Minnesota Department of **Human Services**

May 17, 2013

Heather Hostetler, Project Officer
Division of State Demonstrations & Waivers
Center for Medicaid, CHIP and Survey & Certification, CMS
7500 Security Boulevard
Mail Stop S2-01-06
Baltimore, MD 21244-1850

Re: Minnesota Family Planning Program §1115 Waiver Extension Request

Dear Ms. Hostetler: [redacted]

As you know, Minnesota's Family Planning Program (MFPP) §1115 waiver is currently approved until December 31, 2013. Minnesota submitted an initial waiver extension request for an additional three years on December 31, 2012. Enclosed please find a revised supplemental extension request that includes all the required information for a complete waiver extension request.

We look forward to working with you and the federal review team toward approval of this waiver request. If you have any questions regarding this request, please contact Jan Kooistra, of my staff, at (651) 431-2188 or jan.kooistra@state.mn.us.

Sincerely,

[redacted]

Carol Backstrom
Medicaid Director

cc: Courtenay Savage
Juliana Sharp

Minnesota Family Planning Program Section 1115 Waiver Renewal Request

Project No. 11-W-00183/5

Submitted to:

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services

Submitted by:

Carol Backstrom, Medicaid Director
Minnesota Department of Human Services
P.O. Box 64983
St. Paul, Minnesota 55164-0983

May 17, 2013

Table of Contents

Attachments

Section I – Program Description

1) Provide a summary of the proposed Demonstration program, and how it will further the objectives of title XIX and/or title XXI of the Social Security Act (the Act).

In 2002, the Minnesota Department of Human Services (DHS) applied for a section 1115 Medicaid family planning waiver from the Centers for Medicare & Medicaid Services (CMS) to implement the Minnesota Family Planning Program (MFPP). This waiver was initially approved July 20, 2004, and program implementation began on July 1, 2006. The initial demonstration period ended June 30, 2011. An extension of the waiver was approved on December 29, 2011, effective through December 31, 2013. Minnesota proposes a three-year extension of federal waiver authority necessary to enable the continued implementation and evaluation of the MFPP.

The MFPP demonstration expands the provision of family planning and family planning-related services to men and women, 15 years of age or older and under age 50, who have family income at or below 200 percent of the Federal poverty level (FPL), and who are not enrolled in any other Minnesota Health Care Programs administered by the Minnesota Department of Human Services.

The renewal of the Minnesota Family Planning Program Section 1115 waiver will allow the State of Minnesota to continue to provide family planning services to men and women who would not otherwise access such services in order to reduce the number of unintended pregnancies and births paid for by the Medical Assistance program.

2) Include the rationale for the Demonstration.

The purpose of the Minnesota Family Planning Program is to demonstrate positive health outcomes and cost savings by providing an accessible, preventive approach to family planning services for individuals who normally don't access such services. The waiver program will reduce gaps in coverage and will increase the availability of pre-pregnancy family planning services. Family planning and child spacing promotes healthier pregnancy outcomes.

3) Describe the hypotheses that will be tested/evaluated during the Demonstration's approval period and the plan by which the State will use to test them.

Under the demonstration Minnesota expects to achieve the following objectives:

- Increase the number of Minnesotans who have access to family planning services through Minnesota Health Care Programs (MHCP)
- Increase the proportion of men and women enrolled in MHCP who utilize family planning services;
- Increase the average age of mother at first birth among MHCP enrollees.

- Reduce the teen birth rate among MHCP enrollees

The hypotheses that will be tested during the demonstration renewal period, the program objectives, and associated indicators for measurement of progress toward those objectives, are summarized in Attachment A. The data sources and measurement period that will be used for each indicator are noted.

4) Describe where the Demonstration will operate, i.e., statewide, or in specific regions; within the State.

The MFPP demonstration waiver is implemented statewide.

5) Include the proposed timeframe for the Demonstration.

Minnesota seeks to renew its family planning waiver under Section 1115 of the Social Security Act for the period beginning January 1, 2014 through December 31, 2016.

6) Describe whether the Demonstration will affect and/or modify other components of the state's current Medicaid and CHIP programs outside of eligibility, benefits, cost sharing or delivery systems.

The demonstration will not affect and/or modify other components of the state's current Medicaid and CHIP programs outside of eligibility, benefits, cost sharing or delivery systems.

Section II – Demonstration Eligibility

1) Include a chart identifying any populations whose eligibility will be affected by the Demonstration.

Eligibility Chart
Optional State plan Groups

Eligibility Group Name	Social Security Act and CFR Citations	Income Level
Men and women 15 years of age or older and under age 50 with family income at or below 200% FPL.	none	

2) Describe the standards and methodologies the state will use to determine eligibility for any populations whose eligibility is changed under the Demonstration, to the extent those standards or methodologies differ from the State plan.

Program Eligibility
An MFPP applicant must meet the following requirements to be eligible for the program:

- Be a citizen of the United States or a qualified non-citizen eligible for Medical Assistance with federal financial participation;
- Be a Minnesota resident;
- Be 15 years of age or older and under age 50;
- Have income at or below 200 percent of the federal poverty guideline (applicants under age 21 are treated as a household of one);
- Not be pregnant;
- Not be enrolled in another Minnesota Health Care Program administered by the Department of Human Services; and
- Not reside in a medical institution.

Participation in the program does not require the consent of anyone other than the applicant. Applicants must report available third-party coverage and cooperate with the Department in obtaining third-party payments. The Department may waive this requirement if the applicant states that reporting third-party coverage would place the applicant at risk of physical or emotional harm.

Eligibility Verification Activities

The Department documents the income of applicants and enrollees annually. To qualify for the Minnesota Family Planning Program (MFPP), an applicant must have gross annual income at or below 200% FPG. Income deeming requirements used to determine eligibility for families and children in the medical assistance program apply, except that for a person under age 21, no income from a parent, spouse, or sponsor is deemed to the person. AFDC methodology regarding sources of countable income is followed under the demonstration. There are no income disregards or deductions. There is no asset test for MFPP.

To qualify for ongoing MFPP, individuals must be citizens or noncitizens who qualify for federally-funded programs. Citizenship and immigration status are verified at application, following the reasonable opportunity policies under Medical Assistance. Applicants must document citizenship as required by the Deficit Reduction Act of 2005, Public Law 109-71. The Department utilizes the Systematic Alien Verification for Entitlement (SAVE) program to conduct immigration status verifications for ongoing eligibility determinations. The presumptive eligibility process does not require documentation of citizenship.

Presumptive Eligibility

Individuals may also apply at a provider's office for presumptive eligibility once during a 12-month period. A certified family planning services provider will screen a person for eligibility using preliminary information provided by the person. A person who, based on the preliminary information, appears to meet the eligibility requirements is presumptively eligible. The period of presumptive eligibility begins the first day of the month that a certified family planning services provider determines that a person is presumptively eligible. The period ends the last day of the month following the month that the certified family planning services provider determines that a person was presumptively eligible, or earlier if ongoing eligibility is determined. During the presumptive eligibility period the applicant must apply for ongoing eligibility. The Department then makes the final determination of ongoing eligibility.

Providers that perform presumptive eligibility determinations do not review the applicant's citizenship documentation. However, citizenship verification must be obtained for individuals who apply for ongoing eligibility. If citizenship cannot be verified electronically, documentation of citizenship will be requested from the individual who has at least 90 days to provide such documentation.

MFPP presumptive eligibility providers are available throughout the state in over 47 counties. MFPP applicants may apply for MFPP at any of the certified provider locations. There are no access restrictions related to the geographical location of either the clinics or the applicants

Third Party Liability
Applicants must report available third-party coverage and cooperate with the Department in obtaining third-party payments. The Department may waive this requirement if the applicant states that reporting third-party coverage would place the applicant at risk of physical or emotional harm. Please refer to item 2 on page 1 of the MFPP application for language that aligns with the "good cause" exception. A copy of the MFPP application is provided at Attachment B.

Eligibility Redetermination Process
Eligibility for MFPP is re-determined every 12 months. Earned and unearned income is verified at each renewal. Please refer to Attachment C for a copy of the MFPP renewal application form.

Certification Period
An enrollee is eligible for the MFPP for 12 continuous months from the determination of eligibility regardless of changes in income or family size. MFPP eligibility will end prior to the annual renewal if the enrollee:

- Is no longer a Minnesota resident;
- Enrolls in another Minnesota Health Care Program
- Is no longer a citizen, national, or immigrant with a status eligible for federal funding;
- Reaches 50 years of age;
- Becomes pregnant; or
- Resides in a medical institution.

Applicants and enrollees must report a change in an eligibility factor to the Department within ten days of learning about the change.

Changes in Eligibility Status
The MFPP application form includes a section informing applicants and enrollees of their responsibility to report eligibility status changes within 10 days of the change happening. The state does not act on changes in income or household composition until renewal. The grievance and appeal process available to Medicaid applicants and enrollees is available to all MFPP applicants and enrollees. MFPP applicants are informed of the right to request a fair hearing in the notice of MFPP eligibility. The rights and responsibilities section of the MFPP renewal application also informs applicants of the right to request a fair hearing.

12-month Lock Out

The 12-month lock-out period was established in state rule with the intent of instituting a penalty for failing to report certain changes. The penalty for failing to report a change under MFPP in no way prohibits individuals from applying for coverage under Medicaid or MinnesotaCare. The 12-month lock-out period is unique to the MFPP.

The 12-month lock-out period only applies to applicants and enrollees who fail to report the following changes:

- Is no longer a Minnesota resident
- Becomes an institutionalized individual under Code of Federal Regulations, title 42, sections 435.1009 and 435.1010

If the only unreported change is a pregnancy, applicants and enrollees will not be subject to the 12-month ineligibility period, but pregnant applicants and enrollees will be disenrolled from MFPP and may reapply for the program following the end of the pregnancy. Failure to report a change in income or family size during the MFPP eligibility year does not disqualify an enrollee.

3) Specify any enrollment limits that apply for expansion populations under the Demonstration.

The state does not apply enrollment limits for eligible populations under the MFPP waiver

4) Provide the projected number of individuals who would be eligible for the Demonstration, and indicate if the projections are based on current state programs (i.e., Medicaid state plan, or populations covered using other waiver authority, such as 1915(c)). If applicable, please specify the size of the populations currently served in those programs.

Projected number of persons ever enrolled in demonstration year VII (CY 2014), demonstration year VIII (CY 2015) and demonstration year IX (CY 2016):

CY 2014	45,619
CY 2015	45,799
CY 2016	46,060

Projections are based on the average ratio of persons ever enrolled (unique individuals)/average monthly enrolled across the three-year period from CY 2010 through CY 2012.

5) To the extent that long term services and supports are furnished (either in institutions or the community), describe how the Demonstration will address post-eligibility treatment of income, if applicable. In addition, indicate whether the Demonstration will utilize spousal impoverishment rules under section 1924, or will utilize regular post-eligibility rules under 42 CFR 435.726 (SSI State and section 1634) or under 42 CFR 435.735 (209b State).

N/A

6) Describe any changes in eligibility procedures the state will use for populations under the Demonstration, including any eligibility simplifications that require 1115 authority (such as continuous eligibility or express lane eligibility for adults or express lane eligibility for children after 2013).

Presumptive Eligibility The state has elected to utilize a presumptive eligibility process for this demonstration. The presumptive eligibility process under MFPP complies with the presumptive eligibility process set forth in section 1920C of the Social Security Act and in the State Medicaid Directors Letter #10-013 issued on July 2, 2010.

Eligibility Period The state has elected to provide individuals determined income-eligible at application or annual redetermination with a continuous twelve months of demonstration eligibility, regardless of reported changes in income or family size.

Lock-out Period The state requires individuals to report changes in eligibility within ten days of learning of such a change. Failure to report certain changes results in a twelve-month lock-out period from this demonstration. The twelve-month lock-out period applies to enrollees who do not report:

- Is no longer a Minnesota resident
- Becomes an institutionalized individual under Code of Federal Regulations, title 42, sections 435.1009 and 435.1010

The locked-out individuals may be eligible for Medicaid or other MHCP operated by the state. Individuals locked-out of the demonstration have access to full Medicaid grievance and appeals procedures.

Income Deeming Requirements When determining MFPP eligibility for an individual under age 21, no income from a parent, spouse, or sponsor is deemed to the person.

7) If applicable, describe any eligibility changes that the state is seeking to undertake for the purposes of transitioning Medicaid or CHIP eligibility standards to the methodologies or standards applicable in 2014 (such as financial methodologies for determining eligibility based on modified adjusted gross income), or in light of other changes in 2014.

The state does not intend to adopt the MAGI conversion standards and methodologies as established under the Affordable Care Act to determine eligibility for MFPP applicants.

Section III – Demonstration Benefits and Cost Sharing Requirements

1) Indicate whether the benefits provided under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan:

___ Yes _x_ No (if no, please skip questions 3 – 7)

The MFPP benefit package is the same as the family planning and family planning-related benefit package under the Medicaid state plan.

2) Indicate whether the cost sharing requirements under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan:

_x_ Yes ___ No (if no, please skip questions 8 - 11)

Individuals enrolled in the MFPP are exempt from premiums and copayments.

3) If changes are proposed, or if different benefit packages will apply to different eligibility groups affected by the Demonstration, please include a chart specifying the benefit package that each eligibility group will receive under the Demonstration.

MFPP recipients will be eligible to receive the full scope of family planning and family planning-related benefits set forth in Minnesota's approved state plan.

4) If electing benchmark-equivalent coverage for a population, please indicate which standard is being used:

N/A The state does not intend to use benchmark-equivalent coverage for the MFPP population.

___ Federal Employees Health Benefit Package
___ State Employee Coverage
___ Commercial Health Maintenance Organization
___ Secretary Approved

5) In addition to the Benefit Specifications and Qualifications form: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Benefit-Specifications-and-Provider-Qualifications.pdf, please complete the following chart if the Demonstration will provide benefits that differ from the Medicaid or CHIP State plan.

MFPP recipients will be eligible to receive the full scope of family planning and family planning-related benefits set forth in Minnesota's approved state plan.

6) Indicate whether Long Term Services and Supports will be provided.

___ Yes (if yes, please check the services that are being offered) _X_ No

7) Indicate whether premium assistance for employer sponsored coverage will be available through the Demonstration.

