Florida Medicaid Family Planning Waiver

Agency for Health Care Administration

Presented at the October 18, 2016
Post Award Forum

1115 Research and Demonstration Waivers

- Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects.
- These demonstrations give states additional flexibility to design and improve their programs.
- States can demonstrate and evaluate policy approaches such as:
  - Expanding eligibility to individuals who are not otherwise Florida Medicaid or CHIP eligible.
  - Providing services not typically covered by Florida Medicaid.
  - Using innovative service delivery systems that improve care, increase efficiency, and reduce costs.
- If granted, the initial approval period is five years, and the State may request additional three-year extensions of the program.

Current Waiver Program

- Expands the provision of family planning and family planning-related services, in all 67 counties, to women ages 14 through 55 years, losing their Florida Medicaid coverage, who:

- Have family income at or below 191 percent of the federal poverty level (FPL); and

- Are not otherwise eligible for Florida Medicaid, State CHIP, or health insurance coverage that provides family planning services.

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

Goal

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 191% of the federal poverty level.

Objectives

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

Evaluation

- The Family Planning waiver includes an evaluation that looks at the four objectives of the Waiver and if they are being met.
- The Agency contracts with the University of Florida's Family Data Center to complete the evaluation.
- The Agency received a final evaluation from the University of Florida on June 24, 2016 for the period July 1, 2011 through June 30, 2014.

Waiver History

- Initially approved in 1998
- Current Waiver Period – January 1, 2015 through December 31, 2017

Covered Services

- Physical exams
- Family planning counseling
- Pregnancy tests
- Birth control supplies
- Colposcopies
- Treatment for sexually transmitted infections
- 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 Web site at: http://www.doh.state.fl.us/family/famplan/waiver.html.

Questions and Comments

Thank you!