

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



May 25, 2022

Tom Wallace
Deputy Secretary for Medicaid
Florida Agency for Health Care Administration
2721 Mahan Drive, Mail Stop 8
Tallahassee, FL 32308

Dear Mr. Wallace:

The Centers for Medicare & Medicaid Services (CMS) is approving Florida's request to amend its section 1115 demonstration project entitled, "Florida Medicaid Family Planning Waiver" (Project Number 11-W-00135/4), in accordance with section 1115(a) of the Social Security Act. Approval of this demonstration amendment will enable the state to maintain health coverage for postpartum individuals by aligning the eligibility start date for the family planning coverage provided under the demonstration with the extended 12-month postpartum coverage period approved under the Florida Managed Medical Assistance (MMA) section 1115 demonstration (Project Number 11-W-00206/4). In addition, this amendment will enable the state to remove the language that requires the state to disenroll women who receive a sterilization procedure.

Historically, individuals would maintain their Medicaid State Plan eligibility for 60-days postpartum and then, if they were not otherwise eligible for Medicaid, Children's Health Insurance Program, or health insurance coverage that provides family planning services, transition into the Family Planning program. Consistent with the American Rescue Plan Act of 2021 (ARP), Florida sought approval under the Managed Medical Assistance (MMA) section 1115 demonstration to extend the postpartum period for an additional 10-months, to provide 12-months of continuous postpartum coverage to postpartum individuals enrolled in Medicaid and CHIP. CMS approved the extended postpartum coverage on May 25, 2022 and, concurrent with this approval, we are approving this amendment to the Florida Medicaid Family Planning Waiver, in order to align the start of family planning coverage with the end date of the extended postpartum coverage period. Accordingly, CMS approves this amendment that will revise the eligibility start date for the Florida Medicaid Family Planning Waiver from 60-days postpartum to 12-months postpartum. This approval is effective May 25, 2022 through June 30, 2023, upon which date, unless extended or otherwise amended, all authorities granted to operate this demonstration will expire.

Consistent with CMS requirements for section 1115 demonstrations, and as outlined in the Special Terms and Conditions (STCs), the state will continue conducting systematic monitoring and a thorough evaluation of this section 1115 demonstration, and will accommodate this

amendment into the demonstration’s monitoring and evaluation deliverables, as applicable. The state’s demonstration monitoring and evaluation efforts shall accommodate—to the extent feasible—data collection and analyses stratified by key subpopulations of interest to support understanding of any existing disparities in access, utilization, and health outcomes, and how the demonstration, including this amendment, might support bridging any such inequities.

CMS’s approval of this section 1115(a) demonstration is subject to the limitations specified in the attached waiver and expenditure authorities, STCs, and any supplemental attachments defining the nature, character, and extent of federal involvement in this project. The state may deviate from Medicaid state plan requirements only to the extent those requirements have been specifically listed as waived or not applicable under the demonstration.

Consideration of Public Comments

Florida provided public notice for this amendment in accordance with the processes described in the September 27, 1994 Federal Register notice (59 FR 49249) as generally acceptable methods of state public notice for demonstration amendments. CMS generally considers a state to have provided acceptable public notice if the state uses a commission or other similar process, where meetings are open to members of the public, in the development of the proposal. Accordingly, Florida presented an overview of the amendment proposal at its statewide webinar and in-person meeting on August 9, 2021 to solicit stakeholder input. Additionally, the state provided a public comment period from July 26, 2021 through August 24, 2021 to solicit input on the proposed amendment request.

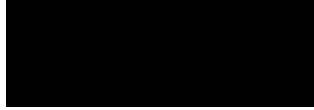
Consistent with the CMS April 27, 2012 State Medicaid Director/State Health Official Letter on the “Revised Review and Approval Process for Section 1115 Demonstrations” (SHO# 12-001), a federal public comment period was opened from September 20, 2021 through October 19, 2021. CMS received 31 comments regarding the application during the federal comment period. Every comment received expressed support for the state’s proposal. The commenters supported the proposal because extending Medicaid coverage to new mothers beyond the 60-day postpartum period is expected to reduce mortality and morbidity for lower income women. Commenters also expressed support because the additional coverage for mothers is expected to have a positive impact on both mother and child.

The award is subject to CMS receiving written acceptance of this award within 30 days of the date of this approval letter. Your project officer is Lieutenant Jack Nocito. LT Nocito is available to answer any questions concerning implementation of the state’s section 1115(a) demonstration and his contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-25-26
7500 Security Boulevard
Baltimore, MD 21244-1850
Email: Jack.Nocito@cms.hhs.gov

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

Sincerely,



Deputy Administrator and Director

Enclosure

cc: Tandra Hodges, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

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

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

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

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

TITLE XIX EXPENDITURE AUTHORITY:

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

Medicaid Requirements Not Applicable to the Medicaid Expenditure Authorities:

All Medicaid requirements apply, except the following:

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

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

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

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

3. Prospective Payment for Federally Qualified Health Centers and Rural Health Centers and Rural Health Clinics **Section 1902(a)(15)**

To the extent necessary for the state to establish reimbursement levels to these clinics that will compensate them solely for family planning and family planning related services.

4. Retroactive Coverage **Section 1902(a)(34)**

To the extent necessary to enable the state to not provide medical assistance to the demonstration population for any time prior to when an application for the demonstration is made.

5. Early and Periodic Screening, Diagnostic, and Treatment **Section 1902(a)(43)(A)**
(EPSDT)

To the extent necessary to enable the state to not furnish or arrange for EPSDT services to the demonstration population.

Centers for Medicare & Medicaid Services

SPECIAL TERMS AND CONDITIONS

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

I. PREFACE

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

The STCs have been arranged into the following subject areas:

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

II. PROGRAM DESCRIPTION AND HISTORICAL CONTEXT

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

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

Historical Context and Objectives

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

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

On September 20, 2021, Florida submitted an amendment to adjust the eligibility start date for postpartum women under the Family Planning Waiver from after 60-days postpartum to after the end of the state-authorized postpartum coverage period to align with Florida's May 25, 2022 approval under the Managed Medical Assistance (MMA) Section 1115 demonstration to extend the postpartum period to 12 months following the last day of pregnancy.

