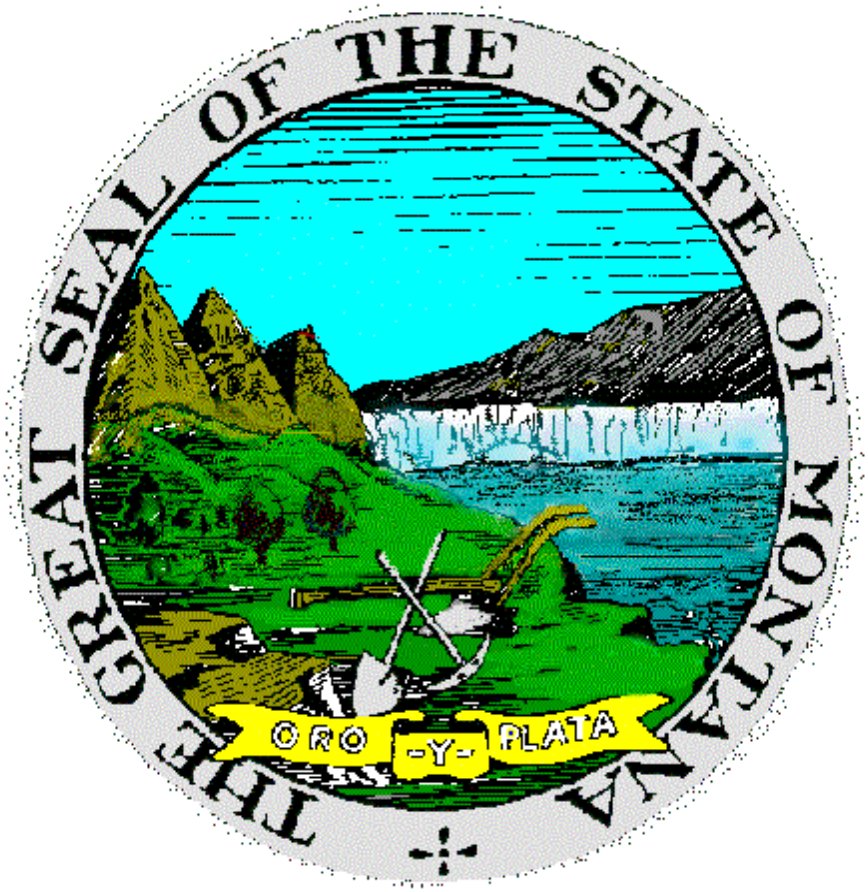
Montana Section 1115 Waiver for Additional Services and Populations Demonstration

Section 1115 Annual Report

Demonstration Reporting Period:
Demonstration Year 15
January 1, 2018 – December 31, 2018



Introduction

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.

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.

Detailed History and Key Dates of Approval/Operation

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. The DY14 Annual Report was 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.

A forum to solicit comments on the progress of the WASP demonstration was held during the Montana Health Coalition Meeting, December 12, 2018, in Helena, Montana. No comments on the WASP were received.

Goal

The goal of the Waiver for Additional Services and Populations (WASP) Demonstration mirrors the state's Medicaid goal, that is to assure medically necessary medical care is available to all eligible Montanans within available funding resources.

Enrollment Information

Enrollment Count

Note: Enrollment counts are person counts, not member months.

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)**	**Disenrolled (annual count)**
Parent and caretaker relatives	16,993	16,550	16,300	16,240	23,578	6,078	10,482
Dental	26,484	26,237	26,116	25,812	30,856	3,932	4,736
WMHSP Adults	1,188	1,193	1,191	1,173	1,325	132	144
• **Schizophrenia**	356	363	366	362	398	39	45
• **Bipolar Disorder**	325	321	318	314	358	30	42
• **Major Depression**	385	389	383	370	423	40	49
• **Other Diagnoses**	122	120	124	127	146	23	8

*The annual enrollment totals are more than any single 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.

Member Months Reporting

Eligibility Group	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual Total
Parent and caretaker relatives	51,570	49,861	49,214	48,658	199,303
Dental	79,659	78,991	78,531	77,923	315,104
WMHSP Adults	3,559	3,575	3,573	3,534	14,241
• **Schizophrenia**	1,068	1,077	1,091	1,094	4,330
• **Bipolar Disorder**	979	969	959	945	3,852
• **Major Depression**	1,150	1,166	1,152	1,122	4,590
• **Other Diagnoses**	362	363	371	373	1,469

Outreach/Innovative Activities:
No new outreach activities or innovations occurred in calendar year 2018.

