DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850

State Demonstrations Group

April 20, 2026

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

Dear Deputy Secretary Meyer:

The Centers for Medicare & Medicaid Services (CMS) completed its review of the Evaluation Design, which is required by the Special Terms and Conditions (STCs), specifically, STC #9.3 "Evaluation Design Approval and Updates" of Florida's section 1115 demonstration, "Florida Medicaid Family Planning" (Project Number 11-W-00135/4), effective through June 30, 2030. CMS has determined that the Evaluation Design, which was submitted on October 27, 2025, and April 2, 2026, meets the requirements set forth in the STCs and our evaluation design guidance, and therefore approves the state's Evaluation Design.

CMS has added the approved Evaluation Design to the demonstration's STCs as Attachment C. A copy of the STCs, which includes the new attachment, is enclosed with this letter. In accordance with 42 CFR 431.424, the approved Evaluation Design may now be posted to the state's Medicaid website within 30 days. CMS will also post the approved Evaluation Design as a standalone document, separate from the STCs, on Medicaid.gov.

Please note that an Interim Evaluation Report, consistent with the approved Evaluation Design, is due to CMS one year prior to the expiration of the demonstration, or at the time of the extension application, if the state chooses to extend the demonstration. Likewise, a Summative Evaluation Report, consistent with this approved design, is due to CMS within 18 months of the end of the demonstration period. In accordance with 42 CFR 431.428 and the STCs, we look forward to receiving updates on evaluation activities in the demonstration monitoring reports.

We appreciate our continued partnership with the Florida Family Planning Waiver section 1115 demonstration. If you have any questions, please contact your CMS demonstration team.

Sincerely,

DANIELLE DALY -S

Digitally signed by DANIELLE DALY -S
Date: 2026.04.20 05:17:18 -04'00'

Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

cc: Kia Carter-Anderson, 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 Section 1115(a) Demonstration**

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 from May 1, 2025 through June 30, 2030, unless otherwise specified, 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" may only be implemented consistent with the approved Special Terms and Conditions (STCs) and shall enable Florida to operate the above-identified section 1115(a) demonstration.

TITLE XIX EXPENDITURE AUTHORITY:

1. Expenditures for extending title XIX family planning services and family planning related services for a transitional period up to 24 months, with a maximum of two 12-month continuous eligibility periods, 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 these 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 Authority 1:

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 assure 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 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 (EPSDT) **Section 1902(a)(43)**

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 Section 1115(a) Demonstration

AWARDEE: Florida Agency for Health Care Administration

1. PREFACE

The following are the Special Terms and Conditions (STCs) for the "Florida Medicaid Family Planning Waiver" section 1115(a) Medicaid demonstration (hereinafter "demonstration"), to enable the Florida Agency for Health Care Administration (AHCA) (hereinafter "state") to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted expenditure authority authorizing federal matching of demonstration costs not otherwise matchable, which are separately enumerated. These STCs set forth conditions and limitations on the expenditure authority, and describe in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS related to the demonstration. These STCs neither grant waivers or additional expenditure authorities, nor expand upon those separately granted.

The STCs related to the programs for those populations affected by the demonstration are effective from May 1, 2025, through June 30, 2030, unless otherwise specified.

The STCs have been arranged into the following subject areas:

1. Preface
2. Program Description, Objectives, and Historical Context
3. General Program Requirements
4. Eligibility and Enrollment
5. Benefits and Delivery Systems
6. Monitoring and Reporting Requirements
7. General Financial Requirements
8. Monitoring Budget Neutrality
9. Evaluation of the Demonstration
10. Schedule of State Deliverables during the Demonstration

Additional attachments have been included to provide supplementary information and guidance for specific STCs.

Attachment A: Developing the Evaluation Design
Attachment B: Preparing the Interim and Summative Evaluation Reports
Attachment C: Evaluation Design

2. PROGRAM DESCRIPTION, OBJECTIVES, AND HISTORICAL CONTEXT

Effective through June 30, 2030, 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 five-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.

On May 25, 2022, CMS approved a demonstration amendment that changed the eligibility start date for the demonstration from after 60-days postpartum to 12-months postpartum. This aligns with Florida's adoption of a 12-month continuous postpartum coverage period for individuals enrolled in Medicaid and CHIP. The amendment also removed language that required women who received a sterilization procedure to be disenrolled from the demonstration. The state has not requested any other program changes.

On June 14, 2023, Florida submitted a request to extend the demonstration for a five-year period with no program changes. Temporary extensions of the demonstration were approved effective July 1, 2023 through June 30, 2024 and July 1, 2024 through April 30, 2025 under the current STCs and expenditure authorities. However, as part of this extension, CMS amended the STCs to identify sexually transmitted infection (STI) and sexually transmitted disease (STD) screening services as a family planning service and STI/STD diagnosis services as a family planning related service.

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;

- Reducing Florida's Medicaid costs by reducing the number of unintended pregnancies by women who otherwise would be eligible for Medicaid pregnancy-related services; and

- Improving or maintaining health outcomes for the target population as a result of access to family planning demonstration services and/or family planning related services.

3. GENERAL PROGRAM REQUIREMENTS

3.1. **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 (ADA), Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and section 1557 of the Patient Protection and Affordable Care Act (Section 1557).

3.2. **Compliance with Medicaid and Children's Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in federal law, regulation, and policy statement, not expressly waived or identified as not applicable in the expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.

3.3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in federal law, regulation, or written policy, come into compliance with changes in law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 3.7. CMS will notify the state 30 business days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.

3.4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

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, as well as a modified allotment neutrality worksheet as necessary to comply with such change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph. Further, the state may seek an amendment to the demonstration (as per STC 3.7 of this section) as a result of the change in FFP.

b. If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the earlier of the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law, whichever is sooner.

3.5. **State Plan Amendments.** The state will not be required to submit title XIX or XXI state plan amendments (SPAs) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan is required, except as otherwise noted in these STCs. In all such cases, the Medicaid and CHIP state plans govern.

3.6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, beneficiary rights, 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 Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid or CHIP state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or medical assistance expenditures, will be available under changes to the demonstration that have not been approved through the amendment process set forth in STC 3.7 below, except as provided in STC 3.3.

3.7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 calendar 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 the failure by the state to submit required elements of a complete amendment request as described in this STC, and failure by the state to submit required reports and other deliverables according to the deadlines specified therein. Amendment requests must include, but are not limited to, the following:

a. An explanation of the public process used by the state, consistent with the requirements of STC 3.12. Such explanation must include a summary of any public feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;

b. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;

c. A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality expenditure limit. Such analysis must include current total computable “with waiver” and “without waiver” status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the “with waiver” expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

d. An up-to-date CHIP allotment worksheet, if necessary;

e. The state must provide updates to existing demonstration reporting and quality and evaluation plans. This includes a description of how the evaluation design and monitoring reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

3.8. **Extension of the Demonstration.** States that intend to request an extension of the demonstration must submit an application to CMS from the Governor of the state in accordance with the requirements of 42 CFR 431.412(c). States that do not intend to request an extension of the demonstration beyond the period authorized in these STCs must submit a phase-out plan consistent with the requirements of STC 3.9.

3.9. **Demonstration Phase-Out.** The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

a. Notification of Suspension or Termination. The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft transition and phase-out plan to CMS no less than six months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with STC 3.12, if applicable. Once the 30-day public comment period has ended, the state must provide a summary of the issues raised by the public during the comment period and how the state considered the comments received when developing the revised transition and phase-out plan.

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 redeterminations of Medicaid or CHIP eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as well as any community outreach activities the state will undertake to notify affected beneficiaries, including community resources that are available.

c. Transition and Phase-out Plan Approval. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 calendar days after CMS approval of the transition and phase-out plan.

d. Transition and Phase-out Procedures. The state must redetermine eligibility for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to making a determination of ineligibility as required under 42 CFR 435.916(d)(1). For individuals determined ineligible for Medicaid and CHIP, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e). The state must comply with all applicable advance notice requirements and fair hearing rights described at 42 CFR 431, Subpart E. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230.

e. Exemption from Public Notice Procedures 42 CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements under 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. The limitation of enrollment into the demonstration does not impact the state's obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan.

g. Federal Financial Participation (FFP). If the project is terminated or any relevant waivers are suspended by the state, FFP must be limited to normal closeout costs associated with the termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

3.10. **Withdrawal of Waiver or Expenditure Authority.** CMS reserves the right to withdraw waivers and/or expenditure authorities at any time it determines that continuing the waiver or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX and title XXI. CMS will 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.

3.11. **Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

3.12. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the state notice procedures as required in 42 CFR section 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 3.7 or extension, are proposed by the state.

3.13. **Federal Financial Participation (FFP).** No federal matching funds for expenditures for this demonstration, including for administrative and medical assistance expenditures, will be available until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.

3.14. **Administrative Authority.** When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency must maintain authority, accountability, and oversight of the program. The State Medicaid Agency must exercise oversight of all delegated

functions to operating agencies, MCOs, and any other contracted entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration

3.15. **Common Rule Exemption.** The state must 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 public benefit or service programs, 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. CMS 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(d)(5).

4. ELIGIBILITY AND ENROLLMENT

4.1. **Eligibility for the Demonstration.** Transitional family planning and family planning related services are provided to eligible individuals as defined below for a period of 12 months of continuous eligibility subsequent to a loss of Medicaid State Plan eligibility. An individual found to be eligible for this demonstration upon initial application or annual redetermination will not require reporting of changes in income or household size for this 12-month period. 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.

4.2. **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.

5. BENEFITS AND DELIVERY SYSTEMS

5.1. **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 and are limited to those services and supplies whose primary purpose is family planning to prevent or delay pregnancy. The specific family planning services provided under this demonstration are as follows:

a. FDA-approved methods of contraception;

b. Screening for sexually transmitted infection (STI) or sexually transmitted disease (STD) during a family planning visit, 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.

5.2. **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 for diagnosis and treatment pursuant to a family planning visit such as contraceptive counseling and are reimbursable at the state's regular Federal Medical Assistance Percentage (FMAP) rate. 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. Treatment of STIs/STDs, except for HIV/AIDS and hepatitis, when the STI/STD is identified during a screen pursuant to a routine or periodic family planning visit. A follow up visit or encounter for the treatments, such as 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. STI/STD diagnosis and treatment pursuant to a family planning visit such as contraceptive counseling.

d. 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.

e. Other medical diagnosis, treatment, and preventive services that are routinely provided pursuant to family planning services.

f. Treatment of major complications arising from a family planning procedure.

