Florida Medicaid Family Planning Waiver
3-Year 1115 Waiver Extension Request

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Agency for Health Care Administration

Presented at the April 22, 2014

Medicaid Medical Care Advisory Meeting

1:00 p.m. – 4:00 p.m.

Waiver Authorization

- Initial 5-Year Period (1998-2003)
- Three-Year Extension Period (2003-2006)
- Three-Year Extension Period (2006-2009)
- Current Extension Period - July 1, 2011 through December 31, 2014

1115 Research and Demonstration Waivers

- Experimental, Pilot or Demonstration Projects.
  - Benefit Packages, Reimbursement Methodologies, Covering Expanded Groups.
  - States Commit to a Policy Experiment that must be Formally Evaluated.
- 1115(a)(1) allows the Secretary to waive compliance with most of the requirements in the Medicaid and State Children's Health Insurance Program (SCHIP) State Plans.
- 1115(a)(2) allows the Secretary to regard as expenditures costs that would not otherwise be matchable under Medicaid or SCHIP.
- If granted, the initial approval period is 5 years and the State may request two 3 year extensions of the program.

Waiver Extension Requirements

- Florida is required to publish a “Public Notice” document for public input 30 days prior to submitting the waiver extension request.

- The public notice document is available at the following link for review and comment from April 1, 2014 through April 30, 2014. http://ahca.myflorida.com/Medicaid/Family_Planning/extension.shtml.

- Written comments may be emailed to FamilyPlanningWaiver@ahca.myflorida.com or mailed to:

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Tallahassee, Florida 32308

Elements of the Public Notice Document

- Program description, goals and objectives.
- Proposed health care delivery system and eligibility requirements, benefit coverage and cost sharing required of individuals impacted by the waiver.
- Estimate of expected increase or decrease in annual enrollment and annual aggregate expenditures.
- Hypothesis and evaluation parameters of the waiver.
- Specific waiver and expenditure authorities.
- Locations and Internet address where the public notice document is available for public review.
- Postal and Internet e-mail addresses where comments may be submitted and reviewed by the public for a minimum of 30-days.
- The location, date and time of at least two public hearings held to solicit public input on the waiver extension request.

Elements of the Waiver Extension Request

- Historical narrative summary of the demonstration project.
- Documentation of compliance with special terms and conditions of the waiver.
- List of waiver and expenditure authorities requested .
- Summary of quality activities under the waiver.
- Documentation of compliance with budget neutrality cap and financial data.
- Evaluation report including evaluation activities and findings to date.
- Documentation of public process in accordance with federal and state regulations.

Current Waiver Program

The Florida Medicaid Family Planning Waiver expands the provision of family planning and family planning-related services, in all 67 counties, to women ages 14 through 55, losing their Medicaid coverage, who:

- Have family income at or below 185 percent of the Federal poverty level (FPL); and
- Are not otherwise eligible for Medicaid, SCHIP or health insurance coverage that provides family planning services.

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

Goals and Objectives

- The overarching goal of the Florida Medicaid Family Planning Waiver is to increase the number of women receiving Florida Medicaid Family Planning Waiver services who are between the ages of 14 through 55 and have income at or below 185% of the federal poverty level.

- The overall Florida Medicaid Family Planning Waiver objectives are:

  - Increase access to family planning services;

  - Increase child spacing intervals through effective contraceptive use;

