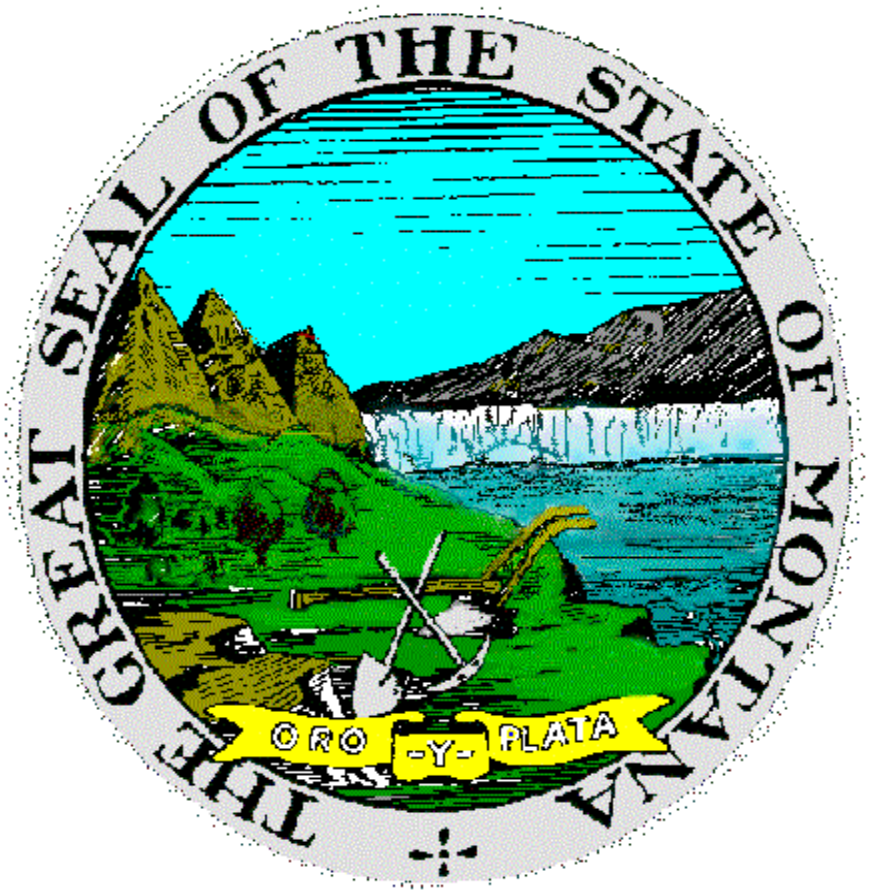
Montana Department of Public Health and Human Services
Section 1115
Waiver for Additional Services and Populations
(Formerly Basic Medicaid Waiver)

DY14, CY 2017
January 2017-December 2017
Annual Report



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Executive Summary

Montana's Waiver for Additional Services and Populations (WASP), formally known as the Basic Medicaid Waiver, has remained a positive source of Medicaid coverage since the program's inception in 1996. The Basic Program was comprised of mandatory Medicaid benefits and a collection of optional services available for emergencies and when necessary, for seeking and maintaining employment. These services were available to Able-Bodied Adults (neither pregnant nor disabled) who were parents and/or caretaker relatives of dependent children. This waiver has undergone multiple changes over the years.

Recent changes that directly impacted this waiver's services in 2016 were precipitated by the implementation of Medicaid expansion, called the Health and Economic Livelihood Partnership (HELP) Plan. Due to Medicaid expansion, many Basic Medicaid / WASP Program members became eligible for Montana Medicaid. At the same time, significant changes were made to the Basic Program / WASP Program. An amendment effective January 1, 2016, reduced the number of persons covered, changed the nature of the population eligible and changed the plan of benefits for WASP members. Basic Medicaid previously did not cover or had very limited coverage of some services. This amendment aligned the Basic Medicaid benefit package with the Standard Medicaid benefit package.