5.3. **Minimum Essential Coverage (MEC).** The Florida family planning demonstration is limited to the provision of services as described in STCs 5.1 and 5.2. Consequently, this demonstration is not recognized as Minimum Essential Coverage (MEC).

5.4. **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.

5.5. **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.

6. MONITORING AND REPORTING REQUIREMENTS

6.1. **Deferral for Failure to Submit Timely Demonstration Deliverables.** CMS may issue deferrals in the amount of $5,000,000 per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items 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. A deferral shall not exceed the value of the federal amount for the demonstration period. The state does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

The following process will be used: 1) 30 calendar days after the deliverable(s) were due if the state has not submitted a written request to CMS for approval of an extension as described below; or 2) 30 calendar days after CMS has notified the state in writing that the deliverable(s) were not accepted for being inconsistent with the requirements of this agreement and the information needed to bring the deliverable(s) into alignment with CMS requirements:

a. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverable(s).

b. For each deliverable, the state may submit to CMS a written request for an extension to submit the required deliverable that includes a supporting rationale for the cause(s) of the delay, the steps the state has taken to address such issue(s), and the state's anticipated date of submission. Should CMS agree in writing to the state's request, a corresponding extension of the deferral process can be provided. CMS may agree to a corrective action plan as an interim step before applying the deferral, if corrective action is proposed in the state's written extension request

c. If CMS agrees to an interim corrective process in accordance with subsection (b), and the state fails to comply with the corrective action plan or, despite the corrective action plan, still fails to submit the overdue deliverable(s) that meet the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the state.

d. If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement for submitting deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the standards outlined in these STCs, the deferral(s) will be released.

As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations, and other deliverables will be considered by CMS in reviewing any application for an extension, amendment, or for a new demonstration.

6.2. **Submission of Post-Approval Deliverables.** The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs unless CMS and the state mutually agree to another timeline.

6.3. **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 Section1115 demonstration, 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.

6.4. **Monitoring Calls.** CMS will convene periodic conference calls with the state.

a. The purpose of these calls is to discuss ongoing demonstration operations, to include (but not limited to) any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, budget neutrality, enrollment and access, and progress on evaluation activities.

b. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.

c. The state and CMS will jointly develop the agenda for the calls.

6.5. **Annual Monitoring Reports.** The state must submit one Annual Monitoring Report each demonstration year (DY) that is due no later than 90 calendar days following the end of the DY. The state must submit a revised Annual Monitoring Report within 60 calendar days after receipt of CMS's comments, if any. The reports will include all required elements as per 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 Annual Monitoring Reports must follow the framework to be provided by CMS, 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.

a. Operational Updates - Per 42 CFR §431.428, Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports must provide sufficient information to document key operational and other challenges, underlying causes of challenges, and how challenges are being addressed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and

descriptions of any public forums held. In addition, Monitoring Reports should describe key achievements, as well as the conditions and efforts to which these successes can be attributed. Monitoring Reports should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.

b. Performance Metrics – The performance metrics will provide data to demonstrate the state's progress toward meeting the goals and milestones of the demonstration initiatives, including relative to their projected timelines. Per 42 CFR §431.428, the Monitoring Reports must document the impact of the demonstration in providing family planning and family planning related services to beneficiaries, as well as access to utilization of care, outcomes of care, and quality and cost of care. Specifically:

   The demonstration's metrics reporting must cover categories including, but not limited to: eligibility, appeals and grievances, utilization of services, unpaid medical bills at application or medical debt, and quality of care and health outcomes. The state must report metrics for all demonstration populations.

   Monitoring reports should include the results of beneficiary satisfaction or experience of care surveys, if conducted.

   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 Monitoring Reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook every quarter that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs for this demonstration should be reported separately on the Form CMS-64.

d. Evaluation Activities and Interim Findings. Per 42 CFR §431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. 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.

6.6. **Corrective Action Plan Related to Monitoring.** If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. A corrective action plan could include a temporary suspension of implementation of demonstration initiatives in circumstances where monitoring data indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.10. CMS will withdraw an authority, as described in STC 3.10, when metrics indicate substantial and sustained directional change inconsistent with the state's demonstration

goals, and the state has not implemented corrective action. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

6.7. **Close-Out Report.** Within 120 calendar days after the expiration of the demonstration, the state must submit a draft Close-Out Report to CMS for comments.

a. The Close-Out Report must comply with the most current guidance from CMS.

b. In consultation with CMS, and per guidance from CMS, the state will include an evaluation of the demonstration (or demonstration components) that are to phase out or expire without extension along with the Close-Out Report. Depending on the timeline of the phase-out during the demonstration approval period, in agreement with CMS, the evaluation requirement may be satisfied through the Interim and/or Summative Evaluation Reports stipulated in STCs 9.5 and 9.7, respectively.

c. The state will present to and participate in a discussion with CMS on the Close-Out Report.

d. The state must take into consideration CMS's comments for incorporation into the final Close-Out Report.

e. A revised Close-Out Report is due to CMS no later than 30 calendar days after receipt of CMS's comments.

f. A delay in submitting the draft or final version of the Close-Out Report may subject the state to penalties described in STC 6.1.

6.8. **Post Award Forum**. Pursuant to 42 CFR 431.420(c), within six months of the demonstration's implementation, and annually thereafter, the state must afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 calendar days prior to the date of the planned public forum, the state must publish the date, time, and location of the forum in a prominent location on its Medicaid website. The state must also post the most recent Annual Monitoring Report on its Medicaid website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the public comments in the Annual Monitoring Report associated with the year in which the forum was held.

7. GENERAL FINANCIAL REQUIREMENTS

7.1. **Allowable Expenditures.** This demonstration project is approved for authorized demonstration expenditures applicable to services rendered and for costs incurred during the demonstration approval period designated by CMS. CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs.

7.2. **Standard Medicaid Funding Process.** The standard Medicaid funding process will be used for this demonstration. The state will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures under this Medicaid section 1115 demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. The state will estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality

expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the form CMS-37 for both the medical assistance payments (MAP) and state and local administration costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state shall submit form CMS-64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter just ended. If applicable, subject to the payment deferral process, 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.

7.3. **Sources of Non-Federal Share.** As a condition of demonstration approval, the state certifies that its funds that make up the non-federal share are obtained from permissible state and/or local funds that, unless permitted by law, are not other federal funds. The state further certifies that federal funds provided under this section 1115 demonstration must not be used as the non-federal share required under any other federal grant or contract, except as permitted by law. CMS approval of this demonstration does not constitute direct or indirect approval of any underlying source of non-federal share or associated funding mechanisms, and all sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable implementing regulations. CMS reserves the right to deny FFP in expenditures for which it determines that the sources of non-federal share are impermissible.

a. If requested, the state must submit for CMS review and approval documentation of any sources of non-federal share that would be used to support payments under the demonstration.

b. If CMS determines that any funding sources are not consistent with applicable federal statutes or regulations, the state must address CMS's concerns within the time frames allotted by CMS.

c. Without limitation, CMS may request information about the non-federal share sources for any amendments that CMS determines may financially impact the demonstration.

7.4. **Pending Litigation.** To the extent any of these Special Terms and Conditions ("STCs") relate to obligations that CMS interprets to be required under section 1903(w) of the Social Security Act (the "Act") and are the subject of pending litigation between the State of Florida and CMS regarding CMS's interpretation of section 1903(w), as stated in CMS's information bulletin dated February 17, 2023 and entitled "Health Care-Related Taxes and Hold Harmless Arrangements Involving the Redistribution of Medicaid Payments" (the "Bulletin"), *See Fla., et al. v. Brooks-LaSure, et al.*, No. 23-CV-61595-WPD, 2024 WL 962433 (S.D. Fla. Mar. 6, 2024), *appeal pending*, No. 24-10875 (11th Cir.) (the "Litigation"), Florida is under no obligation to comply with such STCs if CMS policy is set aside or stayed by any court of competent jurisdiction. Furthermore, until January 1, 2028, CMS will not enforce sections 1903(w)(1)(A)(iii) and (w)(4) of the Social Security Act and 42 CFR § 433.68(b)(3) and (f) with respect to health care-related tax programs with hold harmless arrangements involving provider payment redistributions that existed as of April 22, 2024. *See* "Exercise of Enforcement Discretion until Calendar Year 2028 for Existing Health Care-Related Tax Programs with Hold Harmless Arrangements Involving the Redistribution of Medicaid Payments," CMS Informational Bulletin (April 22, 2024).

7.5. **State Certification of Funding Conditions.** As a condition of demonstration approval, the state certifies that the following conditions for non-federal share financing of demonstration expenditures have been met:

a. If units of state or local government, including health care providers that are units of state or local government, supply any funds used as non-federal share for expenditures under the demonstration, the state must certify that state or local monies have been expended as the non-federal share of funds under the demonstration in accordance with section 1903(w) of the Act and applicable implementing regulations..

b. To the extent the state utilizes certified public expenditures (CPEs) as the funding mechanism for the non-federal share of expenditures under the demonstration, the state must obtain CMS approval for a cost reimbursement methodology. This methodology must include a detailed explanation of the process, including any necessary cost reporting protocols, by which the state identifies those costs eligible for purposes of certifying public expenditures. The certifying unit of government that incurs costs authorized under the demonstration must certify to the state the amount of public funds allowable under 42 CFR 433.51 it has expended. The federal financial participation paid to match CPEs may not be used as the non-federal share to obtain additional federal funds, except as authorized by federal law, consistent with 42 CFR 433.51(c).

c. The state may use intergovernmental transfers (IGT) to the extent that the transferred funds are public funds within the meaning of 42 CFR 433.51 and are transferred by units of government within the state. Any transfers from units of government to support the non-federal share of expenditures under the demonstration must be made in an amount not to exceed the non-federal share of the expenditures under the demonstration.

d. Under all circumstances, health care providers must retain 100 percent of their payments for or in connection with furnishing covered services to beneficiaries. Moreover, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local governments, or third parties to return and/or redirect to the state any portion of the Medicaid payments in a manner inconsistent with the requirements in section 1903(w) of the Act and its implementing regulations. 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.

e. The State Medicaid Director or his/her designee certifies that all state and/or local funds used as the state's share of the allowable expenditures reported on the CMS-64 for this demonstration were in accordance with all applicable federal requirements and did not lead to the duplication of any other federal funds.

