



RICK SCOTT
GOVERNOR

June 27, 2014

Sylvia Mathews Burwell, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue S.W.
Washington, D.C. 20201

Dear Secretary Burwell:

Florida seeks to renew its Medicaid Family Planning Research and Demonstration Waiver (CMS 11-W-00135/4). The Centers for Medicare and Medicaid Services originally approved this waiver for the period September 1998 through August 2003 and subsequently renewed it twice before the most recent renewal period of July 1, 2011 through December 31, 2014. Pursuant to application procedures required in 42 CFR 431.412(c) for Section 1115(a) waivers, the state requests a three-year renewal, through December 31, 2017, under the same waiver and expenditure authorities as those approved in the current demonstration.

The demonstration objectives and eligibility criteria for waiver recipients remain unchanged since implementation of the project. Medicaid services for individuals eligible for this waiver are authorized statewide by section 409.904(5), Florida Statutes. The program provides for family planning services to a population of women who otherwise may be unable to access the services and seeks to improve women's health and improve birth outcomes in our state.

Please find enclosed documentation as required in 42 CFR 431.412(c) to support this request. We appreciate your efforts in working with our state to extend federal authority to maintain Medicaid eligibility for this vulnerable population.

Sincerely,



Rick Scott
Governor

Enclosures

Florida Medicaid Family Planning Waiver

(Project #11-W-00135/4)

**Three-Year Extension Request
Submitted on June 27, 2014**

**1115 Research and Demonstration Waiver
Florida Agency for Health Care Administration**



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I. Purpose, Goals and Objectives

A. Statement of Purpose

The state is seeking federal authority to extend Florida's 1115 Medicaid Family Planning Waiver (FPW) (Project Number 11-W-00135/4) for the period January 1, 2015 through December 31, 2017. The FPW seeks to improve the provision of family planning services to a population of women who otherwise may be unable to access the services. The waiver is designed to decrease unintended pregnancies, increase the child spacing interval, and provide referrals for continued care resulting in improved future birth outcomes and savings to the Medicaid program. The FPW population consists of women, between the ages of 14 through 55, losing their Medicaid coverage who:

- Have family income at or below 185% of the Federal poverty level; and
- Are not otherwise eligible for Medicaid, Children's Health Insurance Program, or health insurance coverage that provides family planning services.

** Eligibility for FPW services is limited to two years after losing Medicaid coverage, subject to an annual eligibility redetermination.*

B. Goals and Objectives

1. Goals and Objectives: The overarching goal of the FPW is to increase the number of women receiving FPW services who are between the ages of 14 through 55 and have income at or below 185% of the federal poverty level. In an effort to increase the number of recipients served, the State will actively promote primary medical care referrals for FPW participants through collaboration with County Health Departments, Rural Health Clinics, Federal Qualified Health Centers, and other primary care providers.

The overall FPW objectives are:

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

C. Current Program

The FPW program is currently authorized as a Section 1115 Research and Demonstration Waiver for the period July 1, 2011 through December 31, 2014, which includes a temporary extension granted by the Centers for Medicare and Medicaid Services (CMS) on June 27, 2013, for the period of January 1, 2014 through December 31, 2014. The current FPW operates in all 67 counties in the State of Florida.

D. Federal Waiver Authority

The following is an historical description of the federal authority granted by the Centers for Medicare and Medicaid Services since authorization of the FPW was obtained in 1998 as a statewide program.

- **Initial 5-Year Period (1998-2003)**
- **Three-Year Extension Period (2003-2006)**
- **Three-Year Extension Period (2006-2009)**
- **Three-Year Extension Period (2011-2013)**
- **One-Year Automatic Extension Period (2014)**
- **Authority for Waiver Extension (2015-2017):** The State is seeking federal approval to extend the waiver authorization period from January 1, 2015 through December 31, 2017.

E. Federal Waiver Extension Requirements

1. Public Notice Document: In accordance with 42 Code of Federal Regulations (CFR) 431.412, the Agency for Health Care Administration (the Agency) posted a “Public Notice” document for public input 30 days prior to submission of this FPW extension request to the Centers for Medicare and Medicaid Services. The public notice document is required to include a comprehensive description of the FPW extension request that contains sufficient level of detail to ensure meaningful input from the public, including:

- a. The program description, goals and objectives to be extended under the FPW, including a description of the current or new recipients who will be impacted by the waiver.
- b. To the extent applicable, the proposed health care delivery system, eligibility requirements, benefit coverage, and cost sharing (premiums, co-payments, and deductibles) required of individuals that will be impacted by the waiver and how such provisions vary from the State's current program features.
- c. An estimate of the expected increase or decrease in annual enrollment and annual aggregate expenditures, including historic enrollment or budgetary data, if applicable. This includes a financial analysis of any changes to the waiver requested by the State in its extension request.
- d. The hypothesis and evaluation parameters of the waiver.
- e. The specific waiver and expenditure authorities that the state believes to be necessary to authorize the waiver.
- f. The locations and Internet address where copies of the waiver extension request are available for public review and comment.
- g. Postal and Internet e-mail addresses where written comments may be sent and reviewed by the public and a minimum 30-day time period in which comments will be accepted.

- h. The location, date, and time of at least two public hearings convened by the State to seek public input on the waiver extension request.

2. Final Waiver Extension Request: After the 30-day public input process ended on April 30, 2014, the Agency included the following information in this final FPW extension request in compliance with the transparency requirements 42 CFR 431.412 and the public notice requirements found in Special Terms and Condition (STC) #13 of the FPW:

- a. **Historical Narrative Summary of the Waiver:** Provide a narrative summary of the waiver, reiterate the objectives set forth when the waiver was proposed and provide evidence of how the objectives have been met, along with the future goals of the program. If changes are requested, the Agency must provide a narrative of the proposed changes along with the objective of the change and desired outcomes.
- b. **Special Terms and Conditions:** Provide documentation of its compliance with each of the Special Terms and Conditions. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information.
- c. **Waiver and Expenditure Authorities:** Provide a list along with a programmatic description of the waivers and expenditure authorities being requested in the extension.
- d. **Quality:** Provide summaries of External Quality Review Organization reports, health plan state quality assurance monitoring and any other documentation of the quality of and access to care provided under the waiver including but not limited to: corrective action taken and the CMS Form 416 EPSDT/CHIP report.
- e. **Financial Data:** Provide financial data (as set forth in the current Special Terms and Conditions) demonstrating the state's detailed and aggregate, historical and projected budget neutrality status for the requested period of the extension as well as cumulatively over the lifetime of the waiver. In addition, the state must provide up to date responses to the Centers for Medicare and Medicaid Services Financial Management standard questions. If Title XXI funding is used in the waiver, a Children's Health Insurance Program allotment neutrality worksheet must be included. This would also include a financial analysis of changes to the waiver requested by the state.
- f. **Evaluation Report (interim evaluation):** Provide a narrative summary of the evaluation design, status (including evaluation activities and findings to date) and plans for evaluation activities during the extension period. The narrative is to include, but not be limited to, describing the hypotheses being tested and any results available. If changes are requested, identification of research hypotheses related to the changes and an evaluation design for addressing the proposed changes.
- g. **Documentation of Public Notice (42 Code of Federal Regulations (CFR) 431.408):** Provide documentation of compliance with public notice process requirements specified in federal regulations and the STCs of the waiver including the post-award public input process described in 42 CFR 431.420(c) with a summary of the issues raised by the public during the comment period and how the state considered the comments when developing the waiver extension request. The state must also provide evidence of solicitation of advice from Florida's Federal Recognized Tribes.

II. Program Overview

A. Eligibility

The Florida Medicaid Family Planning Waiver provides family planning services, as defined under Section II.B of this document, to women between the ages of 14 through 55 years old with family incomes at or below 185% of the Federal poverty level for a period of up to two years after losing Medicaid coverage.

Eligibility Standards and Methodologies

Under the FPW extension authority, the Agency will continue to use the standards and methodologies noted above to determine eligibility.

B. Services Provided

The FPW provides the following medically necessary services and supplies related to birth control and pregnancy prevention:

- Physical exams;
- Family planning counseling and pregnancy tests;
- Birth control supplies;
- Colposcopies and treatment for sexually transmitted diseases; and
- Related pharmaceuticals and laboratory tests.

There are no cost sharing requirements under the FPW.

C. Service Delivery

Recipients enrolled in the FPW have freedom of choice in selection of their family planning providers. The recipient may receive services from any Medicaid provider, such as a doctor (family practitioner, Obstetrics/Gynecology), certified nurse midwife, nurse practitioner, physician assistant, County Health Department, family planning center, birthing center, a Rural Health Clinic, or Federally Qualified Health Clinic.

D. Enrollment and Disenrollment

1. Enrollment Limits

There is no cap on enrollment in the FPW. All women who meet the FPW eligibility standards are provided FPW services as specified above.

2. Enrollment History, Current and Projected Enrollment through Extension Period

See Section IV.A.2 of this document for the enrollment history, current and projected enrollment through the requested extension period.

III. Public Process

This section of the document provides a summary of public notice and input process used by the Agency in compliance with 42 CFR 431.412 and Special Term and Condition #13 of the FPW including: the State Notice Procedures set forth in 59 Federal Register 49249 (September 27, 1994) and the tribal consultation requirements pursuant to Section 1902(a)(73) of the Social Security Act as amended by Section 5006(e) of the American Recovery and Reinvestment Act of 2009.

A. Consultation with Indian Health Programs

The Agency consulted with the Indian Health Programs¹ located in Florida through written correspondence to solicit input on the requested extension of the FPW. Appendix A of this document provides the correspondence sent on March 31, 2014, to the Seminole Tribe of Florida and the Miccosukee Tribe of Florida.

B. Public Notice Process

The following list describes the notification process used to inform stakeholders of the public meetings held to solicit input on the FPW extension request.

- Published public notices for the one public meeting and one advisory meeting in the Florida Administrative Register in compliance with Chapter 120, Florida Statutes.
- Posted on the Agency's home webpage a prominent direct link to the webpage where the following information can be found: the public meeting schedule including dates, times, and locations as well as the public notice document for the FPW extension request. The meeting materials and the public notice document can be viewed by clicking on the following link: http://ahca.myflorida.com/Medicaid/Family_Planning/extension.shtml.

C. Florida Medicaid Medical Care Advisory Meetings

The Agency requested input on the FPW extension request from the members of the Medicaid Medical Care Advisory Committee, a key Medicaid advisory group. The public meeting notice for the Medicaid Medical Care Advisory Committee was published in the Florida Administrative Register on April 1, 2014. During the meeting, the Agency provided a description of the FPW extension request and sought input on the FPW extension request. The agenda and presentation materials are posted on the Agency's website provided at the link above.

- Medicaid Medical Care Advisory Committee meeting was held April 22, 2014.

The following is a brief description of the Medical Care Advisory Committee:

The Medical Care Advisory Committee is mandated in accordance with Section 431.12, Title 42, Code of Federal Regulations. The purpose of the Medical Care Advisory Committee is to provide input on a variety of Medicaid program issues, and to make recommendations to the Agency on Medicaid policies, rules and procedures.

The Medical Care Advisory Committee is comprised of: board-certified physicians and other representatives of the health professions who are familiar with the medical needs of low-income

¹ The State of Florida has two federally recognized tribes: Seminole Tribe and Miccosukee Tribe; and does not have any Urban Organizations.

people; members of consumer groups, including four representatives of Medicaid recipients; and representatives of State of Florida agencies involved with the Medicaid program, including the secretaries of the Florida Department of Children and Families, the Florida Department of Health and the Florida Department of Elder Affairs, or their designees.

D. Public Meetings

The Agency published a public meeting notice in the Florida Administrative Register inviting all interested parties to the two public meetings listed in the table below, which provides the dates, times and locations. Individuals who were unable to attend the meeting in person could participate via conference call by using the toll free number provided in the notice. During the meetings, the Agency provided a description of the extension request and time for public comments.

Schedule of Public Meetings		
Location	Date	Time
Tallahassee Agency for Health Care Administration 2727 Mahan Drive Building 3, Conference Room A Tallahassee, FL 32308	April 22, 2014	1:00 p.m. – 4:00 p.m.
Tampa 6800 N. Dale Mabry Hwy. Suite 220 Tampa, FL 33614	April 24, 2014	10:00 a.m. – 11:00 a.m.

E. Public Notice Document Made Available to the Public

The Agency posted on its website (link provided on page 5), beginning April 1, 2014 through April 30, 2014, the public notice document.

F. Submission of Written Comments

The Agency’s website provided the public the option of submitting written comments on the FPW extension request by mail or email. In addition, the Agency periodically posted directly on its website (link provided on page 5) public comments received during the 30-day public input process to allow for public review of comments by others in accordance with 42 CFR 431.408(a)(1)(iii).

Mailed comments were sent to:

Michele Logan
 Agency for Health Care Administration
 2727 Mahan Drive, Mail Stop 20
 Tallahassee, Florida 32308

E-mailed comments and suggestions were sent to:

FamilyPlanningWaiver@ahca.myflorida.com

G. Summary of Public Comments

The following summarizes the public comments received during the 30-day comment period for the waiver extension request that began April 1, 2014 and ended April 30, 2014. The comments are grouped by topic with an explanation (***bolded and italicized***) describing how issues raised are addressed.

Summary of Comments

Services Provided

1. A recommendation was received to include transportation in the Family Planning Waiver benefit package.

Medicaid provides non-emergency transportation for medically necessary services through the Medicaid State Plan. The State will continue to cover all benefits described in the existing Family Planning Waiver Special Terms and Conditions.