Operational/Policy Development/Issues:
Some reductions to the Montana Standard Medicaid benefit were effective in the second quarter of 2018. These changes were due to 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 worked to minimize the impacts to the benefits package offered to Medicaid recipients. By the fourth quarter of 2018, the service reductions were largely restored.

Financial/Budget Neutrality Development/Issues:
During 2016 and 2017 CMS provided extensive assistance in creating our budget neutrality formula and format. Since that time, no significant issue with financial accounting, budget neutrality or CMS-64 issues have been identified.

Consumer Issues:
In accordance with CFR 431.420(c), Montana held its annual public forum to solicit comments on the progress of the WASP Demonstration on December 12, 2018. The forum was held in Helena, Montana, and via WebEx, in conjunction with the Montana Health Coalition annual meeting. The public presented no comments regarding the WASP Demonstration. No complaints or problems were identified at any time in 2018.

Quality Assurance/Monitoring Activity:
No specific quality assurance or monitoring activities were performed in 2018. Complaints, if any, are addressed as they arise.

Status of Benefits and Cost Sharing:
Montana's 1115 Waiver for Additional Services and Populations (WASP) has no cost sharing component. The few benefits that were reduced in the second quarter of 2018 (due to the budgetary shortfall mentioned earlier) were largely restored during quarter four of 2018.

Demonstration Evaluation:
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 helped us learn about participants' health status, access to health care, and quality of care. A new survey and analysis were completed in late 2017 and findings were included in the 2017 Annual Report.

The next survey is scheduled for mailing in May, 2019 with results by September, 2019.

Enclosures/Attachments:
Enclosed is document 2018waspAnnualReptBNfinal.pdf, the 2018 Budget Neutrality Report for Montana's 1115 Waiver for Additional Services and Populations (WASP).

State Contact(s):
Linda Skiles-Hadduck, Medicaid Program Officer
Phone: (406) 444-6868
Fax: (406) 444-1861
Email: LSkiles-Hadduck@mt.gov
Address: PO Box 202951
Helena, MT 59620

Marie Matthews, State Medicaid Director
Phone: (406) 444-4084
Fax: (406) 444-1970
Email: MMatthews@mt.gov
Address: PO Box 4210
Helena, MT 59620

Date Submitted to CMS:
March 22, 2019

Montana 1115 Waiver for Additional Services and Populations (WASP)

WASP Budget Neutrality Calculation

- **HISTORIC DATA BY YEAR – MOST RECENT 6 YEARS**

SPECIFY TIME PERIOD AND ELIGIBILITY GROUP DEPICTED:

Medicaid Pop 1: MHSP	HY 9 (2/12-1/13)	HY 10 (2/13-1/14)	HY 11 (2/14-1/15)	HY 12 (2/15-1/16)	HY 13 (2/16-12/16)	HY 14 (1/17-12/17)	HY 15 (1/18-12/18)	HY 16 (1/19-12/19)	TOTAL
Total Expenditures*	$ 6,219,506	$ 6,303,185	$ 12,366,954	$ 20,283,672	$ 7,861,453	$ 7,307,944	$ 6,521,168	n/a	$ 66,863,882
Eligible Member Months	9,342	9,591	18,602	30,170	12,271	13,831	14,241	n/a	108,048
PMPM Cost	$ 665.76	$ 657.20	$ 664.82	$ 672.31	$ 640.65	$ 528.37	$ 457,92	n/a	n/a

TREND RATES

		ANNUAL CHANGE							AVERAGE
Total Expenditures	n/a	1.35%	96.20%	64.02%	-61.24%	-7.04%	-10.77%	n/a	4.11%
Eligible Member Months	n/a	2.67%	93.95%	62.19%	-59.33%	12.71%	2.96%	n/a	10.31%
PMPM Cost	n/a	-1.29%	1.16%	1.13%	-4.71%	-17.53%	-13.34%	n/a	-5.61%

*expenditures from Schedule C (CMS-64)

Hypo 1: Dental Cap Above $ 1,125 (ABD)	HY 9 (2/12-1/13)	HY 10 (2/13-1/14)	HY 11 (2/14-1/15)	HY 12 (2/15-1/16)	HY 13 (2/16-12/16)	HY 14 (1/17-12/17)	HY 15 (1/18-12/18)	HY 16 (1/19-12/19)	TOTAL
Total Expenditures*	$ 594,515	$ 516,907	$ 624,927	$ 725,015	$ 800,746	$ 1,285,758	$ 1,551,346	n/a	$ 6,099,214
Eligible Member Months (all eligible)	94,416	98,700	105,120	108,072	261,278	258,062	315,104	n/a	1,240,752
PMPM Cost	$ 6.30	$ 5.24	$ 5.94	$ 6.71	$ 3.06	$ 4.98	$ 4.92	n/a	n/a

