MONTANA DPHHS
Healthy People. Healthy Communities.
Department of Public Health & Human Services

Department of Public Health and Human Services

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Steve Bullock, Governor

Richard H. Opper, Director

July 15, 2016

Eliot Fishman
Group Director
Children and Adults Health Programs Group
Center for Medicaid and CHIP Services
Centers for Medicare & Medicaid Services
7500 Security Blvd, Mailstop: S2-01-16
Woodlawn, MD 21244

Subject: Request for Renewal
Section 1115 Montana Waiver for Additional Services and Populations

Dear Mr. Fishman:

Montana formally requests CMS approval of our Section 1115 Montana Waiver for Additional Services and Populations Renewal, effective January 1, 2017, through December 31, 2021. The Waiver will continue to: 1) cover individuals age 18 or older, with Severe Disabling Mental Illnesses (SDMI) who qualify for, or are enrolled in the State-financed Mental Health Services Plan (MHSP) to receive Standard Medicaid benefits; 2) cover individuals determined categorically eligible as Aged, Blind, and Disabled (ABD) for dental treatment services above the State Plan annual cap of $1,125; and 3) provide a 12-month continuous eligibility period for all non-expansion Medicaid-covered individuals whose eligibility is based on modified adjusted gross income (MAGI).

Montana projects that we can sustain the Section 1115 Waiver for Additional Services and Populations through January 2019. The previous federal variance savings are available to cover the federal portion of the current waiver populations and additional services, while maintaining federal budget neutrality. By continuing to cover Montanans under the Section 1115 Waiver for Additional Services and Populations, individuals will receive needed healthcare coverage for 12-month continuous eligibility, which provides continuity of care.

Please contact Mary Eve Kulawik, Medicaid and CHIP State Plan Amendment and Waiver Coordinator, at (406) 444-2584 or mkulawik@mt.gov; or Holly Mook, Medicaid Waiver Program Officer, at (406) 444-6868 or hmook@mt.gov, with questions. We look forward to your approval of the Section 1115 Waiver for Additional Services and Populations Renewal.

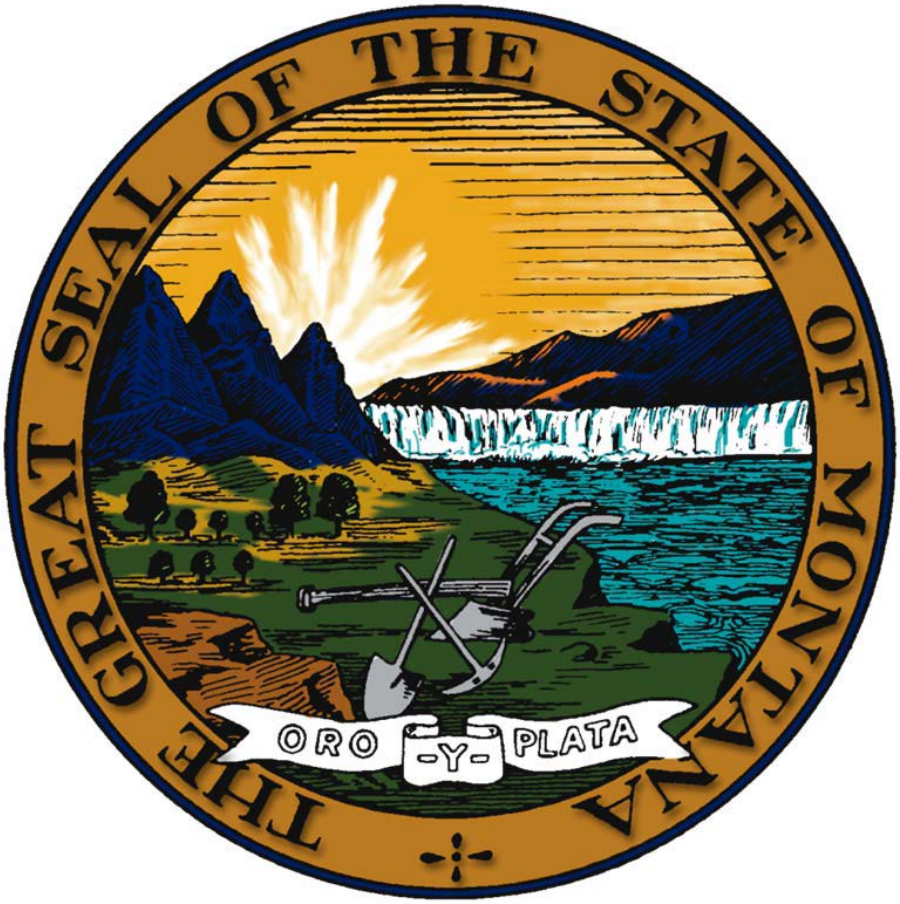
Sincerely,

[redacted]