An additional amendment, effective March 1, 2016, changed the name of the Basic Waiver to Waiver for Additional Services and Populations. It also added dental treatment coverage, above the Medicaid State Plan cap of $1,125, for categorically eligible ABD individuals, as a pass-through cost.

A summary of the waiver changes is included in the WASP Medicaid Demonstration Information, below.

WASP Medicaid Demonstration Information

The Montana Medicaid Program is authorized under 53-6-101, Montana Codes Annotated, and Article XII, Section 3 of the Montana Constitution. The Department of Public Health and Human Services (DPHHS) administers the Medicaid Program. The Basic Medicaid Program was the medical services provided for able-bodied adults (neither pregnant nor disabled) and who were parents and/or caretaker relatives of dependent children, eligible for Medicaid under Sections 1925 or 1931 of the Social Security Act. The Basic Program was operated under a Section 1115 waiver, offering all mandatory services and a reduced package of Medicaid optional services through a fee-for-service delivery. Amount, duration, and scope of services, under Section 1902(a)(10)(B) of the Act were waived enabling Montana to carry out the 1115 demonstration.

In February 1996, Montana implemented its state-specific welfare reform program known as Families Achieving Independence in Montana (FAIM). This sweeping change involved the cash assistance, food stamp, and Medicaid programs that were administered on the federal side by

several agencies under multiple statutes. As part of welfare reform, Montana obtained a Section 1115 waiver, approved in February 1996. On October 23, 2003, the DPHHS submitted an 1115 waiver application to CMS requesting approval to continue the Basic Medicaid Program. CMS approved the waiver application on January 29, 2004, for a five-year period from February 1, 2004, through January 31, 2009. Terms of the request and the approval were consolidated into an Operational Protocol document as of February 2005. The waiver structure remained constant throughout the life of the Basic Program. The State was required to submit a quarterly Basic Medicaid report as one of the Operational Protocol conditions.

A HIFA proposal was submitted on June 27, 2006. 1115 Basic Medicaid Waiver amendments were submitted on March 23, 2007, and January 28, 2008, requesting seven new optional and expansion populations. Tribal Consultation was completed on December 14, 2007. As a result of discussions with CMS, Montana submitted a revised 1115 Basic Medicaid Waiver amendment on June 6, 2008, requesting four new populations. July 30, 2009, and August 6, 2010, submittals requested only one population, Mental Health Service Plan (MHSP) Waiver individuals (individuals with schizophrenia and individuals with bipolar), in addition to Able Bodied Adults. CMS approved the waiver extension and the request to insure the additional population, effective December 1, 2010.

The 1115 Basic Medicaid Waiver renewal was submitted in June of 2013, and approved by CMS effective January 1, 2014. The renewal includes raising the enrollment cap from “up to 800” to “up to 2000”; the primary Severe Disabling Mental Illness (SDMI) clinical diagnosis of major depressive disorder as a covered diagnosis; and home infusion as a covered service.

In June 2014, Montana submitted an amendment to the Section 1115 Basic Medicaid Waiver (Amendment #1) which was approved by CMS with an August 1, 2014, effective date. This amendment increased the enrollment cap for individuals who qualify for the State only MHSP Program from “up to 2,000” to “up to 6,000”. It also updated the eligible diagnosis codes to allow all MHSP Program individuals with SDMI; added a random drawing with the diagnosis code hierarchy selection of schizophrenia first, bipolar second, major depressive disorder third, and then all remaining diagnosis codes. It also updated the per member per month costs of all waiver populations; updated the amount of money (Maintenance of Effort) the State needed to continue to spend on benefits for the mental health waiver population; updated the budget neutrality; revised the CMS approved evaluation design; updated the Federal Poverty Level from 33% FPL to approximately 47% FPL for Able Bodied Adults; and lastly, updated general waiver language.