___ Yes (if yes, please address the questions below) _X_ No (if no, please skip this question)

8) If different from the State plan, provide the premium amounts by eligibility group and income level.

N/A

9) Include a table if the Demonstration will require copayments, coinsurance and/or deductibles that differ from the Medicaid state plan.

N/A

Section IV – Delivery System and Payment Rates for Services

1) Indicate whether the delivery system used to provide benefits to Demonstration participants will differ from the Medicaid and/or CHIP State plan:

__ Yes

_X_ No (if no, please skip questions 2 – 7 and the applicable payment rate questions)

Minnesota currently utilizes both fee-for-service and managed care delivery systems under the Medicaid state plan. Under the MFPP demonstration all enrollees will receive services from enrolled providers who are paid on a fee-for-service basis.

2) Describe the delivery system reforms that will occur as a result of the Demonstration, and if applicable, how they will support the broader goals for improving quality and value in the health care system. Specifically, include information on the proposed Demonstration's expected impact on quality, access, cost of care and potential to improve the health status of the populations covered by the Demonstration. Also include information on which populations and geographic areas will be affected by the reforms.

The MFPP will continue to operate state-wide. MFPP presumptive eligibility providers are available throughout the state in over 47 counties. MFPP applicants may apply for MFPP at any of the certified provider locations. There are no access restrictions related to the geographical location of either the clinics or the applicants.

3) Indicate the delivery system that will be used in the Demonstration by checking one or more of the following boxes:

___ Managed care
- ___ Managed Care Organization (MCO)
- ___ Prepaid Inpatient Health Plans (PIHP)
- ___ Prepaid Ambulatory Health Plans (PAHP)

_X_ Fee-for-service (including Integrated Care Models)
___ Primary Care Case Management (PCCM)

___ Health Homes
___ Other (please describe)

4) If multiple delivery systems will be used, please include a table that depicts the delivery system that will be utilized in the Demonstration for each eligibility group that participates in the Demonstration (an example is provided). Please also include the appropriate authority if the Demonstration will use a delivery system (or is currently seeking one) that is currently authorized under the State plan, section 1915(a) option, section 1915(b) or section 1932 option.

N/A

5) If the Demonstration will utilize a managed care delivery system:

N/A

a) Indicate whether enrollment be voluntary or mandatory. If mandatory, is the state proposing to exempt and/or exclude populations?

b) Indicate whether managed care will be statewide, or will operate in specific areas of the state.

c) Indicate whether there will be a phased-in rollout of managed care.

d) Describe how the state will assure choice of MCOs, access to care and provider network adequacy.

e) Describe how the managed care providers will be selected/procured.

6) Indicate whether any services will not be included under the proposed delivery system and the rationale for the exclusion.

MFPP recipients will be eligible to receive the full scope of family planning and family planning-related benefits set forth in Minnesota's approved state plan.

7) If the Demonstration will provide personal care and/or long term services and supports, please indicate whether self-direction opportunities are available under the Demonstration. If yes, please describe the opportunities that will be available, and also provide additional information with respect to the person-centered services in the Demonstration and any financial management services that will be provided under the Demonstration.

N/A

___ Yes ___ No

8) If fee-for-service payment will be made for any services, specify any deviation from State plan provider payment rates. If the services are not otherwise covered under the State plan, please specify the rate methodology.

Provider payment rates for family planning and family planning-related services provided under MFPP will not deviate from those set forth in Minnesota's approved state plan

9) If payment is being made through managed care entities on a capitated basis, specify the methodology for setting capitation rates, and any deviations from the payment and contracting requirements under 42 CFR Part 438.

N/A

10) If quality-based supplemental payments are being made to any providers or class of providers, please describe the methodologies, including the quality markers that will be measured and the data that will be collected.

N/A

Section V – Implementation of Demonstration

1) Describe the implementation schedule. If implementation is a phase-in approach, please specify the phases, including starting and completion dates by major component/milestone.

Minnesota proposes a three-year extension of its current 1115 waiver authority to enable the continued implementation under the same terms that the demonstration is currently operating.

2) Describe how potential Demonstration participants will be notified/enrolled into the Demonstration.

DHS Public Web Site
Information on MFPP is available to the public on the DHS website at www.dhs.state.mn.us/familyplanning. This web page provides descriptive information about program eligibility and how to access services, including an electronic directory of certified MFPP providers and paper application or online application options.

The MFPP provider web page at www.dhs.state.mn.us/provider/mfpp includes outreach materials for providers to utilize including MFPP program posters, brochures, fact sheets and program FAQs. Please refer to Attachment D for a copy of the MFPP Brochure.

MFPP Provider Web Sites
Many certified MFPP provider agencies provide education and outreach through their web pages.

Program Application
Individuals apply for family planning benefits using the MFPP application. The application is available in providers' offices and on-line. The Department determines an applicant's eligibility

for the program within 45 days of receipt of a complete application. Coverage must be renewed annually.

Provider Qualifications

The following providers are eligible to become certified MFPP providers:

Ambulatory surgical centers
Certified nurse midwives
Clinical nurse specialists
Community health clinics
Family planning agencies
Federally qualified health centers
The Indian Health Service
Laboratories
Nurse practitioners
Outpatient hospital departments
Pharmacies
Physician assistants
Physician-directed clinics
Physicians
Public health clinics
Rural health clinics

Before becoming a certified MFPP provider, providers must be enrolled as a MHCP provider and follow the MHCP provider requirements as defined in the MHCP Provider Agreement (Attachment E). Failure to adhere to these requirements can result in corrective action.

To apply for certification as an MFPP provider, the Assurance Statement for MFPP Certified Providers and the Notification of Certified Provider Locations must be completed and submitted to the state for approval. The Assurance Statement for MFPP Certified Providers is an addendum to the MHCP Provider Agreement and assures that the health care entity agrees to provide federally approved contraception management services to eligible persons with low-income through the state's established MFPP and complies with and provisions of Minnesota Rules, parts 9505.5300 to 9505.5325, which include:

- Complete required training
- Provide information about presumptive eligibility to interested persons
- Help interested persons complete MFPP applications and forms
- Use the department's eligibility verification system to verify a person screened for MFPP eligibility does not receive MHCP coverage
- Determine presumptive eligibility
- Give required notices to a person screened for eligibility
- Promptly forward completed applications and forms to MHCP
- Cooperate with department application tracking and program evaluation activities

A copy of the MFPP Provider Application packet is provided at Attachment F.

The Certified MFPP Provider Training Guide explains the policies and procedures for certified MFPP providers who will help clients apply for the MFPP by determining presumptive eligibility. Providers are certified upon approval of their application and successful review and completion of this training guide. A copy of the Certified MFPP Provider Training Guide can be found at www.dhs.state.mn.us/provider/mfpp.

Access to primary care
Certified MFPP providers are required to give their patients a MHCP Fact Sheet (Attachment G) to inform them about other, more comprehensive health care programs they may wish to apply for, including Medicaid and MinnesotaCare. Certified MFPP providers are also required to give their patients a list of primary care providers who may be available to them to provide primary care services at a reduced cost that are not covered under MFPP (Attachment H). These requirements are outlined in the Certified MFPP Provider Training Guide.

3) If applicable, describe how the state will contract with managed care organizations to provide Demonstration benefits, including whether the state needs to conduct a procurement action.

N/A

Section VI – Demonstration Financing and Budget Neutrality

Please refer to Attachment I for the MFPP budget neutrality worksheet

Section VII – List of Proposed Waivers and Expenditure Authorities

Reasonable Promptness **Section 1902(a)(8)**

To the extent necessary to enable the state to impose a 12-month lock-out period for individuals enrolled in the demonstration who fail to report the following changes with 10 days of: no longer being a Minnesota resident or becoming an institutionalized individual under 42 CFR §435.1009 to 435.1010. The lock-out period applies only to this demonstration and does not apply to any other change in eligibility factor.

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.

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.

Eligibility Procedures **Section 1902(a)(17)**

To the extent necessary to allow the state to exclude parental, spousal or sponsor income when determining demonstration eligibility for an individual under age 21.

To the extent necessary to allow the state to not act on reported changes for income or household size for 12 months, for a person found income-eligible upon application or annual redetermination when determining eligibility for the demonstration.

To the extent necessary to extend presumptive eligibility to members of the demonstration population pursuant to section 1920C of the SSA.

MAGI-based Eligibility Methodologies **Section 1902(e)(14)(A) as added by ACA Section 2002 and Section 2107(e)(1)(E) as added by ACA Section 2101(d)(2)**

To the extent necessary to allow the state to not adopt the MAGI conversion standards and methodologies as established under the Affordable Care Act to determine eligibility for MFPP applicants.

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 initial application for the demonstration is made.

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

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

Ex Parte Eligibility Redetermination **Section 1902(a)(19)**

To the extent necessary to enable the state to require that a separate demonstration application be filed by an applicant who is no longer eligible for regular Medicaid prior to being determined eligible for the demonstration program; and to require a demonstration member to file a separate Medicaid application if they are interested in receiving benefits under any other Medicaid subprogram.

Section VIII – Public Notice

Please include the following elements as provided for in 42 CFR 431.408 when developing this section:

1) Start and end dates of the state's public comment period.

A notice requesting public comment on the proposed MFPP §1115 waiver renewal request was published in the Minnesota State Register on April 1, 2013. This notice announced a 30-day comment period from April 1, 2013 to May 1, 2013 on the MFPP waiver renewal request. The notice informed the public on how to access an electronic copy or request a hard copy of the waiver request. Instructions on how to submit written comments were provided. In addition, the notice included information about two public hearings scheduled to provide stakeholders and other interested parties the opportunity to comment on the waiver request. The time and location for the two public hearings, along with information about how to arrange to speak at either of the hearings, was provided. Finally, the notice provided a link to the state's health care waivers web page for complete information on the MFPP waiver request including the public notice process, the public input process, planned hearings and a copy of waiver application. A copy of the Minnesota State Register Notice published on April 1, 2013 is provided as Attachment J.

2) Certification that the state provided public notice of the application, along with a link to the state's web site and a notice in the state's Administrative Record or newspaper of widest circulation 30 days prior to submitting the application to CMS.

The DHS web page at MFPP Waiver provides the public with information about the MFPP waiver renewal request. The website is updated on a regular basis and includes information about the public notice process, opportunities for public input, planned hearings and additional informational meetings. A copy of the initial draft of the MFPP waiver renewal request and the final draft of the waiver request that includes modifications following the public input process are also posted on the website. The main page of the DHS public website includes a new "Public Participation" link to help people quickly identify what comment periods are open. This page contains a link to the health care waivers web page. During the state comment periods, it instructed how to submit comments on the MFPP waiver renewal request to DHS. After the comment periods, it was updated to alert web visitors that a federal comment period on the MFPP renewal request will be coming soon.

3) Certification that the state convened at least 2 public hearings, of which one hearing included teleconferencing and/or web capability, 20 days prior to submitting the application to CMS, including dates and a brief description of the hearings conducted.

Two public hearings were held to provide stakeholders and other interested parties the opportunity to comment on the waiver request. The first public hearing was held at DHS on April 22, 2013. Public testimony was given by XX people, and XX members of the public were in attendance. The second public hearing was held at The Minnesota Mosquito Control District on April 25, 2013. Public testimony was given by X people, and XX members of the public were in attendance. Teleconferencing was available at each hearing to allow interested stakeholders the option to participate in the hearing remotely.

4) Certification that the state used an electronic mailing list or similar mechanism to notify the public.

On April 1, 2013, an email was sent to all stakeholders on the agency-wide electronic mailing list informing them of the state's intent to submit the MFPP waiver renewal request and directing them to the Minnesota State Register notice published on April 1, 2013. Please refer to the stakeholder e-mail list at Attachment K.

5) Comments received by the state during the 30-day public notice period.

DHS received XXX verbal comments and XXX written comments from stakeholders regarding the proposed MFPP waiver renewal request during the comment period from April 1, 2013 to May 1, 2013. Copies of the written comments received during the comment period are included at Attachment L. Comments that included private medical or public assistance information regarding the commenter have been redacted to remove individually identifying information. DHS' response to the written comments received by May 1, 2013 is included at Attachment M and is also reflected in modifications that have been made throughout the main body of the waiver proposal.

6) Summary of the state's responses to submitted comments, and whether or how the state incorporated them into the final application.

7) Certification that the state conducted tribal consultation in accordance with the consultation process outlined in the state's approved Medicaid state plan, or at least 60 days prior to submitting this Demonstration application if the Demonstration has or would have a direct effect on Indians, tribes, on Indian health programs, or on urban Indian health organizations, including dates and method of consultation.

In Minnesota, there are seven Anishinaabe (Chippewa and Ojibwe) reservations and four Dakota (Sioux) communities. The seven Anishinaabe reservations include Grand Portage located in the northeast corner of the state, Bois Forte located in extreme northern Minnesota, Red Lake located in extreme northern Minnesota west of Bois Forte, White Earth located in northwestern Minnesota; Leech Lake located in the north central portion of the state; Fond du Lac located in northeastern Minnesota west of the city of Duluth; and Mille Lacs located in the central part of the state, south of Brainerd. The four Dakota Communities include: Shakopee Mdewakanton Sioux located south of the Twin Cities near Prior Lake; Prairie Island located near Red Wing; Lower Sioux located near Redwood Falls; and Upper Sioux whose lands are near the city of Granite Falls. While these 11 tribal groups frequently collaborate on issues of mutual benefit, each operates independently as a separate and sovereign entity – a state within a state or nation within a nation. Recognizing American Indian tribes as sovereign nations, each with distinct and independent governing structures, is critical to the work of DHS. DHS has a designated staff person in the Medicaid Director's office who acts as a liaison to the Tribes. Attachment N is Minnesota's tribal consultation policy.

The Tribal Health Work Group was formed to address the need for a regular forum for formal consultation between tribes and state staff. Work group attendees include Tribal Chairs, Tribal Health Directors, Tribal Social Services Directors, and the state consultation liaison. The Native American Consultant from CMS and state agency staff attend as necessary depending on the topics covered at each meeting. The state liaison attends all Tribal Health Work Group meetings and provides updates on state and federal activities. The liaison will often arrange for appropriate DHS policy staff to attend the meeting to receive input from Tribes and to answer questions.