Mary E. Dalton
Montana State Medicaid Director

cc: Andrea Casart, CMS
Valisha Andrus, CMS
Meghan Lepore, CMS
Patricia Hansen, CMS
Juliana Sharp, CMS
Mary Marchioni, CMS
Richard Allen, CMS
Richard H. Opper, DPHHS
Mary Eve Kulawik, DPHHS
Mary LeMieux, DPHHS

Enclosures: 1115 Waiver for Additional Services and Populations Application (redline/final/508 compliant), Budget Neutrality, Draft Evaluation Plan, Proof of Electronic Mailing, Tribal Consultation, Public Notice, Public Notice Schedule, Public Meeting Materials, Montana Health Coalition Memo, and Tribal and Public Comment Summaries



MONTANA DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

Mary E. Dalton, State Medicaid Director

Section 1115 Montana Waiver for Additional Services and Populations Renewal

July 15, 2016 Submittal

Effective January 1, 2017

MONTANA
SECTION 1115 MONTANA WAIVER FOR ADDITIONAL SERVICES AND POPULATIONS RENEWAL
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SECTION 1115 MONTANA WAIVER FOR ADDITIONAL SERVICES AND POPULATIONS DEMONSTRATION RENEWAL EXECUTIVE SUMMARY

The State of Montana, Department of Public Health and Human Services (DPHHS), requests to renew the existing Section 1115 Waiver for Additional Services and Populations effective January 1, 2017, through December 31, 2021. The Waiver will continue to: 1) cover individuals age 18 or older, with Severe Disabling Mental Illnesses (SDMI) who qualify for, or are enrolled in, the State-financed Mental Health Services Plan (MHSP) to receive Standard Medicaid benefits; 2) cover individuals determined categorically eligible as Aged, Blind, or Disabled (ABD) for dental treatment services above the State Plan annual cap of $1,125; and 3) provide a 12-month continuous eligibility period for all non-expansion Medicaid-covered individuals whose eligibility is based on modified adjusted gross income (MAGI).

Waiver Renewal:
The renewal requests to continue the 1115 Waiver for Additional Services and Populations as currently operated.

Public Notice:
A Tribal Consultation letter was sent on March 16, 2016. A memo to the Montana Health Coalition was mailed electronically on March 16, 2016. A public notice was published in newspapers on March 16, 2016. Public meetings were held on March 31, 2016, in Helena, MT and April 5, 2016, in Billings, MT. The meetings were broadcast as a WebEx so interested parties around the state could participate. These public notice items may be found at: http://dphhs.mt.gov/MontanaHealthcarePrograms/Medicaid/Medicaid1115Waiver.

Waiver Populations:
This renewal will allow Montana to continue covering the following:

- *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:*
  - *Have income 0-138% of the federal poverty level (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).*
- *Provide a 12-month continuous eligibility period for all non-expansion Medicaid-covered individuals whose eligibility is based on MAGI.*
- *Individuals determined categorically eligible for ABD for dental treatment services above the $1,125 State Plan dental treatment cap.*

Waiver for Additional Services and Populations Benefit:
Coverage for the Waiver for Additional Services and Populations is the Standard Medicaid benefits package, which includes 12-month continuous coverage for all non-expansion Medicaid-covered individuals whose eligibility is based on MAGI.

The ABD population receives additional dental treatment services above the dental treatment services annual cap outlined in the Medicaid State Plan. (Covered dental treatment services, excluding diagnostic, preventive, denture and anesthesia services for adults age 21 and over, are subject to the annual cap of $1,125 in the State Plan.)

Employer Sponsored Insurance or Private Health Insurance:
If a Medicaid eligible individual becomes covered by an employer sponsored plan, or is able to obtain an individual health care benefit, Medicaid analyzes the cost effectiveness of paying the individual's costs versus the cost of Medicaid. If Medicaid is considered cost effective, Medicaid pays the member's premium, cost share, deductibles, and wrap around services. The Medicaid member is only responsible for the Medicaid cost share.