7.6. **Financial Integrity for Managed Care Delivery Systems.** As a condition of demonstration approval, the state attests to the following, as applicable:

a. All risk-based managed care organization, prepaid inpatient health plan (PIHP), and prepaid ambulatory health plan (PAHP) payments, comply with the requirements on payments in 42 CFR 438.6(b)(2), 438.6(c), 438.6(d), 438.60, and 438.74.

b. For non-risk-based PIHPs and PAHPs, arrangements comply with the upper payment limits specified in 42 CFR §447.362, and if payments exceed the cost of services, the state will recoup the excess and return the federal share of the excess to CMS.

7.7. **Requirements for Health Care-Related Taxes and Provider Donations.** As a condition of demonstration approval, the state attests to the following, as applicable:

a. Except as provided in paragraph (c) of this STC, all health care-related taxes as defined by Section 1903(w)(3)(A) of the Act and 42 CFR 433.55 are broad-based as defined by Section 1903(w)(3)(B) of the Act and 42 CFR 433.68(c).

b. Except as provided in paragraph (c) of this STC, all health care-related taxes are uniform as defined by Section 1903(w)(3)(C) of the Act and 42 CFR 433.68(d).

c. If the health care-related tax is either not broad-based or not uniform, the state has applied for and received a waiver of the broad-based and/or uniformity requirements as specified by 1903(w)(3)(E)(i) of the Act and 42 CFR 433.72.

d. The tax does not contain a hold harmless arrangement as described by Section 1903(w)(4) of the Act and 42 CFR 433.68(f).

e. All provider-related donations as defined by 42 CFR 433.52 are bona fide as defined by Section 1903(w)(2)(B) of the Social Security Act, 42 CFR 433.66, and 42 CFR 433.54.

7.8. **State Monitoring of Non-federal Share.** If any payments under the demonstration are funded in whole or in part by a locality tax, then the state must provide a report to CMS regarding payments under the demonstration no later than January 31, 2026. This deliverable is subject to the deferral as described in STC 6.1. This report must include:

a. A detailed description of and a copy of (as applicable) any agreement, written or otherwise agreed upon, regarding any arrangement among the providers including those with counties, the state, or other entities relating to each locality tax or payments received that are funded by the locality tax;

b. Number of providers in each locality of the taxing entities for each locality tax;

c. Whether or not all providers in the locality will be paying the assessment for each locality tax;

d. The assessment rate that the providers will be paying for each locality tax;

e. Whether any providers that pay the assessment will not be receiving payments funded by the assessment;

f. Number of providers that receive at least the total assessment back in the form of Medicaid payments for each locality tax;

g. The monitoring plan for the taxing arrangement to ensure that the tax complies with section 1903(w)(4) of the Act and 42 CFR 433.68(f); and

h. Information on whether the state will be reporting the assessment on the CMS form 64.11A as required under section 1903(w) of the Act.

7.9. **Extent of Federal Financial Participation (FFP) for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the following demonstration expenditures, subject to the budget neutrality expenditure limits described in the STCs in section 8:

a. Administrative costs, including those associated with the administration of the demonstration;

b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and

c. Medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration extension period; including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third-party liability.

7.10. **Program Integrity.** The state must have processes in place to ensure there is no duplication of federal funding for any aspect of the demonstration. The state must also ensure that the state and any of its contractors follow standard program integrity principles and practices including retention of data. All data, financial reporting, and sources of non-federal share are subject to audit.

7.11. **Medicaid Expenditure Groups.** Medicaid Expenditure Groups (MEG) are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to budget neutrality, components of budget neutrality expenditure limit calculations, and other purposes related to monitoring and tracking expenditures under the demonstration. The Master MEG Chart table provides a master list of MEGs defined for this demonstration.

Table 1. Master MEG Chart

MEG	Which BN Test Applies?	WOW Per Capita	WOW Aggregate	WW	Brief Description
Family Planning	Hypo 1	X		X	Expenditures for approved demonstration services for the demonstration population
ADM	N/A				All additional administrative costs that are directly attributable to the demonstration and not described elsewhere and are not subject to budget neutrality.

BN – budget neutrality; MEG – Medicaid expenditure group; WOW – without waiver; WW – with waiver

7.12. **Reporting Expenditures and Member Months.** The state must report all demonstration expenditures claimed under the authority of title XIX of the Act and subject to budget neutrality each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (11-W-00135/4). Separate reports must be

submitted by MEG (identified by Waiver Name) and Demonstration Year (identified by the two-digit project number extension). Unless specified otherwise, expenditures must be reported by DY according to the dates of service associated with the expenditure. All MEGs identified in the Master MEG Chart as WW must be reported for expenditures, as further detailed in the MEG Detail for Expenditure and Member Month Reporting table below. To enable calculation of the budget neutrality expenditure limits, the state also must report member months of eligibility for specified MEGs.

a. **Cost Settlements.** The state will report any cost settlements attributable to the demonstration 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), or line 7. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.

b. **Premiums and Cost Sharing Collected by the State.** The state will report any premium contributions collected by the state from demonstration enrollees quarterly on the form CMS-64 Summary Sheet line 9D, columns A and B. To assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and federal share) should also be reported separately by demonstration year on form CMS-64 Narrative, and on the Total Adjustments tab in the Budget Neutrality Monitoring Tool. In the annual calculation of expenditures subject to the budget neutrality expenditure limit, premiums collected in the demonstration year will be offset against expenditures incurred in the demonstration year for determination of the state's compliance with the budget neutrality limits.

c. **Pharmacy Rebates.** Because pharmacy rebates are included in the base expenditures used to determine the budget neutrality expenditure limit, the state must report the portion of pharmacy rebates applicable to the demonstration on the appropriate forms CMS-64.9 WAIVER and 64.9P waiver for the demonstration, and not on any other CMS-64.9 form (to avoid double counting). The state must have a methodology for assigning a portion of pharmacy rebates to the demonstration in a way that reasonably reflects the actual rebate-eligible pharmacy utilization of the demonstration population, and which identifies pharmacy rebate amounts with DYs. Use of the methodology is subject to the approval in advance by CMS, and changes to the methodology must also be approved in advance by CMS. Each rebate amount must be distributed as state and federal revenue consistent with the federal matching rates under which the claim was paid.

d. **Administrative Costs.** The state will separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the forms CMS-64.10 WAIVER and/or 64.10P WAIVER. Unless indicated otherwise on the MEG Charts and in the STCs in section 8, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS.

e. **Member Months.** As part of the Quarterly and Annual Monitoring Reports described in section 6, the state must report the actual number of "eligible member months" for all demonstration enrollees for all MEGs identified as WOW Per Capita in the Master

MEG Chart table above, and as also indicated in the MEG Detail for Expenditure and Member Month Reporting table below. 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 eligible for two months each contribute two eligible member months per person, for a total of four eligible member months. The state must submit a statement accompanying the annual report certifying the accuracy of this information.

f. **Budget Neutrality Specifications Manual.** The state will create and maintain a Budget Neutrality Specifications Manual that describes in detail how the state will compile data on actual expenditures related to budget neutrality, including methods used to extract and compile data from the state's Medicaid Management Information System, eligibility system, and accounting systems for reporting on the CMS-64, consistent with the terms of the demonstration. The Budget Neutrality Specifications Manual will also describe how the state compiles counts of Medicaid member months. The Budget Neutrality Specifications Manual must be made available to CMS on request.

Table 2. MEG Detail for Expenditure and Member Month Reporting

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 or 64.10 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
Family Planning	Expenditures for approved demonstration services for the demonstration population	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of Service	MAP	Y	7/1/98	6/30/30
ADM	Administrative costs that are directly attributable to the demonstration	N/A	Follow standard CMS-64.10 Category of Service Definitions	Date of Payment	ADM	N	7/1/98	6/30/30

ADM – administration; DY – demonstration year; MAP – medical assistance payments; MEG – Medicaid expenditure group;

7.13. **Demonstration Years.** Demonstration Years (DY) for this demonstration are defined in the table below.

Table 3. Demonstration Years

Demonstration Year 28	May 1, 2025, to June 30, 2026	14 months
Demonstration Year 29	July 1, 2026, to June 30, 2027	12 months
Demonstration Year 30	July 1, 2027, to June 30, 2028	12 months

Demonstration Year 31	July 1, 2028, to June 30, 2029	12 months
Demonstration Year 32	July 1, 2029, to June 30, 2030	12 months

7.14. **Budget Neutrality Monitoring Tool.** The state must provide CMS with quarterly budget neutrality status updates, including established baseline and member months data, using the Budget Neutrality Monitoring Tool provided through the performance metrics database and analytics (PMDA) system. The tool incorporates the "Schedule C Report" for comparing the demonstration's actual expenditures to the budget neutrality expenditure limits described in section 8. CMS will provide technical assistance, upon request.[1]

7.15. **Claiming Period.** The state will report all claims for expenditures subject to the budget neutrality agreement (including any cost settlements) 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 will 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.

7.16. **Future Adjustments to the Budget Neutrality Expenditure Limit.** CMS reserves the right to adjust the budget neutrality expenditure limit:

a. To be consistent with enforcement of laws and policy statements, including regulations and guidance, regarding impermissible provider payments, health care related taxes, or other payments. CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

b. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration. In this circumstance, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC. The state agrees that if mandated changes in the federal law require state legislation, the changes shall 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 federal law.