On October 29, 2012 a letter was sent to all Tribal Chairs and Tribal Health Directors informing them of the state's intent to submit a request to extend the MFPP waiver. The letter also informed Tribes of the public input process and the initial Minnesota State Register notice to be published on December 3, 2012. Please refer to Attachment O for a copy of the October 29, 2012 letter.

The state's intent to submit a request to extend the MFPP waiver was included in a summary of federal waiver activity provided to Tribal Chairs and Tribal Health Directors at the February 19, 2013 Tribal Health Work Group meeting.

On March 7, 2013 a second letter was sent to all Tribal Chairs and Tribal Health Directors requesting their comment on DHS' intent to submit a MFPP waiver renewal request. The letter informed Tribes that a copy of the waiver request would be available on the DHS web site. The letter also informed Tribes of the second Minnesota State Register notice to be published on April 1, 2013 and the public hearings to be held on April 22, 2013 and April 25, 2013. Please refer to Attachment P for a copy of the March 2013 letter.

If this application is an emergency application in which a public health emergency or a natural disaster has been declared, the State may be exempt from public comment and tribal consultation requirements as outlined in 42 CFR 431.416(g). If this situation is applicable, please explain the basis for the proposed emergency classification and public comment/tribal consultation exemption (if additional space is needed, please supplement your answer with a Word attachment).

N/A

Section IX – Demonstration Administration

Contact

Jan Kooistra
Federal Relations
Minnesota Department of Human Services◦ 540 Cedar Street ◦ St. Paul, MN 55155
Mailing address: P.O. Box 64983 ◦ St. Paul, MN 55164-0983
Email: Jan.kooistra@state.mn.us
Phone: 651-431-2118
Fax: 651-431-7421

Attachment A

MFPP Evaluation Plan Overview

Attachment A
Evaluation Plan Objectives and Indicators for Minnesota Family Planning Program §1115 Waiver

Short Term Objectives

The waiver is expected to increase access to and use of family planning services by low-income women in Minnesota.

- **Objective 1**: Increase the number of Minnesotans who have access to family planning services through Minnesota Health Care Programs (MHCP).
- **Objective 2**: Increase the proportion of men and women enrolled in MHCP who utilize family planning services.

Long Term Objectives

With the improvement of the short-term indicators there should also be improvement in long-term indicators including reductions in teen births and unintended pregnancy, and increases in birth intervals and average age of mother at first birth. There is a lag expected between the inception of the program and any effect of the program on long term objectives.

- **Objective 3**: Increase the average age of mother at first birth among MHCP enrollees.
- **Objective 4**: Reduce the teen birth rate among MHCP enrollees.

Objective 1

Increase the number of Minnesotans who have access to family planning services through MHCP.

Measurement

Access the number of Minnesotans that have access to Family Planning services through MHCP**.**

Hypothesis

Enrollment in the family planning program and/or MHCP programs offering family planning services will increase during the demonstration.

Indicators

Measured for each state fiscal year (SFY) from July 2003 to present (3 SFY before inception of Waiver), stratified by sex, age, race/ethnicity, and major program.

a. Annual unduplicated count of individuals aged 15 to 49 ever enrolled in *MHCP programs that offer family planning services* (including MFPP) will be determined from enrollment data (MMIS).

Measured for each state fiscal year (SFY) since the start of the waiver (July 2006-present), stratified by sex, age, race/ethnicity, and major program.

b. Annual unduplicated count of individuals ever enrolled in MFPP from program implementation to present.
c. Percentage of MFPP enrollees who enroll in the program after the presumptive eligibility period.

Data Sources

MMIS eligibility data

Definitions:

MHCP programs that offer family planning services include all programs except Emergency MA.

Objective 2

Increase the proportion of men and women enrolled in MHCP who utilize family planning services.

Measurement

Access the percentage of MHCP enrollees who utilize family planning services.

Hypothesis

The proportion of MHCP enrollees utilizing family planning services will increase during the demonstration.

Indicators

Measured for each state fiscal year (SFY) from July 2003 to present (3 SFY before inception of Waiver), stratified by sex, age, race/ethnicity, and major program.

a. Annual proportion of MHCP enrollees with a family planning service or pharmacy claim.
b. Annual proportion of MHCP enrollees receiving contraceptive services and supplies.
c. Annual proportion of MHCP enrollees receiving testing for a sexually transmitted disease (STD).

Data Sources

Numerator - MMIS paid claims data; *Denominator* - eligibility data

Definitions

Family planning related claim includes services that are offered in the MFPP benefit set including family planning supplies or health services, and screening, testing, and counseling for STDs and HIV (per Minnesota Rules, part 9505.0280).

Objective 3

Increase the average age of mother at first birth among MHCP enrollees.

Measurement

Access the average age of mother at first birth among MHCP enrollees.

Hypothesis

The mother's age at first birth among MHCP-financed births will increase following implementation of the demonstration.

Indicators

Measured for each calendar year (CY) from 2003 to present (3 CY before inception of Waiver).

a. Maternal age distribution for MHCP-financed births.
b. Annual average maternal age among MHCP-financed births.

Data Sources

Linked State of Minnesota resident birth certificate data and MMIS enrollment/claim data

Definitions

MHCP-financed births are defined as those birth records that match with MMIS data.

Objective 4

Reduce the teen birth rate among MHCP enrollees.

Measurement

Access the teen birth rate among MHCP enrollees.

Hypothesis

The proportion of adolescent MHCP enrollees with a MHCP-financed birth will decrease following implementation of the demonstration.

Indicators

Measured for each calendar year (CY) from 2003 to present (3 CY before inception of Waiver).

a. Annual proportion of adolescent (ages 15-19) female MHCP enrollees with a live birth financed by MHCP.

Data Sources

Linked State of Minnesota resident birth certificate data and MMIS enrollment/claim data

Definitions

MHCP-financed births are defined as those birth records that match with MMIS data.

Table 1. MFPP Short-Term Objectives and Associated Indicators

Objectives	Hypotheses	Indicators	Data Sources	Notes
1) Increase the number of Minnesotans who have access to family planning services through MHCP.	Enrollment in the family planning program and/or MHCP programs offering family planning services will increase during the demonstration.	1a) Annual unduplicated count of individuals aged 15 to 49 enrolled in MHCP offering family planning services (includes Medical Assistance, MinnesotaCare, General Assistance Medical Care, and MFPP; excludes programs that do not offer family planning services)	MMIS eligibility data	Measured for each state fiscal year (SFY) from July 2003 to present (3 SFY before inception of MFPP) Stratify by sex, age group, race/ethnicity and program
		1b) Annual unduplicated count of individuals enrolled in MFPP	MMIS eligibility data	Measured for each SFY since the start of the waiver (July 2006 to present) Stratify by sex, age group, and race/ethnicity
		1c) Percentage of MFPP enrollees who enroll in the program after the presumptive eligibility period	MMIS eligibility data	
2) Increase the proportion of men and women enrolled in MHCP who utilize family planning services.	The proportion of MHCP enrollees utilizing family planning services will increase during the demonstration.	2a) Annual proportion of MHCP enrollees with a family planning service or pharmacy claim	Numerator: MMIS paid claims data Denominator: MMIS eligibility data (annual unduplicated counts from first objective)	Measured for each state fiscal year (SFY) from July 2003 to present (3 SFY before inception of MFPP) Stratify by sex, age group, race/ethnicity and program
		2b) Annual proportion of MHCP enrollees receiving contraceptive services and supplies		
		2c) Annual proportion of MHCP enrollees receiving testing for a sexually transmitted disease (STD)		

Table 2. MFPP Long-Term Objectives and Associated Indicators

Objectives	Hypotheses	Indicators	Data Sources	Notes
3) Increase the average age of mother at first birth among MHCP enrollees.	The mother's age at first birth among MHCP-financed births will increase following implementation of the demonstration.	3a) Maternal age distribution for MHCP-financed births 3b) Annual average maternal age among MHCP-financed births	Linked MN resident birth certificates and MMIS enrollment and claims data	Measured each calendar year, starting with 2003 MHCP-financed births are defined as those birth records that match with MMIS data
4) Reduce the teen birth rate among MHCP enrollees.	The proportion of adolescent MHCP enrollees with a MHCP-financed birth will decrease following implementation of the demonstration.	4a) Annual proportion of adolescent (ages 15-19) female MHCP enrollees with a live birth financed by MHCP	Linked MN resident birth certificates and MMIS enrollment and claims data	Measured each calendar year, starting with 2003 MHCP-financed births are defined as those birth records that match with MMIS data

Attachment B
MFPP Application

Embedded Secure Document

The file *https://edocs.dhs.state.mn.us/lfserver/Public/DHS-4740-ENG* is a secure document that has been embedded in this document. Click the link to view.

Attachment C

MFPP Renewal Application

Embedded Secure Document

The file *https://edocs.dhs.state.mn.us/lfserver/Public/DHS-5440-ENG* is a secure document that has been embedded in this document. Click the link to view.

Attachment D
MFPP Brochure

Embedded Secure Document

The file *https://edocs.dhs.state.mn.us/lfserver/Public/DHS-4740-ENG* is a secure document that has been embedded in this document. Click the link to view.

Attachment E

MHCP Provider Agreement

Embedded Secure Document

The file *https://edocs.dhs.state.mn.us/lfserver/Public/DHS-4138-ENG* is a secure document that has been embedded in this document. Click the link to view.

Attachment F

MFPP Provider Application Packet

Embedded Secure Document

The file *https://edocs.dhs.state.mn.us/lfserver/Public/DHS-4773-ENG* is a secure document that has been embedded in this document. Click the link to view.

Attachment G
MHCP Fact Sheet

Embedded Secure Document

The file *https://edocs.dhs.state.mn.us/lfserver/Public/DHS-3182-ENG* is a secure document that has been embedded in this document. Click the link to view.

Attachment H

List of Primary Care Providers

Embedded Secure Document

The file *https://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-4741-ENG* is a secure document that has been embedded in this document. Click the link to view.

Attachment I

Budget Neutrality Worksheet

Trend Rate

President's budget trend (2009-2014)	6.1%

MNFPP Budget Neutrality

4-Year Trend Cash Based

	CY 2008	CY 2009	CY 2010	CY 2011	CY 2012
FP Expenditures	9,657,101	11,973,816	13,346,637	12,848,826	15,518,520
FP Enrollees for whom a payment was made during the year	36,374	36,828	39,588	36,844	38,634
FP Enrollees	35,531	42,352	46,155	44,338	45,518
FP Enrollee Months	193,788	228,338	265,647	255,540	249,026
Cost per Person Per Month	49.83	52.44	50.24	50.28	62.32
Historical Trend (2008-2012)					5.7%

	DY 09	**DY 10**	**DY 11**
	CY 2014	CY 2015	CY 2016
Average Monthly Enrollment	21,617	21,702	21,826

Per Member/Per Month (PMPM) Cost (Total Computable)

	Trend	**DY 09**	**DY 10**	**DY 11**
		CY 2014	CY 2015	CY 2016
Demonstration Eligibles	**5.7%**	$69.62	$73.59	$77.79

SAMPLE: Extension Budget Neutrality Agreement (Total Computable)

	DY 09	**DY 10**	**DY 11**	Total
	CY 2014	CY 2015	CY 2016	
WITHOUT DEMONSTRATION				
Member Months	259,401	260,425	261,908	781,735
PMPM	$ 69.62	$ 73.59	$ 77.79	
Total Costs	$ 18,060,420.91	$ 19,165,209.86	$ 20,373,000.11	$ 57,598,630.88
WITH DEMONSTRATION				
Member Months	259,401	260,425	261,908	781,735
PMPM	$ 69.62	$ 73.59	$ 77.79	
Total Costs	$ 18,060,420.91	$ 19,165,209.86	$ 20,373,000.11	$ 57,598,630.88
Projected Margin	**$ -**	**$ -**	**$ -**	**$ -**

Attachment J

Minnesota State Register Notice

Department of Human Services

Health Care Administration

Request for Comments on the Minnesota Family Planning Program Section 1115 Medicaid Waiver Renewal Request

DHS is announcing a 30-day comment period on the Minnesota Family Planning Program (MFPP) Section 1115 Medicaid waiver renewal request. Under the MFPP waiver, the State has had the authority to receive federal matching funds for family planning services to men and women, age 15 to 50, who have family incomes at or below 200 percent of the federal poverty level and who are not enrolled in any other Minnesota health care program administered by DHS. Federal authority for the waiver ends December 31, 2013. The renewal request will seek to continue operating MFPP under existing program rules for an additional three years.

A copy of the waiver renewal request can be found at MFPP Waiver. To request a paper copy of the waiver request, please contact Quitina Cook at (651) 431-2191.

Written comments may be submitted to the following email mailbox: Section1115WaiverComments@state.mn.us or by mail to the address below. DHS would like to provide copies of comments received in a format that is accessible for people with disabilities. Therefore, we request that comments be submitted in Microsoft Word format or incorporated within the email text. If you would also like to provide a signed copy of the comment letter, you may submit a second copy in Adobe PDF format or mail it to the address below. Comments must be received by May 1, 2013.

Carol Backstrom
Medicaid Director
Minnesota Department of Human Services
P.O. Box 64998
St. Paul, Minnesota 55164

In addition to the opportunity to submit written comments during the 30 day public comment period, public hearings will be held to provide stakeholders and other interested persons the opportunity to comment on the waiver request. You may attend either hearing by phone or in person. If you would like to attend by phone, please send an email request to Section1115WaiverComments@state.mn.us to obtain the call-in information. If you would like to attend a hearing in person, the time and location for the two public hearings are provided below. If you plan to testify by phone or in person, please send an email to Section1115WaiverComments@state.mn.us indicating that you will testify.

