STATE OF MINNESOTA

Office of Governor Mark Dayton

116 Veterans Service Building ♦ 20 West 12th Street ♦ Saint Paul, MN 55155

June 30, 2015

Ms. Sylvia Mathews Burwell
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Re: Minnesota Family Planning Program

Dear Secretary Burwell:

I am requesting a renewal of the Minnesota Family Planning Program waiver under Section 1115(e) of the Social Security Act. The Minnesota Family Planning Program, now in its ninth year of operation, allows Minnesota to provide family planning benefits to people with incomes up to 200 percent of the federal poverty level. The current waiver expires on December 31, 2015.

On April 1, 2015, we submitted a request to amend Minnesota's Medicaid state plan to operate the Minnesota Family Planning Program under the state plan option. The waiver renewal seeks to continue operating the program under the existing terms and conditions in the event that there are issues with the state plan amendment request.

I look forward to working with you to continue this important preventive care program for Minnesotans.

Sincerely,

[redacted]

Mark Dayton
Governor

cc: Vikki Wachino, Deputy Administrator and Director, Centers for Medicare & Medicaid Services, Center for Medicaid and CHIP Services
Ruth Hughes, Associate Regional Administrator, Region V, Centers for Medicare and Medicaid Services, Division of Medicaid and Children's Health Operations

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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:

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

June 30, 2015

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 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. CMS approved a one-year extension of the MFPP waiver in June 2013 and again in June 2014. The waiver is due to expire on December 31, 2015. State law requires DHS to seek state plan authority for the program. The proposed renewal of the waiver will allow the current program to continue as DHS negotiates the transition to state plan authority.

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 Program administered by the Minnesota Department of Human Services (DHS). The MFPP waiver allows the state of Minnesota 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 MFPP is to demonstrate positive health outcomes and cost savings by providing an accessible, preventive approach to family planning services for individuals who normally do not access such services. The program reduces gaps in coverage and increases 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).[1]

[1] Medical Assistance and MinnesotaCare. Effective January 2015, MinnesotaCare is designated as the state's Basic Health Program (BHP). Minnesota's Medical Assistance and BHP programs are collectively referred to as 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 birth rate for teens.

The hypotheses that will be tested during the demonstration 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.

The Interim Evaluation Report for the MFPP waiver renewal period of July 2011 to June 2014 is provided at Attachment B.

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

The MFPP demonstration waiver operates 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, 2016 through December 31, 2018.

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 have a non-citizen status that qualifies for federally funded Medicaid;
- 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 MHCP administered by DHS; 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 DHS in obtaining third-party payments. DHS 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

DHS documents the income of applicants and enrollees annually. To qualify for the Minnesota Family Planning Program (MFPP), an applicant must have income at or below 200% FPG, using MAGI-based Medicaid income rules. There is no asset test for MFPP.

To qualify for ongoing MFPP, individuals must be citizens, or noncitizens with an immigration status that qualifies for federally-funded Medicaid. 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. DHS 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. DHS then makes the final determination of ongoing eligibility.

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

There are 137 MFPP presumptive eligibility providers available throughout the state in over 47 counties. MFPP applicants may apply for MFPP at any of the certified provider locations.

Third Party Liability
Applicants must report available third-party coverage and cooperate with DHS in obtaining third-party payments. DHS 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 Redetermination Process
Eligibility for MFPP is re-determined every 12 months. Earned and unearned income is verified at each renewal.

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 DHS 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. DHS 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 another MHCP. 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 as defined in 42 C.F.R. §§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.

DHS 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 IX (CY 2016), demonstration year X (CY 2017) and demonstration year XI (2018):

CY 2016	35,564
CY 2017	35,717
CY 2018	36,074

Projections are based on the average ratio of persons ever enrolled (unique individuals)/average monthly enrolled across the three-year period from CY 2012 through CY 2014.

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 C.F.R. 435.726 (SSI state and section 1634) or under 42 C.F.R. 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. DHS 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. DHS 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. DHS 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 as defined in 42 C.F.R. §§435.1009 and 435.1010.

Individuals who are subject to a lock-out period may be eligible for 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.

N/A

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)

There are no premiums or cost-sharing requirements in the MFPP

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 DHS 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)

The Medical Assistance Program utilizes both fee-for-service and managed care delivery systems under the Medicaid state plan. Under the MFPP demonstration, providers 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. There are 137 MFPP presumptive eligibility providers available throughout the state in over 47 counties. MFPP applicants may apply for MFPP at any of the certified provider locations.

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.

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. DHS 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. 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 DHS 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

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 to inform them about other, more comprehensive health care programs they may wish to apply for, including Medicaid. 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. 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 C 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.

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 May 26, 2015. This notice announced a 30-day comment period from May 26, 2015 to June 24, 2015 on the MFPP waiver renewal request. The notice included instructions for accessing an electronic copy or requesting a hard copy of the waiver request. Instructions for submitting 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 a 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 the waiver application. A copy of the Minnesota State Register Notice published on May 26, 2015 is provided as Attachment D.

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 http://www.dhs.state.mn.us/dhs16_175262 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. After the comment period, the website was updated to alert web visitors that a federal comment period on the MFPP renewal request will be coming soon and the link to the relevant CMS web page will be posted as soon as it is available.

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.

DHS 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. 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 Elmer Andersen building on June 10, 2015. There was one member of the public in attendance and public testimony was given by this individual. A written transcript of the testimony provided is found at Attachment E. The second public hearing was held at DHS Lafayette location on June 11, 2015. No 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.

DHS used an electronic mailing list or similar mechanism to notify the public. On May 26, 2015, 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 DHS web page for a copy of the MFPP renewal request and a description of the public notice and hearing processes. Minnesota State Register notice published on May 26, 2015. A second notice was sent to provide notice that the final submitted version of the waiver was on the web site and to alert stakeholders that a federal comment period on the MFPP renewal request is expected soon.

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

DHS receive one written comment from stakeholders regarding the proposed MFPP waiver renewal request during the comment period from May 26, 2015 to June 24, 2015. A copy of the comment is included at Attachment E.

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

DHS receive one written comment from stakeholders regarding the proposed MFPP waiver renewal request during the comment period from May 26, 2015 to June 24, 2015. The comment was supportive of DHS' request to renew the MFPP waiver.

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 F 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 May 26, 2015 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 included information about the public notice process and opportunities for comment. Please refer to

Attachment G for a copy of the May 26, 2015 letter. The state's intent to submit a request to extend the MFPP waiver was also included in a summary of federal waiver activity provided to Tribal Chairs and Tribal Health Directors at the May 27, 2015 Tribal Health Work Group meeting.

8) Summary of the state's compliance with the post-implementation forum requirements in the transparency regulations

DHS held a post-award public forum on June 10, 2015 to provide the public with an opportunity to comment on the progress of the MFPP demonstration. A notice was published in the Minnesota State Register on May 11, 2015 informing the public of the date, time and location of the forum. DHS published the date, time and location of the forum on the PMAP Waiver Web page. An email was also sent to all MFPP waiver stakeholders on May 11, 2015 announcing the date, time and location of the forum. There were no members of the public in attendance at the forum.