2. A recommendation was received to continue and clarify benefits described in the current Family Planning Waiver Special Terms and Conditions.

The State will continue to cover all benefits described in the existing Family Planning Waiver Special Terms and Conditions.

3. A recommendation was received to use the Transition Plan, described in the Family Planning Waiver Special Terms and Conditions, #46, to help enrollees obtain more comprehensive coverage.

The Transition Plan described in the Special Terms and Conditions is specific to those states that elected to transition Family Planning Waiver services to the State Plan. However, the State elected to continue the existing Family Planning Waiver and will not be transitioning to the State Plan; therefore, a Transition Plan is not required.

4. Recommendations were received to convert the Family Planning Waiver services to a State Plan program.

See number 3 above.

5. A recommendation was received to provide sexually transmitted infection (STD) testing, as well as STD treatment beyond six (6) weeks post exam, at any point during the coverage period.

The State will continue to cover STD testing at any point during the coverage period.

Eligibility/Enrollment

1. A range of concerns were expressed regarding the age range associated with the Family Planning Waiver coverage and eligibility.

The State's goal is to be inclusive as possible in an effort to provide Family Planning Services to women of ages that are determined to be that of childbearing years.

2. Questions were received inquiring about the outreach services provided to pregnant women who are losing Medicaid coverage and the overall numbers involved with enrollment and participation in the Family Planning Waiver program.

The Agency, as well as the sister agency, Department of Health (DOH), are involved in outreach efforts designed to inform recipients of the waiver and increase enrollment and participation in the waiver program. Any pregnant women who is losing Medicaid coverage and meets the income criteria associated with the waiver, is passively enrolled in the Family Planning Waiver and receives a letter advising of the enrollment, explaining the waiver, and encouraging participation in the waiver program. The Agency is currently working closely with the program evaluators, at University of Florida, to expand the variables analyzed in an effort to address barriers to improve participation and bolster future outreach efforts. The Family Planning Waiver program and services are also introduced to eligible women during the prenatal care services provided by the County Health Departments.

3. A recommendation was made to expand Family Planning Waiver coverage to all women of reproductive age whose individual income is no greater than 191 percent of the federal poverty level (FPL).

The waiver will continue to include women ages 14 – 55, losing Medicaid coverage, and who have a family income at or below 185 percent of the FPL.

4. A recommendation was made to implement waiver terms and new Affordable Care Act (ACA) income eligibility options.

The State has elected to not amend the State Plan. The Modified Adjusted Gross Income (MAGI) population does not include Family Planning Waiver recipients. The new MAGI rules require the State to include five (5) mandatory and nine (9) optional eligibility groups. Family Planning Services was not included in the mandatory group or the nine (9) eligibility groups chosen by the State.

5. A recommendation was made to implement presumptive eligibility for the Family Planning Waiver.

The State elected to not include demonstration populations covered under section 1115.

Public Notice/Public Meetings

1. Concern was expressed that the Agency conducted the public meetings late in the 30-day public notice period of April 1, 2014 – April 30, 2014, as this provides limited time to submit comments after the public meeting.

The Agency will take this concern into consideration during future public notice periods. Furthermore, the Agency does regularly accept questions, comments and concerns from the public.

2. The question was received as to whether the Agency had received any comments or questions to date.

At that time, no comments or questions were received; however, as of April 30, 2014, the Agency received sixteen (16) comments regarding the Family Planning Waiver Extension.

Evaluation

In accordance with 42 C.F.R.431.424, the Interim Evaluation Report is posted for public viewing at: http://ahca.myflorida.com/Medicaid/Family_Planning/extension.shtml.

IV. Budget Neutrality

A. Budget Neutrality Compliance

The Agency is required to provide financial data demonstrating the detailed and aggregate, historical and project budget neutrality status for the requested FPW extension period (January 1, 2015 through December 31, 2017) and cumulatively over the lifetime of the FPW.

1. General Budget Neutrality Requirements

A requirement of any 1115 Research and Demonstration Waiver is that the program must meet a budget neutrality test and provide documentation that the demonstration did not cost the program more than would have been experienced without the FPW. In addition, prior to an extension of the FPW, a projection and extension of new budget neutrality benchmarks using rebased trends must be provided for the requested FPW extension period.

To comply with Special Terms and Conditions of the approved waiver, the Agency must pass the budget neutrality “test” and submit quarterly on waiver expenditures and member months for budget neutrality monitoring. Florida’s FPW is budget neutral and is in compliance with all Special Terms and Conditions specific to budget neutrality.

2. Enrollment, Expenditures and Budget Neutrality

The following tables (A-D) address the costs and enrollment experienced by this waiver since its inception. In accordance with the waiver’s Special Terms and Conditions (STCs), the waiver’s budget neutrality status is presented, along with the projected target PMPMs for the extension years (January 2015 – December 2017). The waiver’s administrative costs are identified in the final table.

Table A provides the historic information regarding waiver enrollment (member months) and expenditures for each of the demonstration years (DY). The waiver expenditures identified in this table are the same costs as reported in the State’s CMS64. The three most current years (DY14-16) were used to project the member months for the proposed extension years (DY17-20). The cessation of waiver authority during DY12-13 resulted in fluctuations in enrollment and service utilization. Thus, the three most current years are considered to be more reflective of current waiver enrollment and service costs. The resulting trend rate of 4.42% was applied to the member months experienced thus far in DY16 to project DY 17-20. Since DY16 is an incomplete year (July 2013-March 2014) for projection purposes the total member months identified in Table A was annualized by an additional 25%.

Table B is included in order to comply with the requirements stipulated in STC Section VIII Monitoring Budget Neutrality. Table B identifies the actual member months and PMPM costs experienced during the time period authorized under this STC section (DY14-16). As defined in STC #43 (Budget Neutrality Annual Expenditure Limits), the PMPMs actually experienced in the waiver are compared to the waiver’s authorized PMPM target limits. The target PMPMs were applied to the actual member months experienced and then compared to the actual total waiver costs as reported in the CMS64. The result demonstrates that the actual waiver costs did not exceed the waiver’s authorized budget limit for each of these years (DY14-16).

Table C identifies the member months and PMPM projections for the proposed extension years, DY 17 (January-June 2015), DY 18, DY 19 and DY 20 (July-December 2017). The member month projections utilize the annualized DY16 member months with the application of the Table A trend rate. Each subsequent year utilizes the previous year's total increased by the trend rate. For DY 17 and DY 20, the projected member months are limited to a six month time period. The projected PMPMs utilize the actual PMPM experienced thus far in DY 16. This DY 16 PMPM is then projected forward utilizing the President's trend rate of 6.1% as identified in STC #43. Each subsequent year utilizes the previous year's PMPM increased by this trend rate.

B. Financial Management Standard Questions

1. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved state plan. Do providers receive and retain the total Medicaid expenditures claimed by the state (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the state, local governmental entity, or any other intermediary organization. If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the state (i.e., general fund, medical services account, etc.)

Response: Providers retain 100 percent of all payments made relating to Medicaid cost. If an error occurs and payments are returned to the state, the state will track and report appropriately. The federal share is calculated and returned to Federal CMS.

2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and state share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local government entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:

- a. a complete list of the names of entities transferring or certifying funds;
- b. the operational nature of the entity (state, county, city, other);
- c. the total amounts transferred or certified by each entity;

- d. clarify whether the certifying or transferring entity has general taxing authority; and,
- e. whether the certifying or transferring entity received appropriations (identify level of appropriations).

Response: Florida Medicaid provides payments to institutional providers through per diem rates. The state's share of payments is appropriated by the Florida Legislature from the state's General Revenue. Each year we budget for the upcoming year, by applying an inflationary factor to current year payments, as well as making adjustments for estimated changes in caseload. The budget is submitted, reviewed and ultimately approved by the Legislature.

- 3. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

Response: No supplemental Special Medicaid Payments are being made in addition to provider Medicaid per diem rates. The only additional payments being made to hospital providers are those payments permitted through the LIP program, for the continuation of government support for services to Medicaid, uninsured and underinsured populations.

- 4. Please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (state owned or operated, non-state government owned or operated and privately owned or operated). Please provide a current (i.e. applicable to current rate year) UPL demonstration.

Response: On March 18, 2013, Federal CMS issued a State Medicaid Director's Letter (SMDL #13-003) describing the mutual federal and state obligations and accountability on the part of the state and federal governments for the integrity of the Medicaid program. Among the obligations include ongoing consistency with the applicable federal upper payment limit (UPL) requirements described in regulation for certain services. The regulations implement, in part, section 1902(a)(30)(A) of the SSA which requires that Medicaid rates are consistent with efficiency, economy and quality of care. Starting in 2013, states are required to submit UPL demonstrations on an annual basis. Previously this information was collected or updated only when a state was proposing an amendment to a reimbursement methodology in its Medicaid state plan. Beginning in 2013, states must submit UPL demonstrations for inpatient hospital services, outpatient hospital services and nursing facilities.

For Florida State Fiscal Year 2013-14, the UPL analysis involves estimating Medicare payment for a set of Medicaid claims and comparing those payments to actual payments made by Medicaid. The claim data and hospital Medicare cost data are aligned so that they are from the same time frame. In addition, inflation factors are applied as appropriate to make payment and cost amounts comparable under the same time frame. Also if appropriate, other adjustments may be made to the baseline claim data to align with Medicaid program changes that have occurred between the timeframe of the baseline claim data and the UPL rate year.

Comparisons of Medicaid payments to estimated Medicare payments (the upper payment limits) are made separately for hospital inpatient and outpatient services. Also, the

comparisons are made for three categories of providers, 1) state owned; 2) non-state government owned; and 3) privately owned hospitals.

Estimated Medicare payments which determine the upper payment limit were calculated using a detailed costing method. For each hospital, information extracted from Medicare cost reports were used to calculate cost-based per diems for each routine cost center and cost-to-charge ratios for each ancillary cost center. In addition, a mapping of revenue codes to cost centers was created. This mapping allowed a cost center to be identified for each claim detail line based on the revenue code submitted on the line. Costs on detail lines that mapped to routine cost centers were calculated by multiplying the cost center's cost per diem times the number of applicable days indicated on the line. Costs on detail lines that mapped to ancillary cost centers were calculated by multiplying the charges on the line by the cost center's cost-to-charge ratio. Total costs on all claim lines for a provider were summed to get the UPL amount per provider and then summed by category of provider to get the UPL amount for the three UPL categories, state-owned, non-state government owned, and privately owned (all others).

The upper payment limit for each of the three UPL categories was calculated using the detailed costing demonstration method. For each hospital, information extracted from Medicare cost reports was used to calculate cost-based per diems for each routine cost center and cost-to-charge ratios for each ancillary cost center. Standard cost centers as defined by CMS were used. In addition, a mapping was created to assign revenue codes to cost centers. This allowed each claim detail line item to be assigned a cost center. Hospital costs on detail lines that mapped to routine cost centers were calculated by multiplying the cost center's cost per diem times the number of applicable days indicated on the line. Hospital costs on detail lines that mapped to ancillary cost centers were calculated by multiplying the charges on the line by the cost center's cost-to-charge ratio. The hospital cost amounts on all the claim lines for a hospital were summed to get the total cost for the hospital, and total hospital cost was used as the upper payment limit.

5. Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to Federal CMS on the quarterly expenditure report?

Response: Payments to providers would not exceed reasonable costs of providing services. If payments do exceed reasonable cost of providing services, the provider must return the excess amount to the state. Once the state has received the returned funds, appropriate documentation is made and the federal share is calculated and returned to Federal CMS. The excess is returned to the state and the Federal share is reported on the 64 report to Federal CMS.

V. Evaluation Status and Findings

A. Overview of Previous Waiver Period (2006-2009)

In June 2007, the University of Florida's Family Data Center (UF FDC) was contracted by the Agency for Health Care Administration to evaluate the extent to which the following six Family Planning Waiver (FPW) objectives were met during the period corresponding to Demonstration Years 9, 10 and 11 of Florida's Section 1115 Research and Demonstration Waiver.

- Increase the number of reproductive age women receiving Title XIX funded family planning services by improving access to and use of Medicaid family planning services.
- Reduce the number of inadequately spaced pregnancies among women in the target population.
- Reduce the rate of unintended and unwanted pregnancies among teens in the target population.
- Increase the number of referrals for primary care services.
- Provide preconception counseling and education to the target population.
- Estimate the overall savings in Medicaid spending directly attributable to providing family planning services through the demonstration.

1. Family Planning Waiver Evaluation Methodology

The evaluation team utilized quantitative methods to examine both process and outcome measures. The process measures included the number and percentage of FPW Enrollees, Participant and Non-participant women, and member months broken out by age group, race/ethnicity and by FPW program demonstration year. Outcome measures included interbirth interval and cost savings estimates based on overall averted births. Additionally, qualitative methods were utilized to assess the prevalence of primary care referrals among the Participant population.

a. The Study Population

The study population included women who were enrolled in the FPW program, Enrollees. Enrollee eligibility criteria for the 2006-09 FPW extension period included recipients who: (1) had a Medicaid supported birth and who subsequently lost Medicaid coverage; (2) had lost Medicaid coverage for any reason during the previous two years; and, (3) were up to the age of 55 (whereas the previous waiver had only covered women through age 44). This population was broken into two groups:

- "Participants": Women who were enrolled in the FPW program and received at least one family planning service while enrolled in the program during the waiver study period; and
- "Non-participants": Women who were enrolled in the FPW program but did not receive any family planning service during the waiver study period.

b. Hypotheses

The FDC research team tested six hypotheses to evaluate whether Florida's FPW program achieved its objectives during the waiver period. The hypotheses were:

- 1) The waiver will result in an increase in access to and use of family planning services by low-income women, including those who may not have had a Medicaid covered pregnancy in the previous two years.
- 2) Participants will exhibit longer inter-pregnancy intervals.
- 3) Participants will exhibit lower unintended pregnancy rates.
- 4) The number of referrals to primary care will increase among a subset of high risk Participants.
- 5) The waiver will result in an increase in the number of Participants who receive preconception counseling and education.
- 6) Savings achieved from averted births will exceed baseline projections.

c. Data Sources

The following data sources were used for the FPW program evaluation:

- 1) Medicaid Eligibility and Claims data
- 2) Administrative data on Hospital Inpatient Discharges, Hospital Outpatient Discharges, Hospital Ambulatory Visits, and Hospital Emergency Discharges
- 3) Birth Vital Statistics birth certificate data
- 4) Prenatal Screens and Services from Healthy Start
- 5) Birth Facility data
- 6) Survey data from surveys of 600 FPW recipients in order to assess the prevalence of primary care referrals.

d. Analyses

The evaluation team employed descriptive statistics to assess changes over time (rates of enrollment and participation) and altered birth patterns (child spacing and rates of unintended pregnancies).