[1] Per 42 CFR 431.420(a)(2), states must comply with the terms and conditions of the agreement between the Secretary (or designee) and the state to implement a demonstration project, and 431.420(b)(1) states that the terms and conditions will provide that the state will perform periodic reviews of the implementation of the demonstration. CMS's current approach is to include language in STCs requiring, as a condition of demonstration approval, that states provide, as part of their periodic reviews, regular reports of the actual costs which are subject to the budget neutrality limit. CMS has obtained Office of Management and Budget (OMB) approval of the monitoring tool under the Paperwork Reduction Act (OMB Control No. 0938 – 1148) and states agree to use the tool as a condition of demonstration approval.

c. The state certifies that the data it provided to establish the budget neutrality expenditure limit are accurate based on the state's accounting of recorded historical expenditures or the next best available data, that the data are allowable in accordance with applicable federal, state, and local statutes, regulations, and policies, and that the data are correct to the best of the state's knowledge and belief. The data supplied by the state to set the budget neutrality expenditure limit are subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

7.17. **Budget Neutrality Mid-Course Correction Adjustment Request.** No more than once per demonstration year, the state may request that CMS make an adjustment to its budget neutrality agreement based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

a. **Contents of Request and Process**. In its request, the state must provide a description of the expenditure changes that led to the request, together with applicable expenditure data demonstrating that due to these expenditures, the state's actual costs have exceeded the budget neutrality cost limits established at demonstration approval. The state must also submit the budget neutrality update described in STC 7.17.c. If approved, an adjustment could be applied retrospectively to when the state began incurring the relevant expenditures, if appropriate. Within 120 days of acknowledging receipt of the request, CMS will determine whether the state needs to submit an amendment pursuant to STC 3.7. CMS will evaluate each request based on its merit and will approve requests when the state establishes that an adjustment to its budget neutrality agreement is necessary due to changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside of the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

b. **Types of Allowable Changes.** Adjustments will be made only for actual costs as reported in expenditure data. CMS will not approve mid-demonstration adjustments for anticipated factors not yet reflected in such expenditure data. Examples of the types of mid-course adjustments that CMS might approve include the following:

i. Provider rate increases that are anticipated to further strengthen access to care;

ii. CMS or state technical errors in the original budget neutrality formulation applied retrospectively, including, but not limited to the following: mathematical errors, such as not aging data correctly; or unintended omission of certain applicable costs of services for individual MEGs;

iii. Changes in federal statute or regulations, not directly associated with Medicaid, which impact expenditures;

iv. State legislated or regulatory change to Medicaid that significantly affects the costs of medical assistance;

v. When not already accounted for under Emergency Medicaid 1115 demonstrations, cost impacts from public health emergencies;

vi. High-cost innovative medical treatments that states are required to cover; or,

vii. Corrections to coverage/service estimates where there is no prior state experience (e.g., SUD) or small populations where expenditures may vary widely.

c. **Budget Neutrality Update.** The state must submit an updated budget neutrality analysis with its adjustment request, which includes the following elements:

i. Projected without waiver and with waiver expenditures, estimated member months, and annual limits for each DY through the end of the approval period; and,

ii. Description of the rationale for the mid-course correction, including an explanation of why the request is based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or is due to a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

8. MONITORING BUDGET NEUTRALITY

8.1. **Limit on Title XIX Funding.** The state will be subject to limits on the amount of federal Medicaid funding the state may receive over the course of the demonstration approval. The budget neutrality expenditure limits are based on projections of the amount of FFP that the state would likely have received in the absence of the demonstration. The limit consists of one Hypothetical Budget Neutrality Test, as described below. CMS's assessment of the state's compliance with this test will be based on the Schedule C CMS-64 Waiver Expenditure Report, which summarizes the expenditures reported by the state on the CMS-64 that pertain to the demonstration.

8.2. **Risk.** The budget neutrality expenditure limits are determined on either a per capita or aggregate basis as described in Table 1, Master MEG Chart and Table 2, MEG Detail for Expenditure and Member Month Reporting. If a per capita method is used, the state is at risk for the per capita cost of state plan and hypothetical populations, but not for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration for all demonstration populations, CMS will not place the state at risk of changing economic conditions, however, by placing the state at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration. If an aggregate method is used, the state accepts risk for both enrollment and per capita costs.

8.3. **Calculation of the Budget Neutrality Limits and How They Are Applied.** To calculate the budget neutrality limits for the demonstration, separate annual budget limits are determined for each DY on a total computable basis. Each annual budget limit is the sum of one or more components: per capita components, which are calculated as a projected without-waiver PMPM cost times the corresponding actual number of member months, and aggregate components, which project fixed total computable dollar expenditure amounts. The annual limits for all DYs are then added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be

calculated by multiplying the total computable budget neutrality expenditure limit by the appropriate Composite Federal Share.

8.4. **Main Budget Neutrality Test.** This demonstration does not include a Main Budget Neutrality Test. Budget neutrality will consist entirely of Hypothetical Budget Neutrality Tests, including "Supplemental". Any excess spending under the Hypothetical Budget Neutrality Tests must be returned to CMS.

8.5. **Hypothetical Budget Neutrality.** When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority (such as a waiver under section 1915 of the Act), or when a WOW spending baseline for certain WW expenditures is difficult to estimate due to variable and volatile cost data resulting in anomalous trend rates, CMS considers these expenditures to be "hypothetical," such that the expenditures are treated as if the state could have received FFP for them absent the demonstration. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the expenditures on those services. When evaluating budget neutrality, however, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures; that is, savings are not generated from a hypothetical population or service. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies separate, independent Hypothetical Budget Neutrality Tests, which subject hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If the state's WW hypothetical spending exceeds the Hypothetical Budget Neutrality Test's expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending through savings elsewhere in the demonstration or to refund the FFP to CMS.

8.6. **Hypothetical Budget Neutrality Test 1: Family Planning**. The table below identifies the MEG that is used for Hypothetical Budget Neutrality Test 1. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 1 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 4. Hypothetical Budget Neutrality Test 1

MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 28	DY 29	DY 30	DY 31	DY 32
Family Planning	PC	Both	4.7%	$4.24	$4.46	$4.67	$4.89	$5.12

8.7. **Composite Federal Share.** The Composite Federal Share is the ratio that will be used to convert the total computable budget neutrality limit to 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 by total computable demonstration expenditures for the same period, as reported through MBES/CBES and summarized on Schedule C. Since the actual final Composite Federal Share will not be known until the end of the demonstration's approval period, for the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed to method. Each Budget Neutrality Test has its own Composite Federal Share, as defined in the paragraph pertaining to each particular test.

8.8. **Exceeding Budget Neutrality.** CMS will enforce budget neutrality over the life of this demonstration period, which extends from May 1, 2025, to June 30, 2030. If at the end of the demonstration approval period the Hypothetical Budget Neutrality Test 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, the budget neutrality test shall be based on the time elapsed through the termination date.

8.9. **Corrective Action Plan.** If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure limit, CMS will require the state to submit a corrective action plan to CMS for approval. CMS will use the threshold levels in the table below as a guide for determining when corrective action is required.

Table 5. Budget Neutrality Test Corrective Action Plan Calculation

Demonstration	Cumulative Target Definition	Percentage
DY 28	Cumulative budget neutrality limit plus:	2.0 percent
DY 28 through DY 29	Cumulative budget neutrality limit plus:	1.5 percent
DY 28 through DY 30	Cumulative budget neutrality limit plus:	1.0 percent
DY 28 through DY 31	Cumulative budget neutrality limit plus:	0.5 percent
DY 28 through DY 32	Cumulative budget neutrality limit plus:	0.0 percent

9. EVALUATION OF THE DEMONSTRATION

9.1. **Draft Evaluation Design.** The state must submit, for CMS comment and approval, a draft Evaluation Design Framework no later than 180 calendar days after approval of the demonstration. The Evaluation Design must be drafted in accordance with Attachment A (Developing the Evaluation Design) of these STCs, and any applicable CMS evaluation guidance and technical assistance for the demonstration's policy components. The Evaluation Design must also be developed in alignment with CMS guidance on applying robust evaluation approaches, such as quasi-experimental methods like difference-in-differences and interrupted time series, as well as establishing valid comparison groups and assuring causal inferences in demonstration evaluations.

The state is strongly encouraged to use the expertise of the independent party in the development of the draft Evaluation Design. The draft Evaluation Design also must include a timeline for key evaluation activities, including the deliverables outlined in STC 9.5 and STC 9.7.

For any amendment to the demonstration, the state will be required to update the approved Evaluation Design to accommodate the amendment component. The amended Evaluation Design must be submitted to CMS for review no later than 180 calendar days after CMS's approval of the demonstration amendment. Depending on the scope and timing of the amendment, in consultation with CMS, the state may provide the details on necessary modifications to the approved Evaluation Design via the Monitoring Reports. The amendment Evaluation Design must also be reflected in the state's Interim and Summative Evaluation Reports, described below.

In the event of demonstration extensions, for components that are continuing from the prior demonstration approval period, the state's Evaluation Design must reframe and refocus as needed the evaluation hypotheses and research questions to appropriately factor in where it can reasonably expect continued improvements, and where the demonstration's role might be more to help stabilize outcomes. Likewise, for continuing policies, the state must revisit its analytic approaches compared to those used in the prior approval period evaluation activities, to ensure that the evaluation of those policies taps into the longer implementation time span.

9.2. **Evaluation Budget.** A budget for the evaluation must 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.

9.3. **Evaluation Design Approval and Updates.** The state must submit to CMS a revised draft Evaluation Design within 60 calendar days after receipt of CMS's comments, if any. Upon CMS approval of the draft Evaluation Design, the document will be included as an attachment to these STCs. Per 42 CFR §431.424(c), the state will publish the approved Evaluation Design to the state's Medicaid website within 30 calendar days of CMS approval. The state must implement the Evaluation Design and submit a description of its evaluation progress in each of the Monitoring Report. 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.

9 . 4 . **Evaluation Questions and Hypotheses.** Consistent with Attachments A and B ("Developing the Evaluation Design" and "Preparing the Interim and Summative Evaluation Reports") of these STCs, the evaluation deliverables must include a discussion of the evaluation questions and hypotheses that the state intends to test. In alignment with applicable CMS evaluation guidance and technical assistance, the evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components that support understanding the demonstration's impact and its effectiveness in achieving the demonstration's goals.

The hypothesis testing should include, where possible, assessment of both process and outcome measures. The evaluation must study outcomes, such as enrollment and various measures of access, utilization, and health outcomes, as appropriate and in alignment with applicable CMS evaluation guidance and technical assistance, for the demonstration policy components. The evaluation is expected to use applicable demonstration monitoring metrics and other data on the provision of and beneficiary utilization of family planning services. Proposed measures should be selected from

nationally-recognized sources and national measure sets, where possible. Measures sets could include CMS's Core Set of Maternal and Perinatal Health Measures for Medicaid and CHIP (Maternity Core Set); Consumer Assessment of Health Care Providers and Systems (CAHPS); the National Survey of Family Growth (NSFG) the Pregnancy Rish Assessment Monitoring System (PRAMS); and/or measures endorsed by National Quality Forum (NQF).