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

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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	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
		3b) Annual average maternal age among MHCP-financed births		
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

Minnesota Family Planning Program

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

Interim Evaluation Report

Waiver Renewal Period

July 2011 – June 2014

Minnesota Department of Human Services

May 2015

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. An extension of the waiver was approved on December 29, 2011, effective through December 31, 2013. In June 2013 CMS approved a one-year extension of the waiver through December 31, 2014. In July 2014 a second one-year extension was approved for the period January 1, 2015 through December 31, 2015.

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 interim evaluation of MFPP for the renewal period beginning July 2011; data is presented through June 2014.

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) 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)	3 - 7
2) Increase the proportion of men and women enrolled in Minnesota Health Care Programs who utilize family planning services.	a) Annual proportion of MHCP enrollees with a family planning service or pharmacy claim.	8 - 12
3) Increase the average age of mother at first birth among MHCP enrollees.	a) Maternal age distribution for MHCP-financed births. b) Annual average maternal age among MHCP-financed births.	13 - 16
4) Reduce the teen birth rate among MHCP enrollees.	a) Annual proportion of adolescent (ages 15-19) female MHCP enrollees with a live birth financed by MHCP.	17 - 19

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

Indicators: 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).

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

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

Results: Figure 1 presents the number of individuals enrolled in MHCP offering family planning services for SFY 2004-2014. Table 1 presents the number and percentage of individuals enrolled by sex, age group, race/ethnicity and major program of enrollment.

Discussion: The number of individuals aged 15-49 enrolled in MHCP who have access to family planning services has increased from 407,723 in SFY 2004 to 440,665 in SFY 2009 and 607,997 in SFY 2014. A contributing factor to this general increase was the economic recession of 2007 to 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. The launch of Minnesota's state health insurance exchange, MNSure, in October 2013, and the increased income limit for the Medicaid expansion population to 133 percent of the federal poverty level effective January 1, 2014, contributed to the increase in MHCP enrollment between 2013 and 2014.

Figure 1. Unduplicated count of individuals aged 15 to 49 enrolled in Minnesota Health Care Programs offering family planning services, by state fiscal year, July 2003 through June 2014.

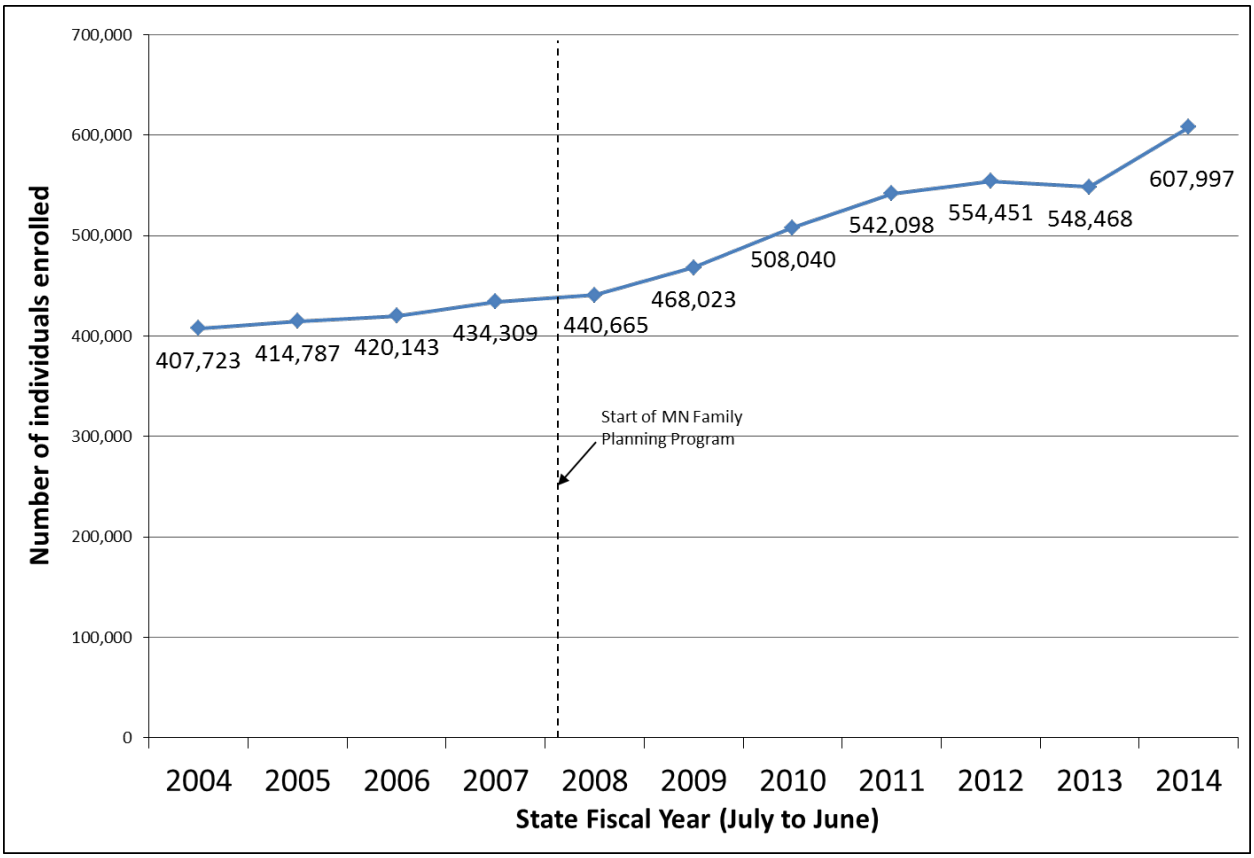

Table 1. Enrollment in MHCP programs that offer family planning services by sex, age, race/ethnicity, and major program, state fiscal years 2004-2007.

	SFY 2004		SFY 2005		SFY 2006		SFY 2007	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Sex								
Female	238,869	58.6%	244,166	58.9%	247,591	58.9%	265,189	61.1%
Male	168,854	41.4%	170,621	41.1%	172,552	41.1%	169,120	38.9%
Age Group								
15 to 19	80,039	19.6%	82,128	19.8%	84,601	20.1%	90,897	20.9%
20 to 24	78,774	19.3%	79,817	19.2%	79,528	18.9%	86,279	19.9%
25 to 29	59,139	14.5%	62,066	15.0%	64,885	15.4%	68,821	15.8%
30 to 34	49,451	12.1%	49,593	12.0%	49,096	11.7%	49,039	11.3%
35 to 39	46,263	11.3%	46,451	11.2%	46,506	11.1%	45,662	10.5%
40 to 44	47,898	11.7%	47,166	11.4%	46,373	11.0%	43,843	10.1%
45 to 50	46,159	11.3%	47,566	11.5%	49,154	11.7%	49,768	11.5%
Race/ethnicity								
White	259,517	63.7%	259,802	62.6%	259,062	61.7%	269,084	62.0%
Black	69,330	17.0%	73,227	17.7%	77,405	18.4%	79,305	18.3%
Hispanic	23,211	5.7%	23,872	5.8%	24,622	5.9%	25,886	6.0%
Asian/Pacific Islander	21,958	5.4%	23,375	5.6%	23,655	5.6%	23,248	5.4%
American Indian	16,594	4.1%	16,960	4.1%	17,426	4.1%	17,773	4.1%
Two or more races	4,099	1.0%	4,538	1.1%	4,933	1.2%	5,432	1.3%
Unknown race	13,014	3.2%	13,013	3.1%	13,040	3.1%	13,581	3.1%
Major Program								
Medical Assistance	246,434	60.4%	259,989	62.7%	269,913	64.2%	274,460	63.2%
MinnesotaCare	113,539	27.8%	104,899	25.3%	97,765	23.3%	99,702	23.0%
General Assistance Medical Care	47,750	11.7%	49,899	12.0%	52,465	12.5%	36,815	8.5%
MN Family Planning Program	0	0.0%	0	0.0%	0	0.0%	23,332	5.4%
TOTAL number enrolled:	407,723	100.0%	414,787	100.0%	420,143	100.0%	434,309	100.0%