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

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

III. GENERAL PROGRAM REQUIREMENTS

- 1. Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.
- 2. Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid programs expressed in law, regulation, and policy statement not expressly waived or identified as not applicable in the expenditure authority document (which is a part of these terms and conditions), must apply to the demonstration.
- 3. Changes in Medicaid Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, court order, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid programs that occur during this demonstration approval period, unless the provision being changed is explicitly waived or identified as not applicable.
- 4. Impact on Demonstration of Changes in Federal Law, Regulation, and Policy Statements.**
 - a) To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change.
 - b) If mandated changes in the federal law require state legislation, the changes must take effect on the day, such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.
- 5. Changes Subject to the Amendment Process.** Changes related to demonstration features such as eligibility, enrollment, benefits, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Social Security Act (the Act). The state must not implement changes to these demonstration elements without prior approval by CMS. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 6 below.
- 6. Amendment Process.** Requests to amend the demonstration must be submitted to CMS in writing for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required reports and other deliverables in a timely fashion according to the deadlines specified therein. Amendment requests must include, but are not limited to, the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

IV. ELIGIBILITY AND ENROLLMENT

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

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

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

18. Streamlined Application and Eligibility Determination Process. Within three years from

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

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

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

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

19. Demonstration Disenrollment. If an individual becomes pregnant while enrolled in the demonstration, they may be determined eligible for Medicaid under the State Plan. The state must not submit claims under the demonstration for any individual who is found to be eligible under the Medicaid State Plan.

V. BENEFITS AND DELIVERY SYSTEMS

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

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

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

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

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

treatment/drugs and subsequent follow-up visits to rescreen for STIs/STDs based on the Centers for Disease Control and Prevention guidelines may be covered.

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

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

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

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

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

VI. GENERAL REPORTING REQUIREMENTS

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

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

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

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

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

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

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

The state must submit Quarterly Monitoring Reports through CMS's designated system using the framework incorporated in these STCs as "Appendix A", which is subject to change as monitoring systems are developed and/or evolve, and will be provided in a structured manner that supports federal tracking and analysis. The intent of the Quarterly Monitoring Reports is to present the state's data along with an analysis of the status of key operational areas under the demonstration. The monitoring reports will include all required elements as per 42 CFR 431.428, and should not direct readers to links outside the monitoring report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. In addition to the data elements outlined in Appendix A, quarterly monitoring reports must include, but are not limited to, all of elements outlined below:

- a) A summary of current notable program activity during the first two quarters of the demonstration year. This includes highlights of the state's progress with implementation of STC 18 with supporting documentation and key operational

milestones anticipated to occur in the near future. Notable program activity includes, but is not limited to, program operations such as provider participation and education, health care delivery, benefits, eligibility, enrollment, beneficiary complaints, quality of care, access, state share of financing and pertinent legislative activity;

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

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

31. Annual Monitoring Report. No later than 90 days following the end of each demonstration year, the state must submit an Annual Monitoring Report that represents the status of the demonstration's various operational areas and any state analysis of program data collected for the demonstration year. As specified in STC 29, the state may combine its fourth quarter monitoring update with the annual progress summary for each demonstration year. The Annual Monitoring Report will include all elements required by 42 CFR §431.428 and

should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a reference/bibliography section. The state must submit the Annual Monitoring Report through CMS's designated system using the framework incorporated in these STCs as "Appendix A", which is subject to change as monitoring systems are developed and/or evolve, and will be provided in a structured manner that supports federal tracking and analysis. Each Annual Monitoring Report must minimally include the following:

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

progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

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

VII. GENERAL FINANCIAL REQUIREMENTS

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

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

project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made (e.g., For reporting expenditures with dates of services made in demonstration year 21 (7/1/2018 – 6/30/2019), the state would use "21" as the project number extension).

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

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

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

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

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

39. Standard Medicaid Funding Process. The standard Medicaid funding process must be used during the demonstration. The state must estimate matchable demonstration

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

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

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

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

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

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

and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

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

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

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

VIII. MONITORING BUDGET NEUTRALITY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

IX. EVALUATION

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

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

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

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

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

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

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

- a) The state shall submit a revised Summative Evaluation Report within 60 days of receiving comments from CMS on the draft.
- b) The final Summative Evaluation Report must be posted to the state's Medicaid website within 30 days of approval by CMS.

55. State Presentations for CMS. CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the state's Interim Evaluation Report, and/or the Summative Evaluation Report. Presentations may be conducted remotely.

56. Public Access. The state shall post the final documents (e.g., Quarterly and Annual Monitoring Reports, Approved Evaluation Design, Interim Evaluation Report, Summative Evaluation Report, and Close-Out Report) on the state's Medicaid website within 30 days of approval by CMS.

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

X. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION

Deliverable	Timeline	STC Reference
Section 1943 Compliance Timeline with Milestones	Within 90 days after the approval of the demonstration extension	STC 18
Quarterly Monitoring Report	Within 60 days following the end of the quarter.	STC 29
Annual Monitoring Report	Within 90 days following the end of each demonstration year	STC 31
Draft Evaluation Design	Within 120 days after the approval of the demonstration extension	STC 48

Revised Evaluation Design Plan	Within 60 days following receipt of CMS comments on Draft Evaluation Design	STC 50
Draft Summative Evaluation Report	Within 18 months following the end of this demonstration extension period	STC 54
Revised Summative Evaluation Report	Within 60 days following receipt of CMS comments on the draft Summative Evaluation Report	STC 54
Draft Interim Evaluation Report	Due when application for extension is submitted or one year prior to the expiration of the demonstration.	STC 52
Revised Interim Evaluation Report	Within 60 days following receipt of CMS comments on the draft Interim Evaluation Report	STC 52

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

Purpose and Scope of Quarterly and Annual Reports:

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

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

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

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

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

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

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

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

2. Program Updates

a. Current Trends and Significant Program Activity

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

3. Policy Issues and Challenges

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

B. Participation Monitoring

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

C. Utilization Monitoring

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

Table 1. Utilization Monitoring Measures

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

Table 2: Unduplicated Number of Enrollees by Quarter

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

Quarter 1					
Quarter 2					
Quarter 3					
Quarter 4					

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

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

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

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

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

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

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

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

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

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

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

Table 7: Breast Cancer Screening

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

Table 8: Post-Partum Contraceptive Care

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

D. Program Outreach and Education

1. General Outreach and Awareness

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

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

E. Program Integrity

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

F. Grievances and Appeals

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

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

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

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

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

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

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

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

I. Annual Post Award Public Forum

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

J. Budget Neutrality

1. Please complete the budget neutrality workbook.

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

K. Demonstration Evaluation Activities and Interim Findings

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

APPENDIX B: Evaluation Design Framework

A. Demonstration Objectives/Goals

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

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

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

B. Evaluation Questions and Hypotheses

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

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

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

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

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

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

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

D. Methodology

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

The required budget will consist of the following line items:

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

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

Florida's Family Planning Waiver (FPW) Program Evaluation Design

Presented to:

Centers for Medicare and Medicaid Services

Prepared by:

Florida Agency for Health Care Administration

and

Department of Behavioral Sciences and Social Medicine

College of Medicine

Florida State University

June 15, 2020

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A. General Background Information

1. Issues Addressed by This Demonstration

Under the FPW demonstration, Florida seeks to continue building upon the following objectives that have been fundamental to Florida's Medicaid improvement efforts over the past 21 years:

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

Based on recent guidance from the Centers for Medicare and Medicaid Services (CMS) and Florida's continued efforts to improve its Medicaid program, the following objective will also be explored:

- Improve or maintain health outcomes for the target population as a result of access to family planning services and/or family planning-related services;

Florida's motivation for improving its Medicaid program stems from two factors: (1) the nationwide concerns about ensuring continued access to high quality care for its Medicaid enrollees while (2) simultaneously addressing the rapid increases in Medicaid costs that have propelled the Medicaid program to the very top of states' budget priorities nationwide.