Specifically, evaluation hypotheses must focus on the impact of the demonstration in helping eligible beneficiaries access family planning and family planning related services. Hypotheses must include, but not be limited to, outcomes such as beneficiary access to and utilization of family planning services (e.g., percentage of beneficiaries reporting difficulty obtaining preferred contraceptive method and percentage of beneficiaries who utilized any contraception by method effectiveness) and family planning related services, and maternal health and birth outcomes (e.g., unintended pregnancies, teen birth rates, and the rate of preterm and low birthweight births). The state must also collect necessary data to accommodate CMS's evaluation expectations to assess the effects of not providing retroactive eligibility on beneficiaries and providers, for example, by examining outcomes such as beneficiary financial status, including changes in medical debt and provider uncompensated care costs. The demonstration evaluation must also assess the effects of the not applicable of NEMT and test evaluation hypotheses related, but not limited, to unmet needs for medical transportation and missed medical appointments.

CMS underscores the importance of the state undertaking a well-designed beneficiary survey and/or interviews to assess, for instance, beneficiary understanding of and experience with access to and quality of care.

9.5. **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 of the demonstration, the Interim Evaluation Report should be posted to the state's Medicaid 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 demonstration authority or any components within the demonstration that expire prior to the overall demonstration's expiration date, and depending on the timeline of expiration/phase-out, the Interim Evaluation Report must include an evaluation of the authority, to be collaboratively determined by CMS and the state.

c. If the state is seeking to extend the demonstration, the draft Interim Evaluation Report is due when the application for the extension is submitted, or one year prior to the end of the demonstration, whichever is sooner. If the state made changes to the demonstration in its application for extension, the research questions and hypotheses, and a description of how the design was adapted should be included. If the state is not requesting an extension for a demonstration, an Interim Evaluation Report is due one year prior to the end of the demonstration. For demonstration phase-outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.

d. The state must submit the revised Interim Evaluation Report 60 calendar days after receiving CMS's comments on the draft Interim Evaluation Report, if any.

e. The Interim Evaluation Report must comply with Attachment (Preparing the Evaluation Report) of these STCs.

9.6. **Cooperation with Federal Evaluators.** As required under 42 CFR §431.420(f), the state must 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 must include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they must 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 6.1.

9.7. **Summative Evaluation Report.** The state must submit to CMS 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 be developed in accordance with Attachment B (Preparing the Interim and Summative Evaluation Reports) of these STCs, and in alignment with the approved Evaluation Design.

a. Unless otherwise agreed upon in writing by CMS, the state must submit a revised Summative Evaluation Report within 60 calendar days of receiving comments from CMS on the draft, if any.

b. Once approved by CMS, the state must post the final Summative Report to the state's Medicaid website within 30 calendar days.

9.8. **Independent Evaluator.** The state must use an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The independent party must sign an agreement to conduct the demonstration evaluation in an independent manner in accordance with the CMS-approved Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

9.9. **Corrective Action Plan Related to Evaluation.** If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of an extension process when associated with the state's Interim Evaluation Report, or as part of the review of the Summative Evaluation Report. A corrective action plan could include a temporary suspension of implementation of demonstration initiatives, in circumstances where evaluation findings indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.10. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

9.10. **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 Interim Evaluation Report, and/or the Summative Evaluation Report.

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

9.12. **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.

10. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION

Timeline	Deliverable	STC
30 calendar days after demonstration approval	State acceptance of demonstration Waivers, STCs, and Expenditure Authorities	Approval letter
Periodic	Monitoring Calls	6.4
30 calendar days after the end of each quarter	Quarterly Expenditure Reports (CMS 64)	6.5(c)
60 calendar days after the end of each quarter, except for Q4 which is submitted with Annual Report	Quarterly Budget Neutrality Reports	6.5(c)
90 calendar days after end of each demonstration year	Annual Monitoring Reports (including Q4 monitoring information)	6.5
60 calendar days after receipt of CMS comments	Revised Monitoring Report	6.5
No later than 180 calendar days after demonstration approval.	Draft Evaluation Design	9.1
60 calendar days after receipt of CMS comments	Revised Evaluation Design	9.3
One year prior to current demonstration expiration date, or when the extension application is submitted, whichever is sooner.	Draft Interim Evaluation Report	9.5(c)

60 calendar days after receipt of CMS comments	Final Interim Evaluation Report	9.5(d)
No later than 18 months after the end of the demonstration approval period.	Draft Summative Evaluation Report	9.7
60 calendar days after receipt of CMS comments	Final Summative Evaluation Report	9.7(a)

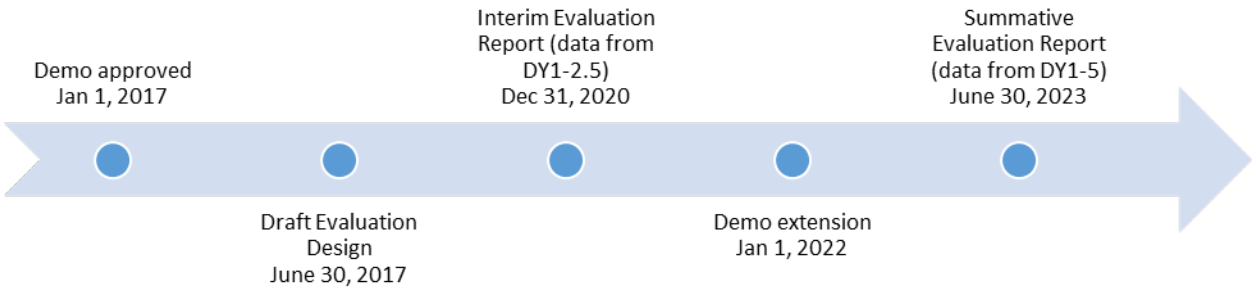
ATTACHMENT A
Developing the Evaluation Design

Introduction

Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions. To that end, for states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate information about these policies. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data. Evaluations should include findings about the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the population of focus), and impacts of the demonstration (e.g., whether the outcomes observed in the population of focus differ from outcomes in similar populations not affected by the demonstration).

Submission Timelines

There is a specified timeline for the state's submission of its draft Evaluation Design and subsequent evaluation reports. The graphic below depicts an example of this timeline for a 5–year demonstration. In addition, the state should be aware that section 1115 evaluation documents are public records. The state is required to publish the Evaluation Design to the state's website within 30 calendar days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.



Expectations for Evaluation Designs

CMS expects Evaluation Designs to be rigorous, incorporate baseline and comparison group assessments, as well as statistical significance testing. Technical assistance resources for constructing comparison groups and identifying causal inferences are available on Medicaid.gov: https://www.medicaid.gov/medicaid/section–1115–demonstrations/1115–demonstration–monitoring–evaluation/1115–demonstration–state–monitoring–evaluation–resources/index.html. If the state needs technical assistance using this outline or developing the Evaluation Design, the state should contact its demonstration team.

All states with section 1115 demonstrations are required to conduct Interim and Summative Evaluation Reports, and the Evaluation Design is the roadmap for conducting these evaluations. The roadmap begins with the stated goals for the demonstration, followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to which the demonstration has achieved its goals. When conducting analyses and developing the

evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

The format for the Evaluation Design is as follows:

- **A.** General Background Information;
- **B.** Evaluation Questions and Hypotheses;
- **C.** Methodology;
- **D.** Methodological Limitations;
- **E.** Attachments.

A. General Background Information – In this section, the state should include basic information about the demonstration, such as:

1. The issues that the state is trying to address with the approved section 1115 demonstration waivers and expenditure authorities, the potential magnitude of the issues, and why the state selected this course of action to address the issues (e.g., a narrative on why the state submitted a section 1115 demonstration application).

2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation.

3. A description of the population groups impacted by the demonstration.

4. A brief description of the demonstration and history of its implementation, and whether the draft Evaluation Design applies to an amendment, extension, or expansion of, the demonstration.

5. For extensions, amendments, and major operational changes: a description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes.

B. Evaluation Questions and Hypotheses – In this section, the state should:

1. Identify the state's hypotheses about the outcomes of the demonstration, and discuss how the evaluation questions align with the hypotheses and the goals of the demonstration.

2. Address how the hypotheses and research questions promote the objectives of Titles XIX and XXI.

3. Describe how the state's demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets can be measured.

4. Include a Logic Model or Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram, which includes information about the goals and features of the demonstration, is a particularly effective modeling tool when working to improve health and health care through specific interventions. A driver diagram depicts

the relationship between the goal, the primary drivers that contribute directly to achieving the goal, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams: https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf.

5. Include implementation evaluation questions to inform the state's crafting and selection of testable hypotheses and research questions for the demonstration's outcome and impact evaluations and provide context for interpreting the findings. Implementation evaluation research questions can focus on barriers, facilitators, beneficiary and provider experience with the demonstration, the extent to which demonstration components were implemented as planned, and the extent to which implementation of demonstration components varied by setting.

C. Methodology – In this section, the state is to describe in detail the proposed research methodology. The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, that the results are statistically valid and reliable, and that it builds upon other published research, using references where appropriate. The evaluation approach should also consider principles of equitable evaluations, and involve partners such as community groups, beneficiaries, health plans, health care providers, social service agencies and providers, and others impacted by the demonstration who understand the cultural context in developing an evaluation approach. The state's Request for Proposal for an independent evaluator, for example, could encourage research teams to partner with impacted groups.

This section also provides evidence that the demonstration evaluation will use the best available data. The state should report on, control for, and make appropriate adjustments for the limitations of the data and their effects on results, and discuss the generalizability of results. This section should provide enough transparency to explain what will be measured and how, in sufficient detail so that another party could replicate the results. Table A below is an example of how the state might want to articulate the analytic methods for each research question and measure.

Specifically, this section establishes:

1. *Methodological Design* – Provide information on how the evaluation will be designed. For example, whether the evaluation will utilize pre/post data comparisons, pre–test or post–test only assessments. If qualitative analysis methods will be used, they must be described in detail.

2. *Focus and Comparison Populations* – Describe the characteristics of the focus and comparison populations, incorporating the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally, discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.

3. *Evaluation Period* – Describe the time periods for which data will be included.