(continued on next page)

Table 1 (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	271,707	61.7%	286,179	61.1%	306,481	60.3%	323,796	59.7%
Male	168,958	38.3%	181,844	38.9%	201,559	39.7%	218,302	40.3%
Age Group								
15 to 19	91,635	20.8%	93,590	20.0%	97,075	19.1%	99,568	18.4%
20 to 24	88,251	20.0%	94,246	20.1%	103,295	20.3%	107,336	19.8%
25 to 29	71,466	16.2%	78,115	16.7%	86,489	17.0%	93,046	17.2%
30 to 34	50,554	11.5%	56,282	12.0%	64,147	12.6%	72,919	13.5%
35 to 39	45,506	10.3%	48,005	10.3%	51,862	10.2%	55,462	10.2%
40 to 44	42,360	9.6%	43,988	9.4%	47,323	9.3%	51,579	9.5%
45 to 50	50,893	11.5%	53,797	11.5%	57,849	11.4%	62,188	11.5%
Race/ethnicity								
White	272,871	61.9%	289,531	61.9%	314,182	61.8%	333,602	61.5%
Black	79,900	18.1%	83,915	17.9%	91,048	17.9%	98,060	18.1%
Hispanic	26,205	5.9%	28,390	6.1%	30,268	6.0%	30,677	5.7%
Asian/Pacific Islander	23,829	5.4%	25,851	5.5%	29,085	5.7%	32,267	6.0%
American Indian	17,850	4.1%	18,363	3.9%	18,953	3.7%	19,693	3.6%
Two or more races	5,969	1.4%	6,797	1.5%	7,669	1.5%	8,564	1.6%
Unknown race	14,041	3.2%	15,176	3.2%	16,835	3.3%	19,235	3.5%
Major Program								
Medical Assistance	280,843	63.7%	296,731	63.4%	314,743	62.0%	396,047	73.1%
MinnesotaCare	98,911	22.4%	101,780	21.7%	118,897	23.4%	97,733	18.0%
General Assistance Medical Care	30,369	6.9%	34,829	7.4%	34,985	6.9%	8,565	1.6%
MN Family Planning Program	30,542	6.9%	34,683	7.4%	39,415	7.8%	39,753	7.3%
TOTAL number enrolled:	440,665	100.0%	468,023	100.0%	508,040	100.0%	542,098	100.0%

(continued on next page)

Table 1 (continued). Enrollment in MHCP programs that offer family planning services by sex, age, race/ethnicity, and major program, state fiscal years 2012-2014.

	SFY 2012		SFY 2013		SFY 2014	
	Number	Percent	Number	Percent	Number	Percent
Sex						
Female	328,927	59.3%	326,061	59.4%	354,073	58.2%
Male	225,524	40.7%	222,407	40.6%	253,924	41.8%
Age Group						
15 to 19	99,667	18.0%	99,280	18.1%	106,772	17.6%
20 to 24	106,401	19.2%	102,298	18.7%	105,349	17.3%
25 to 29	94,604	17.1%	92,373	16.8%	105,598	17.4%
30 to 34	78,848	14.2%	80,877	14.7%	92,251	15.2%
35 to 39	57,677	10.4%	58,995	10.8%	69,105	11.4%
40 to 44	54,060	9.8%	53,393	9.7%	59,665	9.8%
45 to 50	63,194	11.4%	61,252	11.2%	69,257	11.4%
Race/ethnicity						
White	335,063	60.4%	324,583	59.2%	353,759	58.2%
Black	103,338	18.6%	106,047	19.3%	113,105	18.6%
Hispanic	32,067	5.8%	32,482	5.9%	35,815	5.9%
Asian/Pacific Islander	33,910	6.1%	34,593	6.3%	40,233	6.6%
American Indian	20,317	3.7%	20,152	3.7%	20,016	3.3%
Two or more races	9,189	1.7%	9,687	1.8%	11,674	1.9%
Unknown race	20,567	3.7%	20,924	3.8%	33,395	5.5%
Major Program						
Medical Assistance	419,947	75.7%	418,544	76.3%	507,696	83.5%
MinnesotaCare	94,596	17.1%	90,866	16.6%	67,262	11.1%
General Assistance Medical Care	0	0.0%	0	0.0%	0	0.0%
MN Family Planning Program	39,908	7.2%	39,058	7.1%	33,039	5.4%
TOTAL number enrolled:	554,451	100.0%	548,468	100.0%	607,997	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.

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

Indicator: Annual proportion of MHCP enrollees with a family planning service or pharmacy claim.

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 2004-2014. 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 2004-2014.

Discussion: The family planning utilization rate rose from about 17.9 percent of MHCP enrollees before the start of the waiver program, to 23.2 percent of MHCP enrollees in SFY 2010 and waning slightly in later years, with 19.2 percent of MHCP enrollees in the most recent SFY (2014).

The reason for the downturn in overall family planning utilization is unknown, but it may be related to the influx of new MHCP enrollees (discussed under Objective 1). Further analysis of specific types of utilization – contraceptive use and STD testing – in the final evaluation report may be informative.

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, with a gradually tapering off for females to 32.3 percent in SFY 2014.

Figure 2. Family planning utilization rates of Minnesota Health Care Programs enrollees, state fiscal years 2004-2014.