Public Hearing #1
Date: Monday, April 22, 2013
Time: 1:00 - 4:00 p.m.
Location: DHS, Elmer L. Andersen Human Services Building, Room 2370, 540 Cedar St. St. Paul, MN 55164

Public Hearing #2
Date: Thursday, April 25, 2013
Time: 9:00 a.m. – 12:00 p.m.
Location: Metropolitan Mosquito Control, Room 205, 2099 University Avenue, St. Paul, MN 55104

Attachment K

MFPP Stakeholder Email List

Attachment K

MFPP Stakeholder Email List

LeahH@wstcmn.org
brian@annexteenclinic.org
EYoung@PPMNS.org
KBesse@PPMNS.org
alight@familytreeclinic.org
Kevin.leecy@boisforte-nsn.gov
Karendiver@fdlrez.com
norman@grandportage.com
C.Jones@llojibwe.org
gprescott@lowersioux.com
denny.prescott@lowersioux.com
Melanie.Benjamin@millelacsband.com
rjohnson@piic.org
floydjourdain2@hotmail.com
laurie.tolzmann@shakopeedakota.org
mayaw@whiteearth.com
jgoggleye@boisforte-nsn.gov
ddrift@boisforte-nsn.gov
ageshick@boisforte-nsn.gov
philnorrgard@fdlrez.com
chuckells@fdlrez.com
paulas@grandportage.com
geraldinek@grandportage.com
skonig@grandportage.com
jbebeau@llojibwe.org
bernadette.gotchie@llojibwe.org
teri.schemmel@lowersioux.com
sam.moose@millelacsband.com
Salina.rizvi@millelacsband.com
mwells@piic.org
rlchs@paulbunyan.net
paula.s.woods@gmail.com
jimh@uppersiouxcommunity-nsn.gov
candiceh@uppersiouxcommunity-nsn.gov
patb@whiteearth.com
joep@whiteearth.com
Jenny.Jenkins@ihs.gov
prock@ihb-mpls.org
alight@familytreeclinic.org
ewilkins@familytreeclinic.org
jweum@familytreeclinic.org
allie@mmspublichealth.org
amiller@rumriverhs.org
Amy.Kodet@co.hennepin.mn.us
andr0375@umn.edu
annbajari@yahoo.com
bennettl@face2face.org
sikorskir@face2face.org
brian@annexteenclinic.org

christine.austin-roehler@co.wright.mn.us
Coral.Garner@ci.minneapolis.mn.us
Barbara.Kyle@minneapolismn.gov
crastedt@mahube.org
ddubois@wellshareinternational.org
Gary.Greenfield@state.mn.us
gferguson@westsidechs.org
gretchen.musicant@ci.minneapolis.mn.us
jlarson@rumriverhs.org
judith@teenwisemn.org
Katherine.Meerse@co.hennepin.mn.us
lcaseyjr@charter.net
LeahH@MyHealthMN.org
JillH@MyHealthMN.org
linnea@prochoiceminnesota.org
lueth.janis@co.olmsted.mn.us
lynelle.m.wood@healthpartners.com
thecenterclinic@hotmail.com
tsallasmerritt@wholewomanshealth.com
eyoung@ppmns.org
amygilbert@pobox.com
pegmyrna@gmail.com

Attachment L
Public Comment

Attachment M

DHS Response to Public Comment

Attachment N
Tribal Consultation Policy

Attachment N

Medicaid Tribal Consultation Process

May 2010

DHS will designate a staff person in the Medicaid Director's office to act as a liaison to the Tribes regarding consultation. Tribes will be provided contact information for that person.

- The liaison will be informed about all contemplated state plan amendments and waiver requests, renewals, or amendments.

- The liaison will send a written notification to Tribal Chairs, Tribal Health Directors, and Tribal Social Services Directors of all state plan amendments and waiver requests, renewals, or amendments.

- Tribal staff will keep the liaison updated regarding any change in the Tribal Chair, Tribal Health Director, or Tribal Social Services Director, or their contact information.

- The notice will include a brief description of the proposal, its likely impact on Indian people or Tribes, and a process and timelines for comment. At the request of a Tribe, the liaison will send more information about any proposal.

- Whenever possible, the notice will be sent at least 60 days prior to the anticipated submission date. When a 60-day notice is not possible, the longest practicable notice will be provided.

- The liaison will arrange for appropriate DHS policy staff to attend the next Quarterly Tribal Health Directors meeting to receive input from Tribes and to answer questions.

- When waiting for the next Tribal Health Directors meeting is inappropriate, or at the request of a Tribe, the liaison will arrange for consultation via a separate meeting, a conference call, or other mechanism.

- The liaison will acknowledge all comments received from Tribes. Acknowledgement will be in the same format as the comment, e.g. email or regular mail.

- Liaison will forward all comments received from Tribes to appropriate State policy staff for their response.

- Liaison will be responsible for insuring that all comments receive responses from the State.

- When a Tribe has requested changes to a proposed state plan amendment or waiver request, renewal, or amendment, the liaison will report whether the change is included in the submission, or why it was not included.

- Liaison will inform Tribes when the State's waiver or state plan changes are approved or denied by CMS, and will include CMS' rationale for denials.

- For each state plan or waiver change, the liaison will maintain a record of the notification process; the consultation process, including written correspondence from Tribes and notes of meetings or other discussions with Tribes; and the outcome of the process.

Attachment O
Tribal Letter-October 2012

Minnesota Department of **Human Services**

October 29, 2012

Dr. Pat Rock, M.D. Executive Director
Minneapolis Indian Health Board, Inc.
315 East 24th Street
Minneapolis, MN 55404

Re: Upcoming Medicaid waiver submissions

Dear Dr. Rock:

As you know, Minnesota's Prepaid Medical Assistance Project Plus (PMAP+) Section 1115 Medicaid waiver provides federal matching funds for Medical Assistance (MA) and MinnesotaCare services to people who would not otherwise have been eligible. Minnesota has a second Section 1115 Medicaid waiver that authorizes the Minnesota Family Planning Program (MFPP). MFPP is about to enter its seventh year of operation. It provides a family planning benefit to people with incomes up to 200 percent of the federal poverty level.

Both waivers are currently approved until December 31, 2013. Generally, a request for extension must be submitted at least a year in advance. This letter is to notify you that the Minnesota Department of Human Services intends to submit requests to extend the PMAP+ and Family Planning waivers by December 31, 2012 to meet the federal deadline. Notice will be posted in the *Minnesota State Register* and will provide additional information regarding the proposed extension and the public input process. The waiver extension requests will reflect current state law. The Minnesota Department of Human Services may amend the waiver extension requests at the end of the upcoming legislative session, which is expected to focus on health care reform this session.

If you have any questions about these waiver amendments, you may contact Jan Kooistra (651-431-2188 or jan.kooistra@state.mn.us) or Kathleen Vanderwall (651-282-3720 or kathleen.vanderwall@state.mn.us), who are members of my staff.

Sincerely,

Kathleen Vanderwall
Medicaid Tribal Liaison

Attachment P
Tribal Letter-March 2013

Minnesota Department of **Human Services**

March 7, 2013

Re: Extension of Minnesota's Section 1115 Medicaid Waiver entitled Minnesota Family Planning Program

Dear Tribal Leader:

The Minnesota Family Planning Program (MFPP) is in its seventh year of operation. This program is operated under a Section 1115 waiver that allows Minnesota to provide family planning benefits to people with incomes up to 200 percent of the federal poverty level who are not enrolled in any other Minnesota health care program administered by the Minnesota Department of Human Services (DHS). Federal authority for the waiver ends December 31, 2013.

This letter is to notify you that DHS intends to submit a request to extend the Minnesota Family Planning Program waiver. An initial letter of intent to extend the waiver was submitted to CMS in October 2012. DHS plans to submit the complete extension package to CMS for review and approval by the end of May 2013. Notice will be posted in the *Minnesota State Register* and will provide additional information regarding the proposed extension and the public input process. The waiver request will seek to continue operating the program under existing program rules for an additional three years.

If you have any questions about this waiver extension, please contact Jan Kooistra at (651) 431-2188 or jan.kooistra@state.mn.us). Thank you.

Sincerely,

Kathleen Vanderwall
Medicaid Tribal Liaison

Attachment Q

Demonstration Financing Form

Attachment Q

Demonstration Financing Form

Please complete this form to accompany Section VI of the application in order to describe the financing of the Demonstration.

The State proposes to finance the non-federal share of expenditures under the Demonstration using the following (please check all that are applicable):

The state Health Care Access Fund

_x__ State General Funds

___ Voluntary intergovernmental transfers from governmental entities. (Please specify and provide a funding diagram in the narrative section – Section VI of the application).

___ Voluntary certified public expenditures from governmental entities. (Please specify and provide a funding diagram in the narrative section – Section VI of the application).

___ Provider taxes. (Provide description the narrative section – Section VI of the application).

___ Other (If the State is interested in other funding or financing arrangements, please describe. Some examples could include, but are not limited to, safety net care pools, designated state health programs, Accountable Care Organization-like structures, bundled payments, etc.)

Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State Plan. To ensure that program dollars are used only to pay for Medicaid services, we are asking States to confirm to CMS that providers retain 100 per cent of the payments for services rendered or coverage provided.

Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, DRG, DSH, fee schedule, global payments, supplemental payments, enhanced payments, capitation payments, other), including the Federal and non-Federal share (NFS)?

_x__ Yes ___ No

If no, provide an explanation of the provider payment arrangement.

Do any providers (including managed care organizations [MCOs], prepaid inpatient health plans [PIHPs] and prepaid ambulatory health plans [PAHPs]) participate in such activities as intergovernmental transfers (IGTs) or certified public expenditure (CPE) payments, or is any portion of payments are returned to the State, local governmental entity, or other intermediary organizations?

___ Yes _x_ No

Not for services covered by this demonstration

If providers are required to return any portion of any payment, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount of percentage of payments that are returned, and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.). Please indicate the period that the following data is from.

Providers are not required to return payments.

The Minnesota Family Planning Program is an entirely fee-for-service program. Reimbursement rates are the same as those provided in the State Plan. The funding questions have been addressed in the course of State Plan amendments. No changes to coverage or payment for services are proposed as part of this wavier renewal request.

The Health Care Access Fund is the primary source of revenue that makes up the nonfederal share of fee for service payments for the Minnesota Family Planning program. Minnesota has a 2 % tax on health care providers and a 1% tax on MCO premiums, including Medicaid participating MCOs. The 2% tax on health care providers is set out at Minnesota Statutes, section 295.52. The tax is a gross receipts tax on all revenue except Medicare revenue. The 1% tax on managed health care organization premiums is set out at Minnesota Statutes, section 297I.05, subdivision 5. Minnesota Statutes, section 295.58 requires the receipts from both the provider tax and the premium tax to be deposited into the Health Care Access Fund. We believe the tax to be broad-based and uniform.

There are no supplemental payments related to services provided under this demonstration.

Section 1902(a) (2) provides that the lack of adequate funds from other sources will not result in the lowering of the amount, duration, scope, or quality of care and services available under the plan.

Please describe how the NFS of each type of Medicaid payment (normal per diem, DRG, fee schedule, global, supplemental, enhanced payments, capitation payments, other) is funded.

Please describe whether the NFS comes from appropriations from the legislature to the Medicaid agency, through IGT agreements, CPEs, provider taxes, or any other mechanism used by the State to provide NFS. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated.

Please provide an estimate of total expenditures and NFS amounts for each type of Medicaid payment. Please indicate the period that the following data is from:

If any of the NFS is being provided using IGTs or CPEs, please fully describe the matching arrangement, including when the state agency receives the transferred amounts from the local governmental entity transferring the funds.

If CPEs are used, please describe the methodology used by the State to verify that the total expenditures being certified are eligible for Federal matching funds is in accordance with 42 CFR 433.51(b).

For any payment funded by CPEs or IGTs, please provide the following, and indicate the period that the data is from:

Name of Entity Transferring/Certifying Funds	Type of Entity (State, County, City)	Amount Transferred or Certified	Does the entity have taxing authority?	Did the entity receive appropriations?	Amount of appropriations

The Health Care Access Fund is primarily comprised of tax revenue from provider taxes, and client premiums.

The MFPP waiver covers fee-for-service payments to several provider types for several types of services including inpatient and outpatient hospital services, FQHC and RHC services, and physician and pharmacy services. Because these services are reimbursed on a FFS basis in accordance with our State Plan, these funding questions have been asked and answered as part of CMS' review of our various state plan amendments.

Section 1902(a) (30)(A) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a) (1) and 2105(a)(1) provide for Federal financial participation to States for expenditures for services under an approved State Plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type, and indicate the time period that that the data is from.

Provider Type	Supplemental or Enhanced Payment Amount

The Minnesota Family Planning Program is an entirely fee-for-service program. Reimbursement rates have been approved under the State Plan. The appropriateness of the payment rates for family planning services been addressed in the corresponding State Plan amendments. No changes to the existing State Plan payment rates have been proposed with this renewal request.

Please provide a detailed description of the methodology used by the State to estimate the upper payment limit for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated).

The Minnesota Family Planning Program is an entirely FFS program which incorporates payments to several different provider types for several different services. To the extent that payments for the services covered by the family planning waiver are subject to UPLs, the UPL estimates and limit demonstrations were submitted and reviewed by CMS as part of the state plan amendment approval process.

Does any governmental provider or contractor receive payments (normal per diem, DRG, fee schedule, global, supplemental, enhanced, and other) that, in the aggregate, exceed its reasonable costs of providing services?

___ Yes _x__ No

If yes, provide an explanation.

In the case of MCOs, PIHPs, PAHPs, are there any actual or potential payments which supplement or otherwise exceed the amount certified as actuarially sound as required under 42 CFR 438.6(c)? (These payments could be for such things as incentive arrangements with contractors, risk sharing mechanisms such as stop-loss limits or risk corridors, or direct payments to providers such as DSH hospitals, academic medical centers, or FQHCs.)

___ Yes _x__ No ___ Not Applicable

If so, how do these arrangements comply with the limits on payments in §438.6(c)(5) and §438.60 of the regulations?

If payments exceed the cost of services (as defined above), does the State recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

___ Yes ___ No

Providers are not paid in excess of the various limits currently set forth in federal statute and regulations.

Use of other Federal Funds

Are other federal funds, from CMS or another federal agency, being used for the Demonstration program?

___ Yes _x__ No

If yes, provide a list below of grants the State is receiving from CMS or other federal agencies. CMS must ensure these funds are not being used as a source of the non-federal share, unless such

use is permitted under federal law. In addition, this will help to identify potential areas of duplicative efforts and highlight that this demonstration is building off of an existing grant or program.