TREND RATES

		ANNUAL CHANGE							AVERAGE
Total Expenditures	n/a	-13.05%	20.90%	16.02%	10.45%	60.57%	20.66%	n/a	21.27%
Eligible Member Months	n/a	4.54%	6.50%	2.81%	141.76%	-1.23%	22.10%	n/a	28.58%
PMPM Cost	n/a	-16.83%	13.51%	12.85%	-54.32%	62.57%	-1.19%	n/a	-5.69%

*expenditures from QP claims analysis of members exceeding the $ 1,125 cap

Hypo 2: Parent and Caretaker Relatives	HY 9 (2/12-1/13)	HY 10 (2/13-1/14)	HY 11 (2/14-1/15)	HY 12 (2/15-1/16)	HY 13 (2/16-12/16)	HY 14 (1/17-12/17)	HY 15 (1/18-12/18)	HY 16 (1/19-12/19)	TOTAL
Total Expenditures*	$ 30,870,502	$ 33,078,487	$ 46,582,197	$ 47,737,175	$ 1,504,610	$ 590,149	$ 588,061	n/a	$ 160,951,181
Eligible Member Months (all eligible)**	96,158	100,265	142,325	154,023	215,083	229,224	199,303	n/a	1,136,381
PMPM Cost	$ 321.04	$ 329.91	$ 327.29	$ 309.94	$ 7.00	$ 2.57	$ 2.95	n/a	n/a

TREND RATES

	ANNUAL CHANGE								AVERAGE
Total Expenditures	n/a	7.15%	40.82%	2.48%	-96.85%	-60.78%	-0.35%	n/a	-62.82%
Eligible Member Months	n/a	4.27%	41.95%	8.22%	39.64%	6.57%	-13.05%	n/a	24.26%
PMPM Cost	n/a	2.76%	-0.79%	-5.30%	-97.74%	-63.20%	14.61%	n/a	-70.07%

*expenditures from schedule C (CMS-64) reported as "able bodied adults"

**member months from OPS

- **HISTORIC DATA– BY QUARTER, MOST RECENT THREE YEARS**
  - **HY 13 (2/1/2016-12/31/2016, eleven-month demonstration year)**

SPECIFY TIME PERIOD AND ELIGIBILITY GROUP DEPICTED:

Medicaid Pop 1: MHSP	Q1 (FEB-MAR, 2016, short quarter)	Q2 (APR-JUN 2016)	Q3 (JUL-SEP 2016)	Q4 (OCT-DEC 2016)	TOTAL
Total Expenditures	$ 1,041,982	$ 1,351,270	$ 1,797,954	$ 3,670,247	$ 7,861,453
Eligible Member Months	2,096	3,220	3,585	3,370	12,271
PMPM Cost	$ 497.13	$ 419.65	$ 501.52	$ 1,089.09	n/a

TREND RATES

		ANNUAL CHANGE			AVERAGE
Total Expenditures	n/a	29.68%	33.06$	104.13%	37.00%
Eligible Member Months	n/a	53.63%	11.34%	-6.00%	12.61%
PMPM Cost	n/a	-15.59%	19.51%	117.16%	21.66%

Hypo 1: Dental Cap Above $ 1,125 (ABD)	Q1 (FEB-MAR, 2016, short quarter)	Q2 (APR-JUN 2016)	Q3 (JUL-SEP 2016)	Q4 (OCT-DEC 2016)	TOTAL
Total Expenditures	$ 81,354	$ 251,041	$ 475,300	$ 800,746	$ 800,746 **
Eligible Member Months	47,009	118,702	190,205	261,278	617,194**
PMPM Cost	$ 1.73	$ 2.11	$ 2.50	$ 3.06	n/a

**Dental cap total expenditures and MMs do not equal the sum of total of quarterly expenditures. Each quarter represents the amount over $1,125 as of that quarter, so it is a cumulative sum minus $1,125 as of that quarter, so it is a cumulative sum minus $ 1,125. The member months are therefore cumulative as well.

