstration's current approval period within 18 months of the end of the approval period represented by these STCs. The Summative Evaluation Report must include information as outlined in the approved evaluation design.

- a) Unless otherwise agreed upon in writing by CMS, the state shall submit the final summative evaluation report within 60 days of receiving comments from CMS on the draft.
- b) The final summative evaluation report must be posted to the state's Medicaid website within 30 days of approval by CMS.

55. State Presentations for CMS. CMS reserves the right to request that the state present and participate in a discussion with CMS on the evaluation design, the state's interim evaluation report, and/or the summative evaluation.

56. Public Access. The state shall post the final documents (e.g., monitoring reports, approved evaluation design, interim evaluation report, summative evaluation report, and close-out report) on the state's Medicaid website within 30 days of approval by CMS.

57. Additional Publications and Presentations. For a period of 12 months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration over which the state has control. Prior to release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials. CMS will be given 30 days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews. This requirement does not apply to the release or presentation of these materials to state or local government officials.

X. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION

Deliverable	Timeline	STC Reference
Section 1943 Compliance Timeline with Milestones	Within 60 days after the approval of the demonstration extension	STC 18
Quarterly Monitoring Report	Within 60 days following the end of the quarter.	STC 29
Annual Monitoring Report	Within 90 days following the end of each demonstration year	STC 31

Deliverable	Timeline	STC Reference
Section 1943 Compliance Timeline with Milestones	Within 60 days after the approval of the demonstration extension	STC 18
Quarterly Monitoring Report	Within 60 days following the end of the quarter.	STC 29
Draft Evaluation Design Plan	Within 120 days after the approval of the demonstration extension	STC 48
Final Evaluation Design Plan	Within 60 days following receipt of CMS comments on Draft Evaluation Design	STC 50
Draft Summative Evaluation Report	Within 18 months following the end of this demonstration extension period	STC 54
Final Summative Evaluation Report	Within 60 days following receipt of CMS comments on the draft Summative Evaluation Report	STC 54
Draft Interim Evaluation Report	Due when application for extension is submitted	STC 52
Final Interim Evaluation Report	Within 60 days following receipt of CMS comments on the draft Interim Evaluation Report	STC 52

**APPENDIX A: Florida Family Planning Section 1115 Demonstration
Template for Quarterly and Annual Monitoring Reports**

Purpose and Scope of Quarterly and Annual Reports:

In accordance with STCs 29 and 31, the intent of these reports is to present the state’s analysis of collected data and the status of the various operational areas, reported by month in the demonstration year. The report should also include a discussion of trends and issues over the year, including progress on addressing any issues affecting access, quality, or costs.

Each quarterly report must include, at a minimum, the following program elements:

- A. Executive Summary
- B. Participation Monitoring
- C. Utilization Monitoring
- D. Program Outreach and Education
- E. Program Integrity
- F. Grievances and Appeals

In addition to elements A – F above, the state's combined fourth quarter/annual monitoring report shall also include the following elements:

- G. Unduplicated Number of Beneficiaries Losing Coverage after 2-year Period of Enrollment by Demonstration Year
- H. Unduplicated Number of Beneficiaries Re-enrolled in Demonstration Year for a Subsequent 2-year Period of Eligibility
- I. Annual Post Award Public Forum
- J. Budget neutrality
- K. Demonstration evaluation activities and interim findings.

**QUARTERLY MONITORING REPORT
FLORIDA FAMILY PLANNING SECTION 1115 DEMONSTRATION**

State: _____
Demonstration Reporting Period: _____
Demonstration Year: _____
Approved start and end date of the Demonstration _____

- A. Executive Summary**
 - 1. Synopsis of the information contained in the report

2. Program Updates

a. Current Trends and Significant Program Activity

- i. Narrative describing administrative and operational activities occurring in the last quarter including any changes to demonstration processes related, but not limited to, eligibility and enrollment, provider education, systems, health care delivery, benefits, quality of care, anticipated or proposed changes in payment rates, and outreach changes.
- ii. Narrative on any demonstration changes, such as notable changes in enrollment, service utilization, and provider participation (up or down 10 percent). Discussion of any action plan if applicable.
- iii. Narrative on the existence of or results of any audits, investigations, or lawsuits that impact the demonstration.

3. Policy Issues and Challenges

- a. Narrative of any operational challenges or issues the state has experienced.
- b. Narrative of any policy issues the state is considering, including pertinent legislative/budget activity, and potential demonstration amendments.
- c. Discussion of any action plans addressing any policy, administrative or budget issues identified, if applicable.

B. Participation Monitoring

The state will summarize activities and outcomes occurring in the last quarter to address improving demonstration participation and service utilization among demonstration enrollees.