Source of Federal Fund	Amount of Federal Funds	Period of Funding

Minnesota Department of **Human Services**

June 1, 2013

Shanna Wiley, Project Officer
Division of State Demonstrations & Waivers
Center for Medicaid, CHIP and Survey & Certification, CMS
7500 Security Boulevard
Mail Stop S2-01-06
Baltimore, MD 21244-1850

Re: Minnesota Family Planning Program §1115 Waiver – Evaluation Report

Dear Ms. Hostetler:

Enclosed please find the evaluation report for the Minnesota Family Planning Program §1115 waiver. This report presents the results of the Minnesota Department of Human Services evaluation of Minnesota Family Planning Program covering the period July 1, 2006 through June 30, 2010.

If you require additional information concerning the report, please contact Jan Kooistra, of my staff, at (651) 431-2188.

[redacted]
Deputy Medicaid Director

Attachment

Minnesota Family Planning Program

Section 1115 Research and Demonstration Project 11-W-00183/5

Final Evaluation Report

Waiver Years One through Five

July 2006 - June 2011

Minnesota Department of Human Services

April 2013

Overview of the Minnesota Family Planning Program

The Minnesota Department of Human Services (DHS) began implementation of the Minnesota Family Planning Program, a section 1115 Medicaid family planning waiver program, on July 1, 2006. This program was initially approved by the Centers for Medicare and Medicaid Services (CMS) for a 5-year period, ending June 30, 2011.

The goal of the Minnesota Family Planning Program is to provide access to family planning services to individuals who do not have access to those services through other programs. Increased access to family planning services is expected to lead to decreased expenditures by public health care programs by reducing the number of births resulting from unintended pregnancies.

Participants in the Minnesota Family Planning Program must be Minnesota residents 15 to 49 years of age, have income at or below 200 percent of the federal poverty guideline, be US citizens or qualified non-citizens eligible for Medicaid with federal financial participation, not be enrolled in other Minnesota Health Care Programs (MHCP) administered by DHS, not be pregnant, and not reside in a medical institution.

MFPP benefits include family planning office visits, exams, counseling, and education; contraceptive medications and supplies; voluntary sterilization; diagnosis, testing, and treatment of sexually transmitted infections found during family planning visits, HIV testing and counseling, and pharmacy services and laboratory tests related to these benefits.

Evaluation Plan

The evaluation objectives, and associated indicators for measurement of progress toward those objectives, are listed in the table on page 2.

This report presents the results of the DHS final evaluation of MFPP covering the five years of the 5-year waiver period (July 2006 through June 2011, or state fiscal years 2007 through 2011). Data used in this evaluation are gained from three sources: Medicaid Management Information System (MMIS) eligibility and paid claims data, Pregnancy Risk Assessment Monitoring System (PRAMS) and a linked dataset of MMIS paid claims and vital record birth certificate data. The PRAMS and linked dataset only have data reportable by calendar year, instead of state fiscal year, with 2010 being the most up-to-date data currently available.

Evaluation Objectives and Indicators

Objectives	Indicators	Pages
1) Increase the number of Minnesotans who have access to family planning services through Minnesota Health Care Programs.	a) Unduplicated count of individuals aged 15 to 50 ever enrolled in Minnesota Health Care Programs (MHCP) offering family planning services for each state fiscal year (SFY) from July 2003 through June 2011. b) Unduplicated count of individuals ever enrolled in the Minnesota Family Planning Program (MFPP) for each SFY since the inception of the waiver (July 2006 through June 2011).	3 - 8
2) Increase the proportion of men and women enrolled in Minnesota Health Care Programs who utilize family planning services.	The proportion of MHCP enrollees that have a family planning service claim or a family planning pharmacy claim for each SFY from July 2003 through June 2011. This will be referred to as the *family planning utilization rate*.	9 - 12
3) Reduce the number of unintended births among women enrolled in MHCP.	The proportion of Medicaid-covered births that were the result of unintended pregnancies for each calendar year from 2002 through 2010.	13 - 14
4) Reduce the proportion of births to MHCP enrollees that are spaced less than 2 years apart.	The proportion of MHCP-financed births to multiparous women aged 15-49 with a birth interval of less than 24 months will be calculated for each calendar year from 2003 through 2010.	15 - 16
5) Reduce the Medicaid birth rates of women in families with incomes below 200% of poverty.	The ratio of the number MHCP-financed births to women aged 15-49, to the number of Minnesota women aged 15-49 in families with incomes less than 200% of the federal poverty threshold, expressed as a rate per 1,000 women, for each calendar year from 2004 through 2010. This will be referred to as the *Medicaid birth rate*.	17 - 19
6) Facilitate the referral of men and women enrolled under the waiver to appropriate primary care services as needed.	The number and percentage of Minnesota Family Planning Program enrollees who subsequently enroll in other MHCP that cover primary care services by SFY. This will be referred to as the *primary care enrollment rate*.	20 - 21

Objective 1: **Increase the number of Minnesotans who have access to family planning services through Minnesota Health Care Programs.**

Indicators: a) Unduplicated count of individuals aged 15 to 50 ever enrolled in *Minnesota Health Care Programs (MHCP) offering family planning services* for each state fiscal year (SFY) from July 2003 through June 2011.

b) Unduplicated count of individuals ever enrolled in the Minnesota Family Planning Program (MFPP) for each SFY since the inception of the waiver (July 2006 through June 2011).

Data source: Medicaid Management Information System (MMIS) eligibility data.

Definitions: *MHCP offering family planning services* includes

1. Medical Assistance (excluding Emergency Medical Assistance)
2. MinnesotaCare
3. General Assistance Medical Care (excluding Hospital-only GAMC)
4. Minnesota Family Planning Program

Results: Figure 1a presents the number of individuals enrolled in MHCP offering family planning services for SFY 2004-2011. Table 1a presents the number and percentage of individuals enrolled by sex, age group, race/ethnicity and major program of enrollment.

Figure 1b presents the number of individuals enrolled in the Minnesota Family Planning Program for SFY 2007-2011. Table 1b presents the number and percentage of individuals enrolled in MFPP by sex, age group, and race/ethnicity.

Discussion: The number of individuals aged 15-50 enrolled in MHCP who have access to family planning services has increased from 407,724 in SFY 2004 to 542,034 in SFY 2011. These figures reflect increased enrollment in MHCP during the economic recession of 2007-2009. MHCP enrollment continued increasing after the economic recession due to slow economic recovery, and Minnesota's early expansion of the Medicaid program to include childless adults with incomes at or below 75 percent of the federal poverty level in SFY 2011.

During the first year of the waiver (SFY 2007), MFPP enrollees comprised 5.9 percent of MHCP enrollees with access to family planning access. This figure increased to 8.4 percent of MHCP enrollees in SFY 2011, the fifth year of the waiver.

Enrollment in MFPP steadily increased over the first four years of the waiver program and increased slightly in the fifth year. The number of individuals enrolled in MFPP increased from 25,563 in SFY 2007 to 45,671 in SFY 2011. Approximately 99 percent of MFPP enrollees each year have been women, and about 90 percent have been under the age of 30. While the proportion of non-white MFPP enrollees has increased over the five years of the waiver, the majority of enrollees reported non-Hispanic white race/ethnicity.

Figure 1a. Unduplicated count of individuals aged 15 to 50 enrolled in Minnesota Health Care Programs offering family planning services, by state fiscal year, July 2003 through June 2011.

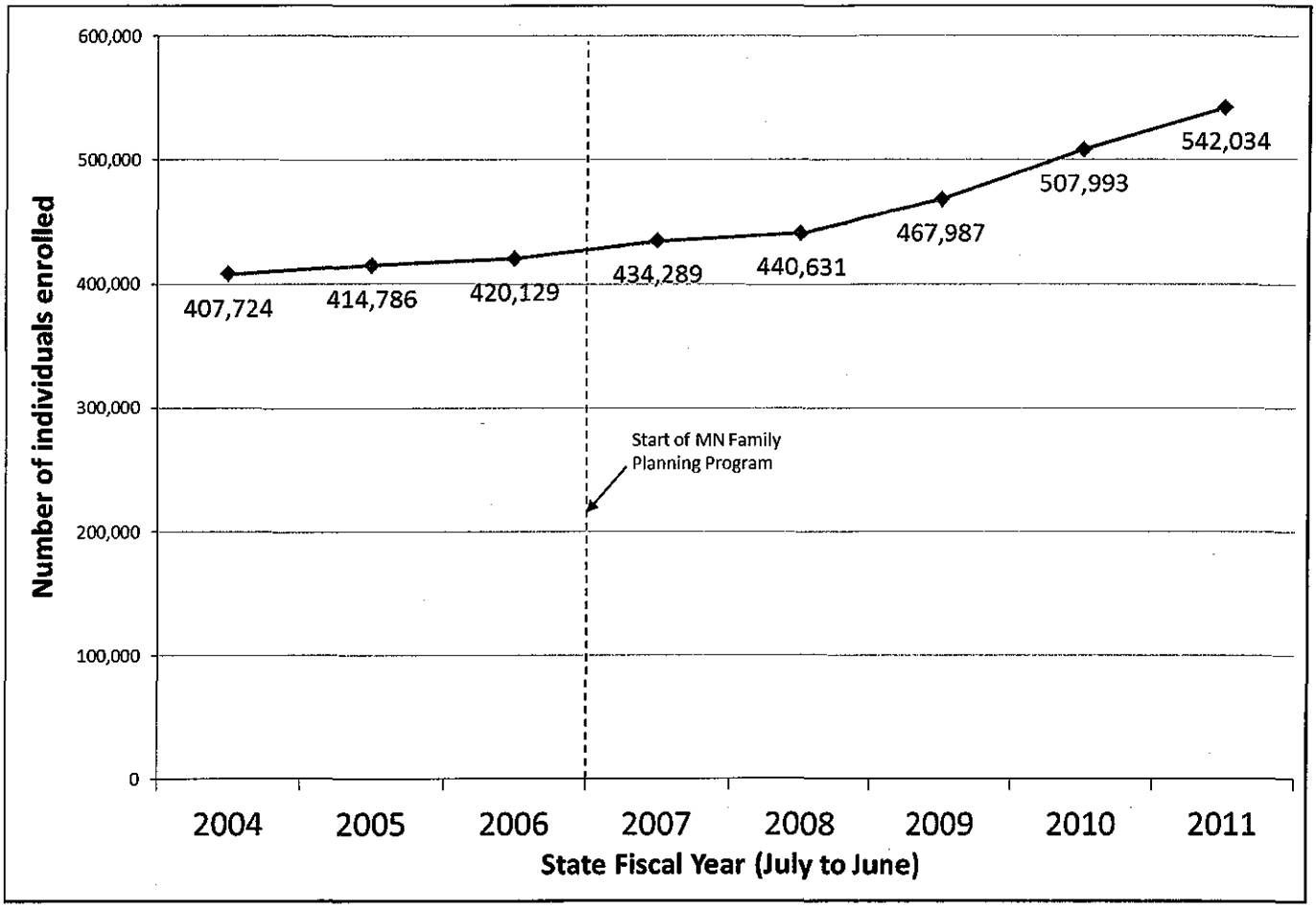


Table 1a. Enrollment in MHCP programs that offer family planning services by sex, age, race/ethnicity, and major program, state fiscal years 2004-2007.

	SFY 2004		SFY 2005		SFY 2006		SFY 2007	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Sex								
Female	238,890	58.6%	244,190	58.9%	247,623	58.9%	265,218	61.1%
Male	168,834	41.4%	170,596	41.1%	172,506	41.1%	169,071	38.9%
Age Group								
15 to 19	80,034	19.6%	82,122	19.8%	84,592	20.1%	90,893	20.9%
20 to 24	78,773	19.3%	79,823	19.2%	79,531	18.9%	86,268	19.9%
25 to 29	59,142	14.5%	62,069	15.0%	64,878	15.4%	68,824	15.8%
30 to 34	49,458	12.1%	49,591	12.0%	49,100	11.7%	49,037	11.3%
35 to 39	46,260	11.3%	46,452	11.2%	46,507	11.1%	45,663	10.5%
40 to 44	47,896	11.7%	47,168	11.4%	46,368	11.0%	43,837	10.1%
45 to 50	46,161	11.3%	47,561	11.5%	49,153	11.7%	49,767	11.5%
Race/ethnicity								
White	262,972	64.5%	263,493	63.5%	262,925	62.6%	273,157	62.9%
Black	70,911	17.4%	75,073	18.1%	79,442	18.9%	81,422	18.7%
Hispanic	23,702	5.8%	24,326	5.9%	25,117	6.0%	26,408	6.1%
Asian/Pacific Islander	22,439	5.5%	23,930	5.8%	24,257	5.8%	23,897	5.5%
American Indian	16,818	4.1%	17,191	4.1%	17,669	4.2%	18,028	4.2%
Two or more races	3,001	0.7%	3,330	0.8%	3,610	0.9%	3,974	0.9%
Unknown race	7,881	1.9%	7,443	1.8%	7,109	1.7%	7,403	1.7%
Major Program								
Medical Assistance	246,431	60.4%	259,990	62.7%	269,898	64.2%	274,440	63.2%
MinnesotaCare	113,539	27.8%	104,895	25.3%	97,761	23.3%	99,702	23.0%
General Assistance Medical Care	47,754	11.7%	49,901	12.0%	52,468	12.5%	36,815	8.5%
Minnesota Family Planning Program	0	0.0%	0	0.0%	0	0.0%	23,332	5.4%
TOTAL number enrolled:	407,724	100.0%	414,786	100.0%	420,129	100.0%	434,289	100.0%