TREND RATES

		ANNUAL CHANGE			AVERAGE
Total Expenditures	n/a	208.58%	89.33%	68.47%	77.12%
Eligible Member Months	n/a	152.51%	60.24%	37.37%	53.54%
PMPM Cost	n/a	22.21%	18.16%	22.64%	15.36%

Hypo 2: Parent and Caretaker Relatives	Q1 (FEB-MAR, 2016, short quarter)	Q2 (APR-JUN 2016)	Q3 (JUL-SEP 2016)	Q4 (OCT-DEC 2016)	TOTAL
Total Expenditures	$ 429	$ 340,595	$ 1,099,182	$ 64,404	$ 1,504,610
Eligible Member Months	39,106	58,659	58,659	58,659	215,083
PMPM Cost	$ 0.01	$ 5.81	$ 18.74	$ 1.10	n/a

TREND RATES

		ANNUAL CHANGE			AVERAGE
Total Expenditures	n/a	79292.77%	222.72%	-94.14%	250.04%
Eligible Member Months	n/a	50.00%	0.00%	0.00%	10.67%
PMPM Cost	n/a	52828.52%	222.72%	-94.14%	216.29%

- **HISTORIC DATA– BY QUARTER, MOST RECENT THREE YEARS**
  - **HY 14 (1/1/2017-12/31/2017)**

SPECIFY TIME PERIOD AND ELIGIBILITY GROUP DEPICTED:

Medicaid Pop 1: MHSP	Q1 (JAN-MAR 2017)	Q2 (APR-JUN 2017)	Q3 (JUL-SEP 2017)	Q4 (OCT-DEC 2017)	TOTAL
Total Expenditures	$ 1,660,993	$ 2,013,783	$ 1,792,200	$ 1,840,968	$ 7,307,944
Eligible Member Months	3,392	3,439	3,456	3,544	13,831
PMPM Cost	$ 489.68	$ 585.57	$ 518.58	$ 519.46	n/a

TREND RATES

		ANNUAL CHANGE			AVERAGE
Total Expenditures	n/a	21.24%	-11.00%	2.72%	2.61%
Eligible Member Months	n/a	1.39%	0.49%	2.55%	1.10%
PMPM Cost	n/a	19.58%	-11.44%	0.17%	1.49%

Hypo 1: Dental Cap Above $ 1,125 (ABD)	Q1 (JAN-MAR 2017)	Q2 (APR-JUN 2017)	Q3 (JUL-SEP 2017)	Q4 (OCT-DEC 2017)	TOTAL
Total Expenditures	$ 191,189	$ 491,468	$ 852,982	$ 1,285,758	$ 1,289.758**
Eligible Member Months	71,076	141,860	212,170	258,062	258.062**
PMPM Cost	$ 2.69	$ 3.46	$ 4.02	$ 4.98	n/a

**Dental cap total expenditures and MMs do not equal the sum of total of quarterly expenditures. Each quarter represents the amount over $1,125 as of that quarter, so it is a cumulative sum minus $1,125 as of that quarter, so it is a cumulative sum minus $ 1,125. The member months are therefore cumulative as well.

TREND RATES

		ANNUAL CHANGE			AVERAGE
Total Expenditures	n/a	157.06%	73.56%	50.74%	61.04%
Eligible Member Months	n/a	99.59%	49.56%	21.63%	38.04%
PMPM Cost	n/a	28.79%	16.04%	23.93%	16.66%

Hypo 2: Parent and Caretaker Relatives	Q1 (JAN-MAR 2017)	Q2 (APR-JUN 2017)	Q3 (JUL-SEP 2017)	Q4 (OCT-DEC 2017)	TOTAL
Total Expenditures	$ 9,168	$ 142,124	$ 268,484	$ 170,373	$ 590,149
Eligible Member Months	57,309	57,309	57,309	57,309	229,236
PMPM Cost	$ 0.16	$ 2.48	$ 4.68	$ 2.97	n/a

TREND RATES

		ANNUAL CHANGE			AVERAGE
Total Expenditures	n/a	1450.22%	88.91%	-36.54%	107.63%
Eligible Member Months	n/a	0.00%	0.00%	0.00%	0.0%
PMPM Cost	n/a	1450.22%	88.91%	-36.54%	107.63%

- **HISTORIC DATA– BY QUARTER, MOST RECENT THREE YEARS**
  - **HY 15 (1/1/2018-12/31/2018)**

SPECIFY TIME PERIOD AND ELIGIBILITY GROUP DEPICTED:

Medicaid Pop 1: MHSP	Q1 (JAN-MAR 2018)	Q2 (APR-JUN 2018)	Q3 (JUL-SEP 2018)	Q4 (OCT-DEC 2018)	TOTAL
Total Expenditures	$ 1,610,573	$ 1,590,010	$ 1,594,979	$ 1,725,606	$ 6,521,168
Eligible Member Months	3,559	3,575	3,573	3,534	14,241
PMPM Cost	$ 452.54	$ 444.76	$ 446.40	$ 488.29	n/a