2. Evaluation Findings

In September 2011, the FDC research team submitted the Final Evaluation Report and reported the following key findings:

a. Objective 1: Increase the number of reproductive age women receiving Title XIX funded family planning services by improving access to, and use of, Medicaid family planning services.

- Overall, the number of women participating in the FPW program increased over the three years from 18,014 to 49,188.
- Over the three year waiver study period, the majority of enrollees (65%) were between 20 and 29 years old, while teenagers (age 19 and below) made up the smallest percent of enrollees (9%). However, women age 19 and below had the highest rate of participation of any age group and within every race/ethnicity group.

- Of the 184,004 unique women who were enrolled in the FPW program, 68,840 (or 37%) received services.
- Of those enrollees who received services, 86% did not deliver during the waiver study period.
- The number of member months increased each year of the demonstration period, from 231,883 in DY9, to 728,593 in DY10, and to 886,790 in DY11. This was an overall increase of 282%.

B. Overview of the Current Waiver Period (2011-2014)

In accordance with Special Terms and Conditions #46, the Agency submitted the draft Evaluation Design for the FPW to the Centers for Medicare and Medicaid Services in October 2011. The Agency worked with a research team in the University of Florida's Family Data Center to develop the evaluation design. This research team conducted previous FPW evaluations for Florida. The contract for the evaluation covering the 2011 through 2014 waiver period began in July 2013 and has been extended through June 30, 2016 so that the evaluator may include the extension period through June 30, 2014. Thus, the following three demonstration years will be included in this evaluation.

- Demonstration Year 14: July 1, 2011 – June 30, 2012
- Demonstration Year 15: July 1, 2012 – June 30, 2013
- Demonstration Year 16: July 1, 2013 – June 30, 2014

1. Family Planning Waiver Evaluation Plan

The research team will use a combination of quantitative and qualitative methods to evaluate the FPW program. Quantitative data will be used to test the four hypotheses regarding the waiver's objectives, while qualitative survey data from FPW program regional administrators will be used to identify strategies that have been successful in meeting the waiver objectives.

a. The Study Population

The study population includes women who are enrolled in the FPW program. This population will be separated into two groups for comparison:

- Participants: women enrolled in the FPW program who received family planning services under the waiver.
- Non-participants: women enrolled in the FPW program who did not receive family planning services under the waiver.

b. Hypotheses

To evaluate whether Florida's FPW program achieves its objectives, the research team will test four hypotheses about implementation and intended outcomes of the FPW program. The hypotheses are:

- 1) More eligible women will participate in the FPW program during the extension period than in previous waiver periods.
- 2) FPW participants will be more likely to increase their interbirth interval to 24 months than non-participants.

- 3) FPW participants will be less likely to have unintended pregnancies than non-participants. Rates of unintended pregnancies will be measured by comparing responses on the Healthy Start Prenatal Risk Screen related to pregnancy intendedness for FPW participants and non-participants.
- 4) Medicaid will achieve cost savings through the FPW program by averting unintended pregnancies and births.

In addition to testing these hypotheses, the research team will generate policy recommendations to improve the FPW program's implementation and outcomes.

c. Data Sources

The following data sources are being used for the FPW program evaluation:

- 1) Medicaid eligibility and claims data
- 2) Administrative data on hospital inpatient discharges, hospital outpatient discharges, hospital ambulatory visits, and hospital emergency discharges
- 3) Vital statistics birth certificate data
- 4) Prenatal screens and services from Healthy Start
- 5) Birth facility data
- 6) Survey data from surveys of regional FPW program administrators regarding what strategies they use to enroll women and to encourage them to obtain waiver covered services.

d. Analyses

The FPW program is being evaluated on the extent to which it achieves the four waiver objectives. The outcome measures consist largely of descriptive statistics related to FPW program implementation (changes in rates of enrollment and participation) and altered birth patterns (changes in child spacing and rates of unintended pregnancies).

Agency staff worked with the research team to develop a report on descriptive statistics for each demonstration year. The information that is included in the report includes:

- Race/ethnicity of enrolled women
- Age of enrolled women
- Ratio of participants to enrollee
- Duration of enrollment
- Provision of evaluation and management services
- Provision of contraceptives
- Provision of sterilization.

2. Evaluation Findings

In February 2014, the research team submitted the Demonstration Year 14 Report Findings to the Agency. The research team conducted a comparison of Demonstration Year 14 to Demonstration Year 11 and reported the following key findings:

- The change in participation ratio between Demonstration Year 11 and Demonstration Year 14 was significant in all Medicaid areas.

- In Demonstration Year 14, over 13,000 fewer women were enrolled in the FPW program compared to Demonstration Year 11.
- In Demonstration Year 14, over 10,000 fewer women participated in FPW program services compared to Demonstration Year 11.
- The participation ratio declined more than five percentage points in Demonstration Year 14 compared to Demonstration Year 11.
- In Demonstration Year 14, seven of 11 Medicaid Areas exceeded the statewide participation ratio of 22.3%.
- The decline in the participation ratio between Demonstration Year 11 and Demonstration Year 14 varied considerably across Medicaid Areas, ranging from a low of 2.7% to a high of 6.2%.

The Demonstration Year 15 Report is due to the Agency in June 2014.

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VI. Special Terms and Conditions of Waiver

CENTERS FOR MEDICARE & MEDICAID SERVICES

SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00135/4

TITLE: Managed Medical Assistance Program

AWARDEE: Agency for Health Care Administration

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Florida family planning section 1115(a) Medicaid Demonstration (hereinafter-"Demonstration"). The parties to this agreement are the Florida Agency for Health Care Administration 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 as of the date of the approval letter through December 31, 2013, unless otherwise specified. All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below. This Demonstration is approved through December 31, 2013.

The STCs have been arranged into the following subject areas:

- I. Preface
- II. Program Description and Objectives
- III. General Program Requirements
- IV. Eligibility
- 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 Quarterly Operational Reports
 - Appendix B: Template for Annual Reports

II. PROGRAM DESCRIPTION AND OBJECTIVES

The Florida family planning section 1115(a) Medicaid Demonstration expands the provision of family planning and family planning-related services to women, ages 14 through 55, losing Medicaid coverage, who have family income at or below 185 percent of the Federal poverty level (FPL), and who are not otherwise eligible for Medicaid, CHIP, or health insurance coverage that provides family planning services. Eligibility is

limited to 2 years after losing Medicaid coverage, subject to an annual redetermination.

Under this Demonstration, Florida expects to promote the objectives of title XIX 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.

II. GENERAL PROGRAM REQUIREMENTS

The State has complied with the General Program Requirements of the waiver.

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 waiver and expenditure authority documents (of which these terms and conditions are part), 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 eligibility, enrollment, benefits, delivery systems, cost sharing, sources of non-Federal share of funding, budget neutrality, and other comparable program elements in the STCs 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 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 paragraph 6 below. The State will notify CMS of proposed Demonstration changes at the quarterly monitoring call, as well as in the written quarterly report, to determine if a formal amendment is necessary.
6. **Amendment Process.** Requests to amend the Demonstration must be submitted to CMS 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) An explanation of the public process used by the State consistent with the requirements of paragraph 13 to reach a decision regarding the requested amendment;
 - b) A data analysis which identifies the specific impact of the proposed amendment on the current budget neutrality expenditure limit.
 - c) A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and
 - d) If applicable, a description of how the evaluation design must be modified to incorporate the amendment provisions.
7. **Demonstration Phase Out.** The State may suspend or terminate this Demonstration in whole or in part at any time prior to the date of expiration. The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date. In the event the State elects to phase out the Demonstration, the State must submit a phase-out plan to CMS at least 6 months prior to initiating phase-out activities. Nothing herein should be construed as preventing the State from submitting a phase-out plan with an implementation deadline shorter than 6 months when

such action is necessitated by emergent circumstances. The phase-out plan is subject to CMS approval prior to implementation of phase out. If the project is terminated or any relevant waivers suspended by the State, FFP must be limited to normal closeout costs associated with terminating the Demonstration, including services and administrative costs of disenrolling participants.

8. **Enrollment Limitation during Demonstration Phase-Out.** If the State elects to suspend, terminate, or not renew this Demonstration as described in paragraph 7, during the last 6 months of the Demonstration, the State may choose to not enroll individuals into the Demonstration who would not be eligible for Medicaid under the current Medicaid State plan. Enrollment may also be suspended if CMS notifies the State in writing that the Demonstration will not be renewed.
9. **CMS Right to Terminate or Suspend.** CMS may 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 suspension or termination, together with the effective date.
10. **Finding of Non-Compliance.** The State does not relinquish its rights to challenge the CMS finding that the State materially failed to comply with the terms of this agreement.
11. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers 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 must 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 authorities, including services and administrative costs of disenrolling participants.
12. **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.
13. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The State must continue to comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) and the tribal consultation requirements set out at section 1902(a)(73) of the Act as added by section 5006(e) of the American Recovery and Reinvestment Act (P.L. 111-5), when any program changes to the Demonstration, including (but

not limited to) those referenced in paragraph 6, are proposed by the State. In States with Federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the State is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any Demonstration proposal, amendment and/or renewal of this Demonstration.

14. **FFP.** No Federal matching funds for expenditures for this Demonstration will take effect until the effective date identified in the Demonstration approval letter.

III. ELIGIBILITY

The State has complied with the Eligibility Requirements of the waiver.

15. **Eligibility Requirements.** Family planning services are provided to eligible individuals for a period of time up to 2 years after losing Medicaid coverage provided the individual is redetermined eligible for the program on an annual basis. The State must enroll only individuals, ages 14 through 55, meeting the following eligibility criteria into the Demonstration who are not otherwise eligible for Medicaid, CHJP, or health insurance coverage that provides family planning services:
 - 1) Women losing Medicaid pregnancy coverage (SOBRA pregnant women) at the conclusion of 60 days postpartum and who have a family income at or below 185 percent of the Federal poverty level (FPL) at the time of annual redetermination; or
 - 2) Women losing Medicaid coverage who have family income at or below 185 percent of the FPL.
16. **Redeterminations.** The State must ensure that redeterminations of eligibility for the Demonstration are conducted at least every 12 months. At the State's option, redeterminations may be administrative in nature.
17. **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 be disenrolled from the Demonstration.

IV. BENEFITS AND DELIVERY SYSTEMS

The State has complied with the Benefits and Delivery Systems Requirements of the waiver.

18. **Family Planning Benefits.** Family planning services and supplies described in section 1905(a)(4)(C) and are limited to those services and supplies whose primary purpose is family planning and which are provided in a family planning setting. Family planning services and supplies are reimbursable at the 90 percent matching rate, including:
- a) Approved methods of contraception;
 - b) Sexually transmitted infection (STI)/sexually transmitted disease (STD) testing, Pap smears and pelvic exams;
 - i) 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.
19. **Family Planning-Related Benefits.** Family planning-related services and supplies are 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 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 IDV/AIDS and hepatitis, when the STI/STD is identified/ diagnosed during a routine/periodic family planning visit. 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 such as:
 - i) Treatment of a perforated uterus due to an intrauterine device insertion;
 - ii) Treatment of severe menstrual bleeding caused by a Depo-Provera injection requiring a dilation and curettage; or
 - iii) Treatment of surgical or anesthesia-related complications during a sterilization procedure.

20. **Primary Care Referrals.** Primary care referrals to other social service and health care providers as medically indicated are 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 participants, and must assure CMS that written materials concerning access to primary care services are distributed to Demonstration participants. The written materials must explain to the participants how they can access primary care services.

21. **Services.** Services provided through this Demonstration are paid fee for service (FFS).

V. GENERAL REPORTING REQUIREMENTS

22. **General Financial Requirements.** The State must comply with all general financial requirements under title XIX set forth in section VII.