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

- FDA-approved methods of contraception;
- Sexually transmitted infection (STI)/sexually transmitted disease (STD) testing, Pap smears and pelvic exams. Note: The laboratory tests done during an initial family planning visit for contraception include a Pap smear, screening tests for STIs/STDs, blood count and pregnancy test. Additional screening tests may be performed depending on the method of contraception desired and the protocol established by the clinic, program or provider. Additional laboratory tests may be needed to address a family planning problem or need during an inter-periodic family planning visit for contraception;
- 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
- Contraceptive management, patient education, and counseling.

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

related services and supplies that would be provided under this demonstration include:

- 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.
- Drugs for the treatment of STIs/STDs, except for HIV/AIDS and hepatitis, regardless of the purpose of the visit, consistent with CMS guidance issued April 14, 2014, SMDL#14-03/ACA# 31. This includes behavioral counseling and a follow-up visit/encounter for the treatment/drugs and subsequent follow-up visits to rescreen for STIs/STDs based on the Centers for Disease Control and Prevention guidelines may be covered.
- 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.
- 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.
- Treatment of major complications arising from a family planning procedure.

A complete listing of all reimbursable service codes for the FPW is available at:

http://ahca.myflorida.com/Medicaid/Family_Planning/reim_services.shtml.

2. Name of the Demonstration, Approval Date, and Time Period

Family Planning Waiver 1115 Waiver Demonstration Extension, Approved March 8, 2019 through June 30, 2023.

3. Description of the Demonstration and History of the Implementation

The Centers for Medicare and Medicaid Services (Federal CMS) initially approved Florida's 1115 Family Planning demonstration, "Florida Medicaid Family Planning Waiver", for a 5-year period on August 23, 1998 and the program was implemented October 1, 1998.

The demonstration was originally implemented to provide a limited Medicaid benefit package of family planning and family planning-related services to an expansion population of women of childbearing age losing Medicaid pregnancy coverage or full Medicaid coverage, that had family income at or below 185 percent of the Federal Poverty Level (FPL), and who were not otherwise eligible for Medicaid or CHIP, or enrolled in other health insurance coverage that provided family planning services. With the implementation of the Affordable Care Act's requirement to transition to the use of Modified Adjusted Gross Income (MAGI) for determining Medicaid income eligibility, the state's comparable income limit increased to 191 percent of the FPL effective January 1, 2014. The state has not had any other program changes.

On September 27, 2017, Florida submitted a request to extend the demonstration for a five-year period with no program changes. On March 8, 2019, Federal CMS approved the State's request for an extension to the FPW 1115 waiver demonstration, along with newly amended STCs and waiver and expenditure authorities through June 30, 2023. Federal CMS approved an extension of the FPW 1115 waiver demonstration (Project No. 11-W-00135/4) for a period of

five years beginning March 8, 2019 through June 30, 2023.

4. Changes to the Demonstration

On September 27, 2017, Florida submitted a request to extend the demonstration for a five-year period with no major operational changes.

5. Populations Covered in the FPW Program

The FPW program provides family planning services to eligible women, ages 14 through 55. Services are provided up to 24 months. Eligibility is limited to family incomes at or below 191 percent of the Federal Poverty Level who are not otherwise eligible for Medicaid, Children's Health Insurance Program, or health insurance coverage that provides family planning services; and who have lost Medicaid eligibility within the last two years. This includes women losing Medicaid managed care coverage.

Recipients losing SOBRA (pregnancy Medicaid) eligibility are automatically enrolled in the FPW program during the first 12 months of losing Medicaid. Non-SOBRA women have to actively apply for the first year of benefits at their local county health department. All women enrolled in the family planning waiver will have active re-determination of eligibility through their local county health department after 12 months of family planning waiver eligibility. In order to receive the second year of benefits, recipients must reapply at their local county health department.

B. Evaluation Questions and Hypothesis

This section presents each evaluation question and corresponding hypothesis. The state of Florida established the FPW program to provide a limited Medicaid benefit package of family planning and family planning-related services to an expansion population of women of childbearing age losing Medicaid pregnancy coverage or full Medicaid coverage, that had family income at or below 185% of the FLP, and who were not otherwise eligible for Medicaid or CHIP, or enrolled in other health insurance coverage that provided family planning services.

1. What differences in recipient demographic characteristics exist between FPW enrollees and eligible women who do not enroll in FPW per Demonstration Year?

Hypothesis: There will be demographic differences between FPW enrollees and eligible women who do not enroll in the FPW program.

2. What are the interbirth intervals for FPW enrollees compared to eligible women who do not enroll in the FPW program who gave birth during the study period?

Hypothesis: Interbirth intervals will be longer for FPW enrollees compared to eligible women who do not enroll in the FPW program.

3. What is the rate of unintended pregnancies for FPW enrollees and eligible women who do not enroll in the FPW program per Demonstration Year?

Hypothesis: The rate of unintended pregnancies will be lower for FPW enrollees compared to eligible women who do not enroll in the FPW program.

4. What is the rate of low birth weight and preterm births for FPW enrollees compared to women who are eligible but do not enroll in the FPW program?

Hypothesis: The rate of low birth weight (<2,500 grams) and preterm births (<37 weeks) will be lower for FPW enrollees compared to eligible women who do not enroll in the FPW program.

5. Is the FPW achieving cost savings by reducing the number of unintended pregnancies?

Hypothesis: The FPW is achieving cost savings by reducing the number of unintended pregnancies among FPW enrollees.

6. What are the reasons that women eligible for the FPW program choose to enroll or not enroll in the FPW program and the reasons women enrolled in the FPW program do not participate?

Hypothesis: This is a qualitative assessment, thus there is no hypothesis to test.

7. How did FPW enrollees utilize covered health services?

Hypothesis: Research question 8 is included to provide context (description of the FPW services used by enrollees). Therefore, there is no hypothesis to test for this research question.

8. What gaps in coverage are experienced by FPW enrollees over time?

Hypothesis: Research question 9 is included to provide context (description of FPW enrollment spells). Therefore, there is no hypothesis to test for this research question.