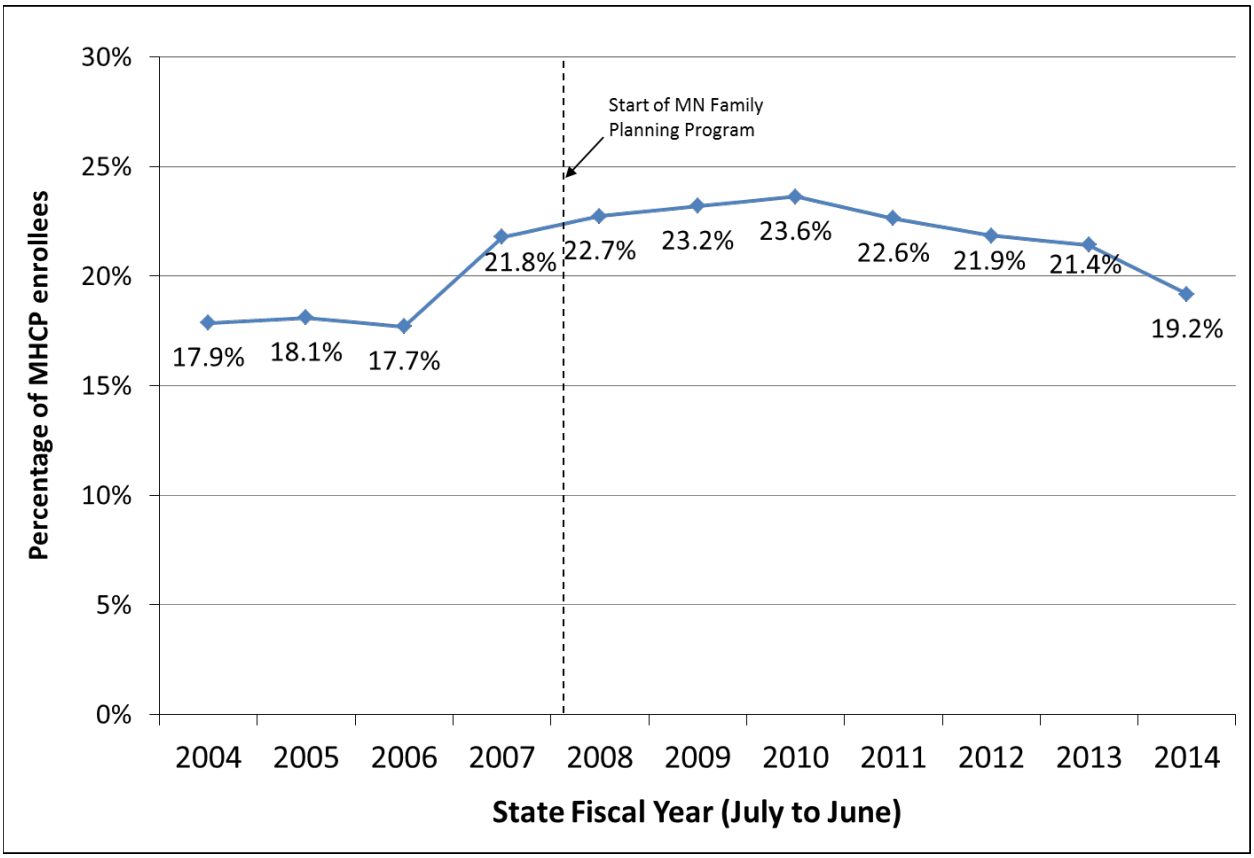

Table 2. Number of MHCP enrollees with family planning service or pharmacy claims, and family planning utilization rates, overall and by sex, age group, race/ethnicity, and major program, SFY 2004-2007.

	SFY 2004			SFY 2005			SFY 2006			SFY 2007		
	Number enrollees with FP claims	Number enrolled	Utilization Rates	Number with FP claims	Number enrolled	Percent of enrolled with FP claims	Number with FP claims	Number enrolled	Percent of enrolled with FP claims	Number with FP claims	Number enrolled	Percent of enrolled with FP claims
Sex												
Female	71,697	238,869	30.0%	73,991	244,166	30.3%	73,369	247,591	29.6%	93,417	265,189	35.2%
Male	1,162	168,854	0.7%	1,116	170,621	0.7%	1,021	172,552	0.6%	1,193	169,120	0.7%
Age Group												
15 to 19	13,041	80,039	16.3%	13,254	82,128	16.1%	13,270	84,601	15.7%	20,372	90,897	22.4%
20 to 24	24,167	78,774	30.7%	24,861	79,817	31.1%	23,908	79,528	30.1%	33,099	86,279	38.4%
25 to 29	16,000	59,139	27.1%	16,953	62,066	27.3%	17,627	64,885	27.2%	20,864	68,821	30.3%
30 to 34	9,354	49,451	18.9%	9,484	49,593	19.1%	9,243	49,096	18.8%	9,968	49,039	20.3%
35 to 39	5,412	46,263	11.7%	5,664	46,451	12.2%	5,587	46,506	12.0%	5,760	45,662	12.6%
40 to 44	3,238	47,898	6.8%	3,183	47,166	6.7%	3,117	46,373	6.7%	2,955	43,843	6.7%
45 to 49	1,647	46,159	3.6%	1,708	47,566	3.6%	1,638	49,154	3.3%	1,592	49,768	3.2%
Race/ethnicity												
White	48,287	259,517	18.6%	48,781	259,802	18.8%	47,746	259,062	18.4%	64,060	269,084	23.8%
Black	11,051	69,330	15.9%	11,977	73,227	16.4%	12,174	77,405	15.7%	12,713	79,305	16.0%
Hispanic	4,974	23,211	21.4%	5,502	23,872	23.0%	5,602	24,622	22.8%	7,228	25,886	27.9%
Asian/Pacific Islander	2,844	21,958	13.0%	2,918	23,375	12.5%	2,925	23,655	12.4%	3,178	23,248	13.7%
American Indian	2,557	16,594	15.4%	2,620	16,960	15.4%	2,651	17,426	15.2%	2,899	17,773	16.3%
Two or more races	1,002	4,099	24.4%	1,114	4,538	24.5%	1,165	4,933	23.6%	1,429	5,432	26.3%
Unknown race	2,144	13,014	16.5%	2,195	13,013	16.9%	2,127	13,040	16.3%	3,103	13,581	22.8%
Major Program												
Medical Assistance	49,217	246,434	20.0%	52,339	259,989	20.1%	53,413	269,913	19.8%	53,998	274,460	19.7%
MinnesotaCare	20,977	113,539	18.5%	19,911	104,899	19.0%	17,993	97,765	18.4%	16,806	99,702	16.9%
General Assistance Medical Care	2,665	47,750	5.6%	2,857	49,899	5.7%	2,984	52,465	5.7%	1,681	36,815	4.6%
MN Family Planning Program	0	0	0.0%	0	0	0.0%	0	0	0.0%	22,125	23,332	94.8%
TOTAL number with FP claims:	72,859	407,723	17.9%	75,107	414,787	18.1%	74,390	420,143	17.7%	94,610	434,309	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 with FP claims	Number enrolled	Percent of enrolled with FP claims	Number with FP claims	Number enrolled	Percent of enrolled with FP claims	Number with FP claims	Number enrolled	Percent of enrolled with FP claims	Number with FP claims	Number enrolled	Percent of enrolled with FP claims
Sex												
Female	98,956	271,707	36.4%	107,167	286,179	37.4%	118,250	306,481	38.6%	120,977	323,796	37.4%
Male	1,258	168,958	0.7%	1,399	181,844	0.8%	1,790	201,559	0.9%	1,740	218,302	0.8%
Age Group												
15 to 19	21,995	91,635	24.0%	23,457	93,590	25.1%	24,865	97,075	25.6%	24,958	99,568	25.1%
20 to 24	35,042	88,251	39.7%	37,421	94,246	39.7%	41,048	103,295	39.7%	40,732	107,336	37.9%
25 to 29	22,042	71,466	30.8%	24,049	78,115	30.8%	27,012	86,489	31.2%	27,904	93,046	30.0%
30 to 34	10,523	50,554	20.8%	11,984	56,282	21.3%	13,882	64,147	21.6%	15,138	72,919	20.8%
35 to 39	5,959	45,506	13.1%	6,478	48,005	13.5%	7,346	51,862	14.2%	7,683	55,462	13.9%
40 to 44	3,030	42,360	7.2%	3,335	43,988	7.6%	3,805	47,323	8.0%	4,043	51,579	7.8%
45 to 49	1,623	50,893	3.2%	1,842	53,797	3.4%	2,082	57,849	3.6%	2,259	62,188	3.6%
Race/ethnicity												
White	67,661	272,871	24.8%	72,446	289,531	25.0%	80,568	314,182	25.6%	81,863	333,602	24.5%
Black	13,200	79,900	16.5%	14,657	83,915	17.5%	16,313	91,048	17.9%	16,883	98,060	17.2%
Hispanic	7,731	26,205	29.5%	8,525	28,390	30.0%	9,015	30,268	29.8%	8,581	30,677	28.0%
Asian/Pacific Islander	3,325	23,829	14.0%	3,701	25,851	14.3%	4,218	29,085	14.5%	4,587	32,267	14.2%
American Indian	2,911	17,850	16.3%	3,046	18,363	16.6%	3,221	18,953	17.0%	3,190	19,693	16.2%
Two or more races	1,655	5,969	27.7%	1,876	6,797	27.6%	2,111	7,669	27.5%	2,293	8,564	26.8%
Unknown race	3,731	14,041	26.6%	4,315	15,176	28.4%	4,594	16,835	27.3%	5,320	19,235	27.7%
Major Program												
Medical Assistance	56,567	280,843	20.1%	60,298	296,731	20.3%	65,337	314,743	20.8%	71,598	396,047	18.1%
MinnesotaCare	15,762	98,911	15.9%	16,147	101,780	15.9%	18,477	118,897	15.5%	17,070	97,733	17.5%
General Assistance Medical Care	1,416	30,369	4.7%	1,712	34,829	4.9%	1,677	34,985	4.8%	140	8,565	1.6%
MN Family Planning Program	26,469	30,542	86.7%	30,409	34,683	87.7%	34,549	39,415	87.7%	33,909	39,753	85.3%
TOTAL number with FP claims:	100,214	440,665	22.7%	108,566	468,023	23.2%	120,040	508,040	23.6%	122,717	542,098	22.6%