Waiver for Additional Services and Populations Cost Share:
All Waiver for Additional Services and Populations individuals age 21 and older pay Standard Medicaid cost share for Standard Medicaid benefits. Individuals age 20 and younger do not pay cost share.

Figure I. Montana's Waiver for Additional Services and Populations Renewal Population Summary

Population ***1) MHSP Waiver*** ***2) ABD Waiver***			***Funding Source***		***Benefit Package***		***Cost Sharing***	
Demonstration Population	***Number of Members***	***Financial Eligibility***	***Current***	***Proposed***	***Current***	***Proposed***	***Current***	***Proposed***
1) MHSP Waiver Population *Expansion See previous description of Waiver population for further detail.*	*3,000 Capped*	*Less than or equal to 150% FPL*	*State Only Funds*	***State Spending:*** *State Mainten-ance of Effort. Funding from the current State only MHSP Program will be used to fund MEG 1) MHSP Waiver.* ***Federal Spending:*** *Budget Neutrality Surplus from the existing Section 1115 Medicaid Waiver will be used to cover MEG 1) MHSP Waiver.*	*Limited Mental Health Benefits, up to $425 Mental Health Prescription Drugs, PACT, and 72 Hour Services.*	*Standard Medicaid Services or pay premium for Employer Sponsored Plan or Private Health Insurance.*	*MHSP State Only Program: $3 Dialectical Behavior Treatment services, $12 generic and $17 non generic, up to $425 mental health pres-cription drug.*	*Standard Medicaid State Plan Cost Share.*

Population			Funding Source		Benefit Package		Cost Sharing	
Demonstration Population	***Number of Members***	***Financial Eligibility***	***Current***	***Proposed***	***Current***	***Proposed***	***Current***	***Proposed***
2) ABD Waiver Population *See previous description of Waiver population for further detail.*	*Unlimited*	*Below the SSI Payment Standard or exceeds the SSI Payment Standard and is medically needy.*	*State and Federal Funds*	***State Spending:*** *State General Fund.* ***Federal Spending:*** *Budget Neutrality Surplus from the existing Section 1115 Medicaid Waiver will be used to cover MEG 2) ABD Waiver Treatment Cap.*	*Limited to annual dental treatment cap of $1,125.*	*Remove the annual dental treatment cap to allow for unlimited dental treatment services.*	*Standard Medicaid State Plan Cost Share.*	*Standard Medicaid State Plan Cost Share.*

Federal and State Waiver for Additional Services and Populations Benefit Cost and Sustainability: *CMS confirmed that states have previously been allowed to carry Waiver savings from an extension year to a new Waiver period. The projected total State and Federal expenditures for Demonstration Year 14 is $23,400,000; $23,400,000 for Demonstration Year 15; $23,400,000 for Demonstration Year16; $23,400,000 for Demonstration Year17; and $23,400,000 for Demonstration Year18. The total State and Federal expenditures for the five year renewal period will be $117,000,000.*

Figure II. State and Federal Waiver Benefit Costs:

	2/2017-1/2018	***2/2018-1/2019***	***2/2019-1/2020***	***2/2020-1/2021***	***2/2021/1/2022***	***Renewal Total***
	DY 14	***DY 15***	***DY 16***	***DY 17***	***DY 18***	
Cumulative Federal Variance	*$17,197,937*	*$2,076,857*	*-$13,044,223*	*-$28,165,303*	*-$43,286,383*	*-$43,286,383*
Federal Variance	*-$15,121,080*	*-$15,121,080*	*-$15,121,080*	*-$15,121,080*	*-$15,121,080*	*-$75,605,400*
Total Federal and State MHSP Waiver Benefit Costs	*$23,400,000*	*$23,400,000*	*$23,400,000*	*$23,400,000*	*$23,400,000*	*$117,000,000*
Total Federal MHSP Waiver Benefit Costs	*$15,121,080*	*$15,121,080*	*$15,121,080*	*$15,121,080*	*$15,121,080*	*$75,605,400*