Effective January 1, 2016, Montana submitted an amendment (Amendment #2), to remove the Able-Bodied Adult population, remove the SDMI population eligible for State Plan expansion, give the MHSP Waiver population the Standard Medicaid benefit, and close the Basic benefit. This amendment proposed to cover individuals age 18 or older, with SDMI who qualify for or are enrolled in the state-financed MHSP, but are otherwise ineligible for Medicaid benefits and either: 1) have income 0-138% of the federal poverty level (FPL) and are eligible for or enrolled in Medicare; or 2) have income 139-150% of the FPL regardless of Medicare status. The MHSP

Waiver enrollment cap was reduced from 6,000 to 3,000. The amendment provided for 12-month continuous eligibility period for all non-expansion Medicaid-covered individuals whose eligibility is based on modified adjusted gross income (MAGI).

On March 7, 2016, an amendment was submitted (Amendment #3) that proposed to: change the name of the Waiver to Section 1115 Montana Waiver for Additional Services and Populations and cover individuals determined categorically eligible for ABD for dental treatment services above the Medicaid State Plan cap of $1,125, as a pass-through cost. This amendment was approved with an effective date of March 1, 2016.

Following the third quarter report for DY13, the decision was made to change the reporting for this demonstration to a January through December calendar year as opposed to the prior February through January schedule. Therefore, the DY13 Annual Report covered an abbreviated year, 02/01/2016 through 12/31/2016. This DY14 Annual Report is applicable to the entire calendar year of 2017.

The Montana WASP Medicaid Demonstration was granted an extension on December 15, 2017. This extension, including new Special Terms and Conditions, was accepted by Montana DPHHS, January 12, 2018, and is effective January 1, 2018 through December 31, 2022.

Medicaid Program Goal

To assure that medically necessary medical care is available to all eligible Montanans within available funding resources.

WASP Medicaid Policies

All requirements of the Medicaid Program expressed in law not expressly waived or identified as not applicable in the award letter of which the terms and conditions are part, shall apply to Montana's demonstration. Montana Medicaid Program administrative rules, policies, processes, eligibility, cost sharing, and reimbursement apply to individuals on WASP Medicaid unless specified, like the WASP plan of benefits.

The *General Information for Providers, Medicaid and Other Medical Assistance Programs*, can be found at Montana Medicaid Provider website.

Medicaid members are directed to the Montana Medicaid Member Guide, found at: Montana Medicaid Members Guide. A chart of Medicaid covered benefits is published with additional service details. Members receive education and information regarding Medicaid services through the Montana Medicaid Hotline.

Accomplishments

At the beginning of 2016 the benefit package from this waiver improved significantly. The more comprehensive Montana Standard Medicaid benefit is now extended to all WASP members.

Another change to the waiver in 2016 was the addition of coverage to individuals determined categorically eligible for ABD for dental treatment services above the Medicaid State Plan cap of $1,125, as a pass-through cost. This population, often exceptionally medically frail, may need more financial flexibility to address dental issues. The addition to the waiver allows for costlier, single treatment events that avoid multiple procedures and multiple sedation sessions that would be necessary due to the standard coverage treatment cap.

Project Status

The WASP now provides a comprehensive benefit package for mental and physical health for members age 65 and older, and for anyone with Medicare.

Case Studies

No formal case studies have been completed at this time.

Interim Evaluation Findings

Montana evaluated the effectiveness of the Waiver for Additional Services and Population with a CMS approved evaluation design from December 2010, through December 2017. A baseline survey of the 800 MHSP Waiver individuals was completed in the summer of 2012, and then a follow-up survey was conducted in October 2015. The 2015 return rate was 25.5% compared to the 2012 return rate of 26.5%. In 2015, approximately 3.5 times the number of surveys were sent out compared to 2012, with about 3.5 times the numbers of surveys returned. In 2015, 704 were returned and in 2012, 209 surveys were returned. The survey has helped us learn about participants' health status, access to health care, and quality of care. A new survey and analysis was completed in late 2017.

Please see Attachment A to review the most recent evaluation findings.