4. *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. The state also should include information about how it will define the

numerators and denominators. Furthermore, the state should ensure the measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval. When selecting metrics, the state shall identify opportunities for improving quality of care and health outcomes, and controlling cost of care. The state also should incorporate benchmarking and comparisons to national and state standards, where appropriate.

Include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by "owning", defining, validating, securing, and submitting for endorsement, etc.). Proposed health measures could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Core Set of Health Care Quality Measures for Medicaid–Eligible Adults, metrics drawn from the Behavioral Risk Factor Surveillance System (BRFSS) survey, or measures endorsed by National Quality Forum. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology.

5. *Data Sources* – Explain from where the data will be obtained, describe any efforts to validate and clean the data, and discuss the quality and limitations of the data sources. If the state plans to collect primary data (i.e., data collected specifically for the evaluation), include the methods by which the data will be collected, the source of the proposed questions and responses, and the frequency and timing of data collection. Additionally, copies of any proposed surveys must be provided to CMS for approval before implementation.

6. *Analytic Methods* – This section includes the details of the selected quantitative and qualitative analysis measures that will adequately assess the effectiveness of the demonstration. This section should:

    a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t–tests, chi–square, odds ratio, ANOVA, regression).
    b. Explain how the state will isolate the effects of the demonstration from other initiatives occurring in the state at the same time (e.g., through the use of comparison groups).
    c. Include a discussion of how propensity score matching and difference–in–differences designs may be used to adjust for differences in comparison populations over time, if applicable.
    d. Consider the application of sensitivity analyses, as appropriate.

7. *Other Additions* – The state may provide any other information pertinent to the Evaluation Design for the demonstration.

Table A. Example Design Table for the Evaluation of the Demonstration

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Hypothesis 1				

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Research question 1a	–Measure 1 –Measure 2 –Measure 3	–Sample e.g. All attributed Medicaid beneficiaries –Beneficiaries with diabetes diagnosis	–Medicaid fee–for–service and encounter claims records	–Interrupted time series
Research question 1b	–Measure 1 –Measure 2 –Measure 3 –Measure 4	–Sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	–Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	–Measure 1 –Measure 2	–Sample, e.g., PPS administrators	–Key informants	Qualitative analysis of interview material

D. Methodological Limitations – This section provides more detailed information about the limitations of the evaluation. This could include limitations about the design, the data sources or collection process, or analytic methods. The state should also identify any efforts to minimize these limitations. Additionally, this section should include any information about features of the demonstration that effectively present methodological constraints that the state would like CMS to take into consideration in its review.

CMS also recognizes that there may be certain instances where a state cannot meet the rigor of an evaluation as expected by CMS. In these instances, the state should document for CMS why it is not able to incorporate key components of a rigorous evaluation, including comparison groups and baseline data analyses. For example, if a demonstration is long–standing, it may be difficult for the state to include baseline data because any pre–test data points may not be relevant or comparable. Other examples of considerations include:

1. When the demonstration is:
    a. Non–complex, unchanged, or has previously been rigorously evaluated and found to be successful; or
    b. Could now be considered standard Medicaid policy (CMS published regulations or guidance).

2. When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:
    a. Operating smoothly without administrative changes;
    b. No or minimal appeals and grievances;
    c. No state issues with CMS–64 reporting or budget neutrality; and
    d. No Corrective Action Plans for the demonstration.

E. Attachments

1. **Independent Evaluator.** This includes a discussion of the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the state will assure no conflict of interest. Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial evaluation and prepare objective Evaluation Reports. The Evaluation Design should include a "No Conflict of Interest" statement signed by the independent evaluator.

2. **Evaluation Budget.** A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated costs, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports 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 draft Evaluation Design, if CMS finds that the draft Evaluation Design is not sufficiently developed, or if the estimates appear to be excessive.

3. **Timeline and Major Milestones.** Describe the timeline for conducting the various evaluation activities, including dates for evaluation–related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The final Evaluation Design shall incorporate milestones for the development and submission of the Interim and Summative Evaluation Reports. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the Final Summative Evaluation Report is due.

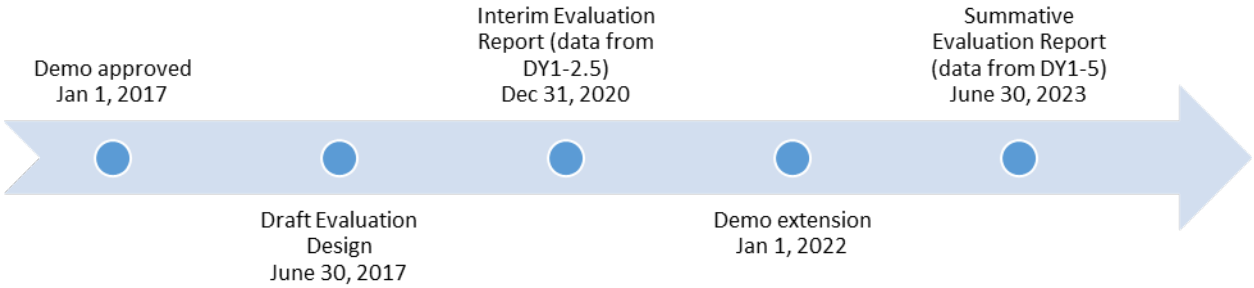
ATTACHMENT B
Preparing the Interim and Summative Evaluation Reports

Introduction

Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions. To that end, for states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate information about these policies. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data. Evaluations should include findings about the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the population of focus), and impacts of the demonstration (e.g., whether the outcomes observed in the population of focus differ from outcomes in similar populations not affected by the demonstration).

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). The graphic below depicts an example of a deliverables timeline for a 5–year demonstration. In addition, the state should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination of the evaluation findings, lessons learned, and recommendations, the state is required to publish the Interim and Summative Evaluation Reports to the state's website within 30 calendar days of CMS approval, as per 42 CFR 431.424(d). CMS will also publish a copy to the Medicaid.gov website.



Expectations for Evaluation Reports

All states with Medicaid section 1115 demonstrations are required to conduct evaluations that are valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). The already–approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses, which will be used to investigate whether the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow the methodology outlined in the approved Evaluation Design. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

When submitting an application for renewal, the Interim Evaluation Report should be posted on the state's website with the application for public comment. Additionally, the Interim Evaluation Report must be included in its entirety with the application submitted to CMS.

CMS expects Interim and Summative Evaluation Reports to be rigorous, incorporate baseline and comparison group assessments, as well as statistical significance testing. Technical assistance resources for constructing comparison groups and identifying causal inferences are available on Medicaid.gov: https://www.medicaid.gov/medicaid/section–1115–demonstrations/1115–demonstration–monitoring–evaluation/1115–demonstration–state–monitoring–evaluation–resources/index.html. If the state needs technical assistance using this outline or developing the evaluation reports, the state should contact its demonstration team.

Intent of this Attachment

Title XIX of the Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's evaluation report submissions must provide comprehensive written presentations of all key components of the demonstration, and include all required elements specified in the approved Evaluation Design. This Attachment is intended to assist states with organizing the required information in a standardized format and understanding the criteria that CMS will use in reviewing the submitted Interim and Summative Evaluation Reports.

Required Core Components of Interim and Summative Evaluation Reports

The Interim and Summative Evaluation Reports present research and findings about the section 1115 demonstration. It is important that the reports incorporate a discussion about the structure of the Evaluation Design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. The evaluation reports should present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in hindsight) the state would further advance, or do differently, and why; and discuss the implications on future Medicaid policy.

The format for the Interim and Summative Evaluation reports is as follows:

A. Executive Summary;
B. General Background Information;
C. Evaluation Questions and Hypotheses;
D. Methodology;
E. Methodological Limitations;
F. Results;
G. Conclusions;
H. Interpretations, and Policy Implications and Interactions with Other State Initiatives;
I. Lessons Learned and Recommendations; and,
J. Attachment(s).

A. **Executive Summary** – A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.

B. **General Background Information about the Demonstration** – In this section, the state should include basic information about the demonstration, such as:
    1. The issues that the state is trying to address with the approved section 1115 demonstration waivers and expenditure authorities, how the state became aware of the issues, the potential magnitude of the issues, and why the state selected this course of action to address the issues.
    2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation.

3. A description of the population groups impacted by the demonstration.
4. A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, or expansion of, the demonstration.
5. For extensions, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and federal level; whether the programmatic changes were implemented to improve beneficiary health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes. Additionally, the state should explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable).

C. **Evaluation Questions and Hypotheses** – In this section, the state should:
   1. Identify the state's hypotheses about the outcomes of the demonstration, and discuss how the goals of the demonstration align with the evaluation questions and hypotheses.
   2. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and XXI.
   3. Describe how the state's demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.
   4. The inclusion of a Logic Model or Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.

D. **Methodology** – In this section, the state is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration, consistent with the approved Evaluation Design. The Evaluation Design should also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published research, (using references), meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable.

An Interim Evaluation Report should provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design should assure there is appropriate data development and collection in a timely manner to support developing an Interim Evaluation Report.

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used. The state also should report on, control for, and make appropriate adjustments for the limitations of the data and their effects on results, and discusses the generalizability of results. This section should provide enough transparency to explain what was measured and how, in sufficient detail so that another party could replicate the results. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

1. *Methodological Design* – Whether the evaluation included an assessment of pre/post or post–only data, with or without comparison groups, etc.

2. *Focus and Comparison Populations* – Describe the focus and comparison populations, describing inclusion and exclusion criteria.

3. *Evaluation Period* – Describe the time periods for which data will be collected.

4. *Evaluation Measures* – List the measures used to evaluate the demonstration and their respective measure stewards.
5. *Data Sources* – Explain from where the data were obtained, and efforts to validate and clean the data.

6. *Analytic Methods* – Identify specific statistical testing which was undertaken for each measure (t–tests, chi–square, odds ratio, ANOVA, regression, etc.).

7. *Other Additions* – The state may provide any other information pertinent to the evaluation of the demonstration.

E. **Methodological Limitations** – This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.

F. **Results** – In this section, the state presents and uses the quantitative and qualitative data to demonstrate whether and to what degree the evaluation questions and hypotheses of the demonstration were addressed. The findings should visually depict the demonstration results, using tables, charts, and graphs, where appropriate. This section should include findings from the statistical tests conducted.