TREND RATES

		ANNUAL CHANGE			AVERAGE
Total Expenditures	n/a	-1.28%	0.31%	8.19%	1.74%
Eligible Member Months	n/a	0.45%	-0.06%	-1.09%	-0.18%
PMPM Cost	n/a	-1.72%	0.37%	9.38%	1.92%

Hypo 1: Dental Cap Above $ 1,125 (ABD)	Q1 (JAN-MAR 2018)	Q2 (APR-JUN 2018)	Q3 (JUL-SEP 2018)	Q4 (OCT-DEC 2018)	TOTAL
Total Expenditures	$ 659,603	$ 843,182	$ 1,147,861	$ 1,551,346	1,551,346**
Eligible Member Months	79,659	158,650	237,181	315,104	315,104**
PMPM Cost	$ 8.28	$ 5.31	$ 4.84	$ 4.92	n/a

**Dental cap total expenditures and MMs do not equal the sum of total of quarterly expenditures. Each quarter represents the amount over $1,125 as of that quarter, so it is a cumulative sum minus $1,125 as of that quarter, so it is a cumulative sum minus $ 1,125. The member months are therefore cumulative as well.

TREND RATES

		ANNUAL CHANGE			AVERAGE
Total Expenditures	n/a	27.83%	36.13%	35.15%	23.84%
Eligible Member Months	n/a	99.16%	49.50%	32.85%	41.03%
PMPM Cost	n/a	-35.82%	-8.94%	1.73%	-12.19%

Hypo 2: Parent and Caretaker Relatives	Q1 (JAN-MAR 2018)	Q2 (APR-JUN 2018)	Q3 (JUL-SEP 2018)	Q4 (OCT-DEC 2018)	TOTAL
Total Expenditures	$ 252,661	$ 178,994	$ 46,832	$ 109,574	$ 588,061
Eligible Member Months	51,570	49,861	49,214	48,658	199,303
PMPM Cost	$ 4.90	$ 3.59	$ 0.95	$ 2.25	n/a

TREND RATES

		ANNUAL CHANGE			AVERAGE
Total Expenditures	n/a	-29.16%	-73.84%	133.97%	-18.85%
Eligible Member Months	n/a	-3.31%	-1.30%	-1.13%	-1.44%
PMPM Cost	n/a	-26.73%	-73.49%	136.65%	-17.66%

- **DENTAL CAP ABOVE $ 1,125 EXAMPLE**
  - **ASSUMPTIONS: assume only one member, with $500 in expenditures each quarter**
    - **In our report, the only expenditures that are required to be reported are those over the annual $ 1,125 cap**

1. Non-cumulative expenditures – the amount reported in "TOTAL EXPENDITURES" is the amount, per each individual quarter, that a member's expenditures exceeded the cap

Hypo 1: Dental Cap Above $ 1,125 (ABD)	Q1 (JAN-MAR)	Q2 (APR-JUN)	Q3 (JUL-SEP)	Q4 (OCT-DEC)	TOTAL
Total Quarter Expenditures	$ 500.00	$ 500.00	$ 500.00	$ 500.00	$ 2,000.00
Total Expenditures (over the cap)	$ -	$ -	$ -	$ -	$ -
Eligible Member Months (all eligible ABD)	1	1	1	1	4
PMPM Cost	$ -	$ -	$ -	$ -	n/a

TREND RATES

	ANNUAL CHANGE				AVERAGE
Total Expenditures	n/a	n/a	n/a	n/a	n/a
Eligible Member Months	n/a	n/a	n/a	n/a	n/a
PMPM Cost	n/a	n/a	n/a	n/a	n/a

2. Cumulative expenditures – the amount reported in "TOTAL EXPENDITURES" is the running total amount a member has spent per quarter and cumulative member months. For example, quarter 4 = quarter 1 + quarter 2 + quarter 3 expenditures. The "TOTAL" will be the same as "Q4"

Hypo 1: Dental Cap Above $ 1,125 (ABD)	Q1 (JAN-MAR)	Q2 (APR-JUN)	Q3 (JUL-SEP)	Q4 (OCT-DEC)	TOTAL
Total Quarter Expenditures	$ 500.00	$ 500.00	$ 500.00	$ 500.00	$ 2,000.00
Total Expenditures (over the cap)	$ -	$ -	$ 375	$ 875	$ 875
Eligible Member Months (all eligible ABD)	1	2	3	4	4
PMPM Cost	$ -	$ -	$ 125.00	$ 218.75	n/a

TREND RATES

	ANNUAL CHANGE				AVERAGE
Total Expenditures	n/a	n/a	n/a	133.33%	n/a
Eligible Member Months	n/a	n/a	50.00%	33.33%	41.42%
PMPM Cost	n/a	n/a	n/a	75.00%	n/a