(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 2012-2014.

	SFY 2012			SFY 2013			SFY 2014		
	Number with FP claims	Number enrolled	Percent of enrolled with FP claims	Number with FP claims	Number enrolled	Percent of enrolled with FP claims	Number with FP claims	Number enrolled	Percent of enrolled with FP claims
Sex									
Female	119,172	328,927	36.2%	115,527	326,061	35.4%	114,296	354,073	32.3%
Male	1,997	225,524	0.9%	2,025	222,407	0.9%	2,261	253,924	0.9%
Age Group									
15 to 19	24,185	99,667	24.3%	22,686	99,280	22.9%	21,711	106,772	20.3%
20 to 24	38,507	106,401	36.2%	36,134	102,298	35.3%	33,668	105,349	32.0%
25 to 29	27,251	94,604	28.8%	26,622	92,373	28.8%	26,633	105,598	25.2%
30 to 34	16,353	78,848	20.7%	16,852	80,877	20.8%	17,922	92,251	19.4%
35 to 39	8,020	57,677	13.9%	8,284	58,995	14.0%	9,120	69,105	13.2%
40 to 44	4,463	54,060	8.3%	4,561	53,393	8.5%	4,799	59,665	8.0%
45 to 49	2,390	63,194	3.8%	2,413	61,252	3.9%	2,704	69,257	3.9%
Race/ethnicity									
White	78,825	335,063	23.5%	75,226	324,583	23.2%	72,643	353,759	20.5%
Black	17,711	103,338	17.1%	17,888	106,047	16.9%	18,269	113,105	16.2%
Hispanic	8,721	32,067	27.2%	8,629	32,482	26.6%	9,066	35,815	25.3%
Asian/Pacific Islander	4,813	33,910	14.2%	4,807	34,593	13.9%	5,107	40,233	12.7%
American Indian	3,193	20,317	15.7%	3,146	20,152	15.6%	3,063	20,016	15.3%
Two or more races	2,431	9,189	26.5%	2,466	9,687	25.5%	2,624	11,674	22.5%
Unknown race	5,475	20,567	26.6%	5,390	20,924	25.8%	5,785	33,395	17.3%
Major Program									
Medical Assistance	71,116	419,947	16.9%	69,532	418,544	16.6%	81,667	507,696	16.1%
MinnesotaCare	16,910	94,596	17.9%	16,032	90,866	17.6%	9,306	67,262	13.8%
General Assistance Medical Care	0	0	0.0%	0	0	0.0%	0	0	0.0%
MN Family Planning Program	33,143	39,908	83.0%	31,988	39,058	81.9%	25,584	33,039	77.4%
TOTAL number with FP claims:	121,169	554,451	21.9%	117,552	548,468	21.4%	116,557	607,997	19.2%

Objective 3: **Increase the average age of mother at first birth among MHCP enrollees.**

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

Data source: Linked MN 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.

Results: Table 3a presents the maternal age distribution for MHCP-financed births for CY 2003-2012. Table 3b presents the average maternal age at first birth among MHCP-financed births, for CY 2003-2012, with this information represented graphically in Figure 3b.

Discussion: In general, the categories that are populated and representative of early live births on the part of the mother have been gradually decreasing over time. Specifically, females age 15 to 19 have seen a decrease in representation from 33.0 percent of all live births in CY 2003, to 27.6 percent of all live births in CY 2008, and 23.5 percent in CY 2012. The category of 20 to 24 years of age saw a similar, if more modest trend, with 46.2 percent of all live births in CY 2003, to 45.2 percent of all live births in CY 2008, and 43.0 percent in CY 2012.

Conversely, the age categories of 25 to 29 and 30 to 34 have seen corresponding trends upwards in terms of representation of all live births. For example, the 30 to 34 category only made up 4.7 percent of all live births in CY 2003, but made up 5.7 percent of all live births in CY 2008, and 8.3 percent of live births in CY 2012.

The average age of mother at first birth has gradually increased as well, with the average age at first birth starting at 21.8 years in CY 2003, to 22.5 in CY 2008, and most recently 23.2 in CY 2012.

These changes in the maternal age distribution at first birth are reflective of national trends of delayed childbearing over the past several years. It is difficult to determine whether MFPP specifically contributed to this trend; however, it is reassuring that these results among MHCP enrollees are consistent with trends in the general population.

Table 3a. Maternal age distribution for MHCP-financed births calendar years 2003-2007.

	CY 2003		CY 2004		CY 2005		CY 2006		CY 2007	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Age Group										
Less than 15	43	0.5%	60	0.7%	39	0.4%	40	0.4%	51	0.5%
15 to 19	2,843	33.0%	2,864	31.5%	2,782	28.8%	2,955	28.5%	3,044	28.8%
20 to 24	3,980	46.2%	4,240	46.6%	4,618	47.7%	4,921	47.4%	4,879	46.2%
25 to 29	1,159	13.5%	1,299	14.3%	1,554	16.1%	1,752	16.9%	1,803	17.1%
30 to 34	405	4.7%	433	4.8%	480	5.0%	491	4.7%	547	5.2%
35 to 39	148	1.7%	173	1.9%	168	1.7%	186	1.8%	194	1.8%
40 to 44	28	0.3%	23	0.3%	30	0.3%	38	0.4%	39	0.4%
45 to 49	1	0.0%	1	0.0%	1	0.0%	0	0.0%	3	0.0%

Table 3a (continued). Maternal age distribution for MHCP-financed births calendar years 2008-2012.