	2/2017-1/2018	*2/2018-1/2019*	*2/2019-1/2020*	*2/2020-1/2021*	*2/2021-1/2022*	***Renewal Total***
	DY 14	***DY 15***	***DY 16***	***DY 17***	***DY 18***	
Total State MHSP Waiver Benefit Costs	*$8,278,920*	*$8,278,920*	*$8,278,920*	*$8,278,920*	*$8,278,920*	*$41,394,600*
Total Federal and State Expenditure (5 Year Total)	*$23,400,000*	*$23,400,000*	*$23,400,000*	*$23,400,000*	*$23,400,000*	*$117,000,000*

Reporting:
The Waiver for Additional Services and Population's goal is to continue to provide healthcare coverage to up to 3,000 adults with SDMI. Montana will use the previously generated Federal Waiver savings for this coverage. Additionally, members will receive healthcare coverage for 12-month continuous eligibility and ABD members will be provided dental treatment services above the $1,125 Medicaid State Plan cap. We will study the effectiveness of our objectives through the described data measurements and reports to CMS. See Figure VI. Waiver Reporting Deliverables.

Conclusion:
By continuing to cover Montanans under the Waiver for Additional Services and Populations, individuals will receive needed healthcare coverage for 12-month continuous eligibility, which provides continuity of care.

I. SECTION 1115 MONTANA MEDICAID WAIVER HISTORY

The Section 1115 Montana Waiver for Additional Services and Populations was previously titled the Basic Medicaid Waiver.

Basic Medicaid Waiver History:
In 1996, under the authority of an 1115 Welfare Reform Waiver referred to as Families Achieving Independence in Montana (FAIM), Montana implemented a limited Medicaid benefit package of optional services to the same group of adults eligible for Medicaid under Sections 1925 or 1931 of the Social Security Act. The limited Medicaid benefit package was referred to as "Basic Medicaid." The FAIM Welfare Reform Waiver expired on January 31, 2004, (confirmed by correspondence dated October 7, 2003, from Mr. Mike Fiore, Director, Family and Children's Health Program Group, Centers for Medicare and Medicaid Services).

Basic Medicaid Waiver 2004:
On October 23, 2003, the State of Montana, Department of Public Health and Human Services (Department) submitted a request for an 1115 Basic Medicaid Waiver of amount, duration and scope of services, Section 1902(a)(10)(B) of the Social Security Act, to provide a limited Medicaid benefit package of optional services for those adults age 21 to 64 who are not pregnant or disabled. The Waiver was approved to operate beginning February 1, 2004, and end January 31, 2009 for those Able Bodied Adults who are eligible for Medicaid under Sections 1925 or 1931 of the Social Security Act.

Previous 1115 Amendments:
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. Further discussion resulted in a July 30, 2009, submittal requesting only one population, MHSP Waiver individuals (individuals previously covered under a State-funded program who had schizophrenia, severe depression, or bipolar disease), in addition to Able Bodied Adults. Small changes were made to the July 30, 2009, application as a result of continuing conversations with CMS and the Basic Medicaid Waiver was approved December 2010. The Basic Medicaid Waiver Renewal was approved December 24, 2013, effective January 1, 2014. A Waiver amendment to increase coverage for the MHSP group to cover all SDMIs was submitted on June 30, 2014, and became effective August 1, 2014.

The amendment submitted on November 15, 2015, with an effective date of January 1, 2016, had the following changes:

- *Removed able-bodied adults from the Waiver;*
- *Removed individuals under age 65 with SDMI who are not covered by or eligible for Medicare and who are between 0-138% of the MAGI income level;*
- *Covered individuals age 18 or older, with SDMI who qualify for or are enrolled in the state-financed MHSP or the Basic Medicaid Waiver, 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).*
- *Aligned the Basic Medicaid benefit package with the Standard Medicaid benefit package. Basic Medicaid previously did not cover or had very limited coverage of audiology, dental and denturist, durable medical equipment (DME), eyeglasses, optometry and ophthalmology for routine eye exams, personal care services, and hearing aids; and*
- *Adopted a 12-month continuous eligibility period for all non-expansion Medicaid-covered individuals whose eligibility is based on MAGI.*

The amendment, submitted on March 7, 2016, effective March 1, 2016, 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.

This renewal, submitted on July 15, 2016, proposes to renew the current Section 1115 Waiver for Additional Services and Populations, effective January 1, 2017, through December 31, 2021.