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

24. **Monitoring Calls.** CMS and the State will participate in quarterly conference calls following the receipt of the quarterly 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, health care delivery, enrollment, quality of care, access,

25. benefits, audits, lawsuits, financial reporting and budget neutrality issues, progress on evaluations, State legislative developments, and any Demonstration amendments the State is considering submitting. The State and CMS will discuss quarterly expenditure reports submitted by the State for purposes of monitoring budget neutrality. CMS will update the State on any amendments under review as well as Federal policies and issues that may affect any aspect of the Demonstration. The State and CMS will jointly develop the agenda for the calls.
26. **Quarterly Operational Reports.** The State must submit progress reports no later than 60 days following the end of each quarter for every Demonstration year (DY) within the format outlined in Appendix A. The intent of these reports is to present the State's data along with an analysis of the status of the various operational areas under the Demonstration. These quarterly reports must include, but are not limited to:
- a) Quarterly expenditures for the Demonstration population, with administrative costs reported separately;
 - b) Quarterly enrollment reports for Demonstration enrollees (enrollees include all individuals enrolled in the Demonstration) that include the member months for each DY, as required to evaluate compliance with the budget neutral agreement and as specified in paragraph 34;
 - c) Total number of participants served monthly during the quarter for each DY (participants include all individuals who obtain one or more covered family planning services through the Demonstration);
 - d) Events occurring during the quarter, or anticipated to occur in the near future that affect health care delivery, benefits, enrollment, systems, grievances, quality of care, access, pertinent legislative activity, eligibility verification activities, eligibility redetermination processes (including the option to utilize administrative redetermination), and other operational issues;
 - e) Notification of any changes in enrollment and/or participation that fluctuate 10 percent or more in relation to the previous quarter within the same DY and the same quarter in the previous DY;
 - f) Action plans for addressing any policy, administrative or budget issues identified;
 - g) An updated budget neutrality monitoring worksheet;
 - h) Progress updates to the transition plan as specified in paragraph 28; and
 - i) Evaluation activities and interim findings.

27. **Annual Report.** The annual report is due 90 days following the end of the fourth quarter of each DY within the format outlined in Appendix B. The report must include a summary of the year's preceding activity as well as the following:
- a) Total annual expenditures for the Demonstration population for each DY, with administrative costs reported separately;
 - b) The average total Medicaid expenditures for a Medicaid-funded birth each DY. The cost of a birth includes prenatal services and delivery and pregnancy-related services and services to infants from birth up to age 1 (the services should be limited to the services that are available to women who are eligible for Medicaid because of their pregnancy and their infants);
 - c) The number of actual births that occur to family planning Demonstration participants within the DY. (participants include all individuals who obtain one or more covered medical family planning services through the family planning program each year);
 - d) Yearly enrollment reports for Demonstration enrollees for each DY (enrollees include all individuals enrolled in the Demonstration) that include the member months, as required to evaluate compliance with the budget neutral agreement and as specified in paragraph 34;
 - e) Total number of participants for the DY (participants include all individuals who obtain one or more covered family planning services through the Demonstration);
 - f) Progress updates to the transition plan as specified in paragraph 28;
 - g) Evaluation activities and interim findings; and
 - h) An updated budget neutrality monitoring worksheet.
28. **Corrective Action Plan.** Due to a technical error with the eligibility system, some eligible individuals enrolled in the Demonstration were prematurely disenrolled from the Demonstration. Within 60 days of the award of the Demonstration extension, the State must fully complete the Corrective Action Plan (as defined in subparagraphs a and b). Failure to meet this deadline will result in a penalty of deferment of FFP as described in paragraph 40.

The State shall provide progress updates on the Correction Action Plan via monthly monitoring calls, addressing the same issues as those addressed in the quarterly monitoring calls described in paragraph 24, during the execution of the Corrective Action Plan, in addition to relevant quarterly and annual reports described in paragraphs 25 and 26.

- a) Within 40 days of the award of the Demonstration extension, the State must make a good faith effort to identify, notify, and enroll women who were prematurely disenrolled from the Demonstration, and did not subsequently become eligible for full Medicaid coverage. The women specified in this paragraph will be enrolled into the Medicaid Family Planning Waiver program for 180 days, and coverage during this time period will not be considered for any Medicaid Eligibility Quality Control or Payment Error Rate Measure purpose. After this initial reinstatement period, women specified in this paragraph may also be eligible for an additional 12 months of eligibility subject to an annual redetermination.
 - b) Within 60 days of the award of the Demonstration extension, the State will implement technical programming changes to the Medicaid Management Information System (MMIS) to facilitate standard eligibility, enrollment and notification requirements and processes related to the Demonstration. These changes will include auto enrollment into the Demonstration for all women losing Medicaid pregnancy SOBRA coverage at the conclusion of 60 days postpartum, and notification to all women losing full Medicaid coverage of potential eligibility for the Demonstration with a requirement of active enrollment.
29. **Transition Plan.** The State is required to prepare and incrementally revise a transition plan consistent with the provisions of the Affordable Care Act for individuals enrolled in the family planning Demonstration. The transition plan must provide details on how the State plans to coordinate the transition of these individuals to a more comprehensive coverage option available under the Affordable Care Act, including the Medicaid eligibility group described in §1902(a)(10)(A)(i)(VIII), the American Health Benefit Exchange or other coverage options available in 2014, without interruption in coverage or access to care to the maximum extent possible. The State must submit a draft to CMS by January 1, 2013, with progress updates included in each quarterly and annual report thereafter. The State will revise the transition plan as needed.
30. **Final Report.** The State must submit a final demonstration report to CMS to describe the impact of the Demonstration, including the extent to which the State met the goals of the Demonstration. The draft report will be due to CMS 180 days after the expiration of the Demonstration. CMS must provide comments within 60 days of receipt of the draft final demonstration report. The State must submit a final demonstration report within 60 days of receipt of CMS comments.

VI. GENERAL FINANCIAL REQUIREMENTS

<p>The State has complied with the General Financial Requirements of the waiver.</p>
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31. **Quarterly Expenditure Reports.** The State must provide quarterly expenditure reports using the Form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the Demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the Demonstration period. CMS must provide FFP for allowable Demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred Florida Medicaid Family Planning Waiver as specified in Section VIIi.
32. **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, Florida must report Demonstration expenditures through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES); following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual. 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, including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made.
 - b) **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 IOB, in lieu of Lines 9 or IOC. For any other cost settlements not attributable to this Demonstration, the adjustments should be reported on lines 9 or 10C as instructed in the State Medicaid Manual.
 - c) **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.
33. **Title XIX Administrative Costs.** Administrative costs will not be included in the budget neutrality agreement, but the State must separately track and report additional administrative costs that are directly attributable to the Demonstration. All administrative costs must be identified on the Forms CMS-64.10.
34. **Claiming Period.** All claims for expenditures subject to the budget neutrality agreement (including any cost settlements) must be made within 2 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 2 years after the conclusion or termination of the Demonstration. During the latter 2-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.

35. **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 quarterly and annual reports as required under paragraph 25 and 26 respectively, the actual number of eligible member months for all Demonstration enrollees. The State must submit a statement accompanying the quarterly and annual reports, 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 3 months contributes three eligible member months to the total. Two individuals who are eligible for 2 months each contribute two eligible member months to the total, for a total of 4 eligible member months.
36. **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 the 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. CMS shall reconcile expenditures reported on the 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.
37. **Extent of Federal Financial Participation (FFP) for the Demonstration.** CMS shall provide FFP for family planning and family planning-related services and supplies at the applicable Federal matching rates described in paragraphs 18 and 19, subject to the limits and processes described below:
 - a) For family planning services, 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.
 - b) Allowable family planning expenditures eligible for reimbursement at the enhanced family planning match rate, as described in paragraph

18, should be entered in Column (D) on the Forms CMS-64.9 Waiver.

- c) Allowable family planning-related expenditures eligible for reimbursement at the FMAP rate, as described in paragraph 19, should be entered in Column (B) on the Forms CMS-64.9 Waiver.
- d) FFP will not be available for the costs of any services, items, or procedures that do not meet the requirements specified above, even if family planning clinics or providers provide them. 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.
- e) 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.

38. **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 for 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 time frames 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.

39. **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.

40. **Monitoring the Demonstration.** The State must provide CMS with information to effectively monitor the Demonstration, upon request, in a reasonable time frame.

41. **Penalty for Failure to Complete Corrective Action Plan.** CMS shall defer claims for FFP, as described in paragraph 36, if the State fails to complete the Corrective Action Plan within the 30 day grace period following the deadlines specified in paragraph 27. FFP will be deferred until such time as the State completes the deliverables set out in the Corrective Action Plan in paragraph 27 (a) and (b). Any available statutory or regulatory appeal procedures, including by not limited to procedures in 42 CFR 430.32 through 430.40, shall apply.

VII. MONITORING BUDGET NEUTRALITY

The State has complied with the Monitoring Budget Neutrality Requirements of the waiver.
--

42. **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 selected Medicaid expenditures during the period of approval of the Demonstration. The budget neutrality expenditure targets are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire Demonstration. Actual expenditures subject to budget neutrality expenditure limit shall be reported by the State using the procedures described in paragraph 31.
43. **Risk.** Florida shall be at risk for the per capita cost (as determined by the method described below in this section) for the Medicaid family planning enrollees, but not for the number of Demonstration enrollees. By providing FFP for enrollees in this eligibility group, 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.
44. **Budget Neutrality Annual Expenditure Limits.** For each DY, an annual budget limit will be calculated for the Demonstration. For the purposes of this Demonstration, the DY aligns with the State fiscal year (SFY) which is July 1 to June 30. 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.

- a) **PMPM Cost.** The following table gives the PMPM (Total Computable) costs for the calculation described above by DY. The PMPM cost was constructed based on the State expenditures in DY 12, and increased by the appropriate growth rate included in the President's Federal Fiscal Year 2012 budget for DY 14, DY 15 and DY 16.

		SFY2012	SFY2013	SFY2014
	Trend:	DY14	DY15	DY16
Demonstrations Enrollees	6.1%	\$16.32	\$17.31	\$18.35

- b) **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 paragraph 31 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 paragraph 9), 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.

- c) Structure. The Demonstration is structured as a "pass-through" or "hypothetical" population. Therefore, the State may not derive savings from the Demonstration.
- d) Application of the Budget Limit. The budget limit calculated above will apply to Demonstration expenditures, as 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.

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 will enforce budget neutrality over the life of the Demonstration, rather than annually. However, no later than 6 months after the end of each DY or as soon thereafter as the data are available, the State will calculate annual expenditure targets for the completed year. This amount will be compared with the actual claimed FFP for Medicaid. Using the schedule below as a guide, if the State exceeds these targets, it will submit a corrective action plan to CMS for approval. The State will subsequently implement the approved corrective action plan.

Year	Cumulative Target Expenditures	Percentage
SFY2012	DY 14 budget limit amount	+2 percent
SFY2013	DYs 14 through 15 combined budget limit amount	+1 percent
SPY 2014	DYs 15 through 16 combined budget limit amount	+0 percent

- a) Failure to Meet Budget Neutrality Goals. 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 must include 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.

VIII. EVALUTION

The State has complied with the Evaluation Requirements of the waiver.

- 47. **Submission of Draft Evaluation Design.** A draft evaluation design report must be submitted to CMS for approval within 120 days from the award

of the Demonstration extension. At a minimum, the evaluation design should include a detailed analysis plan that describes how the effects of the Demonstration will be isolated from those of other initiatives occurring in the State. The report should also include an integrated presentation and discussion of the specific hypotheses (including those that focus specifically on the target population for the Demonstration) that are being tested. The report will also discuss the outcome measures that will be used in evaluating the impact of the Demonstration, particularly among the target population. It will also discuss the data sources and sampling methodology for assessing these outcomes. The State must implement the evaluation design and report its progress in each of the Demonstration's quarterly and annual reports.

48. **Final Evaluation Plan and Implementation.** CMS shall provide comments on the draft design within 60 days of receipt, and the State must submit a final plan for the overall evaluation of the Demonstration described in paragraph 46, within 60 days of receipt of CMS comments.

X. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION

Timeline	Deliverable	STC Reference
Within 60 days from the award of the Demonstration	Complete Corrective Action Plan	Section VI, paragraph 27
Within 120 days from the award of the Demonstration	Submit Draft Evaluation Design	Section IX, paragraph 46
Within 60 days receipt of CMS comments	Submit Final Evaluation Plan	Section IX, paragraph 47
July 1, 2012	Submit Draft Transition Plan	Section VI, paragraph
Annually within 90 days following the end of the 4tb	Submit Annual Report	Section VI, paragraph 26
Quarterly within 60 days following the end of each	Submit Quarterly Operational Reports	Section VI, paragraph 25
Within 180 days after the expiration of the	Submit Draft Final Report	Section VI, paragraph 29
60 days receipt of CMS comments	Submit Final Report	Section VI, paragraph 29

VII. Waiver and Expenditure Authorities

To effectively maintain the FPW, the State is seeking a three-year extension of Florida's Section 1115 Research and Demonstration waiver in order to waive statutory provisions under Section 1902 of the Social Security Act and obtain expenditure authority that permits the state to provide maximum flexibility in administering Florida's Medicaid program. Specifically, the State is requesting no change in the waiver and expenditures authorities previously granted as specified in Appendix C of this document.

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Appendix A

Letters to the Miccosukee Tribe and the Seminole Tribe



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

March 31, 2014

Ms. Cassandra Osceola
Health Director
Miccosukee Tribe of Florida
P.O. Box 440021, Tamiami Station
Miami, FL 33144

Dear Ms. Osceola,

Florida Medicaid is submitting a three-year extension request to the Centers for Medicare and Medicaid Services for the 1115 Family Planning Waiver. This waiver was originally granted in 1998, pursuant to Section 1115(a) of the Social Security Act.

The authority enables the State of Florida to enroll eligible women, including members of Federally Recognized Tribes of Florida, between the ages of 14 and 55 who have lost Medicaid coverage; desire family planning services; are at or below 185% of the federal poverty level; have no medical insurance covering family planning services; and are capable of bearing a child. This will include those recipients losing Medicaid Health Maintenance Organization (HMO) coverage.