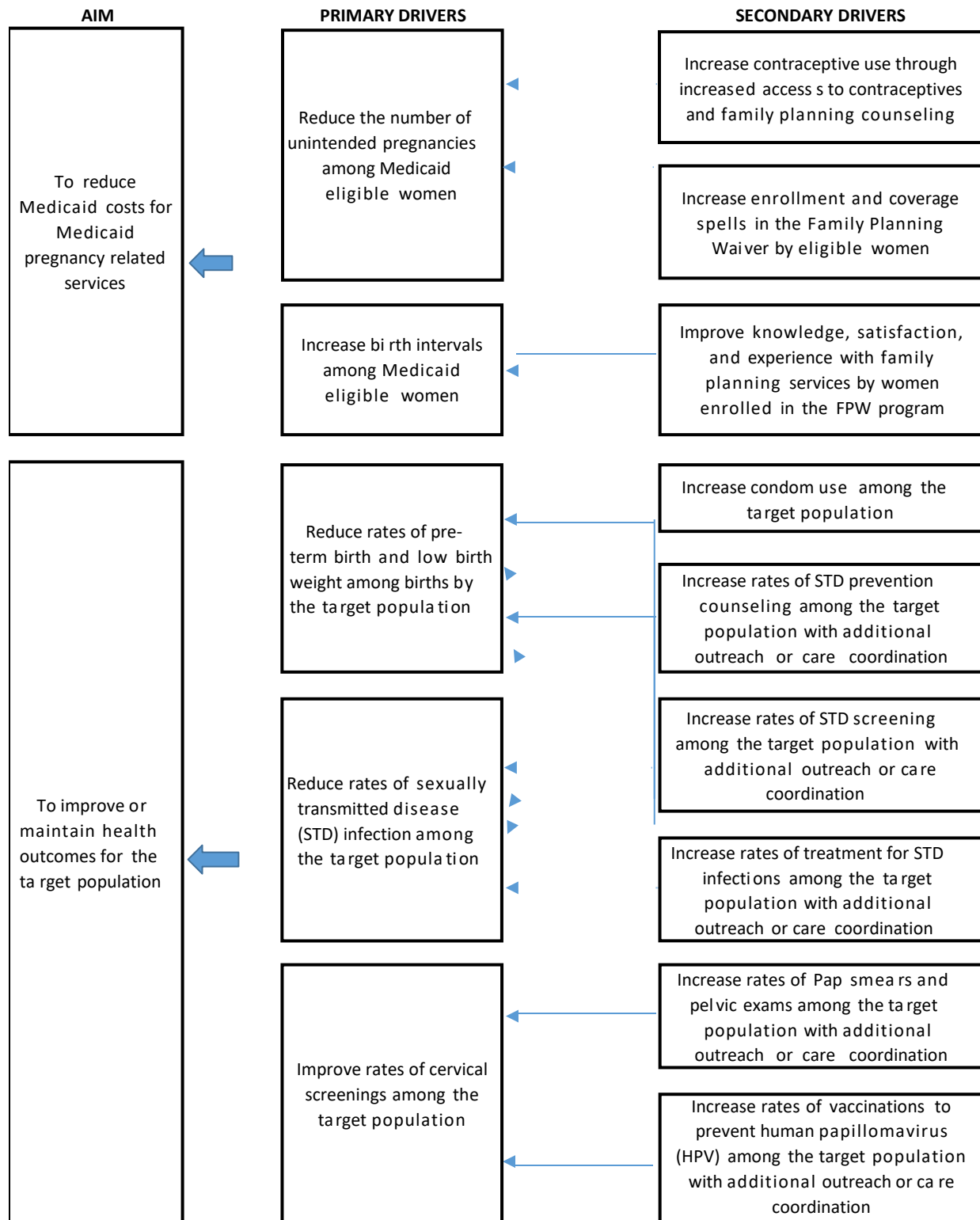
9. Are FPW enrollees satisfied with services?

Hypothesis: FPW enrollees who used FPW services will be satisfied with the services used.

10. What strategies are being used by the Department of Health to increase FPW participation rates?

Hypothesis: Research question 11 is included to provide context (identifying strategies and practices by Department of Health clinics to increase use of FPW services). Therefore, there is no hypothesis to test for this research question.

Driver Diagram



C. Methodology

1. Evaluation Design

This evaluation employs post-only analyses. Because the FPW program was initiated over 20 years ago, a pre-post approach is not ideal. Because the majority of women eligible for the FPW program do not enroll in a given year, this creates an opportunity for a relevant comparison group for several of the evaluation questions. Thus, this will be a post-only analysis with a comparison group where outcomes for FPW enrollees will be compared to outcomes for a control group which will consist of women eligible for FPW but that do not enroll in the program.

The qualitative design is discussed in the context of a specific research questions in “Analytic Methods” below.

2. Target and Comparison Populations

The target population is all FPW program enrollees. While not all evaluation questions will use a comparison population, those that do will use women who are eligible for the FPW program in a given year, but who do not enroll in the program. This will maximize comparability, as these women will also be of child bearing age and will have recently lost Medicaid coverage and will thus likely have similar incomes and sociodemographic characteristics as FPW enrollees. While selection bias using this population is possible, we believe that it will be minimal given that fewer than 10% of eligible women enroll in FPW in any given year. Because most of the eligible women who do not enroll are likely to still have need for and benefit from family planning services, it is unlikely that the decision to enroll or not enroll is strongly correlated with need for these services, which is the main cause of selection bias. Depending on the research question, qualitative analyses will target eligible women who do not enroll in the FPW, FPW enrollees, FPW enrollees who do not use FPW services, FPW enrollees who use services, and Department of Health (DOH) staff who administer the FPW program.

Additionally, some of the evaluation questions will compare first year FPW enrollees to second year FPW enrollees. First year enrollees will be those enrollees within 12 months of their Aid Category Effective Date in the study period (e.g. for DY20, an Aid Category Effective Date between July 1, 2017 and June 30, 2018). Second year enrollees will be those enrollees between 12 and 24 months of their Aid Category Effective Date within the study period.

3. Evaluation Period

The evaluation period began with SFY17/18 (Demonstration Year 20 (DY20)) and extends through SFY20/21 (DY23).