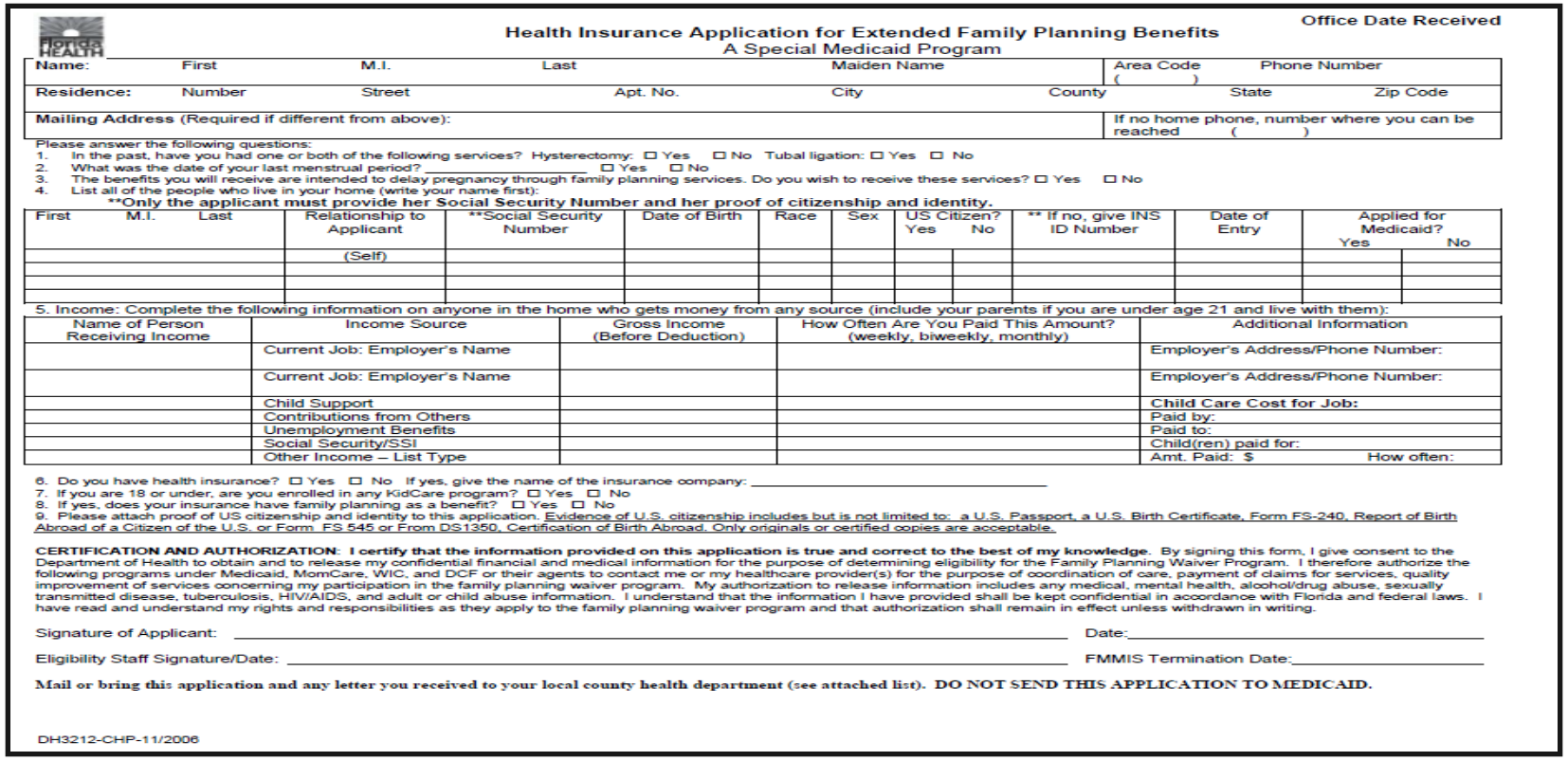
  - Reduce the number of unintended pregnancies in Florida; and

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

Covered Services

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

Recipient Application



Office Date Received

Health Insurance Application for Extended Family Planning Benefits
A Special Medicaid Program

Name:	First	M.I.	Last	Maiden Name	Area Code ( )	Phone Number
Residence:	Number	Street	Apt. No.	City	County	State / Zip Code
Mailing Address (Required if different from above):					If no home phone, number where you can be reached ( )	