C. Utilization Monitoring

The state will summarize utilization through a review of claims/encounter data for the demonstration population in the subsequent tables. This includes the following:

Table 1. Utilization Monitoring Measures

Topic	Measure [reported for each month included in the report]
Utilization Monitoring	Unduplicated Number of Enrollees by Quarter
	Unduplicated Number of Beneficiaries with any Claim by Quarter (by key demographic characteristics such as age, gender, and income level)
	Utilization by Primary Method and Age Group
	Total number of beneficiaries tested for any sexually transmitted disease
	Total number of female beneficiaries who obtained a cervical cancer screening
	Total number of female beneficiaries who received a clinical breast exam

Table 2: Unduplicated Number of Enrollees by Quarter

	Number of Female Enrollees by Quarter				
	14 years old and under	15-20 years old	21-44 years old	45 years old and older	Total Unduplicated Female Enrollment*
Quarter 1					

Quarter 2					
Quarter 3					
Quarter 4					

*Total column is calculated by summing columns 2-5.

Table 3: Unduplicated Number of Beneficiaries with any Claim by Age Group per Quarter in the Demonstration Year (to date)

	Number of Females Who Utilize Services by Age and Quarter					
	14 years old and under	15-20 years old	21-44 years old	45 years old and older	Total Female Users *	Percentage of Total Unduplicated Female Enrollment
Quarter 1						
Quarter 2						
Quarter 3						
Quarter 4						

*Total column is calculated by summing columns 2-5.

Table 4: Contraception Utilization by Age Group per Demonstration Year (to date)

Effectiveness	Users of Contraceptives					
		14 years old and under	15 – 20 years old	21 – 44 years old	45 years old and older	Total
Most and Moderately Effective*	Numerator					
	Denominator					
Long-acting reversible contraceptive (LARC)*	Numerator					
	Denominator					
Total	Numerator					
	Denominator					

*This measure is calculated as per the Medicaid and CHIP Child and Adult Core Set measure for contraceptive care for all women.

Table 5: Number Beneficiaries Tested for any STD by Demonstration Year

Test	Total Tests	
	Number	Percent of Total Enrolled Females
Unduplicated number of beneficiaries who obtained an STD test		

Table 6: Total Number of Female Beneficiaries who obtained a Cervical Cancer Screening

Screening Activity	Number	Percent of Total Enrolled Females
Unduplicated number of female beneficiaries who obtained a cervical cancer screening		

Table 7: Breast Cancer Screening

Screening Activity	Number	Percent of Total Enrolled Females
Unduplicated number of female beneficiaries who received a Breast Cancer Screening		

Table 8: Post-Partum Contraceptive Care

Screening Activity	Number	Percent of Total Enrolled Females
Among female beneficiaries between the ages of 15 to 20 who had a live birth, the percentage that was provided within 3 and 60 days of delivery, a most effective or moderately effective method of contraception:		
Among female beneficiaries between the ages of 15 to 20 who had a live birth, the percentage that was provided within 3 and 60 days of delivery, a long-acting reversible method of contraception (LARC).		
Among female beneficiaries between the ages of 21 to 44 who had a live birth, the percentage that was provided within 3 and 60 days of delivery, a most effective or moderately effective method of contraception:		
Among female beneficiaries between the ages of 21 to 44 who had a live birth, the percentage that was provided within 3 and 60 days of delivery, a long-acting reversible method of contraception (LARC).		

D. Program Outreach and Education**1. General Outreach and Awareness**

- a. Provide information on the public outreach and education activities conducted this demonstration quarter; and,

- b. Provide a brief assessment on the effectiveness of these outreach and education activities.
2. Target Outreach Campaign(s) (if applicable)
- a. Provide a narrative on the populations targeted for outreach and education campaigns and reasons for targeting; and,
 - b. Provide a brief assessment on the effectiveness of these targeted outreach and education activities.

E. Program Integrity

Provide a summary of program integrity and related audit activities for the demonstration; including an analysis of point-of-service eligibility procedures.

F. Grievances and Appeals

Provide a narrative of grievances and appeals made by beneficiaries, providers, or the public, by type and highlighting any patterns. Describe actions being taken to address any significant issues evidenced by patterns of appeals.

The below program elements are to be included only in the state's annual monitoring report at the end of each demonstration year:

G. Table 9: Unduplicated Number of Beneficiaries Losing Coverage after 2-year Period of Enrollment by Demonstration Year

Number of Female Enrollees Losing Coverage in Demonstration Year					
14 years old and under	15-20 years old	21-44 years old	45 years old and older	Total Females Lost Enrollment*	Percent of Total Enrolled Females

*Total column is calculated by summing columns 1-4.