The waiver will provide medically necessary family planning services and supplies related to birth control and pregnancy prevention, with limited testing and treatment for sexually transmitted diseases. Other services include contraceptive management with a variety of methods, patient education, counseling and referrals as needed to other social services and health care providers. Per subsection 409.904(5), Florida Statutes, "women are eligible for family planning services for a period of up to 24 months following a loss of Medicaid benefits."

If you would like additional information or have any questions regarding the Florida Medicaid Family Planning Waiver, please contact Ms. Michele Logan at (850) 412-4268 or by email at Michele.Logan@ahca.myflorida.com.

Sincerely,

/s/

Justin M. Senior
Deputy Secretary for Medicaid

JMS/ml





RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

March 31, 2014

Ms. Connie Whidden
Health Director
Seminole Tribe of Florida
6300 Stirling Road
Hollywood, FL 33024

Dear Ms. Whidden,

Florida Medicaid is submitting a three-year extension request to the Centers for Medicare and Medicaid Services for the 1115 Family Planning Waiver. This waiver was originally granted in 1998, pursuant to Section 1115(a) of the Social Security Act.

The authority enables the State of Florida to enroll eligible women, including members of Federally Recognized Tribes of Florida, between the ages of 14 and 55 who have lost Medicaid coverage; desire family planning services; are at or below 185% of the federal poverty level; have no medical insurance covering family planning services; and are capable of bearing a child. This will include those recipients losing Medicaid Health Maintenance Organization (HMO) coverage.

The waiver will provide medically necessary family planning services and supplies related to birth control and pregnancy prevention, with limited testing and treatment for sexually transmitted diseases. Other services include contraceptive management with a variety of methods, patient education, counseling and referrals as needed to other social services and health care providers. Per subsection 409.904(5), Florida Statutes, "women are eligible for family planning services for a period of up to 24 months following a loss of Medicaid benefits."

If you would like additional information or have any questions regarding the Florida Medicaid Family Planning Waiver, please contact Ms. Michele Logan at (850) 412-4268 or by email at Michele.Logan@ahca.myflorida.com.

Sincerely,

/s/

Justin M. Senior
Deputy Secretary for Medicaid

JMS/ml



2727 Mahan Drive • Mail Stop #8
Tallahassee, FL 32308

Visit AHCA online at
AHCA.MyFlorida.com

Appendix B Budget Neutrality Templates

Table A: Demonstration Historic Trend

	<u>DY 1</u> SFY98/99	<u>DY 2</u> SFY99/00	<u>DY 3</u> SFY00/01	<u>DY 4</u> SFY01/02	<u>DY 5</u> SFY02/03	<u>DY 6</u> SFY03/04	
<i>FP Waiver Expenditures</i>	\$ 2,895,339	\$ 5,430,259	\$ 6,848,141	\$ 7,522,595	\$ 8,396,796	\$ 332,583	
<i>Total Member Months</i>	284,617	985,801	1,379,504	1,289,973	1,310,518	314,472	
<i>Average Monthly Members</i>	31,624	82,150	114,959	107,498	109,210	26,206	
<i>Cost Per Member Per Month</i>	\$ 10.17	\$ 5.51	\$ 4.96	\$ 5.83	\$ 6.41	\$ 1.06	
	<u>DY 7</u> SFY04/05	<u>DY 8</u> SFY05/06	<u>DY 9</u> SFY06/07	<u>DY10</u> SFY07/08	<u>DY11</u> SFY08/09	<u>DY12*</u> SFY09/10	<u>DY13*</u> SFY10/11
<i>FP Waiver Expenditures</i>	\$ 876,631	\$ 1,052,022	\$ 2,776,378	\$ 7,439,059	\$ 8,880,918	\$ 4,126,034	\$ 1,126,701
<i>Total Member Months</i>	32,447	37,740	87,633	574,162	705,308	313,166	42,687
<i>Average Monthly Members</i>	2,704	3,145	7,303	47,847	58,776	26,097	3,557
<i>Cost Per Member Per Month</i>	\$ 27.02	\$ 27.88	\$ 31.68	\$ 12.96	\$ 12.59	\$ 13.18	\$ 26.39
	thru Dec 2013						
	<u>DY14</u> SFY11/12	<u>DY15</u> SFY12/13	<u>DY16</u> SFY13/14	DY1-16 TOTAL			
<i>FP Waiver Expenditures</i>	\$ 5,705,901	\$ 3,778,662	\$ 4,418,124	\$ 71,606,143			
<i>Total Member Months</i>	653,976	701,920	534,826	9,248,750			
<i>Average Monthly Members</i>	54,498	58,493	59,425				
<i>Cost Per Member Per Month</i>	\$ 8.72	\$ 5.38	\$ 8.04	\$ 7.74			
	TREND RATES DY14-DY16						
	Enrollment/Member Months			4.42%			

* During DYs 12 and 13, the demonstration program operation was disrupted due to a time break in CMS waiver authorization which in turn resulted in a temporary suspension of claim payments for this program. Thus, the member months and costs for these two years are not reflective of the actual utilization and cost trends for the current demonstration operation.

Table B: Monitoring Budget Neutrality

STC #43: Budget Neutrality Annual Expenditure Limits:				
	President Trend	DY14	DY15	DY16
<i>Projected PMPM's</i>	6.1%	\$16.32	\$17.31	\$18.35
	DY14	DY15	DY16	
<i>Actual Average Monthly Enrollment</i>	54,498	58,493	59,425	
<u>CALCULATION FOR DEMONSTRATION WAIVER'S BUDGET LIMIT CAP</u>				
	DY14	DY15	DY16	
	SFY 11/12	SFY 12/13	SFY 13/14	Total
Application of the Budget Limit, Utilizing Projected PMPM Targets				
<i>Member Months</i>	54,498	58,493	59,425	172,416
<i>PMPM</i>	\$16.32	\$17.31	\$18.35	
<i>Budget Limit Cap</i>	\$ 10,672,888	\$ 12,150,235	\$ 9,814,057	\$ 32,637,181
Budget Limit Calculation Utilizing Actual PMPMs				
<i>Member Months</i>	54,498	58,493	59,425	172,416
<i>Actual PMPM</i>	\$ 8.72	\$ 5.38	\$ 8.26	
<i>Actual Costs</i>	\$ 5,705,901	\$ 3,778,662	\$ 4,418,124	\$ 13,902,687
<i>Actual Waiver costs are less than BN Expenditure Limit</i>	\$ (4,966,987)	\$ (8,371,573)	\$ (5,395,933)	\$ (18,734,494)

* DY16 costs are based on data through March 2014 (first 9 months of the demonstration year).

Table C: Extension DYs Projected PMPs for BN Annual Cost Limits

	Jan-Jun 2015		Jul-Dec 2017	
	DY17	DY18	DY19	DY20
	SFY 14/15	SFY 15/16	SFY 16/17	SFY 17/18
<i>Projected Annual Member Months</i>	372,310	777,533	811,900	423,893
<i>Projected Monthly Average</i>	62,052	64,794	67,658	70,649
<u>Projected Per Member Per Month for Extension DYs (Total Computable)</u>				
STC #43: President's Budget Trend Rate:			6.1%	
	Jan-Jun 2015		Jul-Dec 2017	
	DY17	DY18	DY19	DY20
	SFY 14/15	SFY 15/16	SFY 16/17	SFY 17/18
<i>Projected PMPM</i>	\$8.76	\$9.30	\$9.87	\$10.47

Table D: Administrative Costs

	SFY 08/09	SFY 09/10	SFY 10/11	SFY 11/12	SFY 12/13	SFY 13/14	SFY 14/15
Administrative Costs							
<i>PERSONNEL</i>	\$ 30,820	\$ 31,591	\$ 32,381	\$ 19,575	\$ 42,338	\$ 46,755	\$ 46,755
<i>SYSTEMS CHANGES</i>							
<i>PUBLIC AWARENESS</i>							
<i>EVALUATION UF</i>	\$ 115,000	\$ 120,000	\$ 120,000	\$ 120,000	\$ 120,000	\$ 220,420	\$ 210,210
<i>OTHER</i>							

The Agency's administrative accounting system has been modified to account for administrative costs relating to the Family Planning Waiver, and thus the administrative costs have been reported on the CMS 64 Report. In May 2012, the position responsible for the Family Planning waiver was reclassified as a Government Operations Consultant III. Prior to May 2012, the position was classified as a Registered Nurse Consultant.

Appendix C

Waiver and Expenditure Authorities

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 authorities and the provisions specified as "not applicable" enable Florida to operate its section 1115 Medicaid Family Planning Demonstration effective as of the date of the approval letter through December 31, 2013, unless otherwise stated.

1. Expenditures for extending Medicaid eligibility for family planning and family planning-related services for 2 years, subject to an annual redetermination, to individuals, ages 14 through 55, who are not otherwise eligible for Medicaid, the Children's Health Insurance Program (CHIP), or health insurance coverage that provides family planning services, and are:
 - a. Women losing Medicaid pregnancy coverage at the conclusion of 60 days postpartum and who have a family income at or below 185 percent of the Federal poverty level (FPL) at the time of annual redetermination; or
 - b. Women losing Medicaid, who have family income at or below 185 percent of the FPL.
2. Expenditures for family planning and family planning-related services for women who are granted eligibility in conformance with the Corrective Action Plan described in the attached Special Terms and Conditions, paragraph 27.

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**

Appendix D

Interim Evaluation Report

MED145 Deliverable 1.4 Interim Report

Presented to



by



April 7, 2014

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Introduction

This report by the University of Florida's (UF) Family Data Center (FDC) features information about Enrollees and Participants of Florida's Medicaid Family Planning Waiver (FPW) program during Demonstration Year (DY) 15 (July 1, 2012 to June 30, 2013). The report is structured around six components outlined in contract Amendment No. 1, currently being finalized by the Agency and UF as of February 14, 2014:

- Project status, accomplishments, and challenges as discussed in Agency conference calls.
- Key, relevant information from conference calls with FPW state evaluators.
- Schedule of meetings (including dates, times and participants) and draft agenda, using data, to discuss DY14 Area success, trends, measures and outcomes.
- Descriptive statistics of new DY15 Enrollees and Participants.
- Preliminary lessons learned and recommendations for program implementation, including improvements supported by the data presented.

Project status, Accomplishments and Challenges

Project Status

On February 20, 2014, the Agency sent to UF a list of 13 counties where participant rates in the FPW were either above or below the state average. UF is going to contact county health department officials who are in charge of providing family planning services through the Medicaid FPW and ask them to respond to an online survey. The online survey was approved by the Agency on February 27, 2014 and can be found in Appendix 1.

UF will survey these officials to help the Agency understand the different methods that county health departments used in 2011- 12 to advertise the program, enroll clients, deliver family planning services, track participation and discontinuation. These officials will be contacted by UF via email where they will be directed to an online survey to answer six questions about their outreach efforts to DY14 Enrollees and Participants. The responses will be aggregated and analyzed by UF and reported in Deliverable 1.5, due June 16, 2014.

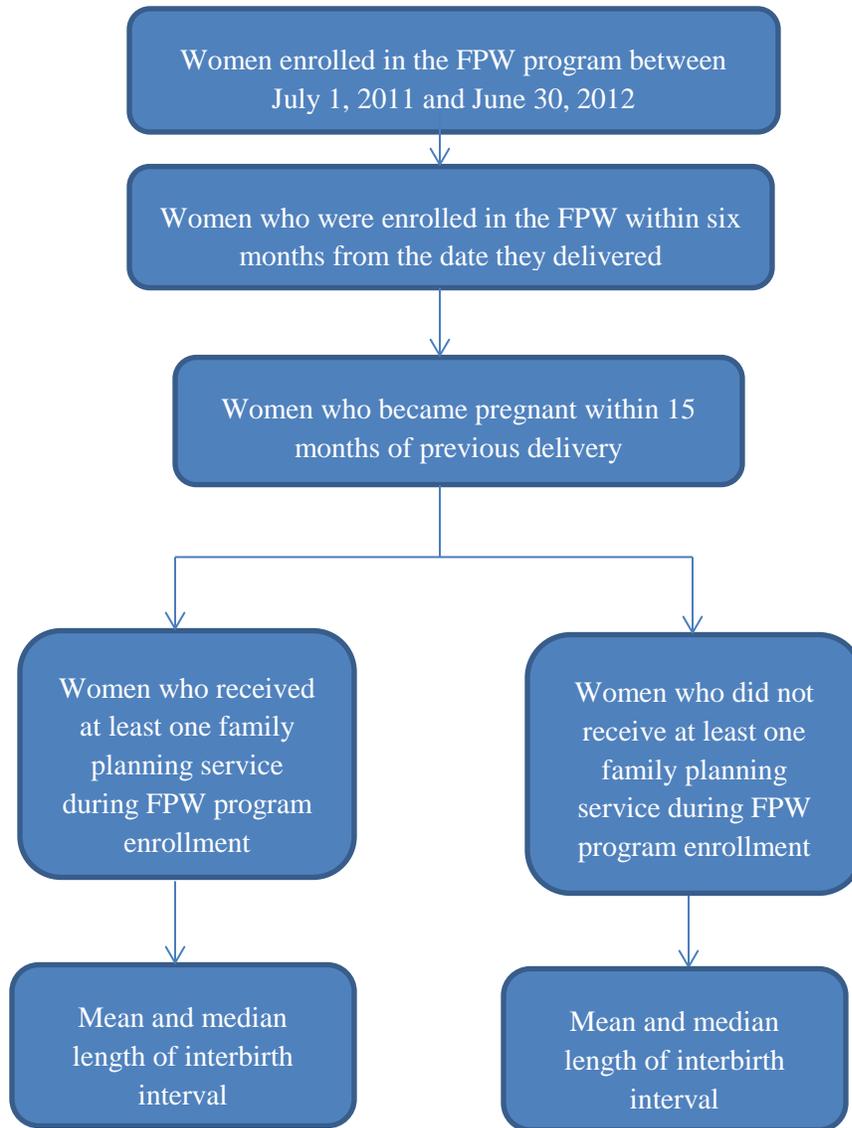
UF has made progress in further defining how the evaluation will measure achievement of four key program objectives:

1. Changes in access to Title XIX funded family planning services.

Changes in access to Title XIX funded family planning services in DY14 and 15 (July 1, 2011 – June 30, 2013) will be measured by conducting a trend analysis of program enrollment and participation data using DY10 and 11 (December 1, 2007 - November 30, 2009) as the baseline. The trend analysis will be supported by Chi-Square statistical tests to verify statistically significant findings on increased or decreased program participation between the two periods for each Florida county and Medicaid Area. In addition to the trend analysis, information collected from survey responses on barriers to enrollment and/or participation will be summarized to report lessons learned and recommendations concerning this program objective.

