State _____

Department _____

Name of Demonstration Program _____

Date Proposal Submitted _____

Projected Date of Implementation _____

Authorizing Signature& Title _____

Primary Family Planning Program Contact:

Name _____

Title _____

Phone Number _____

Email Address _____

The State of _____, Department of _____ proposes a Section 1115 Family Planning demonstration entitled _____, which will increase the number of individuals receiving family planning services.

Date Proposal Submitted: _____

Projected Date of Implementation: _____

I. Enrollment Projections and Goals

The _____ (program name) will provide family planning services to an estimated _____ residents of the State of _____ over the life of the demonstration. Specifically, the State estimates that it will cover the following number of enrollees for each demonstration year (please break the number down into women and men, if the State is proposing to cover both). Renewal States should use the first three demonstration year lines to represent each year of the proposed renewal period:

Demonstration Year 1:
Demonstration Year 2:
Demonstration Year 3:
Demonstration Year 4:
Demonstration Year 5:

Please describe the goals of the demonstration.

II. Family Planning Demonstration Standard Features

Please provide an assurance that the following requirements will be met by this demonstration, and include the signature of the authorizing official.

☐ The Family Planning demonstration will be subject to Special Terms and Conditions (STCs). The core set of STCs is included in the application package. Depending upon the design of the State's family planning demonstration, additional STCs may apply.

☐ The State has utilized a public process to allow interested stakeholders to comment on its proposed family planning demonstration.

☐ Family Planning demonstrations are intended to provide family planning services to low-income men and women who would not otherwise have access to services for averting pregnancy. Eligible individuals are those who are uninsured, are not enrolled in Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), or who have creditable

health insurance coverage.

Signature: _____

Title: _____

III. Eligibility

A. Eligible Populations

Please indicate with check marks the populations which the State is proposing to include in the family planning demonstration, and fill in the age, sex and income information where appropriate. Note that these demonstrations are intended to cover uninsured, low-income individuals with incomes no higher than 200 percent of the Federal poverty level (FPL).

☐ Women losing Medicaid pregnancy coverage at the conclusion of 60 days postpartum.

_____ Period for which individuals would have coverage (e.g. 12 months).

☐ Individuals losing Medicaid coverage with gross income up to and including ___ % FPL.

☐ Men ☐ Women

☐ Individuals losing SCHIP coverage with gross income up to and including ___ % FPL.

☐ Men ☐ Women

☐ Uninsured individuals eligible based solely on income, with gross income from _____ % FPL up to and including ____ % FPL.

☐ Men , Ages _____

☐ Women, Ages _____

A. Initial Eligibility Process

1. **Please describe the initial eligibility process. Please note any differences in the eligibility process for different groups:**

2. **Will the State use an automatic eligibility process for any of the groups described under III (A)?** (e.g. Will the State automatically enroll women losing Medicaid after 60 days postpartum?)

☐ Yes
☐ No

If only for certain groups, please describe which groups.

If yes, please describe the process for auto-enrollment, including (1) any information verification processes; (2) the process for notifying enrollees of their change in program eligibility; and (3) the timeframe for automatic eligibility.

3. ☐ **Please assure (with a check mark) that the State will not enroll individuals who are enrolled in Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), have private insurance, pregnant or unable to become pregnant.**

4. **Where is the initial application accepted?**

   ☐ Medicaid eligibility sites
   ☐ County health department/ local health agency
   ☐ Provider
   ☐ Mail-In
   ☐ On-line
   ☐ Other (Please specify.)

5. **Is the application for family planning simplified or the same as full Medicaid? Please attach a copy of the application.**

   ☐ Simplified
   ☐ Same as full Medicaid

6. **Is point-of-service eligibility granted?**
   ☐ Yes
   ☐ No

   If yes, please describe the process, including: the entity or entities that will make the point-of-service determination; the services available at initial eligibility determination; how the final eligibility determination is made by the State; how the information is verified; and what information the State receives to make a final eligibility determination.

7. ☐ **Please assure (with a check mark) that the State uses gross income prior to applying any income disregards.**

8. **What income disregards does the State use? Please indicate any differences by eligibility group or age.**

9. **Are these income disregards the same as the disregards used in the Medicaid State Plan?**

   ☐ Yes
   ☐ No

   If no, please describe how income disregards differ from the Medicaid State Plan.

10. **What elements and verification must be provided in the initial application process? For those elements that are required, please check a box indicating whether the State allows self-declaration or requires documentation. Please also indicate whether there are differences by eligibility group or age.**

a. **Proof of Income:**
   ☐ Self-declaration
   ☐ Documentation required
      - What documents are sufficient to document income?
      - When are documents required?
      - Are there differences by eligibility group or age?