4. Evaluation Measures

Table 1. Evaluation Measures

Measure	Description	Research Question(s)
Demographic characteristics of FPW enrollees and eligible women who do not enroll in the FPW program	Descriptive statistics of the population enrolled in FPW compared to eligible women who do not enroll.	1
Interbirth intervals for FPW enrollees and eligible women who do not enroll in the FPW program	Average number of months between multiple births (deliveries) by FPW enrollees within the 24 month index period and the proportion of women having a second birth within the 24 month index period. Average number of months between multiple births (deliveries) by eligible women who do not enroll in the FPW program within the 24 month index period and the proportion of women having a second birth within the 24 month index period.	2
FPW enrollees' unintended pregnancy rates	Rate of unintended pregnancies among FPW enrollees: Number of FPW enrollees that gave birth and recorded a negative response to Ques. 5 & 14 on the Healthy Start Prenatal Risk Screen /Total Number of FPW enrollees who responded to Ques. 5 & 14 on the Healthy Start Prenatal Risk Screen.	3
Eligible women who do not enroll in the FPW program unintended pregnancy rates	Rate of unintended pregnancies among eligible women who do not enroll in the FPW program: Number of eligible women who do not enroll in the FPW program that gave birth and recorded a negative response to Ques. 5 & 14 on the Healthy Start Prenatal Risk Screen /Total Number of eligible women who do not enroll in the FPW program who responded to Ques. 5 & 14 on the Healthy Start Prenatal Risk Screen.	3
Rate of low birth weight babies born to FPW enrollees	Number of low birth weight babies (<2,500 grams) born to FPW enrollees/total number of babies born to FPW enrollees	4
Rate of low birth weight babies born to eligible women who do not enroll in the FPW program	Number of low birth weight babies (<2,500 grams) born to eligible women who do not enroll in the FPW program/total number of babies born to eligible women who do not enroll in FPW	4
Rate of preterm babies born to FPW enrollees	Number of preterm (<37 weeks) babies born to FPW enrollees/total number of babies born to FPW enrollees	4
Rate of preterm babies born to eligible women who do not enroll in the FPW program	Number of preterm (<37 weeks) babies born to eligible women who do not enroll in FPW/total number of babies born to eligible women who do not enroll in the FPW program	4
FPW Cost Savings	(Averted birth costs – Cost of providing FPW services)	5
FPW enrollment/non-enrollment and participation/non-participation reasons	Common themes from samples of women enrolled in FPW, women eligible for the FPW program but not enrolled, women enrolled in the FPW program who participate, and women enrolled in the FPW program who do not participate	6
FPW enrollment rate	Number of FPW enrollees/number of women eligible for the FPW program	7
FPW participation rate	Number of FPW enrollees who had any FPW related service encounter (including contraceptive care, cancer screen, or STD screen) in each year of the demonstration/total number of FPW enrollees	7

Measure	Description	Research Question(s)
FPW Contraceptive participation rate	Number of FPW enrollees who had an encounter for family planning counseling and/or contraceptive care/ total number of FPW enrollees	7
FPW Cancer screening rate	Number of FPW enrollees who received a cancer screening/total number of FPW enrollees	7
FPW STD screening rate	Number of FPW enrollees tested for any sexually transmitted disease (by STD) as defined by Rule 64D-3.028, Florida Administrative Code/total number of FPW enrollees	7
FPW participation rate by eligibility group	Number of FPW first year enrollee participants/total number of first year FPW enrollees Number of FPW second year enrollee participants/total number of second year FPW enrollees	7
FPW enrollment rate by length of enrollment	Number of women enrolled for 1 year vs. 2 years	8
FPW enrollment rate by time between current and previous enrollment	Average length of time between an enrollee's most recent enrollment period and the previous enrollment period (limited to the last 5 years)	8
FPW enrollment rate by coverage loss	Number of enrollees who lose coverage after the 2 year period	8
Satisfaction with FPW services	Proportion of FPW participants rating satisfaction with FPW services as 8, 9, or 10 on a 10-point satisfaction scale	9
Strategies to improve FPW participation rates	Common themes from DOH central administration and clinic staff	10

5. Data Sources

This evaluation will collect both quantitative and qualitative data from a variety of sources as outlined below in Table 2, “Quantitative and Qualitative Data Sources for Florida FPW Evaluation”. Quantitative data will be collected predominantly from secondary sources (e.g., claims and encounter data) although some data will be obtained through primary data collection (e.g. satisfaction surveys with FPW participants). Qualitative data will be collected using structured surveys. Fully coded transcriptions of qualitative interviews will be analyzed through iterations of content analysis and grounded theory to identify salient themes.

The cleaning of Medicaid eligibility, enrollment, encounter, and claims data is done by both the Agency and the evaluation team. These data are extensively error-checked upon receipt to ensure that the data are complete and error-free.

Additional checks may produce questions from the evaluation team for the Agency data team concerning errors and anomalies. Answers given by the Agency data team are documented for future reference. Questions that cannot be readily answered are resolved by the involvement of additional data personnel and/or the transmittal of corrected data as needed. Florida hospital discharge, vital statistics, Healthy Start prenatal screens, and other data obtained from DOH are cleaned and error-checked by the Florida Health Data Center upon receipt.

Table 2. Data Sources

Data Source	Time Period	Variables
DOH Birth Vital Statistics (BVS) birth certificates	2000 - 2021	Birth certificate data including infant and mother names, date of birth, address, and social security number.
DOH Healthy Start Prenatal Screens	2011 - 2021	Names, date of birth, address, and social security number. Data elements to estimate gestational age and conception date pregnancy intendedness responses
DOH HIV Registry data	2017 - 2021	Names, date of birth, address, and social security number
Medicaid Eligibility Files	2011 - 2021	Names, date of birth, address, and social security number for all female recipients aid category code and the eligibility begin and end dates
Medicaid Claims Files	2011 - 2021	All claims paid during the month including the following data elements: date of service, amount paid, program code, procedures and diagnosis
Medicaid Enrollment Files	2011 - 2021	Personal identifiers for all female recipients including names, date of birth, address, and social security number to link to the birth certificate and the Healthy Start Prenatal Screens
State of Florida Hospital Discharge Data	2011- 2021	Patient discharge data from all licensed acute care hospitals (including psychiatric and comprehensive rehabilitation units); comprehensive rehabilitation hospitals; ambulatory surgical centers and emergency departments, as directed by Section 408.061, Florida Statutes
Qualitative Interview Data	2020	Qualitative interviews from FPW eligible women and FPW enrollees. Qualitative interviews from DOH staff.
Satisfaction Survey Data	2020 – 2022	Structured interviews with FPW participants conducted each DY.

6. Analytic Methods

This evaluation will employ both quantitative and qualitative methods in answering the research questions outlined above. The quantitative methods will be simple descriptive methods and the qualitative methods will include analysis of structured administrative interview data and thematic analyses of semi-structured interview data (using content analyses and grounded theory).

The remainder of this section describes these methods in greater detail. Table 3 following these descriptions lists each research question along with the associated analytic method to be used in answering that question.

For research question 1 (What differences in recipient demographic characteristics exist between FPW enrollees and eligible women who do not enroll in FPW per DY?), Medicaid eligibility files will be used to identify women who are eligible for the FPW program as well as women enrolled in the FPW program. Medicaid eligibility files will also be used to identify demographic characteristics for eligible and enrolled women, and descriptive statistics of the demographic characteristics of FPW enrollees as well as eligible women who do not enroll in the FPW program will be calculated for each demonstration year in the study period (DY20-DY23). Eligible women will be identified as women between the ages of 14-55 who lost Medicaid eligibility for any reason in the two years prior to the DY being examined. FPW enrollees will be identified from Medicaid eligibility files.

For research question 2 (What are the interbirth intervals for FPW enrollees compared to eligible women who do not enroll in the FPW program who gave birth during the study period?), Medicaid claims and eligibility data, as well as vital statistics birth certificate data, will be merged and used to compare the average inter-birth intervals (IBI) in number of months for FPW enrollees and eligible women who do not enroll in the FPW program. The IBI will be the time between the first birth that occurred during the DY being examined and the second live birth observed with available birth certificate data. IBI rates will be compared between FPW enrollees and eligible women who are not enrolled in the FPW program using descriptive statistics for each DY.