II. GENERAL DESCRIPTION OF PROGRAM

The Waiver for Additional Services and Population's goal is to continue to provide healthcare coverage up to 3,000 adults with SDMI, provide dental treatment to ABD members above the $1,125 State Plan cap, and provide 12-month continuous coverage for non-expansion Medicaid-covered individuals whose eligibility is based on MAGI. Montana will use the generated Federal Waiver savings from the previously approved Section 1115 Montana Medicaid Waiver for this coverage.

The following is a description of the Waiver for Additional Services and Populations.

MEG 1) MHSP Waiver – Expansion Population

Individuals age 18 or older, with SDMI who qualify for or are enrolled in the State-financed MHSP or the Waiver for Additional Services and Population, 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).*

MHSP Waiver Population Funding:

State Funds: *The State's Maintenance of Effort of current State funding levels for a portion of the Mental Health Services Plan State only program.*

Federal Funds: *Federal matching Medicaid funds for the expanded population will be from Montana's existing Section 1115 Montana Medicaid Waiver surplus budget neutrality savings.*

MEG 2) ABD Waiver – Optional Population

Individuals determined categorically eligible for ABD and who have reached the State Plan annual dental treatment services cap of $1,125. (The State Plan cap excludes diagnostic, preventive, denture and anesthesia services for adults age 21 and over.)

ABD Waiver Population Funding:

Funding is consistent with CMS guidance, which describes costs as a pass through.

Continuous Eligibility Population:

Funding is consistent with CMS guidance, which describes costs as a pass through.

III. DEFINITIONS

Income: In the context of the HIFA demonstration, income limits for coverage expansions are expressed in terms of gross income, excluding sources of income that cannot be counted pursuant to other statutes (such as Agent Orange payments).

Mandatory Populations: Refers to those eligibility groups that a State must cover in its Medicaid State Plan, as specified in Section 1902(a)(10) and described at 42 CFR Part 435, Subpart B. For example, States currently must cover children under age 6 and pregnant women up to 133 percent of poverty.

Optional Populations: Refers to eligibility groups that can be covered under a Medicaid or SCHIP State Plan, i.e., those that do not require a section 1115 demonstration to receive coverage and who have incomes above the mandatory population poverty levels.
Groups are considered optional if they can be included in the State Plan, regardless of whether they are included. The Medicaid optional groups are described at 42 CFR Part 435, Subpart C. Examples include children covered in Medicaid above the mandatory levels, children covered under SCHIP, and parents covered under Medicaid. For purposes of the HIFA demonstrations, Section 1902(r)(2) and Section 1931 expansions constitute optional populations.

Expansion Populations: Refers to any individuals who cannot be covered in an eligibility group under Title XIX or Title XXI and who can only be covered under Medicaid or SCHIP through the section 1115 Waiver authority.

Private health insurance coverage: This term refers to both group health plan coverage and health insurance coverage as defined in section 2791 of the Public Health Service Act.

IV. HIFA DEMONSTRATION STANDARD FEATURES

Please place a check mark beside each feature to acknowledge agreement with the standard features.

☑ The HIFA demonstration will be subject to Special Terms and Conditions (STCs). The core set of STCs is ***not*** included in the application package. Depending upon the design of its demonstration, additional STCs may apply.

☑ Federal financial participation (FFP) will not be claimed for any existing State-funded program. If the State is seeking to expand participation or benefits in a State-funded program, maintenance of effort will apply.

☑ Any eligibility expansion will be statewide, even if other features of the demonstration are being phased-in.

☑ HIFA demonstrations will not result in changes to the rate for Federal matching payments for program expenditures. If individuals are enrolled in both Medicaid and SCHIP programs under a HIFA demonstration, the Medicaid match rate will apply to FFP for Medicaid eligibles, and the SCHIP enhanced match rate will apply to SCHIP eligibles.

☑ HIFA demonstrations covering childless adults can only receive the Medicaid match rate. As a result of the passage of the Deficit Reduction Act (DRA), states can no longer receive the SCHIP enhanced match rate for childless adults for HIFA applications submitted on, or after, October 1, 2005.

☑ Premium collections and other offsets will be used to reduce overall program expenditures before the State claims Federal match. Federal financial payments will not be provided for expenditures financed by collections in the form of pharmacy rebates, third party liability, or premium and cost sharing contributions made by or on behalf of program participants.

☑ The State has utilized a public process to allow beneficiaries and other interested stakeholders to comment on its proposed HIFA demonstration.