Policy and Administrative Difficulties & Solutions

Some reductions to the Montana Standard Medicaid benefit will become effective in the spring of 2018. These changes are due to recent state funding reductions. In November of 2017, a Special Session was called to address the variances in revenue and high fire season expenditures. A compromise included a number of proposed spending reductions and a reduction to the DPHHS budget of $49 million general fund dollars. DPHHS is doing everything it can to minimize the impacts to the benefits package offered to Medicaid recipients. Administrative Rule Hearings for changes will occur in calendar year 2018 and may have an impact on the WASP population.

Primary Care Case Management – Status Update

Populations and services currently included in the WASP waiver are not eligible for Montana's Primary Care Case Management (PCCM) program. Montana's PCCM program, Passport to Health, renewed its 1915(b) waiver with approval through March 31, 2019.

WASP Medicaid Population

WASP Medicaid coverage includes:

1) Individuals age 18 or older, with Severe and Disabling Mental Illness (SDMI) diagnosis who qualify for or are enrolled in the state-financed Mental Health Services Plan (MHSP), but are otherwise ineligible for Medicaid benefits and either:
    - Have income 0 – 138% of the FPL and are eligible for or enrolled in Medicare; or
    - Have income 139 – 150% of the FPL regardless of Medicare status (they can be covered or not covered by Medicare and be eligible).
2) Individuals determined categorically eligible for Aged, Blind and Disabled (ABD) for dental treatment services above the $1,125 State Plan dental treatment cap.
3) Individuals that are non-expansion Medicaid-covered individuals whose eligibility is based on MAGI (the Parent and Caretaker Relatives population) to provide a 12-month continuous eligibility period.

WASP ENROLLMENT COUNT

Demonstration Populations (as hard coded in the CMS 64)	Enrollment (last day of quarter) Q1	Enrollment (last day of quarter) Q2	Enrollment (last day of quarter) Q3	Enrollment (last day of quarter) Q4	Enrollment Annual Total*	Newly Enrolled (annual count)	Dis-enrolled (annual count)
Parent and caretaker relatives	19,384	18,004	17,424	17,235	27,846	5,757	17,778
Dental	26,728	26,539	26,478	26,263	31,555	4,239	4,891
WMHSP Adults	1,133	1,146	1,153	1,177	1,335	221	454
• Schizophrenia	354	351	347	354	404	56	91
• Bipolar Disorder	317	318	318	325	370	52	158
• Major Depression	364	375	377	379	432	72	168
• Other Diagnoses	98	102	111	119	129	41	37

*The annual enrollment totals are more than any quarterly total because the quarterly totals are based on enrollment on the last day of the quarter while the annual total counts members enrolled at any point during the year.

WASP MEMBER MONTHS REPORTING

Eligibility Group	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual Total
Parents and caretaker relatives	57,823	53,941	51,810	50,663	**50,663**
Dental	71,129	70,862	70,624	70,004	**70,004**
WMHSP Adults	3,392	3,439	3,456	3,544	**3,544**
• **Schizophrenia**	348	348	344	351	**351**
• **Bipolar Disorder**	320	321	322	328	**328**
• **Major Depression**	366	375	378	384	**384**
• **Other Diagnoses**	97	103	108	119	**119**

WASP (MHSP) Enrollment Comparisons

In DY14, CY 2017 a quarterly average of 1,152 individuals were enrolled in WASP (MHSP) Medicaid compared to the 4,028 Standard (not expansion) Medicaid individuals and 83,834 Expansion Medicaid individuals, age 21-64.