For research question 3 (What is the rate of unintended pregnancies for FPW enrollees and eligible women who do not enroll in the FPW program per DY?), Medicaid claims and DOH data will be merged. Unintended pregnancies will be identified using questions 5 and 14 on the Healthy Start Prenatal Risk Screen related to pregnancy intendedness. Unintended pregnancy rates will be calculated as the number of unintended pregnancies for FPW enrollees divided by the total number of births by FPW enrollees. This rate will also be calculated for eligible women who do not enroll in the FPW program and compared to the rate for FPW enrollees using descriptive statistics for each DY.

For research question 4 (What is the rate of low birth weight and preterm births for FPW enrollees compared to women who are eligible but do not enroll in the FPW program?), Medicaid eligibility and claims data will be merged with Vital Statistics birth certificate data and hospital discharge data to identify low birth weight births, defined as a baby that is less than 2,500 grams at birth, and preterm births, defined as a birth at less than 37 weeks gestation. The rate of preterm births and rates of low birthweight will be calculated for both FPW enrollees and eligible women who do not enroll in the FPW program by dividing the total number of preterm or low birthweight births in a DY by the total number of births by each group in the DY. Preterm and low birthweight rates will be compared between FPW enrollees and eligible women who are not enrolled in the FPW program using descriptive statistics for each DY.

For research question 5 (Is the FPW program achieving cost savings by reducing the number of unintended pregnancies?), the difference in the birth rate from unintended pregnancies between FPW enrollees and eligible women who do not enroll in the FPW program will be used to calculate the number of unintended births averted. Total cost savings will be calculated as the total number of unintended births averted times the average cost of the birth, which will include

the cost of the birth as well as the Medicaid costs for the infant during the first year of life, minus the cost of administering the FPW program. This will be calculated for each DY.

For research question 6 (What are the reasons that women eligible for the FPW program choose to enroll or not enroll in the FPW program and the reasons women enrolled in the FPW program do not participate?), qualitative interviews will be administered to identify common themes. Separate qualitative interviews will be administered to eligible women who do not enroll in the FPW program, FPW enrollees who use FPW services (participants), and FPW enrollees who do not use FPW services (non-participants). Eligible women who do not enroll will be asked for reasons why they did not enroll. FPW enrollees (both participants and non-participants) will be asked for reasons why they enrolled. FPW non-participants will be asked why they did not use any FPW services. The samples (FPW enrollee participants, FPW enrollee non-participants, eligible women who do not enroll in the FPW program) for the qualitative interviews will be identified from Medicaid eligibility and claims data. A total of 25 women will be interviewed from each of the three groups or until saturation is achieved, whichever comes first. Interviews will take place in spring 2020. Interviews will not be repeated in future DYs as we do not expect responses to change from year to year. Common themes will be identified using a grounded theory approach utilizing NVivo qualitative data analysis software. Draft survey questions are included in the Appendix.

For research question 7 (How did FPW enrollees utilize covered health services?), Medicaid eligibility, enrollment, and claims data will be used to assess enrollment rates, participation rates (use of any service covered by FPW), contraceptive services participation rates, cancer screening participation rates, and STD screening participation rates for all FPW enrollees per DY. Overall participation rates will also be compared between first year FPW enrollees and second year FPW enrollees. Enrollment rates will be calculated as the total number of women enrolled in FPW/total number of women eligible for FPW for all enrollees. FPW participation rates will be calculated as the total number of FPW enrollees who use any FPW service/total number of FPW enrollees. These participation rates will also be calculated separately for first year enrollees and second year enrollees. FPW contraceptive care participation rates will be calculated as the total number of FPW enrollees who use contraceptive services/total number of FPW enrollees. FPW cancer screening rates will be calculated as the total number of FPW enrollees who use any cancer screening services/total number of FPW enrollees. FPW STD screening rates will be calculated as the total number of FPW enrollees who use STD screening services/total number of FPW enrollees. Each of these rates will be calculated separately for each DY.

For research question 8 (What gaps in coverage are experienced by FPW enrollees over time?), Medicaid enrollment and eligibility data will be used. The following measures will be calculated for each DY and used to assess coverage experience: (1) total number of FPW enrollees who are only enrolled for the first year/total number of FPW enrollees; (2) total number of FPW enrollees who are enrolled for the second year/total number of FPW enrollees; (3) average length of time between FPW enrollees' most recent enrollment period and the previous enrollment period (limited to previous 5 years); and (4) total number of women who lose FPW coverage after the 2 year enrollment period.

For research question 9 (Are FPW enrollees satisfied with services?), satisfaction surveys will be administered to FPW enrollees. Surveys will be administered during each DY. FPW enrollees will be randomly selected and administered a telephone-based satisfaction survey (see Appendix for satisfaction survey instrument). Surveys will be administered each year until 300 completed surveys are achieved. Surveys will be administered during the fourth quarter of each calendar year. Descriptive statistics of survey responses will be used to summarize FPW enrollee experiences and satisfaction.

For research question 10, (What strategies are being used by the Department of Health to increase FPW participation rates?), qualitative interviews will be administered to staff at DOH clinics offering FPW services. Florida DOH clinics will be randomly selected and a knowledgeable staff member will be identified and asked what strategies are employed to increase use of FPW services. Qualitative interviews will be conducted until saturation is achieved (e.g. no new strategies are identified). It is expected that saturation will be achieved with 25 or fewer qualitative interviews. Interviews will be administered during the first two quarters of 2020. These interviews will only take place during the first year of the evaluation. Common themes/strategies will be identified using a grounded theory approach utilizing NVivo qualitative data analysis software. Draft interview questions are included in the Appendix.