H. Table 10: Unduplicated Number of Beneficiaries Re-enrolled in Demonstration Year for a Subsequent 2-year Period of Eligibility

Number of Female Enrollees Re-enrolled for a Subsequent 2-year Period of Eligibility					
14 years old and under	15-20 years old	21-44 years old	45 years old and older	Total Females Re-enrolled*	Percent of Total Enrolled Females

*Total column is calculated by summing columns 1-4.

I. Annual Post Award Public Forum

Provide a summary of the annual post award public forum conducted by the state as required by 42 CFR §431.420(c) that includes a report of any issues raised by the public and how the state is considering such comments in its continued operation of the demonstration.

J. Budget Neutrality

1. Please complete the budget neutrality workbook.
2. Discuss any variance noted to the estimated budget, including reasons for variance in enrollment and/or in total costs, and/or in per enrollee costs. Describe any plans to mitigate any overages in budget neutrality by the end of the demonstration period.

K. Demonstration Evaluation Activities and Interim Findings

1. Please provide a summary of the progress of evaluation activities, including key milestones accomplished. Include:
 - a. Status of progress against timelines outlined in the approved Evaluation Design.
 - b. Any challenges encountered and how they are being addressed.
 - c. Status of any evaluation staff recruitment or any RFPs or contracts for evaluation contractual services (if applicable).
2. Description of any interim findings or reports, as they become available.

APPENDIX B: Evaluation Design Framework

A. Demonstration Objectives/Goals

The purpose of this demonstration is to provide Medicaid coverage for family planning and/or family planning-related services for states that have not elected to include these benefits in their state plan through the new eligibility group authorized in section 1902(a)(10)(A)(ii)(XXI) of the Social Security Act (the Act).

The minimum demonstration goals that will be tested are as follows:

1. Ensure access to family planning and/or family planning-related services for low income individuals not otherwise eligible for Medicaid;
2. Improve or maintain health outcomes for the target population as a result of access to family planning services and/or family planning-related services;
3. Other goals the state may identify.

B. Evaluation Questions and Hypotheses

The demonstration's core evaluation questions, hypothesis, and recommended data sources and analytic approaches are provided in the below table. The state should report on the measures in the table, and can add additional measures if desired. The state should confirm the data sources it plans to use to measure each hypothesis in the table. If the state has listed additional goals in section A, it should add the associated evaluation question, hypothesis, data source, and analytic approach in the table below. Please note:

- Evaluation questions should include an assessment of process and outcome.
- Measures should be specified with a numerator and denominator. Recommended sources for measures are nationally recognized indicators, such as the National Quality Forum (NQF), HEDIS measures, the Family Planning Annual Reports (FPAR), or taken from existing validated instruments, such as the Behavioral Risk Factor Surveillance System (BRFSS).
- Recommended/potential data sources for consideration:
 - Medicaid claims
 - Managed care encounter data
 - Enrollment and disenrollment data
 - EHR and/or HIE clinical data repositories
 - Enrollee surveys
 - Interviews
 - Focus groups
 - State data warehouses

C. Summary of Key Evaluation Questions, Hypotheses, Data Sources, and Analytic Approaches

Summary of Key Evaluation Questions, Hypotheses, Data Sources, and Analytic Approaches

Evaluation Component	Evaluation Question	Evaluation Hypotheses	Measure (to be reported for each Demonstration Year)	Recommended Data Source	Analytic Approach
Demonstration Goal 1: Ensure access to and utilization of family planning and/or family planning-related services for individuals not otherwise eligible for Medicaid.					
Process	How did FPW enrollees utilize covered health services?	FPW enrollees will utilize family planning services and/or family planning related services.	Number of FPW enrollees who had a family planning or family planning related service encounter in each year of the demonstration/total number of FPW enrollees	Administrative data (state should specify source)	Descriptive statistics (frequencies and percentages)
			Number of family planning services utilized/total number of FPW enrollees		
			Number of FPW enrollees who utilized contraceptives in each year of the demonstration/total number of FPW enrollees		
			Number of FPW enrollees who utilized long-acting reversible contraceptives in each year of the demonstration/total number of FPW enrollees		
			Number of FPW enrollees tested for any sexually transmitted disease (by STD) as defined by Rule 64D-3.028, Florida Administrative Code/total number of FPW enrollees		
			Number of FPW enrollees who received a cervical cancer screening/total number of FPW enrollees		
			Number of FPW enrollees who received a pelvic and/or clinical breast exam/total number of FPW enrollees		
	How are FPW enrollees experiencing FPW coverage?	FPW enrollees will not experience long spells without FPW coverage.	Average number of women enrolled in the FPW for only 1 year and the average number of women enrolled in the FPW for 2 years	Administrative data (state should specify source)	Descriptive statistics (frequencies and percentages)
			Average length of time between a FPW enrollee’s most recent enrollment period and the previous enrollment period (limited to the last five years)		
			Number of FPW enrollees who lose FPW coverage after a 2 year period of enrollment/total number of FPW enrollees		