   ☐ Income Verification and Eligibility System (IEVS)

b. **Proof of Resources:**
   ☐ Self-declaration
   ☐ Documentation required
      - What documents are sufficient to document resources?
      - When are documents required?
      - Are there differences by eligibility group or age?

c. **Social Security Number:**
   ☐ **Please assure (with a check mark) that the State requires a Social Security Number (SSN) for all family planning demonstration enrollees.**

   ☐ Documentation required

- What documents are sufficient to document SSN?
- When are documents required?
- Are there differences by eligibility group or age?

d. **Citizenship Status:**
☐ **Please assure (with a check mark) that the State is in compliance with the citizenship documentation requirements of the Deficit Reduction Act in its Medicaid State Plan and will require (or continue to require for renewals) the same documentation under the family planning demonstration.**

11. **What entity is responsible for determining final eligibility for the demonstration?**

☐ State agency
☐ County Agency

B. Eligibility Redetermination Process

1. ☐ **Please assure (with a check mark) that the State will conduct an eligibility redetermination at a minimum of every 12 months**.

2. **Is the eligibility redetermination process identical to the initial eligibility process?**

☐ Yes – This section is now complete. Please go to Section III: Program Integrity.

☐ No – Please complete question number 3 below.

3. **Please describe the eligibility redetermination process. Please note any differences in the eligibility process for different groups and whether the information and verification requirements differ from the initial application**. Note: the process for eligibility redeterminations are not passive in nature, but will require an action by the family planning program recipient in order to continue eligibility. For example, the State may satisfy this requirement by having the recipient sign and return a renewal form to verify the current accuracy of the information previously reported to the State.

4. **Please describe the process for <u>verifying</u> the information that applicants provide at redetermination.**

IV. Program Integrity

1. **Please describe the State's overall program integrity plan including system edits and checks that the State uses to ensure the integrity of eligibility determinations.**

2. ☐ **Please assure (with a check mark) that the State assures that all claims made for Federal financial participation under this demonstration, if approved by CMS, will meet all Medicaid financial requirements**.

3. **Please describe the process the State will use to monitor and ensure that eligibility determinations are conducted according to State and Federal requirements.**

   ☐ Medicaid Eligibility Quality Check (MEQC)
   ☐ Other (Please specify.)

4. **How does the State ensure that services billed to the Medicaid family planning demonstration program are not also billed to Title X?**

5. **How does the State ensure that enrollees are not dually-enrolled in Medicaid or SCHIP and also in the family planning demonstration?**

6. **How does the State ensure that the services billed to this family planning program are not also billed under the regular Medicaid State Plan or SCHIP State Plan?**

6. **How does the State ensure that the enrollee does not have creditable health insurance coverage?**

V. Service Codes – Federal financial participation (FFP) will be considered for family planning services provided to individuals under the Section 1115 Family Planning Demonstration will be available, as approved by CMS, at the following rates and as described in Attachment B (note: the State should fill out the template in Attachment B). Specifically:

- For services whose primary purpose is family planning (i.e., contraceptives and sterilizations), FFP will be available at the 90-percent matching rate. Procedure codes for office visits, laboratory tests, and certain other procedures must carry a primary diagnosis that specifically identifies them as family planning services.

- Family planning-related services reimbursable at the Federal Medical Assistance Percentage (FMAP) rate are defined as those services generally performed as part of, or as follow-up to, a family planning service for contraception. Such services are provided

because a "family planning-related" problem was identified/diagnosed during a routine/periodic family planning visit. Services/surgery, which are generally provided in an ambulatory surgery center/facility, a special procedure room/suite, an emergency room, an urgent care center or a hospital for family planning-related services, are not considered family planning-related services and are not covered under the demonstration.

- FFP will not be available for the costs of any services, items or procedures that do not meet the requirements specified above, even if family planning clinics or providers provide them.

VI. Delivery System

1. **Please describe the general delivery system for the family planning program.**

   ☐ Fee for Service
   ☐ Primary Care Case Management
   ☐ Other (Please specify.)

2. **Please describe the provider network being used under the family planning demonstration. Please also provide the percentage of patients each of these provider types will be serving**:

☐ Managed Care Organizations	**Estimated Percentage of Patients:**
☐ All Medicaid Providers	**Estimated Percentage of Patients:**
☐ Health Departments	**Estimated Percentage of Patients:**
☐ Family Planning Clinics	**Estimated Percentage of Patients:**
☐ FQHCs/RHCs	**Estimated Percentage of Patients:**
☐ Private Providers	**Estimated Percentage of Patients:**

3. **Primary Care Referrals:** Under the demonstration, the State is required to evaluate primary care referrals as described in Section IX: Evaluation.

   A. ☐ **Please assure (with a check mark) that the State will provide primary care referrals. (Please attach a letter of support from your State Primary Care Association in Attachment A.)**

   B. **How is information about primary care services given to people enrolled in the demonstration?**

   ☐ Mailed to enrollees by State Medicaid agency
   ☐ Distributed at application sites during enrollment
   ☐ Given by providers during family planning visits
   ☐ Other (Please specify.)