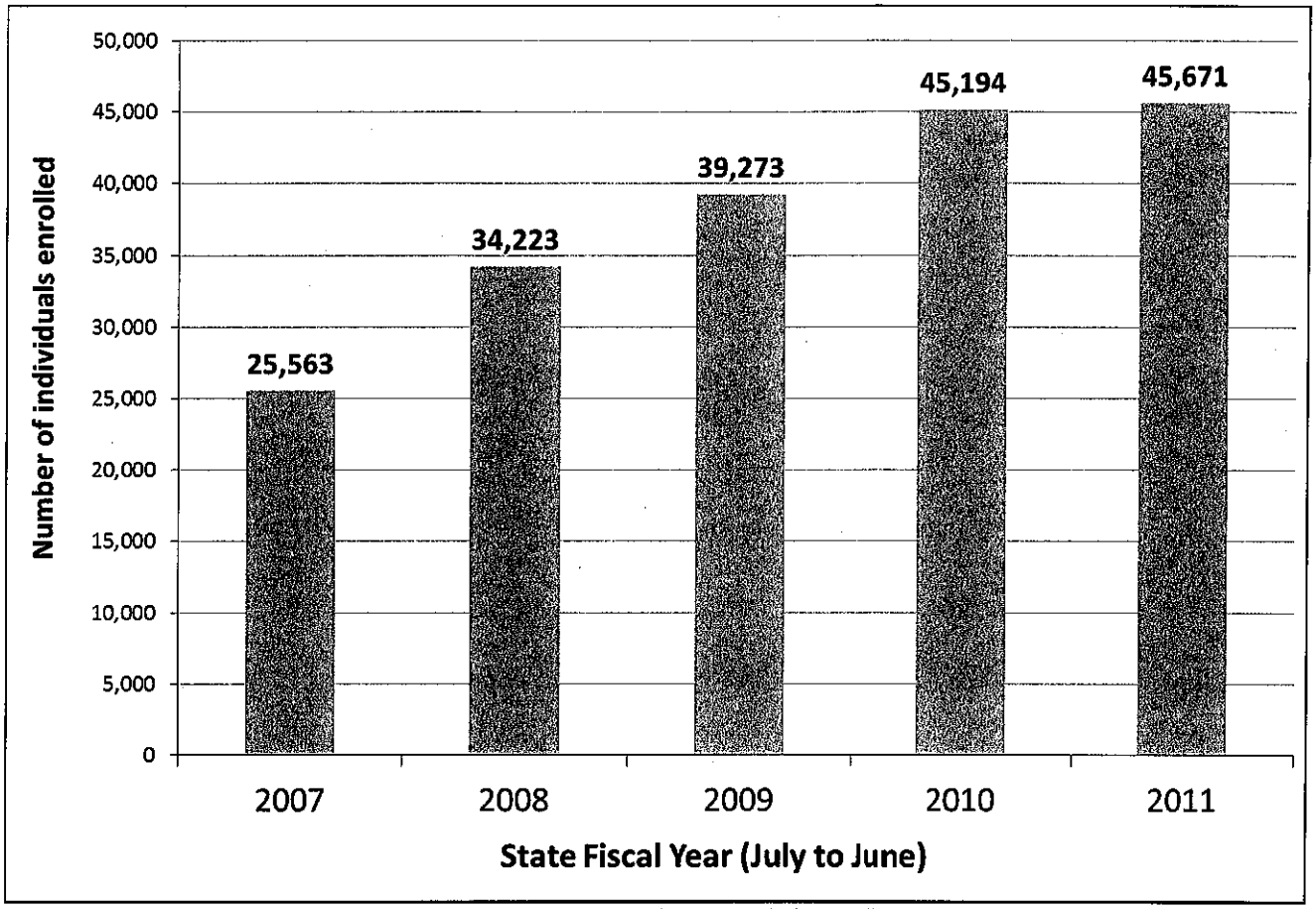
(continued on next page)

Table 1a (continued). Enrollment in MHCP programs that offer family planning services by sex, age, race/ethnicity, and major program, state fiscal years 2008-2011.

	SFY 2008		SFY 2009		SFY 2010		SFY 2011	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Sex								
Female	271,726	61.7%	286,207	61.2%	306,501	60.3%	323,814	63.7%
Male	168,905	38.3%	181,780	38.8%	201,492	39.7%	218,220	43.0%
Age Group								
15 to 19	91,624	20.8%	93,593	20.0%	97,065	19.1%	99,557	19.6%
20 to 24	88,243	20.0%	94,228	20.1%	103,276	20.3%	107,318	21.1%
25 to 29	71,465	16.2%	78,113	16.7%	86,480	17.0%	93,035	18.3%
30 to 34	50,554	11.5%	56,281	12.0%	64,149	12.6%	72,904	14.4%
35 to 39	45,499	10.3%	48,000	10.3%	51,855	10.2%	55,454	10.9%
40 to 44	42,355	9.6%	43,984	9.4%	47,321	9.3%	51,580	10.2%
45 to 50	50,891	11.5%	53,788	11.5%	57,847	11.4%	62,186	12.2%
Race/ethnicity								
White	277,258	62.9%	294,484	62.9%	320,053	63.0%	340,031	66.9%
Black	82,170	18.6%	86,419	18.5%	93,888	18.5%	101,165	19.9%
Hispanic	26,750	6.1%	28,997	6.2%	30,987	6.1%	31,507	6.2%
Asian/Pacific Islander	24,526	5.6%	26,621	5.7%	30,008	5.9%	33,295	6.6%
American Indian	18,112	4.1%	18,691	4.0%	19,294	3.8%	20,075	4.0%
Two or more races	4,338	1.0%	4,912	1.0%	5,481	1.1%	6,074	1.2%
Unknown race	7,477	1.7%	7,863	1.7%	8,282	1.6%	9,887	1.9%
Major Program								
Medical Assistance	280,810	63.7%	296,692	63.4%	314,683	61.9%	395,985	78.0%
MinnesotaCare	98,908	22.4%	101,779	21.7%	118,893	23.4%	97,730	19.2%
General Assistance Medical Care	30,371	6.9%	34,833	7.4%	35,002	6.9%	8,566	1.7%
Minnesota Family Planning Program	30,542	6.9%	34,683	7.4%	39,415	7.8%	39,753	7.8%
TOTAL number enrolled:	440,631	100.0%	467,987	100.0%	507,993	100.0%	542,034	100.0%

Notes: Age group was determined based on age calculated at end of each State Fiscal Year (June 30th).
Major program was determined based on enrollment data during the last month of enrollment for each person during each State Fiscal Year. Enrollees may have been enrolled in more than one major program over the course of a year.
Race/ethnicity - Hispanics can be of any race; all other groups are non-Hispanic.

Figure 1b. Unduplicated count of individuals enrolled in the Minnesota Family Planning Program, state fiscal years 2007-2011.



Notes: Numbers of enrollees for SFY 2007-2011 enrolled in MFPP do not match the enrollment figures in Table 1, because MHCP enrollees may be enrolled in more than one program over the course of an SFY. Enrollees may be enrolled in MFPP during more than one SFY.

Table 1b. Enrollment in Minnesota Family Planning Program by sex, age, and race/ethnicity, state fiscal years 2007-2011.

	SFY 2007		SFY 2008		SFY 2009		SFY 2010		SFY 2011	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Sex										
Female	25,307	99.0%	33,877	99.0%	38,778	98.7%	44,503	98.5%	44,870	98.2%
Male	256	1.0%	346	1.0%	495	1.3%	691	1.5%	801	1.8%
Age Group										
15 to 19	7,610	29.8%	9,454	27.6%	10,220	26.0%	10,917	24.2%	11,019	24.1%
20 to 24	12,198	47.7%	16,443	48.0%	18,497	47.1%	21,412	47.4%	21,412	46.9%
25 to 29	3,779	14.8%	5,454	15.9%	6,737	17.2%	8,104	17.9%	8,270	18.1%
30 to 34	1,124	4.4%	1,606	4.7%	2,156	5.5%	2,700	6.0%	2,898	6.3%
35 to 39	486	1.9%	760	2.2%	1,004	2.6%	1,225	2.7%	1,198	2.6%
40 to 44	242	0.9%	343	1.0%	432	1.1%	564	1.2%	586	1.3%
45 to 50	124	0.5%	163	0.5%	227	0.6%	272	0.6%	288	0.6%
Race/ethnicity										
White	20,848	81.6%	27,218	79.5%	29,752	75.8%	34,742	76.9%	34,563	75.7%
Black	945	3.7%	1,506	4.4%	2,082	5.3%	2,528	5.6%	2,683	5.9%
Hispanic	1,808	7.1%	2,445	7.1%	3,466	8.8%	3,628	8.0%	3,348	7.3%
Asian/Pacific Islander	629	2.5%	892	2.6%	1,099	2.8%	1,332	2.9%	1,385	3.0%
American Indian	219	0.9%	267	0.8%	283	0.7%	323	0.7%	358	0.8%
Two or more races	147	0.6%	227	0.7%	289	0.7%	304	0.7%	314	0.7%
Unknown race	967	3.8%	1,668	4.9%	2,302	5.9%	2,337	5.2%	3,020	6.6%
TOTAL number enrolled:	25,563	100.0%	34,223	100.0%	39,273	100.0%	45,194	100.0%	45,671	100.0%

Note: Numbers of enrollees for SFY 2007-2011 enrolled in MFPP do not match the enrollment figures in Table 1, because MHCP enrollees may be enrolled in more than one program over the course of an SFY.

Objective 2: **Increase the proportion of men and women enrolled in Minnesota Health Care Programs who utilize family planning services.**

Indicator: The proportion of MHCP enrollees that have a *family planning service claim* or a *family planning pharmacy claim* for each SFY from July 2003 through June 2011. This will be referred to as the *family planning utilization rate.*

Data source: Numerator: MMIS paid claims data.
Denominator: MMIS eligibility data.
The denominator is the unduplicated count of individuals enrolled in MHCP offering family planning services for each SFY (reported in results for Objective 1).

Definitions: *Family planning service claim* includes claims for services that are offered in the MFPP benefit set (including family planning supplies or health services, and screening, testing, and counseling for STDs and HIV). Claims with an ICD-9-CM diagnosis code in the V25.xx range and a HCPCS/CPT code on the list of covered services for MFPP were included. These claims included CMS-1500 claims for professional services, outpatient claims, and Medicare crossover claims.

Family planning pharmacy claim includes pharmacy claims for drugs or devices with a therapeutic class code indicating a contraceptive.

Results: Figure 2 presents the family planning utilization rates of MHCP enrollees for SFY 2004-2011. Table 2 presents the number of MHCP enrollees with a family planning service or pharmacy claim, and the family planning utilization rates by sex, age group, race/ethnicity, and major program of enrollment, for SFY 2004-2011.

Discussion: The family planning utilization rate rose from about 17.7 percent of MHCP enrollees before the start of the waiver program, to 23.6 percent of MHCP enrollees in SFY 2010 and waning slightly in SFY 2011 to 22.6 percent.

Family planning utilization rates vary by sex, age, race/ethnicity, and major program. Before the start of the waiver, about 30 percent of females and less than 1 percent of males enrolled in MHCP used family planning services or had family planning pharmacy claims. After the start of the waiver, utilization rates increased for females, to 37.4 percent in SFY 2011, but remained under 1 percent for males.

The increase in utilization rates after the start of the waiver was largest for the two youngest age groups (under age 25). Utilization rates increased more for whites, Hispanics, and individuals of unknown race/ethnicity than for other race/ethnic groups. Utilization rates were similar before and after the start of the waiver for Medical Assistance, and declined slightly for MinnesotaCare. The shifts in General Assistance Medical Care utilization reflect the ending of that program for adults without children and the transition to Medical Assistance and MinnesotaCare in SFY 2011. .

Figure 2. Family planning utilization rates of Minnesota Health Care Programs enrollees, state fiscal years 2004-2011.

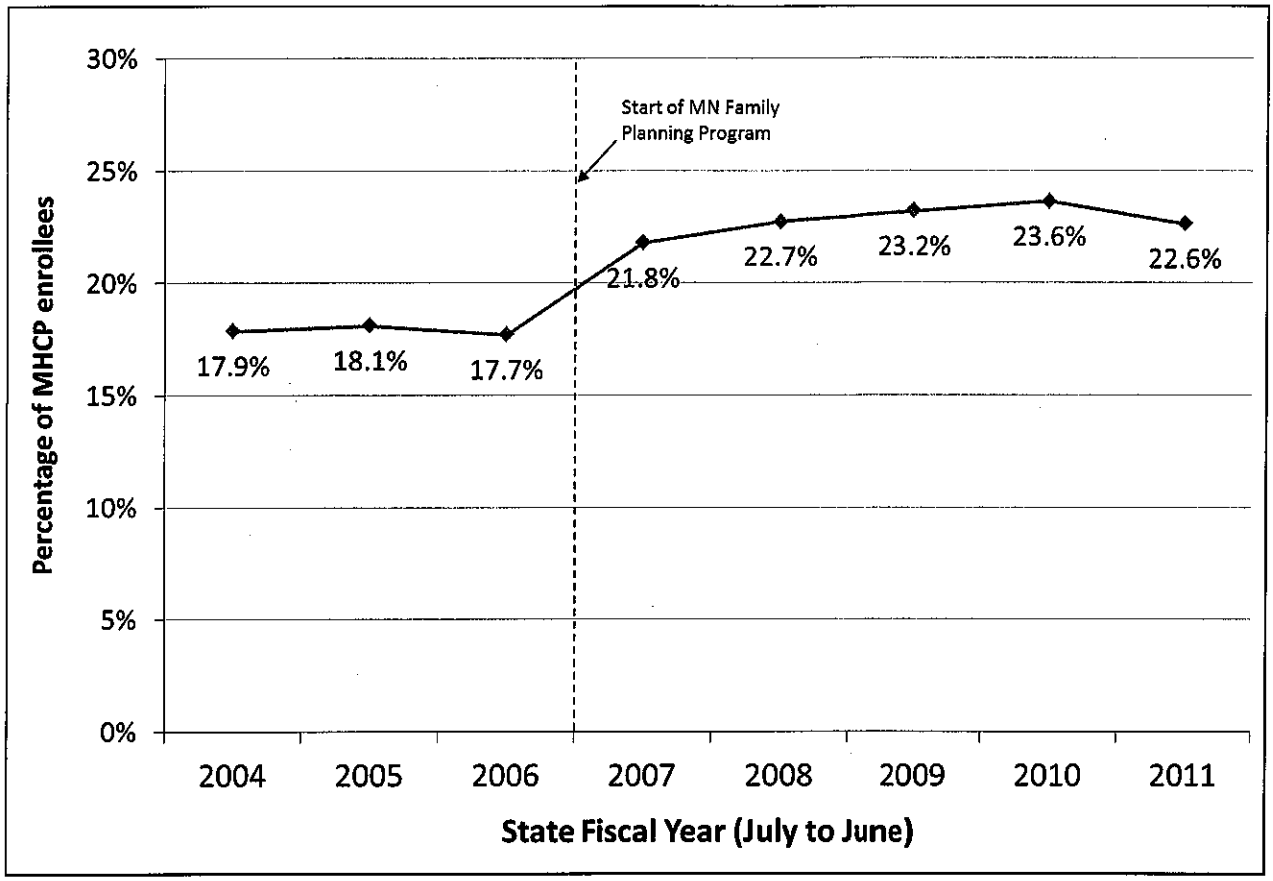


Table 2. Number of MHCP enrollees with family planning service or pharmacy claims, and family planning utilization rates, overall and by sex, age group, race/ethnicity, and major program, SFY 2004-2007.