Evaluation Component	Evaluation Question	Evaluation Hypotheses	Measure (to be reported for each Demonstration Year)	Recommended Data Source	Analytic Approach
			Number of FPW enrollees who do not re-enroll in the FPW after the first year/total number of FPW enrollees		
			Number of FPW enrollees who enroll in the FPW after losing FPW coverage for a 2 year enrollment period/total number of FPW enrollees		
Demonstration Goal 2: Improve or maintain health outcomes for the target population as a result of access to family planning and family planning-related services.					
Outcome/ Impact	Does the demonstration improve health outcomes? [Calculate for target population and similar population from Medicaid within-state]	Health outcomes will improve as a result of the demonstration.	Number of second live births that occurred at an interval of 18 months or longer/total number of second live births (FPW Participants compared to FPW non-Participants)	Administrative data (state should specify source)	Descriptive statistics (proportions) and significance testing (chi-squared of the proportions)
			Number of low birth weight babies (<2,500 grams) born to FPW enrollees /total number of babies born to FPW enrollees (FPW Participants compared to FPW non-Participants)		
			Number of preterm (<37 weeks) babies born to FPW enrollees/total number of babies born to FPW enrollees (FPW Participants compared to FPW non-Participants)		
	How does the demonstration affect health outcomes for FPW enrollees who lose FPW coverage?	Health outcomes will improve as a result of the demonstration.	Number of pregnancies for individuals who lost FPW coverage and were not re-enrolled at the time of pregnancy/total number of FPW enrollees who lost FPW coverage (limited to the last five years)		
			Number of low birth weight babies (<2,500 grams) born to FPW enrollees who achieved pregnancy during a lapse in FPW coverage/total number of babies born to individuals who lost FPW coverage (limited to the last five years)		
			Number of preterm (<37 weeks) babies born to FPW enrollees who achieved pregnancy during a lapse in FPW coverage /total number of babies born to individuals who lost FPW coverage (limited to the last five years)		
Are FPW enrollees satisfied with services? [Calculate for	FPW enrollees will be satisfied with services.	Satisfaction survey questions for FPW enrollees	Survey developed by Evaluation team	Descriptive statistics (proportions) and significance testing	

Evaluation Component	Evaluation Question	Evaluation Hypotheses	Measure (to be reported for each Demonstration Year)	Recommended Data Source	Analytic Approach
	target population and similar population from Medicaid within-state]				(chi-squared of the proportions)

D. Methodology

1. Evaluation design: The evaluation design will utilize a post-only assessment with a comparison group. The timeframe for the post-only period will begin when the current demonstration period begins, and ends when the current demonstration period ends.
2. Data Collection and sources: For the data sources identified in the above table, describe how the data will be collected. Additionally, identify the frequency of the data collection, and limitations of the data. Identify which data will be collected prospectively via beneficiary surveys or interviews (if applicable), or retrospectively through administrative data.
3. Data Analysis Strategy: Describe the analytic methods that will be utilized to answer the evaluation questions identified in the above table. If the design is mixed-methods (collecting both quantitative and qualitative), the state should explain how the evaluation team plans to integrate the findings from both types of assessments.
 - **Quantitative Methods**: For each evaluation question, include the statistical and analytical methods that will be employed (and are consistent with what was listed in the table above).
 - Sources of comparative data: When conducting statistical comparative analyses, the state may be able to identify similar populations to the 1115 beneficiaries by using Medicaid and CHIP data, users of Title X services, statewide birth data from the Office of Vital Statistics, Healthy people 2020, or other sources that the state may identify.
 - **Qualitative Methods**: If conducting interviews or focus groups, describe the process for selecting interviewees and focus group attendees, and any incentives used in recruitment. Explain reasons for and how focus groups will be stratified. Identify the analysis plan, to include if the interviews/focus groups will be transcribed, the analysis approach the evaluation team will utilize (e.g., thematic analysis, grounded theory, etc.). The evaluation design should reference draft interview and focus group questions.
4. Simplified Evaluation Budget:

The required budget will consist of the following line items:

 1. Computer programming (cost per hour x hours);
 2. Analysis of the data (cost per hour x hours);
 3. Preparation of the report (cost per hour x hours);
 4. Other (specify work, cost per hour, and hours). If work is outside the requirements of the basic evaluation this should be identified in the draft evaluation design along with justification for an increased budget match.

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

APPENDIX C: Approved Evaluation Design

(reserved)