2. Changes in child spacing among FPW Enrollees and Participants

Changes in child spacing will be identified by comparing the difference in length of the mean and median interbirth interval in two groups of women: 1) those who were enrolled in DY14 and received at least one family planning service during enrollment and 2) those who were enrolled in DY14 and did not receive any family planning services during enrollment. The two groups will be constructed by linking women who were enrolled in the FPW program in DY14 to Medicaid Claims records that identify a delivery before enrolling in FPW and a subsequent pregnancy within 15 months of program enrollment (See Appendix 3). The linkage will be based on Medicaid Recipient ID. Chi-square statistical tests will be conducted to identify significant differences between the mean and median length of inter-birth intervals between the two groups. The following flowchart summarizes the process to construct the datasets for the comparative analysis of child spacing.



3. Change in the number of unintended pregnancies in Florida.

To measure the change in the number of unintended pregnancies, the rate of unintended pregnancies will be compared between two groups of women: 1) those who were enrolled in DY14 and received at least one family planning service during enrollment and 2) those who were enrolled in DY14 and did not receive any family planning services during enrollment. Medicaid eligibility records will be linked to Healthy Start Prenatal Risk Screen records based on personal identifiers such as Social Security Number, Name, and Date of Birth. Answers to

questions 5 and 14 on the Healthy Start Screen will be collected to determine the woman's intention to become pregnant.* The analysis will be limited to FPW Enrollees who are screened by Healthy Start from the time they enroll in the program and December 31, 2012. Since the available data may be limited by small sample sizes, statistical tests may need to be conducted to establish the statistical significance of the differences in the proportion of unintended pregnancies among women who did and did not participate in the FPW.

4. Reduce Florida's Medicaid costs by reducing the number of unintended pregnancies by women who otherwise would be eligible for Medicaid pregnancy-related services.

Once a statistically significant estimate of the number of averted unintended pregnancies is established, an analysis will be conducted to estimate the Medicaid costs savings generated by averting these pregnancies. To obtain an accurate estimate of costs associated with prenatal care, delivery, and first year postnatal care, a cost distribution will be constructed based on age and race indicators from the latest data available Medicaid Claims data. Groups of averted unintended pregnancies by age and race will be matched to mean and median costs for each age-by-race group. The total cost savings will be estimated by summing the individual contributions of each age-by-race group.

Accomplishments

Working together, the Agency and UF designed a 10-item survey questionnaire that will be circulated via email to 13 county health department officials as referenced earlier on page 1. The several iterations of the survey combined the interests of the Agency to identify county-level variations in recruitment and retention of FPW Participants with UF expertise in survey research and resulted in an efficient questionnaire whose responses will be linked to variations in participation rates to identify program features and practices that are successful and ones that need strengthening.

* Question 5 asks: Is this a good time for you to be pregnant? [Yes/No]. Question 14 asks: Thinking back to just before you got pregnant, did you want to be . . . ? pregnant now pregnant later not pregnant [A check in the third box indicates an unintended pregnancy.]

Challenges

Starting on February 14, 2014 UF sought permission from the Florida Department of Health (DOH) officials to use the survey tool, Qualtrics, to gather responses from county health department officials. On March 13, 2014, UF asked the Administrator of the Child and Adolescent Health Section, Bureau of Family Health Services for a list of email addresses of county health department officials who provide services to women through the FPW. After supplying UF with email addresses, DOH agreed to email these officials informing them that DOH supported UF's use of Qualtrics to conduct the survey and encouraged their participation.

Key, relevant information from conference calls with FPW state evaluators

Monthly conference calls hosted by the Cecil G. Sheps Center for Health Services Research, University of North Carolina, Division of Health Affairs were held on January 13th and February 6th, 2014. Highlights from those calls follow.

- UF alerted other states that for this evaluation of Florida's FPW, our state Medicaid office had devised a data reporting spreadsheet that included information on long-acting reversible contraceptives (LARCs). This method of family planning is known to be highly effective and other states have also expressed an interest in tallying the use of this method among its FPW Participants.
- Discussion continued about focusing program evaluation measures more directly on women in need of family planning services. It is clear that potential study populations, such as economically eligible women and automatically enrolled women, contain individuals who have decided to have children. Including women who are choosing to have children automatically lowers participation ratios because these women have no intention of using FPW services.
- One way to possibly exclude such women from being included in the denominator is to use some national estimate or state estimate of women whose pregnancy was unwanted. Florida has aggregate-level data on unwanted pregnancy from two surveys: the Pregnancy Risk Assessment Monitoring System (PRAMS) and the Healthy Start Prenatal Risk Screen.

- The Centers for Disease Control and Prevention and the Office of Population Affairs are expected to release this month a set of updated Program Guidelines for Project Grants for Family Planning Services (last issued January 2001).
- The facilitator of the monthly conference calls, Dave Murday, Clinical Associate Professor, Center for Health Services and Policy Research, Arnold School of Public Health, University of South Carolina, circulated via email nine articles about barriers to participation in Medicaid (not specifically barriers to participation in the Medicaid FPW program). The point in circulating these articles is to see whether the southeastern states can agree on a reasonable national-level benchmark that establishes the percentage of financially eligible women who enroll in Medicaid and possibly a reasonable national-level benchmark that establishes the percentage of women enrolled in Medicaid who go on to receive services. Note however that none of these articles directly examines either enrollment or participation in the Medicaid FPW Program.

Schedule of meetings (including dates, times and participants) and draft agenda, using data, to discuss DY14 Area success, trends, measures and outcomes

The Agency prepared a list of 13 county health department officials who are in charge of providing services through the Florida Medicaid FPW program. In lieu of face-to-face meetings, or telephone interviews, the Agency and UF agreed that gathering qualitative information from these service providers should focus on the different methods that county health departments use to advertise the program, enroll clients, deliver family planning services, track participation and discontinuation.

Since an online survey will be used instead of meetings, a draft agenda is not needed. UF anticipates that the online survey will be completed by the identified 13 county health departments in time for the submission of Deliverable 1.5.

Descriptive statistics of DY15 Enrollees and Participants

Starting on page 15, there is a set of descriptive statistics tables about DY15 Enrollees and Participants. The sequence of tables provides information about these DY15 women broken out in eight different ways: 1) Race/Ethnicity of FPW Enrolled Women; 2) Age of FPW Enrolled Women; 3) Ratio of Participants to Enrollees; 4) Ratio of New Participants to New Enrollees; 5)

Length of Enrollment; 6) Types of Visits; 7) Types of Contraceptives; and, 8) Counts of Sterilization. Tables 1-5 (pages 15-27) were utilized to identify Medicaid Areas and counties that performed above or below the state average during DY15.

The following definitions apply to Enrollees and Participants that appear in Tables 1, 2, 3 and 5:

1. Enrollees are women who have a Family Planning (FP) Aid Category Code in the Medicaid Eligibility file. The time period (any given day or span of days) for this Aid Category Code must fall between July 1, 2012 and June 30, 2013.
2. Participants refer to Enrollees who have at least one paid Medicaid Claim record and an FP program code (PGMCD). Participants must have a date of service within the enrollment time period (any given day or span of days) and it must fall between July 1, 2012 and June 30, 2013.

Table 4 (on page 24) reports program enrollment and participation differently from the other tables. This table uses the concept of *new* Enrollees vs. Enrollees (as defined in number 1 above) to refer to women who enrolled only during DY15, as opposed to women who enrolled in DY14 and whose enrollment may have extended into DY15. This distinction allows the evaluation to measure enrollment and rate of participation for DY15 only. The distinction facilitates trend comparisons with previous or future reporting periods. New Enrollees and their program participation are defined in the footnotes on page 24.

Tables 1 and 2 (on pages 15–20) report counts by Race/Ethnicity and Age group categories of women enrolled in the FPW during DY15 for each Medicaid Area and County. Tables 3 and 4 (on pages 21-26) report program enrollment and participation and are used to assess which Medicaid Areas and/or counties performed above or below the state average in terms of ratio of Participants to Enrollees. Table 5 (page 27) provides information about four different types of reports about FPW Participants during FY15 by age group category: Participation, Evaluation and Management Services, Contraceptives, and Sterilization.

Summarized Results from Table 1

- At 26% each, Black and Hispanics account for half of all statewide Enrollees while White Enrollees represent approximately 42% of all Enrollees.

- Of all Black Enrollees statewide, 77% are enrolled in Areas 4, 6, 7, 9, 10, and 11. In these Areas, the percent of Enrollees who are Black ranges from 24% in Area 6 to 48% in Area 10. At the county level, 64% of Black Enrollees are enrolled in Broward, Duval, Hillsborough, Miami Dade, Orange, and Palm Beach counties. In these counties, the percent of Enrollees who are Black ranges from 26% in Miami Dade to 48% in Broward County.
- White Enrollees in Area 3 account for 67% of all Enrollees in the Area and approximately 14% of all white Enrollees statewide. In Areas 3, 4, 5 and 8, more than half of the Enrollees are white. At the county level, approximately half of all White Enrollees statewide are enrolled in Brevard, Broward, Duval, Hillsborough, Lee, Orange, Palm Beach, Pasco, Pinellas, and Polk counties. In these counties, the percent of Enrollees who are White ranges from 19% in Broward County to 74% in Pasco County. Hispanics in Area 11 comprised by Miami Dade and Monroe counties account for about 36% of statewide Hispanic Enrollees. In this Area, Hispanics represent 66% of all Enrollees.

Summarized Results from Table 2

- Statewide, 60% of all Enrollees are in the 20-29 age category and 21% are in the 30-34 age category. The 14-19 age category accounts for about 3% of all statewide Enrollees. More than half of the Enrollees in each county are in the 20-29 age group category.
- Approximately 46% of Enrollees of ages 14-19 are enrolled in Broward, Duval, Hillsborough, Miami Dade, Orange, Palm Beach, Pinellas and Polk counties. In these counties, the percent of Enrollees who are ages 14-19 ranges from a low of 2% in Broward, Miami Dade, and Palm Beach counties to 4% in Hillsborough and Polk counties.
- The percent of Enrollees who are in age group category of 35-44 ranges from a low of 9% in Area 2 to a high of 22% in Area 11. At the county level, more than half of statewide Enrollees who are ages 35-44 are enrolled in Broward, Hillsborough, Miami Dade, Orange, and Palm Beach counties. In these counties, the percent of Enrollees who

are ages 35-44 ranges from a low of 15% in Orange County to 22% in Miami Dade County.

Summarized Results from Table 3

- One out of three DY15 Enrollees participated in the program.
- Area 11 had the highest number of Enrollees (20,656), followed by Area 7 (19,573), Area 6 (18,071), and Area 4 (17,038). At the county level, Miami Dade had the highest number of Enrollees (20,209), followed by Broward (11,467), Orange (10,356), Hillsborough (10,353), Palm Beach (8,953), and Duval (8,832).
- The ratio of participation by Medicaid Area in DY15 ranges from 28% in Area 10 to 44% in Area 1. At the county level, the ratio of participation ranges from 27 % in Sarasota County to 54% in Walton County.

Summarized Results from Table 4

- Approximately half of the Enrollees in DY15 (71,666, last row of Table 4, page 26) were newly enrolled in DY15 (145,438 Total Enrollees, last row of Table 3, page 23)
- Approximately 40% of Participants received their first service during DY15.
- The ratio of new Participants to new Enrollees by Medicaid Area in DY15 ranges from 24% in Area 10 to 39% in Area 1. At the county level, the ratio of new Participants ranges from 21% in Sarasota County to 49% in Walton County.

Summarized Results from Table 5

- The average length of DY15 enrollment was 9 months.
- Approximately nine percent of DY15 Enrollees received a Family Planning counseling service (12,839 women in all ages column [page 27] divided by 145,438 DY15 Enrollees (Table 3 last row, third column from left, page 23).
- 2,301 DY15 Enrollees received contraceptive services.

- 467 DY15 Enrollees received sterilization services.

Preliminary lessons learned and recommendations for program implementation, including improvements, supported by the data presented

The goal of the evaluation is to identify Areas and, within them, particular counties that were successful or not successful in providing services to women who enrolled in the Medicaid FPW program. The descriptive statistics presented in Tables 1-5 highlight differences in the magnitude of participation by Race/Ethnicity and Age group in the 11 Medicaid Areas and their constituent counties. The analysis of the survey completed by county health department officials may shed light on why certain counties and Areas were more successful in recruiting and retaining women eligible for the Medicaid FPW program.

A preliminary lesson learned is that the evaluation needs to drill down deeper to generate participation ratios broken out by Race/Ethnicity and Age. Since one of the chief objectives of the evaluation is to help increase participation of Enrollees, it will be important to identify which Medicaid Areas and counties are recruiting and retaining women belonging to different Race/Ethnicity and Age groups.