	SFY 2004		SFY 2005		SFY 2006		SFY 2007	
	Number enrollees with FP claims	Utilization Rate	Number enrollees with FP claims	Utilization Rate	Number enrollees with FP claims	Utilization Rate	Number enrollees with FP claims	Utilization Rate
Sex								
Female	71,705	30.0%	73,997	30.3%	73,375	29.6%	93,426	35.2%
Male	1,156	0.7%	1,111	0.7%	1,014	0.6%	1,184	0.7%
Age Group								
15 to 19	13,039	16.3%	13,252	16.1%	13,268	15.7%	20,371	22.4%
20 to 24	24,170	30.7%	24,862	31.1%	23,907	30.1%	33,098	38.4%
25 to 29	16,001	27.1%	16,956	27.3%	17,629	27.2%	20,867	30.3%
30 to 34	9,356	18.9%	9,480	19.1%	9,243	18.8%	9,968	20.3%
35 to 39	5,412	11.7%	5,667	12.2%	5,587	12.0%	5,761	12.6%
40 to 44	3,236	6.8%	3,183	6.7%	3,117	6.7%	2,953	6.7%
45 to 50	1,647	3.6%	1,708	3.6%	1,638	3.3%	1,592	3.2%
Race/ethnicity								
White	49,056	18.7%	49,590	18.8%	48,564	18.5%	65,062	23.8%
Black	11,365	16.0%	12,310	16.4%	12,548	15.8%	13,142	16.1%
Hispanic	5,074	21.4%	5,601	23.0%	5,689	22.6%	7,364	27.9%
Asian/Pacific Islander	2,920	13.0%	2,988	12.5%	2,993	12.3%	3,255	13.6%
American Indian	2,623	15.6%	2,682	15.6%	2,713	15.4%	2,948	16.4%
Two or more races	719	24.0%	837	25.1%	867	24.0%	1,040	26.2%
Unknown race	1,104	14.0%	1,100	14.8%	1,015	14.3%	1,799	24.3%
Major Program								
Medical Assistance	49,219	20.0%	52,340	20.1%	53,413	19.8%	53,997	19.7%
MinnesotaCare	20,977	18.5%	19,911	19.0%	17,992	18.4%	16,807	16.9%
General Assistance Medical Care	2,665	5.6%	2,857	5.7%	2,984	5.7%	1,681	4.6%
Minnesota Family Planning Program	0	0.0%	0	0.0%	0	0.0%	22,125	94.8%
TOTAL number with FP claims:	72,861	17.9%	75,108	18.1%	74,389	17.7%	94,610	21.8%

(continued on next page)

Table 2 (continued). Number of MHCP enrollees with family planning service or pharmacy claims, and family planning utilization rates, overall and by sex, age group, race/ethnicity, and major program, SFY 2008-2011.

	SFY 2008		SFY 2009		SFY 2010		SFY 2011	
	Number enrollees with FP claims	Utilization Rate	Number enrollees with FP claims	Utilization Rate	Number enrollees with FP claims	Utilization Rate	Number enrollees with FP claims	Utilization Rate
Sex								
Female	98,967	36.4%	107,173	37.4%	118,256	38.6%	120,980	37.4%
Male	1,247	0.7%	1,390	0.8%	1,779	0.9%	1,736	0.8%
Age Group								
15 to 19	21,994	24.0%	23,454	25.1%	24,861	25.6%	24,955	25.1%
20 to 24	35,041	39.7%	37,420	39.7%	41,043	39.7%	40,738	38.0%
25 to 29	22,047	30.9%	24,052	30.8%	27,015	31.2%	27,902	30.0%
30 to 34	10,520	20.8%	11,983	21.3%	13,885	21.6%	15,137	20.8%
35 to 39	5,959	13.1%	6,476	13.5%	7,346	14.2%	7,683	13.9%
40 to 44	3,030	7.2%	3,336	7.6%	3,804	8.0%	4,042	7.8%
45 to 50	1,623	3.2%	1,842	3.4%	2,081	3.6%	2,259	3.6%
Race/ethnicity								
White	68,687	24.8%	73,569	25.0%	81,982	25.6%	83,268	24.5%
Black	13,700	16.7%	15,167	17.6%	16,945	18.0%	17,522	17.3%
Hispanic	7,881	29.5%	8,708	30.0%	9,175	29.6%	8,739	27.7%
Asian/Pacific Islander	3,418	13.9%	3,787	14.2%	4,323	14.4%	4,718	14.2%
American Indian	2,988	16.5%	3,136	16.8%	3,311	17.2%	3,301	16.4%
Two or more races	1,178	27.2%	1,331	27.1%	1,465	26.7%	1,593	26.2%
Unknown race	2,362	31.6%	2,865	36.4%	2,834	34.2%	3,575	36.2%
Major Program								
Medical Assistance	56,567	20.1%	60,294	20.3%	65,332	20.8%	71,596	18.1%
MinnesotaCare	15,762	15.9%	16,147	15.9%	18,477	15.5%	17,070	17.5%
General Assistance Medical Care	1,416	4.7%	1,713	4.9%	1,677	4.8%	141	1.6%
Minnesota Family Planning Program	26,469	86.7%	30,409	87.7%	34,549	87.7%	33,909	85.3%
TOTAL number with FP claims:	100,214	22.7%	108,563	23.2%	120,035	23.6%	122,716	22.6%

Objective 3: Reduce the number of unintended births among women enrolled in MHCP.

Indicator: The proportion of *Medicaid-covered births* that were the result of *unintended pregnancies* for each calendar year from 2002 through 2010.

Data source: Pregnancy Risk Assessment Monitoring System (PRAMS) survey data.

Definitions: *Medicaid-covered births* are defined as births where the mother answered that their delivery was paid for by "Medicaid, Medical Assistance, or MinnesotaCare" on the PRAMS survey.

Unintended pregnancies are defined as pregnancies that were either mistimed or unwanted at the time of conception, based on the mother's answer to the PRAMS survey question "Thinking back to just before you got pregnant with your new baby, how did you feel about becoming pregnant?" Mistimed pregnancies are those for which the mother answered "I wanted to be pregnant later." Unwanted pregnancies are those for which the mother answered "I didn't want to be pregnant then or at any time in the future."

Results: Figure 3 shows the percentage of unintended pregnancies by calendar year for Medicaid-covered births, non-Medicaid-covered births, and all Minnesota births.

Table 3 shows the percentage of unintended pregnancies by calendar year for Medicaid-covered births with 95% confidence intervals, sample sizes, and weighted population estimates.

Discussion: The percentage of unintended pregnancies among Medicaid-covered births fluctuated between 53 and 58 percent of births during 2002-2010, and did not significantly change during the years examined. The p-value for a test for linear trend during 2002-2009 was 0.74. A test for linear trend for the years after the start of the waiver (2007-2009) was also non-significant (p=0.82).

The percentages of unintended pregnancies among non-Medicaid births, and among all Minnesota births, also did not significantly change during 2002-2010.

Figure 3. Percentage of unintended pregnancies among Medicaid births, non-Medicaid births, and among all Minnesota births, by calendar year of birth, Minnesota PRAMS 2002-2010.

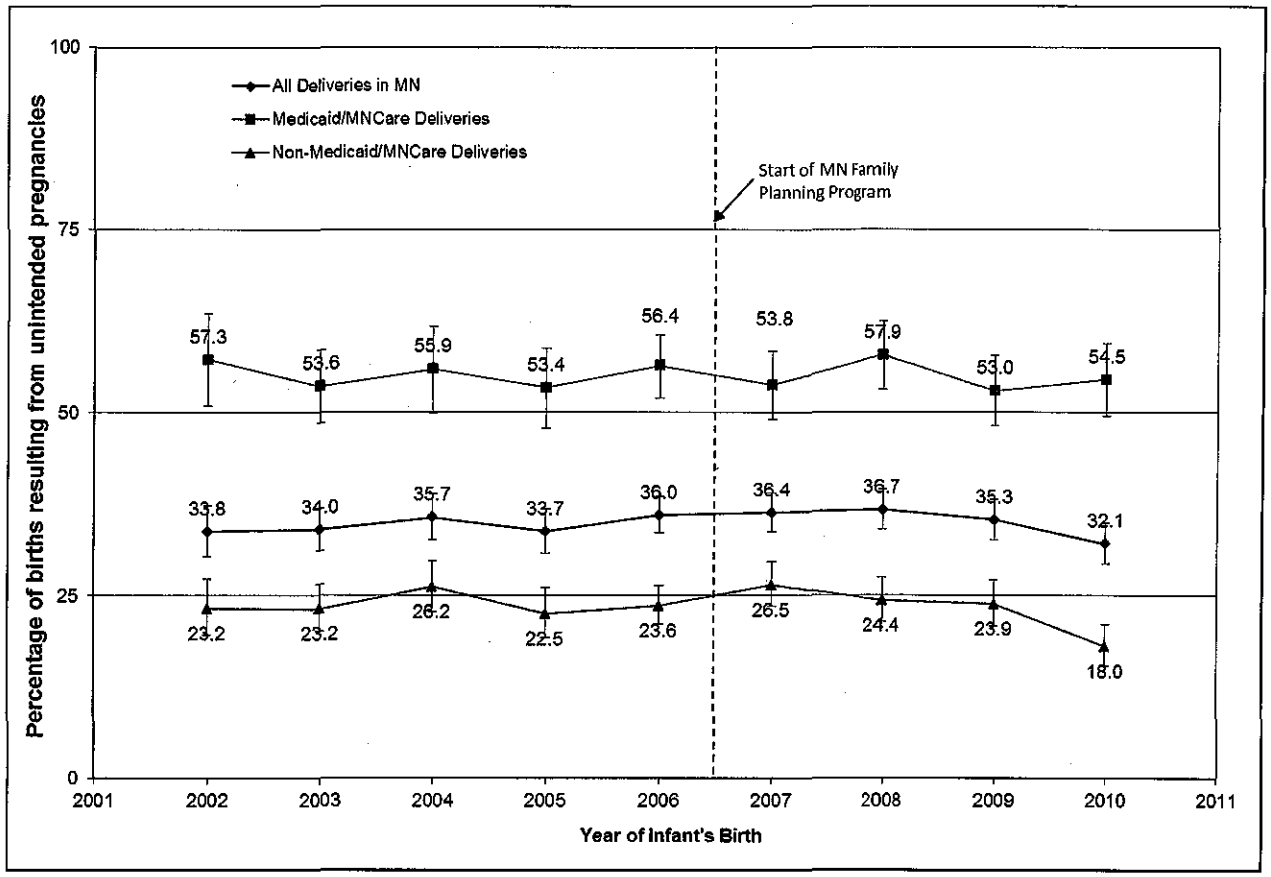


Table 3. Percentage of unintended pregnancies among Medicaid-covered births, by calendar year of birth, Minnesota PRAMS 2002-2010.

Year of birth	% unintended	95% Confidence Interval	Sample size	Weighted population estimate
2002	57.27	50.86 - 63.46	316	7697
2003	53.62	48.55 - 58.63	496	12455
2004	55.92	49.88 - 61.78	428	11625
2005	53.38	47.84 - 58.83	478	13113
2006	56.41	52.00 - 60.71	285	14467
2007	53.79	49.06 - 58.45	379	13228
2008	57.85	53.07 - 62.49	356	14176
2009	53.00	48.18 - 57.77	326	13739
2010	54.50	49.52 - 59.52	310	13508

Objective 4: **Reduce the proportion of births to MHCP enrollees that are spaced less than 2 years apart.**

Indicator: The proportion of *MHCP-financed births* to *multiparous women* aged 15-49 with a *birth interval* of less than 24 months will be calculated for each calendar year from 2003 through 2010.

Data source: Linked Minnesota resident birth certificates and MMIS enrollment and claims data.

Definitions: *MHCP-financed births* are defined as births for which the birth certificate has been matched to MHCP enrollment and claims data.

Multiparous women are defined as women who have had a previous live birth as indicated on the birth certificate.

Birth interval is defined as the number of years between the birth date and the mother's last live birth as recorded on the birth certificate.

Results: Figure 4 presents the percentage of MHCP-financed births with a birth interval of less than 24 months by calendar year.

Table 4 shows the number and percentage of MHCP-financed births with a birth interval of less than 24 months, and the median birth interval in months, by calendar year.

Discussion: The percentage of MHCP births with birth intervals of less than 24 months did not vary much over the years examined. Before the start of the waiver, approximately 28 to 29 percent of MHCP births to multiparous women were less than 24 months after the previous birth. After the start of the waiver, there was a slight increase in 2007 and 2008 (29.4 percent and 30.1 percent of births respectively), followed by a small decrease in 2009 and 2010 (28.4 percent and 27.9 percent of births respectively). Data for additional years is needed to determine if the downturn in 2009 and 2010 is the beginning of a trend toward increased birth spacing.

Figure 4. Percentage of MHCP-financed births to multiparous women aged 15-49 with a birth interval of less than 24 months, Minnesota, 2003-2010.