	CY 2008		CY 2009		CY 2010		CY 2011		CY 2012	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Age Group										
Less than 15	46	0.4%	33	0.3%	41	0.4%	39	0.4%	41	0.4%
15 to 19	2,866	27.7%	3,180	27.6%	2,957	26.6%	2,603	24.1%	2,490	23.5%
20 to 24	4,681	45.2%	5,074	44.1%	4,797	43.1%	4,634	42.9%	4,550	43.0%
25 to 29	1,904	18.4%	2,246	19.5%	2,276	20.4%	2,379	22.0%	2,283	21.6%
30 to 34	594	5.7%	688	6.0%	773	6.9%	836	7.7%	882	8.3%
35 to 39	228	2.2%	246	2.1%	235	2.1%	243	2.3%	280	2.6%
40 to 44	33	0.3%	41	0.4%	51	0.5%	53	0.5%	55	0.5%
45 to 49	0	0.0%	5	0.0%	5	0.0%	7	0.1%	1	0.0%

Notes: A trivial percentage of births occurred for females over the age of 49. These births were excluded for the purposes of presentation.

Figure 3b. Annual average maternal age among MHCP-financed births calendar years 2003-2012.

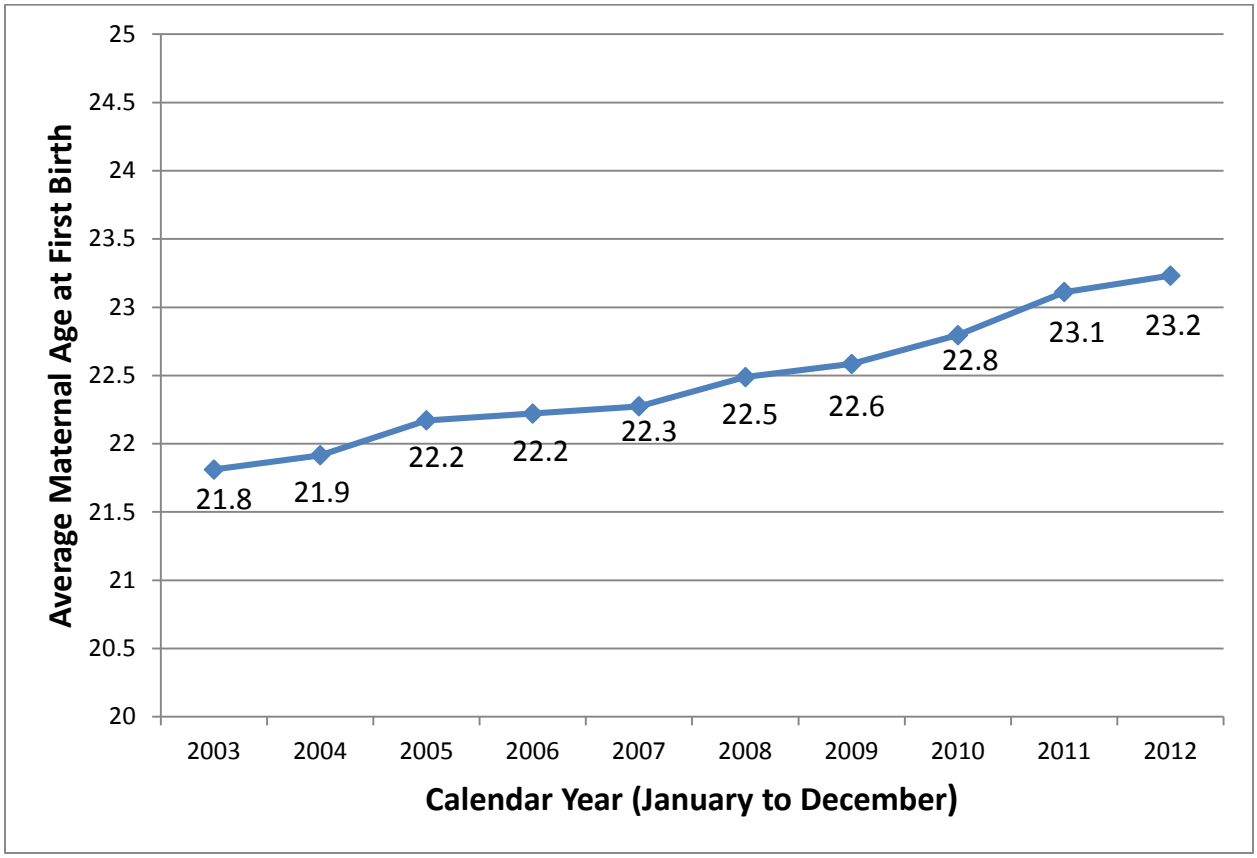

Table 3b. Annual average maternal age among MHCP-financed births calendar years 2003-2012.

	Mean	Standard Deviation	Lower 95% Confidence Interval	Upper 95% Confidence Interval
CY				
2003	21.8	4.4	21.7	21.9
2004	21.9	4.4	21.8	22.0
2005	22.2	4.4	22.1	22.3
2006	22.2	4.4	22.1	22.3
2007	22.3	4.5	22.2	22.4
2008	22.5	4.6	22.4	22.6
2009	22.6	4.7	22.5	22.7
2010	22.8	4.8	22.7	22.9
2011	23.1	4.9	23.0	23.2
2012	23.2	4.9	23.1	23.3

Notes: Birth data is not available for calendar years 2013 and 2014.

Objective 4	**Reduce the teen birth rate among MHCP enrollees.**
Indicator:	Annual proportion of adolescent (ages 15-19) female MHCP enrollees with a live birth financed by MHCP.
Data source:	Linked MN 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.
Results:	Figure 4 presents the annual proportion of adolescent female MHCP enrollees with a live birth financed by MHCP for CY 2003-2012. Table 4 presents these proportions for CY 2003-2012.
Discussion:	The teen birth rate within the population of MHCP enrollees has been steadily decreasing since the inception of the waiver program, and has been especially small in recent years, with approximately 4.5 percent of MHCP enrollees giving a live birth in CY 2011 and CY 2012. This finding is consistent with the trend found under Objective 3, showing an increase over time in the average age of first birth among MHCP enrollees. Teen birth rates have been decreasing throughout the United States during this time period for all racial and ethnic groups.

Figure 4. Annual proportion of adolescent female MHCP enrollees with a live birth financed by MHCP.