One caveat needs to be noted in reviewing the counts and percentages in the descriptive statistics tables: the Medicaid Areas and counties reference either an urban or a rural grouping. Since percentages are calculated from counts, it is important to recognize that large population differences exist between an urban and a rural grouping (Area or county). Going forward, the Agency and the UF evaluation team may want to try some form of standardizing or weighting the FPW enrollment population in each geographical unit so that comparisons between Areas and counties take into account differences in the size of the population in the regions being served.

Appendix 1. Final Approved Version of Survey Questionnaire Sent to County Health Department Officials who provide services though the Medicaid Family Planning Waiver

Dear County Health Department Official:

The Florida Agency for Health Care Administration has contracted with the University of Florida Family Data Center to evaluate the Medicaid Family Planning Waiver (FPW). Counties vary in the way they administer the FPW program. The questions below are designed to help the Agency understand the different methods that county health departments used to advertise the program, enroll clients, deliver family planning services, track participation and discontinuation during the period July 2011 – June 2012. Staff at the Family Data Center [rothj@peds.ufl.edu] are available to answer any questions about the survey. Please complete this survey by April 15, 2014. Thank you for your participation.

During the period July 2011-June 2012:

1. What kind of public transportation was available to your facility?
 - a. City Bus
 - b. County Van
 - c. Not Sure/Don't Know
 - d. None
 - e. Other (please describe) _____

2. Did you conduct outreach activities to alert women ages 14-55 in your county about the Medicaid Family Planning Waiver (FPW)?
 - a. If yes, what kind of outreach activities did you conduct?

 - b. If not, what kind of barriers did you encounter that prevented you from doing outreach?

3. How did you identify women that were eligible to be enrolled in the FPW? (Mark all that apply).
 - a. Received a list from AHCA
 - b. Received a list from DOH
 - c. Women self-presented at the health department
 - d. Other (please describe) _____

4. How did you train your staff about features and regulations governing the FPW? (Mark all that apply).
 - a. In service workshops
 - b. Online tutorials
 - c. Circulate relevant documents
 - d. Other (please describe) _____

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5. What administrative barriers did you experience in implementing the FPW? (Mark all that apply).
- a. Lack of funding for outreach activities
 - b. Lack of funding for staff positions
 - c. Lack of information about the program
 - d. Other (please describe) _____
6. Have you distributed customer satisfaction surveys to FPW Participants?
- a. If yes, how have you collected and analyzed the surveys?

 - b. If not, why did you not distribute the surveys?

Appendix 2. Codes to identify deliveries in Medicaid Claims records

ICD-9 Diagnosis Codes

Codes	Description
640.xx-648.xx ¹	Complications mainly related to pregnancy
650.xx-659.xx ¹	Normal delivery, and other indications for care in pregnancy, labor, and delivery
660.xx-669.xx ¹	Complications occurring mainly in the course of labor and delivery
670.xx-677.xx ¹	Complications of the puerperium
763.xx	Fetus or newborn affected by other complications of labor and delivery
V27.xx, except V27.1, V27.4, or V27.7 ²	Outcome of delivery
V30.xx-V39.xx	Liveborn infants according to type of birth

1 Fifth digit of 3 or 4 indicates no delivery.

2 This category is intended for coding of the outcome of delivery on the mother's record.

ICD-9 Procedure Codes

Codes	Description
72.xx-75.xx, except 75.0x	Obstetrical procedures

CPT Procedure Codes

Codes	Description
59400-59410	Vaginal delivery, antepartum, postpartum care
59510-59515	Cesarean delivery
59610	Routine obstetric care including...vaginal delivery...
59612	Vaginal delivery only, after previous cesarean delivery
59614	Vaginal delivery only...including postpartum care
59618	Routine obstetrical care including cesarean delivery...
59620	Cesarean delivery only...
59622	Cesarean delivery, including postpartum care

DRG Codes

Codes	Description
370-375	C-section or vaginal delivery

Appendix 3. Codes to identify a pregnancy in Medicaid Claims records

Any visit to an OB/GYN, family practitioner or other PCP with either an ultrasound or a principal diagnosis of pregnancy.

To meet the pregnancy criteria the member must have at least one code in Part A OR at least one code in Part B on the same date as at least one code in Part C. When using ICD-9 Diagnosis Codes from Part B, a CPT or UB code from Part C must be in the same claim.

Part A	HCPCS Codes	
	Codes	Description
	H1000-H1004	Prenatal Care
	CPT Category II Codes	
Codes	Description	
0500F	Initial Prenatal Care	
0501F	Prenatal Care Flow	
0502F	Subsequent Prenatal Care	
Part B	ICD-9 Diagnosis Codes	
	Codes	Description
	640.x3-649.x3	Complications mainly related to pregnancy
	651.x3-659.x3	Normal delivery, and other indications for care in pregnancy, labor, and delivery
	678.x3-679.x3	Complications of pregnancy, childbirth, or the puerperium
	V22-V23	Supervision of pregnancy
	V28	Antenatal screening of mother
	ICD-9 Procedure Codes	
	Codes	Description
	88.78	Diagnostic ultrasound or gravid uterus
CPT Procedure Codes		
Codes	Description	
76801	OB Ultrasound	
76805	OB Ultrasound	
76811	High risk OB ultrasound	
76813	High risk OB ultrasound	
76815-76818	Transvaginal OB ultrasound	
Part C	CPT Procedure Codes	
	Codes	Description
	99201-99205	New patient visit
	99211-99215	Evaluation and management
	99241-99245	Office consults
	UB Revenue Codes	
	Codes	Description
0514	OB/GYN clinic	

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Table 1: Indicator A. Race/Ethnicity of FPW Enrolled Women, DY15*

Medicaid Area	County	Black	White	Asian	Hispanic	American or Asian Indian & Other	Total
Area 1	Escambia	800	1,438	80	79	79	2,476
	Okaloosa	289	1,291	41	97	53	1,771
	Santa Rosa	60	965	28	25	18	1,096
	Walton	30	405	3	19	4	461
	Total	1,179	4,099	152	220	154	5,804
Area 2	Bay	296	1,477	40	69	42	1,924
	Calhoun	18	122	1	3	3	147
	Franklin	9	100		1	3	113
	Gadsden	240	71	2	32	4	349
	Gulf	16	110		2	3	131
	Holmes	4	213		3	2	222
	Jackson	149	315	2	4	6	476
	Jefferson	45	43		3	2	93
	Leon	1,023	574	21	59	43	1,720
	Liberty	2	60		1		63
	Madison	144	114		3	2	263
	Taylor	55	175	5	2	1	238
	Wakulla	19	167	1	1	3	191
	Washington	37	188	2	4	5	236
Total	2,057	3,729	74	187	119	6,166	
Area 3	Alachua	706	762	38	95	63	1,664
	Bradford	40	197		3	6	246
	Citrus	47	939	4	65	18	1,073
	Columbia	127	475	1	19	19	641
	Dixie	10	133			2	145
	Gilchrist	10	139		4	4	157
	Hamilton	39	78	1	9	1	128
	Hernando	96	996	14	148	45	1,299
	Lafayette	6	48		3		57
	Lake	340	1,276	27	362	102	2,107
	Levy	36	277		18	6	337

* Enrollees are women who have a Family Planning (FP) Aid Category Code in the Medicaid Eligibility file. The time period (any given day or span of days) for this Aid Category code must fall between July 1, 2012 and June 30, 2013.

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Medicaid Area	County	Black	White	Asian	Hispanic	American or Asian Indian & Other	Total
	Marion	560	1,725	29	355	72	2,741
	Putnam	200	522	4	90	14	830
	Sumter	65	242	2	36	8	353
	Suwannee	72	317	2	23	11	425
	Union	17	116		5	2	140
	Total	2,371	8,242	122	1,235	373	12,343
Area 4	Baker	29	216	1	1	3	250
	Clay	213	979	20	98	75	1,385
	Duval	4,114	3,424	308	630	356	8,832
	Flagler	114	498	11	70	45	738
	Nassau	38	498	3	14	16	569
	St Johns	128	778	10	47	34	997
	Volusia	795	2,714	67	579	104	4,259
	Total	5,431	9,107	420	1,439	633	17,030
Area 5	Pasco	210	2,508	49	467	141	3,375
	Pinellas	1,231	3,409	172	588	287	5,687
	Total	1,441	5,917	221	1,055	428	9,062
Area 6	Hardee	14	107	3	136	5	265
	Highlands	128	396	6	176	29	735
	Hillsborough	2,759	3,756	217	3,095	526	10,353
	Manatee	390	1,092	28	492	65	2,067
	Polk	990	2,520	53	948	140	4,651
	Total	4,281	7,871	307	4,847	765	18,071
Area 7	Brevard	600	2,374	64	334	154	3,526
	Orange	3,471	2,760	274	3,456	395	10,356
	Osceola	370	852	46	1,794	115	3,177
	Seminole	534	1,236	52	599	93	2,514
	Total	4,975	7,222	436	6,183	757	19,573
Area 8	Charlotte	77	731	15	57	18	898
	Collier	298	704	33	814	62	1,911
	Desoto	36	152	1	95	14	298
	Glades	3	24		14	2	43
	Hendry	50	116	1	242	11	420
	Lee	755	2,208	64	1,257	149	4,433
	Sarasota	256	1,515	37	276	85	2,169
	Total	1,475	5,450	151	2,755	341	10,172
Area 9	Indian River	217	561	17	167	19	981

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Medicaid Area	County	Black	White	Asian	Hispanic	American or Asian Indian & Other	Total
	Martin	86	385	8	156	27	662
	Okeechobee	29	268	3	105	9	414
	Palm Beach	3,678	2,547	211	2,257	260	8,953
	St Lucie	746	1,058	35	445	62	2,346
	Total	4,756	4,819	274	3,130	377	13,356
Area 10	Broward	5,540	2,220	237	2,915	555	11,467
	Total	5,540	2,220	237	2,915	555	11,467
Area 11	Miami Dade	5,167	999	121	13,582	340	20,209
	Monroe	52	227	9	141	18	447
	Total	5,219	1,226	130	13,723	358	20,656
Unknown*	Unknown [†]	284	1,018	30	334	72	1,738
	Total	284	1,018	30	334	72	1,738
Statewide		39,009	60,920	2,554	38,023	4,932	145,438

* The unknown Medicaid Area groups records for which the County is unknown

† An unknown County means that County of Residence information was not available in the recipient's Medicaid Eligibility records from which FPW enrollment was derived

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Table 2: Indicator B. Age of FPW Enrolled Women, DY15*

Medicaid Area	County	14 - 19 yrs.	20 - 29 yrs.	30 - 34 yrs.	35 - 44 yrs.	45 - 55 yrs.	Other Age Groups [†]	Grand Total
Area 1	Escambia	83	1,682	459	232	10	10	2,476
	Okaloosa	84	1,136	331	191	12	17	1,771
	Santa Rosa	57	692	210	124	5	8	1,096
	Walton	24	299	82	55		1	461
	Total	248	3,809	1,082	602	27	36	5,804
Area 2	Bay	89	1,308	335	173	5	14	1,924
	Calhoun	9	96	21	20	1		147
	Franklin	6	79	17	9		2	113
	Gadsden	15	215	86	28	4	1	349
	Gulf	6	83	27	15			131
	Holmes	15	148	41	16	1	1	222
	Jackson	18	335	77	42	2	2	476
	Jefferson	3	62	18	10			93
	Leon	47	1,132	354	167	14	6	1,720
	Liberty	5	43	10	5			63
	Madison	13	184	48	17	1		263
	Taylor	17	166	31	22	2		238
	Wakulla	9	120	39	23			191
	Washington	13	171	35	17			236
Total	265	4,142	1,139	564	30	26	6,166	
Area 3	Alachua	40	1,103	323	190	7	1	1,664
	Bradford	12	159	47	27		1	246
	Citrus	53	715	186	109	8	2	1,073
	Columbia	33	428	118	61	1		641
	Dixie	2	102	32	7	2		145
	Gilchrist	5	113	25	12	1	1	157
	Hamilton	6	83	27	11	1		128
	Hernando	53	842	230	166	8		1,299
	Lafayette	4	41	9	3			57
	Lake	90	1,334	393	273	15	2	2,107

* Enrollees are women who have a Family Planning (FP) Aid Category Code in the Medicaid Eligibility file. The time period (any given day or span of days) for this Aid Category code must fall between July 1, 2012 and June 30, 2013.