G. **Conclusions** – In this section, the state will present the conclusions about the evaluation results. Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically, the state should answer the following questions:
    1. In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?
    2. If the state did not fully achieve its intended goals, why not?
    3. What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

H. **Interpretations, Policy Implications and Interactions with Other State Initiatives** – In this section, the state will discuss the section 1115 demonstration within an overall Medicaid context and long–range planning. This should include interrelations of the demonstration with other aspects of the state's Medicaid program, interactions with other Medicaid demonstrations, and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This section provides the state with an opportunity to provide interpretations of the data using evaluative reasoning to make judgments about the demonstration. This section should also include a discussion of the implications of the findings at both the state and national levels. Interpreting the implications of evaluation findings should include involving partners, such as community groups, beneficiaries, health plans, health care providers, social service agencies and providers, and others impacted by the demonstration who understand the cultural context in which the demonstration was implemented.

I. **Lessons Learned and Recommendations** – This section of the evaluation report involves the transfer of knowledge. Specifically, it should include potential "opportunities" for future or revised demonstrations to inform Medicaid policymakers, advocates, and stakeholders. Recommendations for improvement can be just as significant as identifying current successful strategies. Based on the evaluation results, the state should address the following questions:

1. What lessons were learned as a result of the demonstration?
2. What would you recommend to other states which may be interested in implementing a similar approach

ATTACHMENT C
Evaluation Design

Florida Medicaid 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

October 27, 2025

Table of Contents

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 contraction 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 May 1, 2025 through June 30, 2030.

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 June 13, 2023, Florida submitted a request to extend the demonstration for a five-year period with no program changes. On April 30, 2025, 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, 2030. Federal CMS approved an extension of the FPW 1115 waiver demonstration (Project No. 11-W-00135/4) for a period of five years

beginning May 1, 2025, through June 30, 2030.

4. Changes to the Demonstration

On May 25, 2022, CMS approved a demonstration amendment that changed the eligibility start date for the demonstrations from after 60-days postpartum to 12-months postpartum. On June 13, 2023, 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 is the enrollment rate and demographic profile of FPW enrollees?

> **Hypothesis:** Research question 1 is included to provide context. Therefore, there is no hypothesis to test for this research question.

2. How did FPW enrollees utilize covered health services?

> **Hypothesis:** Research question 2 is included to provide context (description of the FPW services used by enrollees). Therefore, there is no hypothesis to test for this research question.

3. What proportion of FPW enrollees experience financial strain as a result of no retroactive eligibility?

> **Hypothesis:** Research question 3 is included to provide context (description of impact of not providing retroactive eligibility on beneficiaries). Therefore, there is no hypothesis to test for this research question.

4. To what extent does transportation need impact FPW enrollee access to care?

> **Hypothesis:** Research question 4 is included to provide context (description of FPW enrollees who are impacted by the not applicable NEMT). Therefore, there is no hypothesis to test for this research question.

5. What is the rate of unintended pregnancies for FPW enrollees and eligible women who do not enroll in FPW 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.

6. 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.

7. Is the type of contraception provided to FPW enrollees associated with interbirth intervals and birth rate?

> **Hypothesis:** FPW enrollees who utilize long-acting reversible contraception (LARC) will have longer interbirth intervals and a lower birth rate compared to other FPW enrollees.

8. 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.

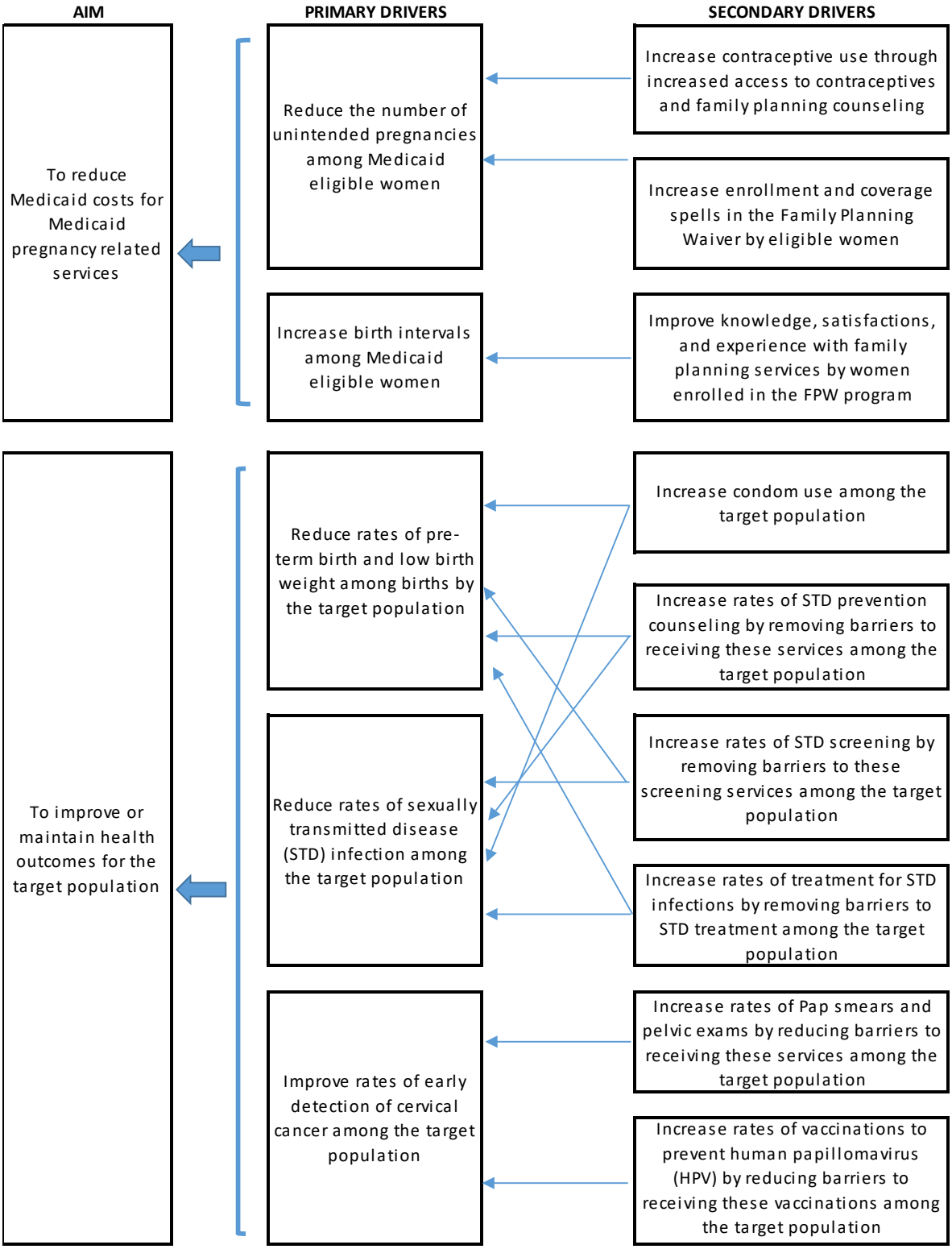
9. Is the FPW achieving cost savings by reducing the number of unintended births?

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

10. Are FPW enrollees satisfied with services?

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

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 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 childbearing 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, and FPW enrollees who use services.

3. Evaluation Period

The evaluation period will begin May 1, 2025 (Demonstration Year 28 (DY28)) and will extend through SFY29/30 (DY32).

4. Evaluation Measures

Table 1. Evaluation Measures

Measure	Description	Research Question(s)
Demographic characteristics of population	Descriptive statistics of the population enrolled in FPW .	1
FPW enrollment rate	Number of FPW enrollees/Number of women eligible for the FPW program	1
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	2
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	2
FPW cancer screening rate	Number of FPW enrollees who received a cancer screening/Total number of FPW enrollees	2
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	2
FPW financial strain rate	Proportion of FPW participants rating Always/Very Often/Sometimes on a 5-point scale from Always to Never *Note: This measure only represents FPW participants who participate in the telephone-based satisfaction survey.*	3
FPW enrollees with transportation-related barriers	Proportion of FPW participants rating Always/Very Often/Sometimes on a 5-point scale from Always to Never *Note: This measure only represents FPW participants who participate in the telephone-based satisfaction survey.*	4
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. *Note: This measure only represents those who responded to the Healthy Start Prenatal Risk Screen.*	5
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. *Note: This measure only represents those who responded to the Healthy Start Prenatal Risk Screen.*	5
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	6

	of women having a second birth within the 24 month index period.	
FPW enrollee LARC users interbirth intervals	Average number of months between multiple births (deliveries) by FPW enrollees who used LARC 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 FPW enrollees who did not use LARC within the 24 month index period and the proportion of women having a second birth within the 24 month index period. *Note: LARC refers to intrauterine devices (IUDs) and subdermal implants.*	7
FPW enrollee LARC users birth rate	Number of live births born to FPW enrollees who use LARC x 1,000 / Mid-year number of FPW enrollees who use LARC Number of live births born to FPW enrollees who do not use LARC x 1,000 / Mid-year number of FPW enrollees who do not use LARC *Note: LARC refers to intrauterine devices (IUDs) and subdermal implants.*	7
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	8
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 the FPW program	8
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	8
Rate of preterm babies born to eligible women who do not enroll in the FPW program	Number of preterm (<37 weeks) babies born eligible women who do not enroll in FPW/Total number of babies born to eligible women who do not enroll in the FPW program	8
FPW cost savings	(Averted birth costs – Cost of providing FPW services)	9
Satisfaction with FPW services	Proportion of FPW participants rating satisfaction with FPW services as 3 or 4 on a 4-point satisfaction scale *Note: This measure only represents FPW participants who participate in the telephone-based satisfaction survey.*	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. Quantitative and Qualitative Data Sources for Florida FPW Evaluation

Data Source	Time Period	Variables
DOH Birth Vital Statistics birth certificates	2000 - 2030	Birth certificate data including infant and mother names, date of birth, address, and social security number.
DOH Healthy Start Prenatal Screens	2011 - 2030	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 - 2030	Names, date of birth, address, and social security number
Medicaid Eligibility Files	2011 - 2030	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 - 2030	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 - 2030	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- 2030	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	2025 – 2030	Qualitative interviews from FPW eligible women and FPW enrollees.
Satisfaction Survey Data	2025 – 2030	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 is the enrollment rate and demographic profile of FPW enrollees?), 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. 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. The determined number of women eligible for the FPW program and not enrolled will be used to calculate the enrollment rate (the total number of women enrolled in FPW/total number of women eligible for FPW for all enrollees). Demographic characteristics for the FPW enrollees, including age and race/ethnicity, will be produced and compared across years during the demonstration period.