Table 3. Design Table

Evaluation Component	Evaluation Question	Evaluation Hypotheses	Measure (to be reported for each Demonstration Year)	Recommended Data Source	Analytic Approach
Process	1. What differences in recipient demographic characteristics exist between FPW enrollees and eligible women who do not enroll in the FPW program per DY?	There will be demographic differences between FPW enrollees and eligible women who do not enroll.	<p>Distribution of age and race/ethnicity for FPW enrollees</p> <p>Distribution of age and race/ethnicity for eligible women who do not enroll in the FPW program</p>	Medicaid enrollment, eligibility and claims files	Descriptive statistics including demographic characteristics
Outcome/impact	2. What are the interbirth intervals for FPW enrollees compared to eligible women who do not enroll in the FPW program who gave birth during the study period?	The interbirth intervals will be longer for FPW enrollees compared to eligible women who do not enroll in FPW.	Time between the first birth that occurred during the DY and the second live birth	Medicaid eligibility, Medicaid claims, Vital statistics birth certificates, hospital discharge data	Descriptive statistics
Outcome/impact	3. What is the rate of unintended pregnancies for FPW enrollees compared to eligible women who do not enroll in	The rate of unintended pregnancies will be lower for FPW enrollees compared to eligible women	Number of unintended pregnancies for women enrolled in the FPW program/total number of FPW enrollees	Healthy Start screens, Medicaid eligibility, Vital statistics birth certificate data, hospital discharge data	Descriptive statistics

	the FPW program per DY?	who do not enroll in FPW.	Number of unintended pregnancies for women who are eligible but do not enroll in FPW/total number of eligible women who do not enroll in the FPW program		
Outcome/impact	4. What is the rate of low birth weight and preterm births for FPW enrollees compared to women who are eligible but do not enroll in the FPW program?	The rate of low birth weight (<2,500 grams) babies and preterm babies (<37 weeks) for FPW enrollees will be lower compared to eligible women who do not enroll in FPW	Number of low birth weight or preterm birth babies born to FPW enrollees/total number of babies born to FPW enrollees Number of low birth weight or preterm birth babies born to women who are eligible but do not enroll in FPW/total number of babies born to women who are eligible but do not enroll in the FPW program	Medicaid eligibility, Vital statistics birth certificate data	Descriptive statistics
Outcome/impact	5. Is the FPW program achieving cost savings by reducing the number of unintended pregnancies?	The FPW is achieving cost savings by reducing the number of unintended pregnancies among FPW enrollees.	Difference in the number of unintended pregnancies between FPW enrollees and eligible women who did not enroll in FPW * cost of the birth and first year of care for the baby.	Medicaid enrollment, eligibility, and claims data, vital statistics birth certificate data, Healthy Start screening data.	1. To determine the total number of averted births that are attributed to the FPW program, compare the number of observed births from unintended pregnancies by women enrolled in the FPW program in the

					<p>DY to the number of observed births from unintended pregnancy by women eligible for the FPW program who do not enroll in the DY.</p> <p>2. To determine gross savings, multiply the number of averted births by average birth costs (includes costs for the first year of the baby's life).</p> <p>3. To calculate net cost savings, subtract FPW program expenditures from gross savings.</p>
Process	6. What are the reasons that women eligible for the FPW program choose to enroll or not enroll in the FPW program and the reasons women enrolled in the FPW program do not participate?	This is a qualitative assessment, thus there are no hypotheses to test.	Reasons for FPW enrollment or non-enrollment	Qualitative interviews with FPW enrollees and eligible women who do not enroll in FPW	Identification of common themes using qualitative statistical software (NVivo)
			Reasons for FPW participation or non-participation	Qualitative interviews with FPW participants and FPW enrollees who do not participate	
Process	7. How do FPW enrollees utilize	This is descriptive, so there is no	Total number of women enrolled in FPW/total		Descriptive statistics

	covered health services?	hypotheses associated with this question	<p>number of women eligible for FPW</p> <p>Total number of FPW enrollees who use any FPW services/total number of FPW enrollees</p> <p>Total number of FPW enrollees who use contraceptive services/total number of FPW enrollees</p> <p>Total number of FPW enrollees who use any cancer screening services/total number of FPW enrollees</p> <p>Total number of FPW enrollees who use any STD screening services/total number of FPW enrollees</p> <p>Total number of first year FPW enrollees who use any FPW services/total number of first year FPW enrollees</p> <p>Total number of second year FPW enrollees who use any FPW services/total number of second year FPW enrollees</p>	Medicaid enrollment, eligibility, and claims data	
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Process	8. What gaps in coverage are experienced by FPW enrollees over time?	This is descriptive, so there are no hypotheses associated with this question	Total number of FPW enrollees who are only enrolled for first year/Total number of FPW enrollees	Medicaid enrollment and eligibility data	Descriptive statistics
			Total number of FPW enrollees who enrolled for the second year/total number of FPW enrollees		
			Average length of time between FPW enrollees most recent enrollment period and the pervious enrollment period (limited to the previous 5 years)		
			Total number of women who lose FPW coverage (i.e. did not regain Medicaid coverage) after the 2 year enrollment period		
Outcome/impact	9. Are FPW enrollees satisfied with services?	FPW enrollees who used FPW services will be satisfied with the services used.	Proportion of survey respondents indicating that they are satisfied with FPW services received	Telephone based satisfaction survey	Descriptive statistics
Process	10. What strategies are being used by the Department of Health to increase FPW participation rates?	This is a qualitative assessment, thus there are no hypotheses to be tested	Common FPW engagement strategies used by DOH staff	Qualitative surveys	Description of strategies used by DOH staff to increase participation rates.

D. Methodological Limitations

Because the waiver was initially implemented over 20 years ago, a pre-post comparison is not appropriate, and analyses will be limited to a post-only approach. Using a post-only approach will limit causal inference. However, for several of the evaluation questions, a comparison group will be used. FPW program enrollees will be compared to women who are eligible for the FPW program but do not enroll. While this approach will improve causal inference, there is still the potential for unobserved confounding to bias results. All analyses will control for the demographic characteristics of the populations being compared to minimize potential bias.

Additionally, measures of health status are not available for FPW enrollees, thus it is not possible to directly assess the impact of the FPW program on the health status of enrollees.

E. Special Methodological Considerations (if applicable)

Not applicable

F. Attachments

1) Independent Evaluator

The Agency contracts with Florida State University to perform an independent evaluation of the Family Planning Waiver.

The Principal Investigator for the project is Dr. Jeffrey Harman, whose contact information is as follows:

Behavioral Sciences and Social Medicine, Florida State University College of Medicine
1115 West Call Street
Tallahassee, FL 32306-4300
(850) 645-1540
Jeffrey.harman@med.fsu.edu

The state has assured that the Independent Evaluator will conduct a fair and impartial evaluation, will prepare an objective Evaluation Report, and that there will be no conflict of interest. "Conflict of interest" statements have been signed by appropriate Agency staff attesting to the following: No immediate family or business partners have financial interest in the vendor, no immediate family or business partners have a personal relationship with the vendor or their representatives; no gratuities, favors, or anything of monetary value has been offered to or accepted by the vendor or their representatives; no state parties have been employed by the vendor within the past 24 months; no discussions to seek or accept future employment with the

vendor or their representatives; and, no other conditions exist which may cause conflict of interest.

2) Evaluation Budget

The Agency's most recent contract with Florida State University was for a period of three (3) years (SFY 2016-17 through SFY 2018-19) at a total cost of \$441,816.00.

The Agency is currently renewing the contract for a period of three years (SFY 2019-20 through SFY 2021-22) with an anticipated total budget of \$3,003,075.00*. The satisfaction survey will be added upon Agency approval, at which time a revised budget will be requested from the evaluators.