WASP (MHSP), Standard, and Expansion Medicaid Enrollment
January 2017 – December 2017 DY14, CY 2017 Average

N/A	1st Quarter January – March 2017	2nd Quarter April – June 2017	3rd Quarter July - September 2017	4th Quarter October – December 2017	January – December 2017 DY14, CY 2017 Average
WASP (MHSP) Medicaid Enrollment	1,133	1,146	1,153	1,177	1,152
Standard Medicaid Enrollment - Not Expansion (Age 21-64)	45,512	44,318	43,493	42,789	44,028
Medicaid Expansion Enrollment (Age 21-64)	76,625	82,147	85,738	90,827	83,834

The change in population covered under WASP between DY12, CY 2015 and DY13, CY 2016 is significant. Removal of the Able-Bodied population and the portion of the MHSP population who qualified for the newly implemented Medicaid Expansion, effective 01/01/2016, greatly reduced the WASP population. The Average quarterly WASP enrollment (MHSP and Able-Bodied) in DY12, CY 2015, was 15,406 compared to the average quarterly WASP (MHSP only) enrollment of 1,083 in DY13, CY 2016. This year, the DY14, CY2017 average quarterly WASP (MHSP only) increased to 1,152, an increase of 69 members over the CY2016 average. The

counts of the Aged, Blind and Disabled (ABD) population eligible for dental coverage only under this waiver are recorded later in this report.

Gender, Ethnic and Race Comparisons

- WASP (MHSP) Medicaid is 51.27% female as compared to 63.37% females for Standard and 53.83% for Expansion Medicaid in the 21-64 age group.
- There are 12.1% fewer males in Standard and 2.56% fewer males in Expansion Medicaid, ages 21-64, then there are in the WASP (MHSP) population.
- The American Indian quarterly average for WASP (MHSP) is 3.07%, which is 14.54% less than the Standard average of 17.61% and 2.10% more than the Expansion Medicaid average of 0.97%.

WASP (MHSP) Medicaid Gender, Ethnic and Race
January 2017 – December 2017 DY14, CY 2017 Average

N/A	1st Quarter January – March 2017	2nd Quarter April – June 2017	3rd Quarter July – September 2017	4th Quarter October – December 2017	January – December 2017 DY14, CY 2017 Average
(Gender) Female	51.63%	51.22%	51.08%	51.15%	51.27%
(Gender) Male	48.37%	48.78%	48.92%	48.85%	48.73%
(Ethnic and Race) Hispanic of Any Race	2.15%	2.40%	2.29%	2.25%	2.27%
(Ethnic and Race) White	93.54%	93.88%	93.92%	94.12%	93.87%
(Ethnic and Race) American Indian/AK	3.50%	2.93%	3.00%	2.85%	3.07%
(Ethnic and Race) Other: African American, Asian, Pacific Islander	0.81%	0.80%	0.79%	0.78%	0.80%

Standard Medicaid Gender, Ethnic and Race (Age 21-64)
January 2017– December 2017 DY14, CY 2017Average

N/A	1st Quarter January – March 2017	2nd Quarter April – June 2017	3rd Quarter September 2017	4th Quarter October – December 2017	January – December 2017 DY14, CY 2017 Average
(Gender) Female	63.96%	63.51%	63.21%	62.81%	63.37%
(Gender) Male	36.04%	36.49%	36.79%	37.19%	36.63%
(Ethnic and Race) Hispanic of Any Race	0.20%	0.19%	0.21%	0.20%	0.20%
(Ethnic and Race) White	80.58%	80.67%	80.94%	81.33%	80.88%
(Ethnic and Race) American Indian/AK	17.92%	17.84%	17.54%	17.12%	17.61%
(Ethnic and Race) Other: African American, Asian, Pacific Islander	1.30%	1.31%	1.32%	1.35%	1.32%

Expanded Medicaid Gender, Ethnic and Race (Age 21-64)
January 2017 – December 2017 DY14, CY 2017 Average