Please answer the following questions:
1. In the past, have you had one or both of the following services? Hysterectomy: ☐ Yes ☐ No Tubal ligation: ☐ Yes ☐ No
2. What was the date of your last menstrual period? _____ ☐ Yes ☐ No
3. The benefits you will receive are intended to delay pregnancy through family planning services. Do you wish to receive these services? ☐ Yes ☐ No
4. List all of the people who live in your home (write your name first):

****Only the applicant must provide her Social Security Number and her proof of citizenship and identity.**

First M.I. Last	Relationship to Applicant	**Social Security Number	Date of Birth	Race	Sex	US Citizen? Yes	No	** If no, give INS ID Number	Date of Entry	Applied for Medicaid? Yes	No
	(Self)										

5. Income: Complete the following information on anyone in the home who gets money from any source (include your parents if you are under age 21 and live with them):

Name of Person Receiving Income	Income Source	Gross Income (Before Deduction)	How Often Are You Paid This Amount? (weekly, biweekly, monthly)	Additional Information
	Current Job: Employer's Name			Employer's Address/Phone Number:
	Current Job: Employer's Name			Employer's Address/Phone Number:
	Child Support			**Child Care Cost for Job:**
	Contributions from Others			Paid by:
	Unemployment Benefits			Paid to:
	Social Security/SSI			Child(ren) paid for:
	Other Income – List Type			Amt. Paid: $ How often:

6. Do you have health insurance? ☐ Yes ☐ No If yes, give the name of the insurance company: _____
7. If you are 18 or under, are you enrolled in any KidCare program? ☐ Yes ☐ No
8. If yes, does your insurance have family planning as a benefit? ☐ Yes ☐ No
9. Please attach proof of US citizenship and identity to this application. Evidence of U.S. citizenship includes but is not limited to: a U.S. Passport, a U.S. Birth Certificate, Form FS-240, Report of Birth Abroad of a Citizen of the U.S. or Form FS 545 or From DS1350, Certification of Birth Abroad. Only originals or certified copies are acceptable.

CERTIFICATION AND AUTHORIZATION: I certify that the information provided on this application is true and correct to the best of my knowledge. By signing this form, I give consent to the Department of Health to obtain and to release my confidential financial and medical information for the purpose of determining eligibility for the Family Planning Waiver Program. I therefore authorize the following programs under Medicaid, MomCare, WIC, and DCF or their agents to contact me or my healthcare provider(s) for the purpose of coordination of care, payment of claims for services, quality improvement of services concerning my participation in the family planning waiver program. My authorization to release information includes any medical, mental health, alcohol/drug abuse, sexually transmitted disease, tuberculosis, HIV/AIDS, and adult or child abuse information. I understand that the information I have provided shall be kept confidential in accordance with Florida and federal laws. I have read and understand my rights and responsibilities as they apply to the family planning waiver program and that authorization shall remain in effect unless withdrawn in writing.

Signature of Applicant: _____ Date: _____

Eligibility Staff Signature/Date: _____ FMMIS Termination Date: _____

Mail or bring this application and any letter you received to your local county health department (see attached list). DO NOT SEND THIS APPLICATION TO MEDICAID.

DH3212-CHP-11/2006

May be accessed from the Department of Health website at: http://www.doh.state.fl.us/family/famplan/waiver.html.

Impact of the Florida Medicaid Family Planning Waiver Extension

- The extension does not impact any other eligibility or service provision of the Medicaid or SCHIP programs.
- Extension of the waiver will allow the Agency to continue providing family planning services to the eligible population.

Begin Public Comment

Public Comment Period:

- April 1, 2014 – April 30, 2014

Public Meeting Locations:

- April 22, 2014: Agency for Health Care Administration, Tallahassee, Florida
- April 24, 2014: Medicaid Area Office Six, Tampa, Florida

Details regarding the meetings may be viewed at:
http://ahca.myflorida.com/Medicaid/Family_Planning/extension.shtml