C. **Does the State verify that referrals to primary care services are being made? If so, how?**

D. **How does the State notify primary care providers that enrollees in the demonstration will be receiving primary care referrals and may seek their services?**

VII. Program Administration and Coordination

1. **What other State agencies or program staff coordinate or collaborate on the family planning demonstration program? Please describe the relationship and function of each office in this demonstration.**

   ☐ Primary care office **Relationship/Function:**
   ☐ Maternal and child health **Relationship/Function:**
   ☐ Family planning **Relationship/Function:**
   ☐ Public health **Relationship/Function:**
   ☐ Other (Please specify.) **Relationship/Function:**

2. **Please describe how the Medicaid agency coordinates with the Title X family planning program.**

3. **How will the State provide training/monitoring to providers?**

4. **How often will provider training/monitoring be offered?**

5. **Will the State provide a written manual for providers on claiming for family planning demonstration services?** Claiming guidance to providers should be separate and distinct from the claiming guidance provided for family planning services under the Medicaid State plan.

   ☐ Yes
   ☐ No

6. **How does the State communicate information to providers in the demonstration program?**

VIII. Evaluation

A. Demonstration Purpose, Aim, and Objectives

1. Objectives/Hypotheses: Please describe the purpose, aim and objectives of the demonstration, including the overarching strategy, principles, goals, and objectives; the State's hypotheses on outcomes of the demonstration; and key interventions planned.

B. Evaluation Design

1. Coordination: Please describe the management/coordination of the evaluation, including: information about the organization conducting the evaluation; and timelines for implementation of the evaluation and reporting deliverables.

2. Performance Measures/Data Sources: Please describe the demonstration performance measures, including:

- **specific performance measures and the rationale for selection, including statistical reliability and validity;**
- **measurement methodology and specifications, including eligible / target populations and time period of study for the specific measure; and,**
- **data sources, method for data collection, rationale for the approach, and sampling methodology. Note: CMS recommends the following minimum data set for family planning demonstrations:**

Measure	Number	Percentage Change
Enrollment		
Averted Births		

3. Primary Care Referrals: Please describe how the State will evaluate the extent to which clinical referrals to primary care are provided since health concerns requiring follow-up by a primary care provider may be identified during a family planning visit. (For example, some States may be able to provide quantitative information about the frequency of these clinical referrals and how it has changed over time. Other States may prefer to evaluate clinical referrals using qualitative information, which might be obtained, for example, from a focus group of enrollees participating in the family planning demonstration.)

4. Integrate Earlier Findings: For renewal States, please describe how the evaluation design plan for the renewal will integrate earlier evaluation findings and recommendations. (Note: renewal States are also asked to provide their interim evaluation report as Attachment E.)

5. Please provide an evaluation design plan for analysis, including:
- **Evaluation of performance;**
- **Outcomes;**
- **Limitations/Challenges/Opportunities;**
- **Successes/Best Practices;**
- **Interpretations/Conclusions;**
- **Revisions to strategy or goals; and,**
- **Recommendations and implications at the State and Federal levels.**

IX. Budget Neutrality Agreement: The State needs to provide a budget neutrality spreadsheet as provided in Attachment C. The State also needs to describe the assumptions on which the budget neutrality spreadsheet is based. (For renewal States, the State also needs to provide the annual budget limits data described in the State's Special Terms and Conditions for each year of the demonstration.)

1. State Assumptions on Which the Budget Spreadsheet is Based.

2. State Source of Funds: Please also describe the source of funds that will make up the State's share of the demonstration.

X. Waivers and Authority Requested

The following waivers are requested pursuant to the authority of Section 1115 of the Social Security Act (Please check all applicable that the State is requesting and attach further information if necessary):

☐ Amount Duration and Scope 1902(a)(10)(B) and (C) – The State will offer to the demonstration population a benefit package consisting only of approved family planning services.

☐ Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) 1902(a)(43)(A) – The State will not furnish or arrange of EPSDT services to the demonstration population.

☐ Retroactive Coverage 1902(a)(34) – Individuals in the family planning demonstration program will not be retroactively eligible.

☐ Eligibility Procedures 1902(a)(17) – Parental income will not be included when determining a minor's (individual under age 18) eligibility for the family planning demonstration.

☐ Other (Please specify.)

XI. Attachments

Place check marks beside the attachments you are including with the application.

- ☐ Attachment A: Letter of Support from State Primary Care Association
- ☐ Attachment B: Service Codes
- ☐ Attachment C: Budget Neutrality Worksheet
- ☐ Attachment D: Implementation Schedule
- ☐ Attachment E: Interim Evaluation Report (for renewals only)
- ☐ Attachment F: Draft Application
- ☐ Other Attachments (Please indicate subject of attachment.)

XII. Contact Information and Signature

Please provide contact information for the person CMS should contact for questions related to the family planning demonstration project.

Family Planning Contact:

Name: _____

Title: _____

Phone Number: _____

_____ _____
Date Name of Authorizing State Official (Typed)

_____
Signature of Authorizing State Official