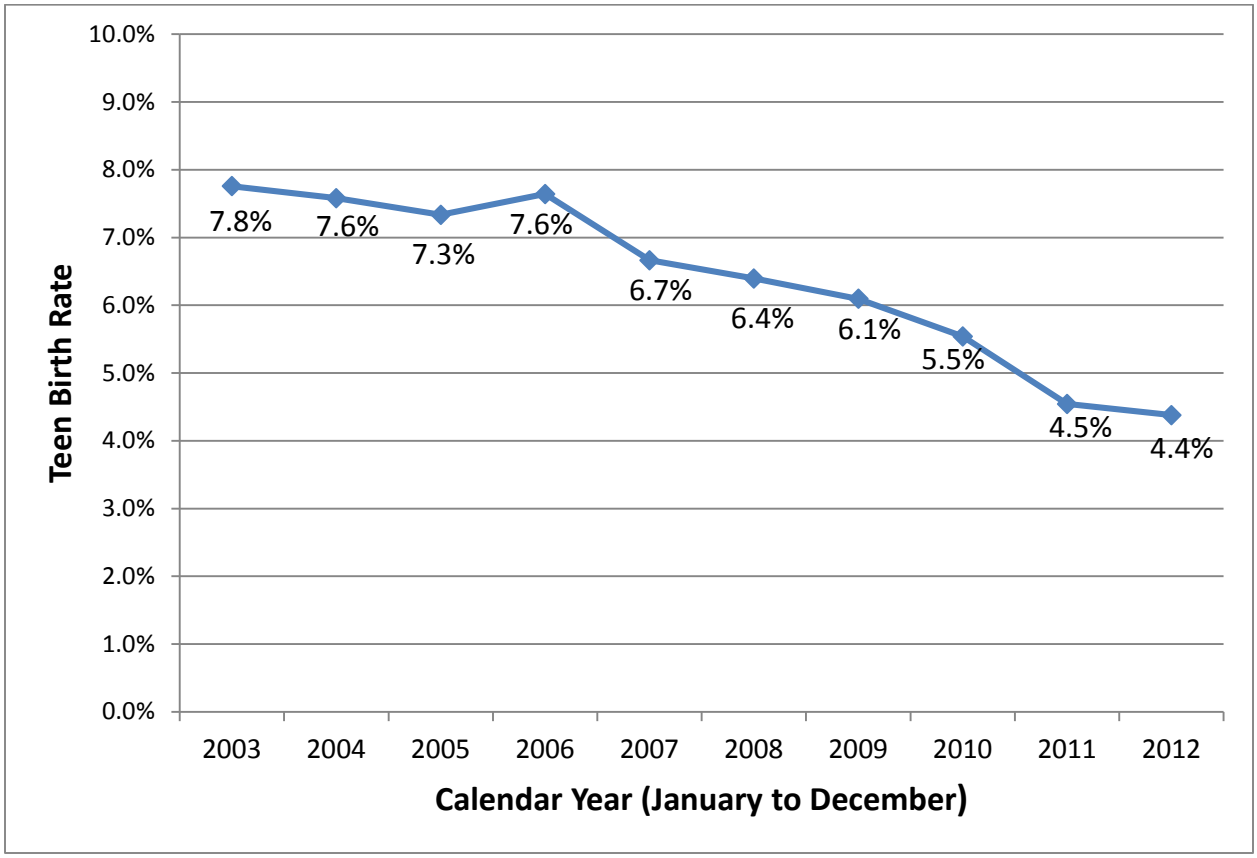

Table 4. Annual proportion of adolescent female MHCP enrollees with a live birth financed by MHCP.

CY	Adolescences without a Live Birth	Adolescences with a Live Birth	Adolescent Female MHCP Enrollees	Proportion with Live Birth
2003	37,045	3,115	40,160	7.8%
2004	38,296	3,141	41,437	7.6%
2005	39,260	3,107	42,367	7.3%
2006	40,102	3,318	43,420	7.6%
2007	46,538	3,322	49,860	6.7%
2008	47,714	3,260	50,974	6.4%
2009	48,672	3,159	51,831	6.1%
2010	50,614	2,969	53,583	5.5%
2011	52,158	2,483	54,641	4.5%
2012	51,937	2,378	54,315	4.4%

5 YEARS OF HISTORIC DATA

SPECIFY TIME PERIOD AND ELIGIBILITY GROUP DEPICTED:

Family Planning	**HY 1**	**HY 2**	**HY 3**	**HY 4**	**HY 5**	**5-YEARS**
TOTAL EXPENDITURES	$ 12,119,500	$ 13,480,980	$ 12,843,829	$ 15,386,397	$ 15,757,887	$ 69,588,593
ELIGIBLE MEMBER MONTHS	253,571	262,716	250,092	245,366	227,499	
PMPM COST	$ 47.80	$ 51.31	$ 51.36	$ 62.71	$ 69.27	
TREND RATES			**ANNUAL CHANGE**			**5-YEAR AVERAGE**
TOTAL EXPENDITURE		11.23%	-4.73%	19.80%	2.41%	6.78%
ELIGIBLE MEMBER MONTHS		3.61%	-4.81%	-1.89%	-7.28%	-2.68%
PMPM COST		7.36%	0.08%	22.10%	10.46%	9.72%
	FY2010	FY2011	FY2012	FY2013	FY2014	

DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP	TREND RATE 1	MONTHS OF AGING	BASE YEAR DY 00	TREND RATE 2	DEMONSTRATION YEARS (DY) DY 01	DY 02	DY 03	TOTAL WOW
Family Planning								
Pop Type:	**Medicaid**							
Eligible Member Months	-2.7%	0	227,499	-2.7%	221,402	215,468	209,694	
PMPM Cost	9.7%	0	$ 69.27	9.7%	$ 76.00	$ 83.39	$ 91.50	
Total Expenditure					$ 16,826,554	$ 17,967,914	$ 19,186,992	$ 53,981,460
			FY2015		FY2016	FY2017	FY2018	

DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP	DY 00	DEMO TREND RATE	DEMONSTRATION YEARS (DY) DY 01	DY 02	DY 03	TOTAL WW
Family Planning						
Pop Type:	**Medicaid**					
Eligible Member Months	227,499	-2.7%	221,402	215,468	209,694	
PMPM Cost	$ 69.27	9.7%	$ 76.00	$ 83.39	$ 91.50	
Total Expenditure			$ 16,826,554	$ 17,967,914	$ 19,186,992	$ 53,981,460
	FY2015		FY2016	FY2017	FY2018	

Budget Neutrality Summary

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)			TOTAL
	DY 01	DY 02	DY 03	
Medicaid Populations				
Family Planning	$ 16,826,554	$ 17,967,914	$ 19,186,992	$ 53,981,460
TOTAL	$ 16,826,554	$ 17,967,914	$ 19,186,992	$ 53,981,460

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)			TOTAL
	DY 01	DY 02	DY 03	
Medicaid Populations				
Family Planning	$ 16,826,554	$ 17,967,914	$ 19,186,992	$ 53,981,460
TOTAL	$ 16,826,554	$ 17,967,914	$ 19,186,992	$ 53,981,460

VARIANCE	$ -	$ -	$ -	$ -

FY2016 FY2017 FY2018

Population Status Drop-Down
Medicaid
Expansion

Attachment D

Department of Human Services

Health Care Administration

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

DHS is announcing a 30-day comment period on a request to extend the Minnesota Family Planning Program (MFPP) Section 1115 Medicaid waiver. Through this waiver, the State has 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 Medical Assistance or MinnesotaCare. On June 22, 2014 the Centers for Medicare & Medicaid Services (CMS) approved a temporary extension of the MFPP waiver. The waiver is currently approved through December 31, 2015. State law requires DHS to seek state plan authority for the program. An extension of the waiver will allow the current program to continue as DHS negotiates the transition to state plan authority. The waiver extension request will seek to continue operating MFPP under the existing program rules.