N/A	1st Quarter January – March 2017	2nd Quarter April – June 2017	3rd Quarter July – September 2017	4th Quarter October – December 2017	January – December 2017 DY14, CY 2017 Average
(Gender) Female	53.76%	53.75%	53.94%	53.86%	53.83%
(Gender) Male	46.24%	46.25%	46.06%	46.14%	46.17%
(Ethnic and Race) Hispanic of Any Race	0.35%	0.35%	0.35%	0.34%	0.35%
(Ethnic and Race) White	81.93%	81.21%	80.66%	80.69%	81.12%
(Ethnic and Race) American Indian/AK	0.95%	0.95%	1.00%	0.98%	0.97%
(Ethnic and Race) Other: African American, Asian, Pacific Islander	1.47%	1.48%	1.56%	1.54%	1.51%

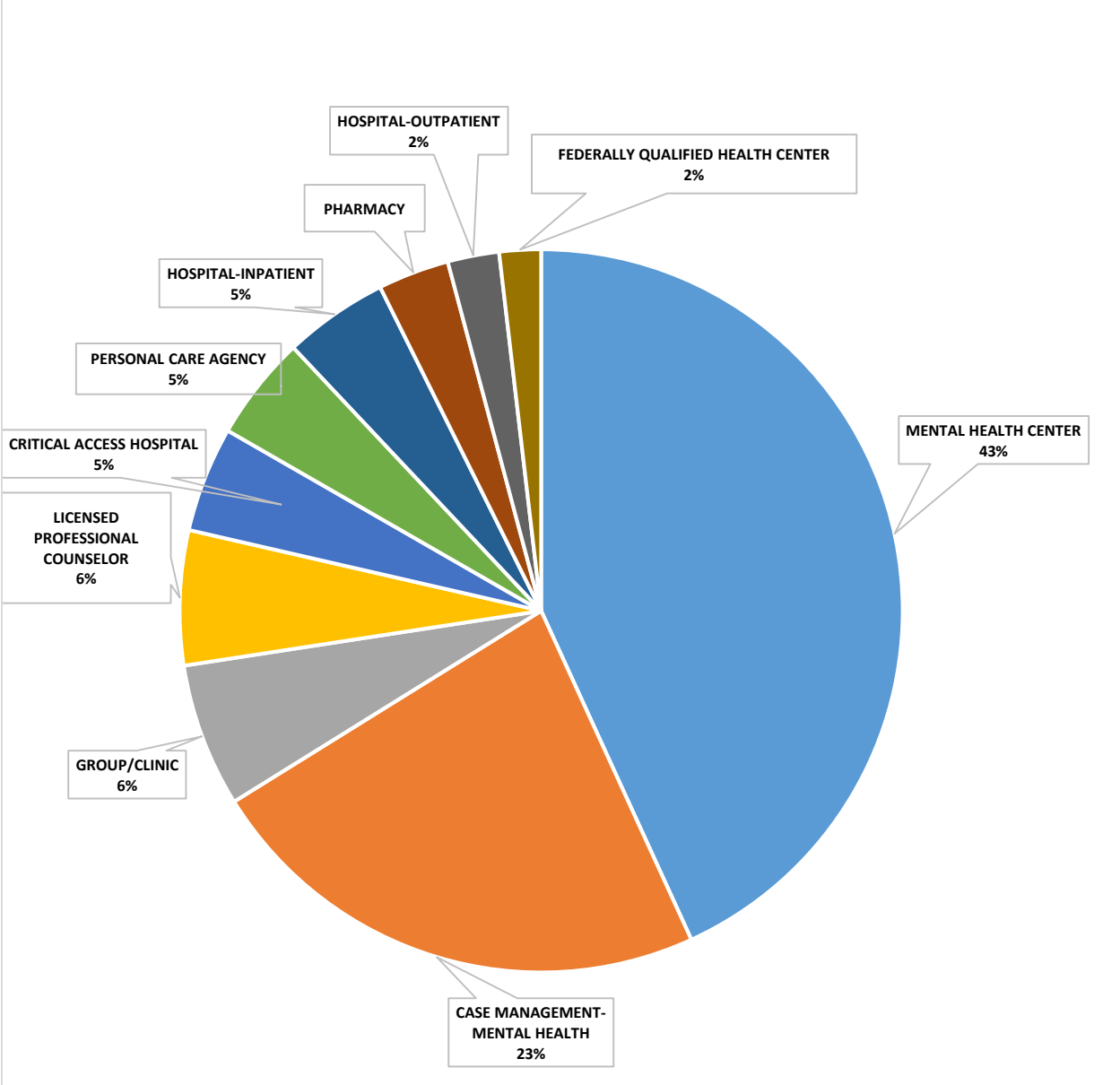
Expenditures by Provider Type

WASP (MHSP) DY14, CY 2017 Expenditures by Provider Type

PROV PAY TO TYPE	1st Quarter January – March 2017	2nd Quarter April – June 2017	3rd Quarter July – September 2017	4th Quarter October – December 2017	TOTAL	PERCENT of TOTAL
MENTAL HEALTH CENTER	$711,603.29	$763,708.47	$743,298.99	$771,213.85	$2,989,824.60	43.18%
CASE MANAGEMENT -MENTAL HEALTH	$396,584.01	$426,777.02	$415,707.74	$351,573.12	$1,590,641.89	22.97%
GROUP/CLINIC	$118,650.32	$113,031.80	$104,042.41	$109,170.00	$444,894.53	6.43%
LICENSED PROFESSIONAL COUNSELOR	$91,833.33	$104,410.60	$107,029.81	$113,380.88	$416,654.62	6.02 %
CRITICAL ACCESS HOSPITAL	$72,821.27	$112,096.79	$75,012.58	$66,408.28	$326,338.92	4.71%
PERSONAL CARE AGENCY	$50,674.64	$74,228.67	$88,263.40	$110,581.15	$323,747.86	4.68%
HOSPITAL-INPATIENT	$91,430.80	$97,106.44	$44,249.03	$90,769.65	$323,555.92	4.67%
PHARMACY	$58,347.51	$56,775.13	$54,613.55	$50,815.30	$220,551.49	3.19%
HOSPITAL-OUTPATIENT	$47,306.30	$44,955.90	$30,751.90	$36,281.77	$159,295.87	2.30%