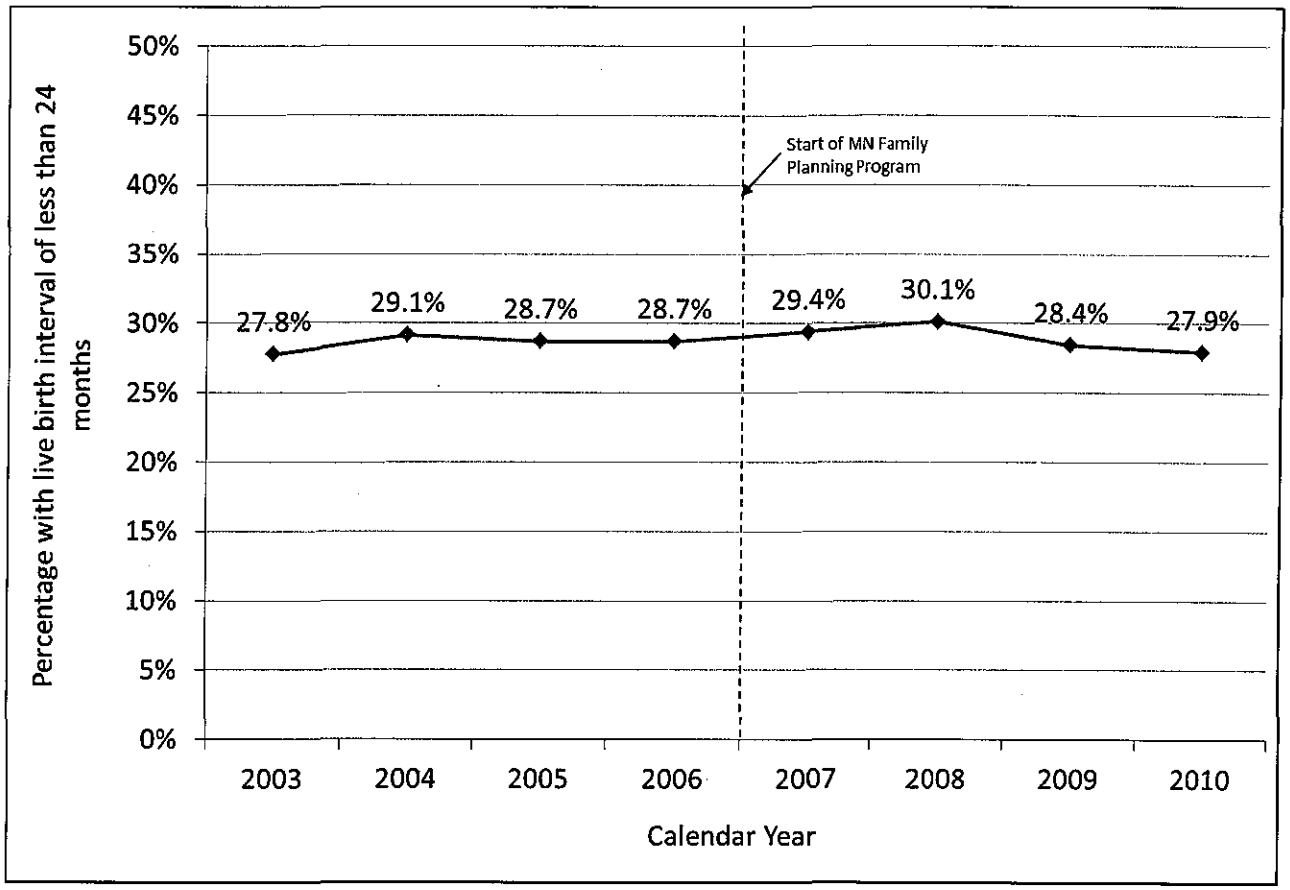


Table 4. Percentage of MHCP-financed births to multiparous women aged 15-49 with a birth interval of less than 24 months, Minnesota, 2003-2010.

Birth year	Percent of MHCP births with a birth interval of less than 2 years	Numerator	Denominator	Median birth interval (months)
2003	27.76%	3537	12742	35.0
2004	29.14%	3834	13156	34.0
2005	28.65%	4232	14773	34.0
2006	28.71%	4536	15797	34.0
2007	29.37%	4711	16040	34.0
2008	30.07%	5010	16659	34.0
2009	28.43%	4911	17277	34.0
2010	27.94%	4856	17383	35.0

Objective 5: **Reduce the Medicaid birth rates of women in families with incomes below 200% of poverty.**

Indicator: The ratio of the number *MHCP-financed births* to women aged 15-49, to the number of Minnesota women aged 15-49 in families with incomes less than 200% of the federal poverty threshold, expressed as a rate per 1,000 women, for each calendar year from 2004 through 2010. This will be referred to as the *Medicaid birth rate.*

Data source: Numerator: Linked Minnesota resident birth certificates and MMIS enrollment and claims data.
Denominator: American Community Survey 1-year Public Use Microdata Sample files, US Census Bureau.

Definitions: *MHCP-financed births* are defined as births for which the birth certificate has been matched to MHCP enrollment and claims data.

Results: Figure 5 presents the Medicaid birth rate for calendar years 2004-2010.

Tables 5a, 5b, and 5c present the Medicaid birth rates for 2004-2010 stratified by maternal age group, race, and Hispanic ethnicity.

Discussion: The overall Medicaid birth rate increased between 2004 and 2005, remained stable between 2005 and 2009, and decreased between 2009 and 2010. Additional years of data are needed to determine if the decrease seen between 2009 and 2010 is the beginning of a downward trend or reduction in Medicaid birth rates.

This indicator is difficult to interpret, because it depends on not only the fertility of low-income women enrolled in MHCP, but also on trends in MHCP enrollment. There is an unknown amount of mismatch between the number of MHCP-financed births in the numerator, and the number of low-income women in the denominator. Pregnant women with household incomes up to 275 percent of the federal poverty guideline (FPG) are generally eligible for MHCP; while the majority of MHCP-financed births are to women with household incomes below 200 percent of FPG, there are some women with incomes 200 to 275 percent of FPG not included in the denominator whose births are included in the numerator. It is unknown whether or not the proportion of MHCP-financed births to women with incomes 200-275 percent of FPG changed over this time period. Additionally, not all low-income women included in the denominator are eligible for or enrolled in MHCP; some low-income women who gave birth during this time period had private insurance or were uninsured at the time of delivery. The trends that can be seen include a consistent increase from 2004 to 2010 in Minnesota women with incomes below 200% of poverty from 288,782 to 358,879 along with steady increase in MHCP enrollment (see objective 1).

Figure 5. Medicaid birth rate per 1,000 women aged 15-49 in families with incomes below 200% of the federal poverty threshold, Minnesota, 2004-2010.

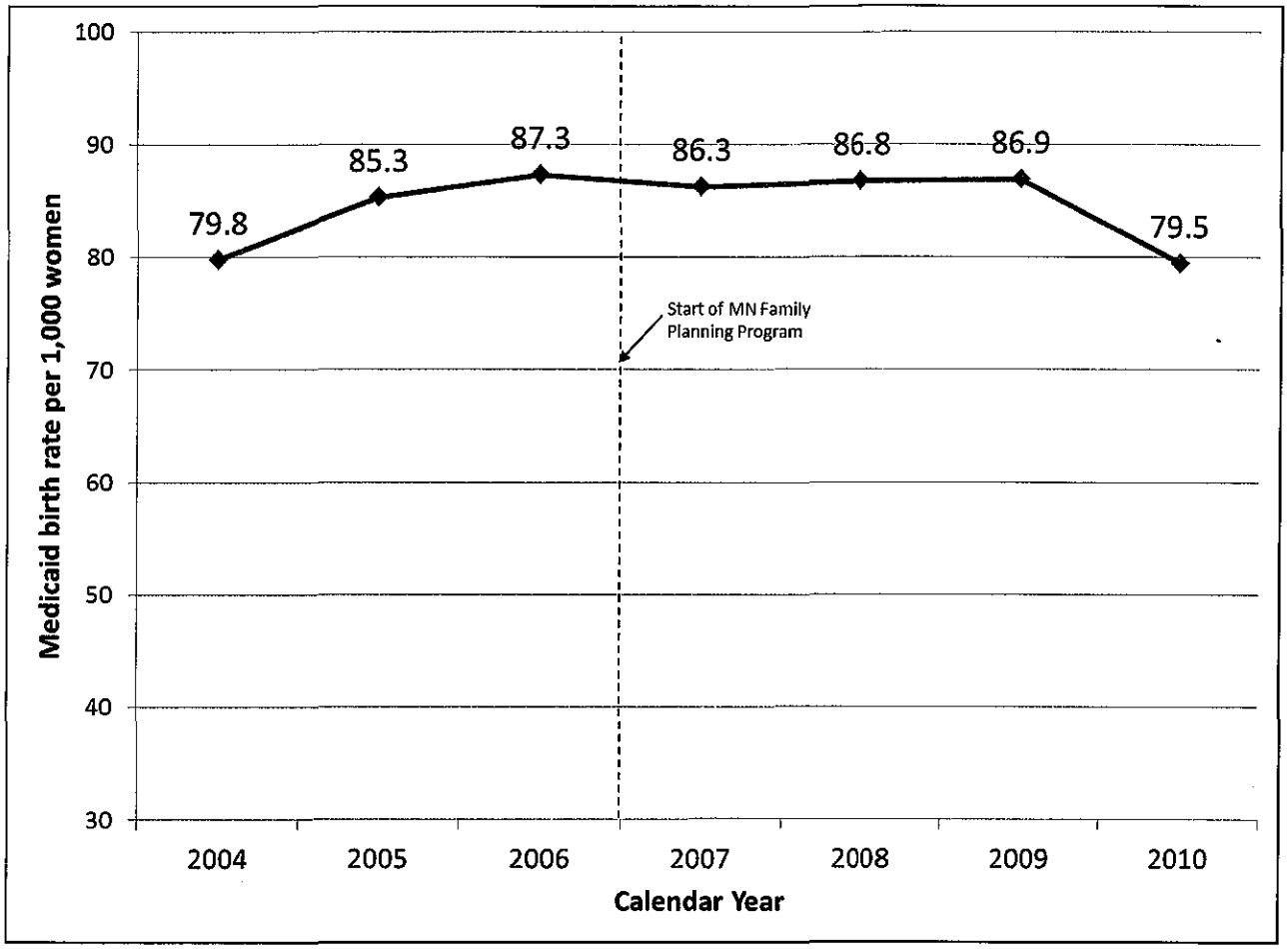


Table 5a. Medicaid birth rates per 1,000 women in families with incomes below 200% of the federal poverty threshold, stratified by 5-year maternal age group.

Maternal Age Group	Year of Birth						
	2004	2005	2006	2007	2008	2009	2010
Age 15-19	82.4	70.1	78.0	86.3	69.0	76.0	69.9
Age 20-24	130.9	150.0	135.5	131.3	135.9	119.8	113.6
Age 25-29	146.7	147.0	154.3	144.9	142.8	162.8	146.3
Age 30-34	79.5	90.2	103.2	95.3	105.0	96.6	102.7
Age 35-39	31.2	40.6	43.6	37.7	45.6	58.3	45.7
Age 40-44	9.5	10.4	10.0	12.4	11.2	11.3	11.3
Age 45-49	0.9	1.2	1.0	0.9	1.5	0.9	0.7

Table 5b. Medicaid birth rates per 1,000 women in families with incomes below 200% of the federal poverty threshold, stratified by maternal race as indicated on the birth certificate.

Maternal Race	Year of Birth						
	2004	2005	2006	2007	2008	2009	2010
White alone	60.3	65.9	64.7	65.2	62.7	64.1	63.5
Black alone	129.0	127.7	129.9	126.7	132.6	148.0	109.3
American Indian/ Alaska Native alone	140.9	107.2	163.7	154.9	109.2	100.2	112.0
Asian/ Pacific Islander alone	72.1	89.0	109.8	86.6	131.9	110.9	90.8
Other race	269.5	242.4	288.8	306.0	493.2	383.9	301.7
Two or more races	67.0	118.5	81.9	95.7	132.1	86.8	50.8

Table 5c. Medicaid birth rates per 1,000 women in families with incomes below 200% of the federal poverty threshold, stratified by maternal Hispanic ethnicity as indicated on the birth certificate.

Maternal Hispanic Ethnicity	Year of Birth						
	2004	2005	2006	2007	2008	2009	2010
Hispanic	194.9	166.9	146.8	148.2	162.2	154.8	122.5
Non-Hispanic	69.7	76.6	79.2	78.7	78.8	79.3	74.3

Table 6. Primary care enrollment rates of SFY 2007-2011 MFPP enrollees as of December 2011, overall and stratified by sex, age group, and race/ethnicity.

	Number of MFPP enrollees SFY 2007-2011	Number of enrollees who subsequently enrolled in MHCP primary care coverage	Primary care enrollment rate
Sex			
Female	101,402	14,627	14.4%
Male	2,101	251	11.9%
Age Group at start of MFPP enrollment			
15 to 19	33,118	4,045	12.2%
20 to 24	43,539	6,065	13.9%
25 to 29	16,163	2,815	17.4%
30 to 34	5,910	1,070	18.1%
35 to 39	2,826	511	18.1%
40 to 44	1,319	251	19.0%
45 to 50	628	121	19.3%
Race/ethnicity			
White	77,011	11,209	14.6%
Black	6,428	1,623	25.2%
Hispanic	9,435	945	10.0%
Asian/Pacific Islander	3,070	435	14.2%
American Indian	917	242	26.4%
Two or more races	771	201	26.1%
Unknown race/ethnicity	5,871	223	3.8%
TOTAL	**103,503**	**14,878**	**14.4%**

Overview of the Findings

Since the implementation of the Minnesota Family Planning Program, on July 1, 2006 there has been an increase in the number of Minnesotans who have access to family planning services through enrollment in Minnesota Health Care Programs (MHCP). There has also been an increase in the proportion of men and women enrolled in MHCPs who utilize family planning services. From 2006-2011, 14.4 percent of MHCP enrollees were enrolled in the Minnesota Family Planning Program prior to MHCP enrollment, showing that the Minnesota Family Planning Program helped facilitate some Minnesotans to get the primary care services they need.

After the implementation of the demonstration in 2006 the Medicaid Birth rate leveled out and in 2010 a reduction in rate to 79.5 per 1000 was the lowest rate seen from 2004-2010. The proportion of birth intervals of less than 24 months varied slightly with a small downturn toward increased birth spacing was seen in 2009 and 2010. From 2003-2010 the number of unintended births among MHCP enrolled women fluctuated with no significant trend of reduction. Unintended births, birth spacing, and birth rates are long-term objectives that take many years after an implementation of a program to observe; data for additional years is needed to determine if the downturns in 2009 and 2010 are the beginning of trends.

The continuation of the Minnesota Family Planning Program and evaluation will allow for better understanding of its impact on the Minnesota Health Care Program population.