DHS invites public comment on the extension of this waiver. Comments received during the comment period will be posted on the DHS website. A copy of the waiver extension request can be found at http://www.dhs.state.mn.us/dhs16_175262. 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 June 24, 2015.

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

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 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 locations 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: June 10, 2015
Time: Wednesday, 4:00 p.m.
Location: Department of Human Services, Elmer L. Andersen Human Services Building, 540 Cedar St., St. Paul, MN 55101. Room 2223

(This hearing will be held in conjunction with the previously scheduled post-award public forum on the MFPP waiver)

Public Hearing #2
Date: Thursday, June 11, 2015
Time: 10:00 a.m.
Location: Department of Human Services, 444 Lafayette Rd., St. Paul, MN 55155. Room 6146

Family Tree Clinic
Because Your Sexual Health Matters

Attachment E

June 10, 2015

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

Dear Ms. Zimmerman,

Thank you for allowing me to testify today in support of the continuation of the Minnesota Family Planning Waiver Program (MFPP). My name is Alissa Light, I'm the Executive Director of Family Tree Clinic, a nonprofit family planning health center in St. Paul and the Board President of Reproductive Health Alliance a statewide coalition of reproductive health providers.

The Minnesota Family Planning Program is absolutely critical to supporting a reproductive health safety across the state, and to supporting access to family planning tools among some of our most disenfranchised, marginalized and at-risk community members.

The Minnesota Family Planning Program enabled over 1,400 low and no income patients to get the family planning care they need and deserve at Family Tree in the last year alone. This includes providing 579 doses of Emergency Contraception to prevent unintended pregnancy, 982 packs of birth control pills, and 108 long-term birth control methods, like IUDs, effective for 310 years. When you do the math this is equal to 789 YEARS of pregnancy prevention, again provided in just one year and all made possible by MFPP.

Young, low income women in particular face significant barriers to accessing consistent medical care and medical coverage. They are among the highest group of uninsured in the state and country, and low income young women experience nearly 5 times the rates of unintended pregnancy as their upper income counterparts.

The clinics who offer the Minnesota Family Planning Program are safety net clinics serving people who fall through the cracks of our human and social service sector consistently. MFPP allows clinics to provide covered services to patients immediately under presumptive eligibility and work with clients to gain access to longer term and more robust coverage.
Continuation of the Minnesota Family Planning Program is critical to ensuring women, men and teens have access to cost effective, high quality, culturally competent and necessary family planning care. Thank you for your time.

Alissa Light

Wed 6/24/2015 4:01 PM

Godfrey, David W David.Godfrey@hcmed.org

HCMC Comments

To *DHS_Section1115WaiverComments <Section1115WaiverComments@state.mn.us>

Marie Zimmerman

Medicaid Director

Minnesota Department of Human Services

P.O. Box 64983

St. Paul, Minnesota 55164-0983

Sent via email to Section1115WaiverComments@state.mn.us

June 24, 2015

Dear Ms. Zimmerman:

Hennepin Healthcare System Inc., dba Hennepin County Medical Center (HCMC), appreciates the request for comments on extension of the Minnesota Family Planning Program (MFPP) Section 1115 Medicaid waiver. HCMC fully supports extension of this waiver as a transition to eventual state authority. This valuable program ensures continued support for family planning services for women and men at/below 200% FPL not enrolled in MA or MnCare.

*Access to care for uninsured youth, women, and men at/below 200% FPL: As the state's largest safety net hospital and health care system, HCMC sees thousands of patients annually who are uninsured. Although HCMC financial counselors work with patients individually to enroll them, for various reasons, coverage remains inaccessible to many. Clinicians verify what's generally known to be true: unplanned pregnancies remain a concern for girls and women, their partners, and their families. HCMC providers report that their ability to use the family planning waiver removes barriers to providing contraception to girls and women. Because the waiver covers a full range of contraceptive methods, the patient is able to choose what works best for her, in consultation with her provider; such shared decision-making engages girls and women and promotes self-efficacy in their health and well-being.

*Access to STI screening and treatment: The family planning umbrella waiver allows for sexually transmitted disease screening and treatment. STIs exact a disproportionate toll on people from communities of color, lower-income communities, and immigrant groups, and HCMC's patient population is 2/3rds people from communities of color and immigrant communities. Minnesota's 2014 chlamydia rates tripled overall from 1996 to 2014, but Blacks experienced chlamydia at a rate nine times higher than that of whites. The American Indian rate is 4.4 times higher than that of whites, and the Hispanic rate is 2.5 times the rate among whites. HCMC views the waiver as a key tool in the diagnosis and treatment of STIs.

*Presumptive eligibility: Both HCMC clinicians and those in administrative roles report lack of knowledge about using the family planning waiver in general, and particular confusion about presumptive eligibility. For instance, providers need to time patient care appropriately, so that patient obtains all needed services within the eligibility period. Such timing can be complicated by the need to refer patients across HCMC's clinical system—from primary care to the urology clinic, for instance, for an outpatient vasectomy. HCMC and other health care systems would benefit from additional DHS and/or CMSprovided education on presumptive eligibility.

*Electronic health record codes: Similarly, HCMC clinicians lack clarity about appropriately coding patient encounters in the EHR. If patient visit is for both MFPP-covered services and non-covered services (e.g., a physical), then two separate encounters and two codes must be entered, using the family planning code as primary. HCMC suggests further conversation and planning with DHS and other health care systems on streamlining this process.

*Appointment of a single point person at DHS: HCMC suggests that a DHS point person serve as a single source of information and resources about the MFPP family planning waiver. This individual could serve in a coordination role with MDH, to ensure that its family planning-focused grant making fully accounts for the MFPP family planning waiver rules.

Thank you for soliciting comments. As a member of the Reproductive Health Alliance, HCMC is committed to supporting MFPP and the extension of the family planning waiver. We welcome further engagement in this matter.

Sincerely,

David Godfrey

Director, Public Policy and Advocacy

Confidentiality Notice:

Attachment F

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 30 days prior to the anticipated submission date. When a 30-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.

Minnesota Department of **Human Services**

Attachment G

May 26, 2015

Re: Minnesota Family Planning Program (MFPP) Section 1115 Medicaid Waiver

Dear Tribal Leader:

This letter is to inform you that DHS is announcing a 30-day comment period on a request to extend the Minnesota Family Planning Program (MFPP) Section 1115 Medicaid waiver. Through this waiver, the State has the authority to receive federal matching funds for family planning services to men and women, 15 years of age or older and under age 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. On June 22, 2014 the Centers for Medicare & Medicaid Services (CMS) approved an extension of the MFPP waiver. The current waiver ends December 31, 2015.

State law requires DHS to seek state plan authority for the program. The proposed renewal of federal waiver authority will allow the current program to continue as DHS negotiates the transition to state plan authority.

We invite you to comment on the proposed waiver extension. For additional information on the MFPP waiver and the public input process please refer to the MFPP Waiver web page.

If you have questions about the waiver, please contact me at (651) 431-2188 or jan.kooistra@state.mn.us. Thank you.

Sincerely,

Jan Kooistra