FEDERALLY QUALIFIED HEALTH CENTER	$29,828.29	$35,589.21	$32,454.66	$30,944.22	$128,816.38	1.86%
GRAND TOTAL	**$1,669,079.76**	**$1,828,680.03**	**$1,695,424.07**	**$1,731,138.22**	**$6,924,322.08**	**100%**

Top ten provider types equal 100% of total cost.

DY14, CY2017 Expenditures by Provider Type



Dental Benefits Population

This waiver, via Amendment #3, also covers eligible members for dental treatment services only, above the Medicaid State Plan dental cap of $1,125 per year, as a pass-through cost. This amendment was approved with effective date of March 1, 2016. The unique member usage and costs per quarter are included in the tables below.

ABD Unique Member Usage of Dental Benefit above State Plan Limit during DY14, CY 2017

N/A	Quarter 1 January – March 2017	Quarter 2 April – June 2017	Quarter 3 July – September 2017	Quarter 4 October – December 2017	Yearly Total January – December 2017	January – December 2017 DY14, CY 2017 Quarterly Average
# of Unique ABD WASP Users of the Above State Plan Dental Cap Benefit	118	184	189	242	733	183

ABD Member Cost of Benefit above State Plan Limit during DY14, CY 2017

N/A	Quarter 1 January – March 2017	Quarter 2 April – June 2017	Quarter 3 July – September 2017	Quarter 4 October – December 2017	Yearly Total January – December 2017	January – December 2017 DY14, CY 2017 Quarterly Average
Cost of ABD WASP Users of the Above State Plan Dental Cap Benefit	$81,353.91	$123,959.52	$142,711.56	$190,684.05	$538,709.04	$134,677.26

There was an average of 183 unique benefit users per quarter and an overall average quarterly cost of $134,677.26 for an average cost per unique user $735.94 for DY14, CY 2017.

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