Simplified Evaluation Budget:

1. Computer programming (\$61.87 x 2,517 hours) = \$155,736.64
2. Analysis of the data (\$61.88 x 5,663 hours) = \$350,407.43
3. Preparation of the report (\$61.87 x 1,888 hours) = \$116,802.48
4. Other (project and contract management) (\$61.87 x 2,517 hours) = \$155,737.00

*Note: The total budget includes cost share contributed by the University.

3) Timeline and Major Milestones

The below table outlines the timeline for conducting the evaluation activities, including deliverable submissions and activities related to the renewal and reprocurement of a contract.

The satisfaction survey will be added to the table upon Agency approval.

Table 4. FPW Evaluation Activities

Deliverable/Activity	Due Date
Evaluation Design submitted to CMS*	July 5, 2019
DY 20 (SFY17/18) Medicaid Data Request and Verification	March 23, 2020
Quarterly Monitoring Report*	August 29, 2019
Quarterly Monitoring Report*	November 29, 2019
DY21 (SFY18/19) Medicaid Data Request and Verification	March 24, 2020
Quarterly Monitoring Report*	February 29, 2020
FPW DY 20 (SFY17/18) and DY 21 (SFY18/19) Interim Evaluation Report	May 15, 2020

Quarterly Monitoring Report*	May 30, 2020
Quarterly Monitoring Report*	August 29, 2020
Annual Monitoring Report*	September 30, 2020
FPW DY 20 (SFY17/18) and DY 21 (SFY18/19) Final Evaluation Report	October 15, 2020
Quarterly Monitoring Report*	November 29, 2020
DY22 (SFY19/20) Medicaid Data Request and Verification	Request due: January 15, 2021 Verification due: 30 calendar days after data delivery
Quarterly Monitoring Report*	February 29, 2021
Quarterly Monitoring Report*	May 30, 2021
FPW DY22 (SFY19/20) Evaluation Report	May 14, 2021
Quarterly Monitoring Report*	August 29, 2021
Annual Monitoring Report*	September 30, 2021
Quarterly Monitoring Report*	November 29, 2021
DY23 (SFY 20/21) Medicaid Data Request and Verification	Request due: January 14, 2022 Verification due: 30 calendar days after data delivery
Quarterly Monitoring Report*	February 29, 2022
Draft of Draft Interim Evaluation Report DY20, 21 and 22 (SFY17/18, 18/19, and 19/20) due to the Agency	March 1, 2022
FPW DY23 (SFY20/21) Draft Evaluation Report	April 1, 2022
Final Draft Interim Evaluation Report DY20, 21 and 22 (SFY17/18, 18/19, and 19/20) due to the Agency	May 1, 2022
Quarterly Monitoring Report*	May 30, 2022
Quarterly Monitoring Report*	August 29, 2022
Annual Monitoring Report*	September 30, 2022
Quarterly Monitoring Report*	November 29, 2022
Draft Interim Evaluation Report DY20, 21 and 22 (SFY17/18, 18/19, and 19/20) due to CMS*	December 31, 2022

DY24 (SFY21/22) Medicaid Data Request and Verification	Request due: January 16, 2023 Verification due: 30 calendar days after data delivery
Quarterly Monitoring Report*	February 29, 2023
FPW DY24 (SFY21/22) Evaluation Report	April 3, 2023
Quarterly Monitoring Report*	May 30, 2023
Draft of Draft Summative Evaluation Report due to Agency	August 15, 2023
Final Draft Summative Report due to Agency	November 1, 2024
Draft Summative Evaluation Report due to CMS*	December 31, 2024

*Deliverables due to CMS

4) APPENDIX (Survey Instruments)

The appropriate qualitative interview questions below will be administered to the relevant sample group:

- **Women who are eligible for FPW but did not enroll**

Florida's Agency for Health Care Administration has contracted with FSU to talk to women who have lost Medicaid coverage but are still eligible to enroll in their Family Planning Waiver program, which offers free family planning services to women of child bearing age who no longer qualify for Medicaid. Records provided by the Agency for Health Care Administration show that you are potentially eligible for the Family Planning Waiver program but have not enrolled. Could you please describe the reasons why you did not enroll in the Family Planning Waiver program?
- **Women who are enrolled in the FPW program but did not use services**

Florida's Agency for Health Care Administration has contracted with FSU to talk to women who have enrolled in their Family Planning Waiver program, which offers free family planning services to women of child bearing age who no longer qualify for Medicaid, but who did not use any of the family planning services available. Records provided by the Agency for Health Care Administration show that you are enrolled in the Family Planning Waiver program but did not use any services. Could you please describe the reasons why you enrolled in the Family Planning Waiver program and why you did not use any of the family planning services available?
- **Women who are enrolled in FPW and used family planning services**

Florida's Agency for Health Care Administration has contracted with FSU to talk to women who have enrolled in their Family Planning Waiver program and who used at least one of the family planning services available through the program. Records provided by the Agency for Health Care Administration show that you are enrolled in the Family Planning Waiver program and used at least one of these services. Could you please describe the reasons why you enrolled in the Family Planning Waiver program and why you decided to use at least one of the family planning services available?
- **DOH Clinic Staff**

Florida's Agency for Health Care Administration has contracted with FSU to determine strategies being used by DOH clinics to increase participation in the Family Planning Waiver program. What strategies are you currently using to get women who are enrolled in FPW to use the family planning services that are available to them?

The proposed Family Planning Waiver Satisfaction Survey below will be administered to a sample of enrollees who use FPW services:

You are currently enrolled in Florida's Family Planning Waiver program, which offers you access to family planning services including contraceptive services, cervical cancer screening services, and sexually transmitted disease screening services.

1. How satisfied are you with the types of services offered to you through the Family Planning Waiver program?
 - a. Very satisfied
 - b. Satisfied
 - c. Dissatisfied
 - d. Very Dissatisfied
 - e. I have not used any family planning services
 - f. I was not aware that I was enrolled in the Family Planning Waiver program (if selected, end survey)

2. How satisfied were you with the information and customer service provided to you about the Family Planning Waiver program?
 - a. Very satisfied
 - b. Satisfied
 - c. Dissatisfied
 - d. Very Dissatisfied

3. How easy was it to access these family planning services?
 - a. Very easy
 - b. Somewhat easy
 - c. Somewhat difficult
 - d. Very difficult
 - e. I did not attempt to access family planning services (if selected, exit survey)

4. Which of the following family planning services did you use? Please select all that apply.
 - a. Contraceptive care (e.g. contraception, contraceptive counseling/education)
 - b. Sexually transmitted disease testing (e.g. pap smears, pelvic exams)
 - c. Cervical cancer screening (e.g. pap smears, pelvic exams)

5. How satisfied were you with [insert name of FPW service used by respondent in question 4]? (this questions can be repeated up to 3 times depending on the number of types of FPW benefits used by the respondent)
 - a. Very satisfied
 - b. Satisfied
 - c. Dissatisfied
 - d. Very Dissatisfied

6. Do you have any recommendations for improving access or other aspects of the program?