[†] Other Age Groups refers to women who were younger than 14 or older than 55 on June 30, 2013 or on the last day of enrollment if it was before June 30, 2013

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Medicaid Area	County	14 - 19 yrs.	20 - 29 yrs.	30 - 34 yrs.	35 - 44 yrs.	45 - 55 yrs.	Other Age Groups [†]	Grand Total
	Levy	17	218	63	35	4		337
	Marion	114	1,755	542	306	21	3	2,741
	Putnam	42	555	135	94	2	2	830
	Sumter	17	235	59	39	2	1	353
	Suwannee	23	298	54	46	1	3	425
	Union	8	97	25	10			140
	Total		519	8,078	2,268	1,389	73	16
Area 4	Baker	15	177	36	21		1	250
	Clay	61	881	271	167	3	2	1,385
	Duval	301	5,695	1,735	1,033	56	12	8,832
	Flagler	20	419	172	120	5	2	738
	Nassau	19	401	96	51	2		569
	St Johns	29	598	238	120	9	3	997
	Volusia	145	2,757	824	498	30	5	4,259
	Total		590	10,928	3,372	2,010	105	25
Area 5	Pasco	126	2,104	685	429	24	7	3,375
	Pinellas	196	3,480	1,198	757	29	27	5,687
	Total	322	5,584	1,883	1,186	53	34	9,062
Area 6	Hardee	19	196	26	23	1		265
	Highlands	28	476	134	92	5		735
	Hillsborough	364	6,387	2,068	1,422	86	26	10,353
	Manatee	102	1,276	393	274	14	8	2,067
	Polk	204	3,031	845	544	24	3	4,651
	Total	717	11,366	3,466	2,355	130	37	18,071
Area 7	Brevard	97	2,169	770	463	20	7	3,526
	Orange	304	6,189	2,177	1,601	69	16	10,356
	Osceola	114	1,921	622	489	25	6	3,177
	Seminole	68	1,478	571	380	10	7	2,514
	Total	583	11,757	4,140	2,933	124	36	19,573
Area 8	Charlotte	34	579	170	109	5	1	898
	Collier	67	1,075	401	349	18	1	1,911
	Desoto	20	189	63	24	2		298
	Glades	2	25	10	5	1		43
	Hendry	24	264	75	50	7		420
	Lee	130	2,639	936	686	39	3	4,433
	Sarasota	82	1,231	490	341	20	5	2,169
	Total	359	6,002	2,145	1,564	92	10	10,172

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Medicaid Area	County	14 - 19 yrs.	20 - 29 yrs.	30 - 34 yrs.	35 - 44 yrs.	45 - 55 yrs.	Other Age Groups [†]	Grand Total
Area 9	Indian River	47	599	184	142	7	2	981
	Martin	27	448	99	82	5	1	662
	Okeechobee	13	281	75	41	4		414
	Palm Beach	208	4,969	2,043	1,633	89	11	8,953
	St Lucie	75	1,338	513	396	21	3	2,346
	Total		370	7,635	2,914	2,294	126	17
Area 10	Broward	226	6,010	2,835	2,279	103	14	11,467
	Total	226	6,010	2,835	2,279	103	14	11,467
Area 11	Miami Dade	328	10,646	4,632	4,372	211	20	20,209
	Monroe	9	248	97	85	6	2	447
	Total	337	10,894	4,729	4,457	217	22	20,656
Unknown [*]	Unknown [†]	50	1,198	331	151	3	5	1,738
	Total	50	1,198	331	151	3	5	1,738
Statewide		4,586	87,403	30,304	21,784	1,083	278	145,438

* The unknown Medicaid Area groups records for which the County is unknown

† An unknown County means that County of Residence information was not available in the recipient's Medicaid Eligibility records from which FPW enrollment was derived

Table 3: Indicator C.1. Ratio of Participants* to Enrollees†, DY15

Medicaid Area	County	Total Women enrolled in the FPW	Total Women participating in the FPW	Participation ratio
Area 1	Escambia	2,476	1,001	40.4%
	Okaloosa	1,771	827	46.7%
	Santa Rosa	1,096	459	41.9%
	Walton	461	251	54.4%
	Total	5,804	2,538	43.7%
Area 2	Bay	1,924	648	33.7%
	Calhoun	147	57	38.8%
	Franklin	113	50	44.2%
	Gadsden	349	154	44.1%
	Gulf	131	57	43.5%
	Holmes	222	96	43.2%
	Jackson	476	206	43.3%
	Jefferson	93	40	43.0%
	Leon	1,720	611	35.5%
	Liberty	63	32	50.8%
	Madison	263	122	46.4%
	Taylor	238	100	42.0%
	Wakulla	191	78	40.8%
	Washington	236	97	41.1%
Total	6,166	2,348	38.1%	
Area 3	Alachua	1,664	548	32.9%
	Bradford	246	104	42.3%
	Citrus	1,073	408	38.0%
	Columbia	641	252	39.3%
	Dixie	145	54	37.2%
	Gilchrist	157	58	36.9%
	Hamilton	128	60	46.9%
	Hernando	1,299	468	36.0%

* DY15 Participants are women enrolled in the FPW program who have at least one paid Medicaid Claim record with a program code (PGMCD) of FP and a date of service during enrollment†

† DY15 Enrollees are women who have a Family Planning (FP) Aid Category Code in the Medicaid Eligibility whose eligibility as determined by Aid Category Code Effective and End dates include any day between July 1, 2012 and June 30, 2013

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Medicaid Area	County	Total Women enrolled in the FPW	Total Women participating in the FPW	Participation ratio
	Lafayette	57	23	40.4%
	Lake	2,107	660	31.3%
	Levy	337	138	40.9%
	Marion	2,741	993	36.2%
	Putnam	830	382	46.0%
	Sumter	353	162	45.9%
	Suwannee	425	190	44.7%
	Union	140	54	38.6%
	Total	12,343	4,554	36.9%
Area 4	Baker	250	79	31.6%
	Clay	1,385	409	29.5%
	Duval	8,832	2,991	33.9%
	Flagler	738	266	36.0%
	Nassau	569	189	33.2%
	St Johns	997	350	35.1%
	Volusia	4,259	1,527	35.9%
	Total	17,030	5,811	34.1%
Area 5	Pasco	3,375	1,153	34.2%
	Pinellas	5,687	1,846	32.5%
	Total	9,062	2,999	33.1%
Area 6	Hardee	265	112	42.3%
	Highlands	735	311	42.3%
	Hillsborough	10,353	3,226	31.2%
	Manatee	2,067	719	34.8%
	Polk	4,651	1,563	33.6%
	Total	18,071	5,931	32.8%
Area 7	Brevard	3,526	1,165	33.0%
	Orange	10,356	3,110	30.0%
	Osceola	3,177	981	30.9%
	Seminole	2,514	834	33.2%
	Total	19,573	6,090	31.1%
Area 8	Charlotte	898	333	37.1%
	Collier	1,911	580	30.4%
	Desoto	298	113	37.9%
	Glades	43	15	34.9%
	Hendry	420	149	35.5%
	Lee	4,433	1,575	35.5%

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Medicaid Area	County	Total Women enrolled in the FPW	Total Women participating in the FPW	Participation ratio
	Sarasota	2,169	582	26.8%
	Total	10,172	3,347	32.9%
Area 9	Indian River	981	326	33.2%
	Martin	662	247	37.3%
	Okeechobee	414	183	44.2%
	Palm Beach	8,953	2,978	33.3%
	St Lucie	2,346	837	35.7%
	Total	13,356	4,571	34.2%
Area 10	Broward	11,467	3,226	28.1%
	Total	11,467	3,226	28.1%
Area 11	Miami Dade	20,209	6,006	29.7%
	Monroe	447	151	33.8%
	Total	20,656	6,157	29.8%
Unknown*	Unknown [†]	1,738	191	11.0%
	Total	1,738	191	11.0%
Grand Total		145,438	47,763	32.8%

* The unknown Medicaid Area groups records for which the County is unknown

† An unknown County means that County of Residence information was not available in the recipient's Medicaid Eligibility records from which FPW enrollment was derived

Table 4: Indicator C.2. Ratio of New Participants* to New Enrollees†, DY15

Medicaid Area	County	Total Women newly enrolled in the FPW	Total new Participants in DY15	Participation ratio
Area 1	Escambia	1,248	449	36.0%
	Okaloosa	903	365	40.4%
	Santa Rosa	549	206	37.5%
	Walton	231	113	48.9%
	Total	2,931	1,133	38.7%
Area 2	Bay	1,015	300	29.6%
	Calhoun	69	21	30.4%
	Franklin	59	18	30.5%
	Gadsden	158	55	34.8%
	Gulf	66	22	33.3%
	Holmes	117	37	31.6%
	Jackson	242	103	42.6%
	Jefferson	53	16	30.2%
	Leon	862	248	28.8%
	Liberty	32	11	34.4%
	Madison	149	62	41.6%
	Taylor	119	40	33.6%
	Wakulla	101	31	30.7%
	Washington	120	47	39.2%
Total	3,162	1,011	32.0%	
Area 3	Alachua	894	262	29.3%
	Bradford	124	43	34.7%
	Citrus	526	171	32.5%
	Columbia	340	114	33.5%
	Dixie	81	31	38.3%
	Gilchrist	77	25	32.5%
	Hamilton	61	28	45.9%
	Hernando	661	214	32.4%
	Lafayette	22	7	31.8%

* DY15 New Participants are women that are newly enrolled in DY15 who have at least one paid Medicaid Claim record with a program code (PGMCD) of FP and a date of service between July 1, 2012 and June 30, 2013

† DY15 New Enrollees are women who have a Family Planning (FP) Aid Category Code in the Medicaid Eligibility records with Aid Category Effective Date between July 1, 2012 and June 30, 2013

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Medicaid Area	County	Total Women newly enrolled in the FPW	Total new Participants in DY15	Participation ratio
	Lake	1,075	286	26.6%
	Levy	164	53	32.3%
	Marion	1,337	413	30.9%
	Putnam	415	163	39.3%
	Sumter	159	55	34.6%
	Suwannee	224	85	37.9%
	Union	72	27	37.5%
	Total	6,232	1,977	31.7%
Area 4	Baker	115	30	26.1%
	Clay	725	170	23.4%
	Duval	4,549	1,320	29.0%
	Flagler	366	107	29.2%
	Nassau	281	78	27.8%
	St Johns	562	174	31.0%
	Volusia	2,240	688	30.7%
	Total	8,838	2,567	29.0%
Area 5	Pasco	1,665	506	30.4%
	Pinellas	2,814	739	26.3%
	Total	4,479	1,245	27.8%
Area 6	Hardee	118	37	31.4%
	Highlands	317	118	37.2%
	Hillsborough	4,892	1,306	26.7%
	Manatee	993	289	29.1%
	Polk	2,131	591	27.7%
	Total	8,451	2,341	27.7%
Area 7	Brevard	1,621	442	27.3%
	Orange	4,822	1,195	24.8%
	Osceola	1,576	408	25.9%
	Seminole	1,256	371	29.5%
	Total	9,275	2,416	26.0%
Area 8	Charlotte	455	156	34.3%
	Collier	909	233	25.6%
	Desoto	135	37	27.4%
	Glades	24	8	33.3%
	Hendry	213	56	26.3%
	Lee	2,224	669	30.1%
	Sarasota	1,099	235	21.4%

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Medicaid Area	County	Total Women newly enrolled in the FPW	Total new Participants in DY15	Participation ratio
	Total	5,059	1,394	27.6%
Area 9	Indian River	427	129	30.2%
	Martin	275	79	28.7%
	Okeechobee	177	73	41.2%
	Palm Beach	4,325	1,194	27.6%
	St Lucie	1,048	319	30.4%
	Total	6,252	1,794	28.7%
Area 10	Broward	5,996	1,419	23.7%
	Total	5,996	1,419	23.7%
Area 11	Miami Dade	9,909	2,432	24.5%
	Monroe	214	67	31.3%
	Total	10,123	2,499	24.7%
Unknown*	Unknown [†]	868	56	6.5%
	Total	868	56	6.5%
Grand Total		71,666	19,852	27.7%

* The unknown Medicaid Area groups records for which the County is unknown

† An unknown County means that County of Residence information was not available in the recipient's Medicaid Eligibility records from which FPW enrollment was derived

Table 5: Indicators D-G--Participation^{*}, Evaluation and Management Services, Contraceptives, Sterilization, DY15

Report Type	Measure	14 - 19 yrs.	20 - 29 yrs.	30 - 34 yrs.	35 - 44 yrs.	45 - 55 yrs.	Other Age Groups [†]	All ages
Participation	total # of women enrolled in the FPW [‡]	4,586	87,403	30,304	21,784	1,083	278	145,438
	total months of enrollment	38,712	830,134	289,674	209,336	10,653	2,446	1,380,955
	average period of enrollment (months)	8	9	10	10	10	9	9
	portion of the waiver that women remain enrolled [§]	36.7%	41.3%	41.6%	41.8%	42.8%	38.3%	41.3%
Evaluation and Management Services	total natural FP visits	1	48	33	10	4		96
	total FP services for treatment of STIs	647	7,902	1,625	1,075	53		11,302
	total # of women enrolled for 90+ days	4,020	80,298	27,963	20,092	1,022	245	133,640
	total # receiving at least one FP Counseling service	443	8,301	2,453	1,565	76	1	12,839
	participation ratio	11.0%	10.3%	8.8%	7.8%	7.4%	0.4%	9.6%
Contraceptives	total # of women receiving services	119	1,623	367	181	11		2,301
	total # of services	348	4,806	1,035	504	48		6,741
	J1055 - Depo-Provera	44	508	106	63	4		725
	J7300 - Paraguard	20	396	105	58	6		585
	J7302 - Mirena	32	554	143	53	2		784
	J7307 - Implanon	24	209	22	11			266
Sterilization	total # of services		203	158	105	1		467

* Participants refers to Enrollees who have at least one paid Medicaid Claim record and a program code (PGMCD). Participants must have a date of service with the time period (any given day or span of days) and it must fall between July 1, 2012 and June 30, 2013.

† Other Age Groups refers to women who were younger than 14 or older than 55 on June 30, 2013 or on the last day of enrollment if it was before June 30, 2013.

‡ Enrollees are women who have a Family Planning (FP) Aid Category Code in the Medicaid Eligibility file. The time period (any given day or span of days) for this Aid Category Code must fall between July 1, 2012 and June 30, 2013.

§ Portion of the waiver that women remain enrolled refers to the number of months that an average DY15 enrollee is enrolled out of the number of months elapsed since the waiver period began (July 1, 2011) and the end of DY15 (June 30, 2013).

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