For research question 2 (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. FPW participation rates will be calculated as the total number of FPW enrollees who use any FPW service/total number of FPW 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 3 (What proportion of FPW enrollees experience financial strain as a result of no retroactive eligibility?), surveys will be administered to FPW enrollees. Questions related to this topic will be incorporated in the satisfaction surveys that will be administered to FPW enrollees 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 complete surveys are achieved. Surveys will be administered during the first quarter of each calendar year. Descriptive statistics of survey responses will be used to summarize the proportion of FPW enrollees who experience financial strain as a result of no retroactive eligibility.

For research question 4 (To what extent does transportation need impact FPW enrollee access to care?), surveys will be administered to FPW enrollees. Questions related to this topic will be incorporated in the satisfaction surveys that will be administered to FPW enrollees 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 complete surveys are achieved. Surveys will be administered during the first quarter of each calendar year. Descriptive statistics of survey responses will be used to summarize the proportion of FPW enrollees who experience transportation as a barrier to care for FPW services.

For research question 5 (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 and with appropriate regression modeling that will adjust for differences in age, race, and ethnicity.

For research question 6 (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 and with appropriate regression modeling that will adjust for differences in age, race, and ethnicity.

For research question 7 (Is the type of contraception provided to FPW enrollees associated with interbirth intervals and birth rate?) Medicaid claims data, as well as Vital Statistics birth certificate data, will be merged. FPW enrollees who use long-acting reversible contraception (LARC) will be identified based on Medicaid claims data. LARC refers to intrauterine devices (IUDs) and subdermal implants. The merged data will be used to compare the average IBI in number of months for FPW enrollees who use LARC and FPW enrollees who do not. Birth rate (Number of live births x 1,000 /Mid-year population) will be compared between these groups as well.

For research question 8 (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 and with appropriate regression modeling that will adjust for differences in age, race, and ethnicity.

For research question 9 (Is the FPW achieving cost savings by reducing the number of unintended births?), the difference in the birth rate from unintended births 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 10 (Are FPW enrollees satisfied with services?), satisfaction surveys will be administered to FPW enrollees during each DY during the first quarter of the calendar year. Sampling files will be generated based on Medicaid enrollment, eligibility and claims files. From these sampling files, FPW enrollees will then be randomly selected and administered a telephone-based satisfaction survey (see Appendix for satisfaction survey instrument). Contact protocol includes an initial contact followed by a one-week follow-up if the initial contact is not successful. Surveys will be administered each year until 300 complete surveys are achieved. Weighting for non-responses will be calculated and applied. Descriptive statistics of survey responses will be used to summarize FPW enrollee experiences and satisfaction.

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 is the enrollment rate and demographic profile of FPW enrollees?	This is descriptive so there are no hypotheses associated with this question.	Distribution of age and race/ethnicity for FPW enrollees Total number of women enrolled in FPW/Total number of women eligible for FPW	Medicaid enrollment, eligibility and claims files	Descriptive statistics including demographic characteristics
Process	2. How do FPW enrollees utilize covered health services?	This is descriptive, so there are no hypotheses associated with this question.	Total number of FPW enrollees who use any FPW services/Total number of FPW enrollees Total number of FPW enrollees who use contraceptive services/Total number of FPW enrollees Total number of FPW enrollees who use any cancer screening services/Total number of FPW enrollees Total number of FPW enrollees who use any STD screening services/Total number of FPW enrollees	Medicaid enrollment, eligibility, and claims data	Descriptive statistics
Outcome/impact	3. What proportion of FPW enrollees financial strain as a result of no retroactive eligibility?	This is descriptive, so there are no hypotheses associated with this question.	Total number of women who experience financial strain.	Surveys	Descriptive statistics

Outcome/impact	4. To what extent does transportation need impact FPW enrollee access to care?	This is descriptive, so there are no hypotheses associated with this question.	Total number of women who have limited access to care due to lack of reliable transportation.	Surveys	Descriptive statistics
Outcome/impact	5. What is the rate of unintended pregnancies for FPW enrollees compared to eligible women who do not enroll in the FPW program per DY?	The rate of unintended pregnancies will be lower for FPW enrollees compared to eligible women who do not enroll in FPW.	Number of unintended pregnancies for women enrolled in the FPW program/Total number of FPW enrollees 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 FPW	Healthy Start screens, Medicaid eligibility, Vital Statistics birth certificate data, hospital discharge data	Descriptive statistics, Regression modeling (e.g., count data models)
Outcome/impact	6. 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, Regression modeling (e.g., count data models)
Outcome/impact	7. Is the type of contraception provided to FPW enrollees associated with interbirth intervals and birth rate?	FPW enrollees who utilize long-acting reversible contraception (LARC) will have longer interbirth intervals and a lower birth rate compared to other FPW enrollees.	Average number of months between births (deliveries) for FPW enrollees who use LARC Average number of months between births (deliveries) for FPW enrollees who do not use LARC	Medicaid eligibility, Medicaid claims, Vital Statistics birth certificates	Descriptive statistics

			Number of live births born to FPW enrollees who use LARC x 1,000 / Mid-year number of FPW enrollees who use LARC Number of live births born to FPW enrollees who do not use LARC x 1,000 / Mid-year number of FPW enrollees who do not use LARC		
Outcome/impact	8. 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, Regression modeling (e.g., count data models)
Outcome/impact	9. Is the FPW achieving cost savings by reducing the number of unintended births?	The FPW is achieving cost savings by reducing the number of unintended births among FPW enrollees.	Difference in the number of unintended births 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 pregnancy by women enrolled in FPW in the DY to the number of observed births from unintended pregnancy by women

					eligible for the FPW program who do not enroll in the DY. 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). 3. To calculate net cost savings, subtract expenditures to operate the FPW waiver from gross savings.
Outcome/impact	10. 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

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 2023-24 through SFY 2025-26) at a total cost of $1,153,197, not including University cost share.

The Agency is currently inquiring about the potential to renew the contract for a period of five years (SFY 2026-27 through SFY 2030-31) with an anticipated total budget of $2,219,156, not including University cost share.

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.

Table 4. FPW Evaluation Activities

Deliverable/Activity	Due Date
Evaluation Design submitted to CMS*	October 27, 2025
Quarterly Monitoring Report*	August 29, 2026
Quarterly Monitoring Report*	November 29, 2026
DY28 (SFY25/26) Medicaid Data Request and Verification	Request due: January 15, 2027 Verification due: 30 calendar days after data delivery
Quarterly Monitoring Report*	February 26, 2027
FPW DY28 (SFY25/26) Draft Evaluation Report	May 3, 2027
Quarterly Monitoring Report*	May 31, 2027
Quarterly Monitoring Report*	August 29, 2027
Annual Monitoring Report*	September 30, 2027
FPW DY28 (SFY25/26) Final Evaluation Report	October 15, 2027
Quarterly Monitoring Report*	November 30, 2027
DY29 (SFY26/27) Medicaid Data Request and Verification	Request due: January 14, 2028 Verification due: 30 calendar days after data delivery
Quarterly Monitoring Report*	February 29, 2028

FPW DY29 (SFY26/27) Draft Evaluation Report	May 16, 2028
Quarterly Monitoring Report*	May 31, 2028
Quarterly Monitoring Report*	August 29, 2028
Annual Monitoring Report*	September 29, 2028
FPW DY29 (SFY26/27) Final Evaluation Report	October 15, 2028
Quarterly Monitoring Report*	November 29, 2028
DY30 (SFY27/28) Medicaid Data Request and Verification	Request due: January 15, 2029 Verification due: 30 calendar days after data delivery
Quarterly Monitoring Report*	February 28, 2029
FPW DY30 (SFY27/28) Draft Evaluation Report	May 15, 2029
Interim Evaluation Report DY28 and 29 (SFY25/26 and 26/27)*	May 30, 2029
Quarterly Monitoring Report*	May 30, 2029
Quarterly Monitoring Report*	August 29, 2029
FPW DY30 (SFY27/28) Final Evaluation Report	October 17, 2029
Annual Monitoring Report*	September 28, 2029
Quarterly Monitoring Report*	November 28, 2029
DY31 (SFY28/29) Medicaid Data Request and Verification	Request due: January 16, 2030 Verification due: 30 calendar days after data delivery
Quarterly Monitoring Report*	February 27, 2030
FPW DY31 (SFY28/29) Draft Evaluation Report	May 16, 2030
Quarterly Monitoring Report*	May 30, 2030
Quarterly Monitoring Report*	August 29, 2030
Annual Monitoring Report*	September 27, 2030
FPW DY31 (SFY28/29) Final Evaluation Report	October 16, 2030
Quarterly Monitoring Report*	November 25, 2030
DY32 (SFY29/30) Medicaid Data Request and Verification	Request due: January 16, 2031 Verification due: 30 calendar days after data delivery

Quarterly Monitoring Report*	February 26, 2031
FPW DY32 (SFY29/30) Draft Evaluation Report	May 15, 2031
Quarterly Monitoring Report*	May 30, 2031
Draft of Draft Summative Evaluation Report due to Agency	August 15, 2031
Annual Monitoring Report*	September 26, 2031
FPW DY32 (SFY29/30) Final Evaluation Report	October 1, 2031
Final Summative Report*	November 1, 2031

*Deliverables due to CMS

Appendix (Survey Instruments)

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 current medical debt due to family planning related services prior to enrolling in the program?
    a. No (skip to question 8)
    b. Yes (if selected, ask question 7)

7. If yes, which category of debt best describes your current situation?
    a. $0.01-$249.99
    b. $250.00-$749.99
    c. $750.00-$999.99
    d. $1,000.00+

8. How often does this describe you? It is hard for me to pay for family planning medical services.
    a. Always
    b. Very Often
    c. Sometimes
    d. Rarely
    e. Never

9. How often does this describe you? I have a difficult time finding transportation for family planning medical appointments?
    a. Always
    b. Very Often
    c. Sometimes
    d. Rarely
    e. Never

10. How often does this describe you? I have missed a family planning medical appointment because of problems with transportation.
    a. Always
    b. Very Often
    c. Sometimes
    d. Rarely
    e. Never

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