V. STATE SPECIFIC ELEMENTS

A. <u>Upper Income Limit:</u>

The upper income limit for the eligibility expansion under the demonstration is ***150*** percent FPL.

150 percent of the FPL will be the upper limit for individuals in:

- ***MEG 1) MHSP Waiver Population***

If the upper income limit is above 200 percent of the FPL, the State will demonstrate that focusing resources on populations below 200 percent of the FPL is unnecessary because the State already has high coverage rates in this income range, and covering individuals above 200 percent of the FPL under the demonstration will not induce individuals with private health insurance coverage to drop their current coverage. (Please include a detailed description of your approach as Attachment A to the proposal.)

B. Eligibility:

Please indicate with check marks which populations you are proposing to include in your HIFA demonstration.

Mandatory Populations *(as specified in Title XIX)*

☑ Blind and Disabled

☑ Aged

MEG 2) ABD Waiver Population additional benefits *- individuals receive Standard Medicaid benefits package through the State Plan. Waiver covers dental treatment services above the $1,125 State Plan dental treatment cap.*

❑ Poverty-related Children and Pregnant Women

Optional Populations *(included in the existing Medicaid State Plan)*

Categorical

❑ Children and pregnant women covered in Medicaid above the mandatory level

❑ Parents or caretaker relatives covered under Medicaid

❑ Children covered under SCHIP

❑ Parents or caretaker relatives covered under SCHIP

❑ Other (please specify)

Medically Needy

❑ TANF Related

☑ Blind and Disabled

☑ Aged

MEG 2) ABD Waiver Population additional benefits *- individuals receive Standard Medicaid benefits package through the State Plan. Waiver covers dental treatment services above the $1,125 State Plan dental treatment cap.*

❑ Title XXI children (Separate SCHIP Program)

❑ Title XXI parents or caretaker relatives (Separate SCHIP Program)

Additional Optional Populations

(Not included in the existing Medicaid or SCHIP State Plan.) If the demonstration includes optional populations not previously included in the State Plan, the optional eligibility expansion must be statewide in order for the State to include the cost of the expansion in determining the annual budget limit for the demonstration. Populations that can be covered under a Medicaid or SCHIP State Plan.

❑ Children above the income level specified in the State Plan. This category will include children from ___ percent FPL through ___ percent FPL.

❑ Pregnant women above the income level specified in the State Plan. This category will include individuals from ___ percent FPL through ___ percent FPL.

- ❑ Parents above the current level specified in the State Plan. This category will include individuals from ___percent FPL through ___ percent FPL.
- ❑ Other:

Existing Expansion Populations

Populations that are not defined as an eligibility group under Title XIX or Title XXI, but are already receiving coverage in the State by virtue of an existing section 1115 demonstration.

- ❑ Pregnant Women in SCHIP (This category will include individuals from ___ percent FPL through ___ percent FPL.)
- ❑ Other. Please specify:
  (If additional space is needed, please include a detailed discussion as Attachment B to your proposal and specify the upper income limits.)

New Expansion Populations

Populations that are not defined as eligibility group under Title XIX or Title XXI, and will be covered only as a result of the HIFA demonstration.

- ❑ Pregnant Women in SCHIP (This category will include individuals from ___ percent FPL through ___ percent FPL.)
- ☑ Other. Please specify:
  MEG 1) MHSP Waiver Population
  Individuals age 18 or older, with SDMI who qualify for or are enrolled in the State-financed MHSP or the Waiver for Additional Services and Population, 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).*

C. Enrollment/Expenditure Cap:

- ❑ No ☑ Yes If Yes, Number of participants or dollar limit of demonstration (express dollar limit in terms of total computable program costs).
- ***Enrollment Cap:***
  - ***MEG 1) MHSP Waiver Population*** *will be capped at 3,000 individuals served.*

D. Phase-In:

Please indicate below whether the demonstration will be implemented at once or phased in.

- ☑ The HIFA demonstration will be implemented at once. *Montana will enroll MHSP Waiver individuals each month until we reach the goal of 3,000. Since our PMPM for the MHSP Waiver group is estimated, we will continue to study the sustainability of 3,000 individuals.*
- ❑ The HIFA demonstration will be phased-in.
  If applicable, please provide a brief description of the State's phase-in approach (including a timeline): *N/A*

E. Benefit Package:

Please use check marks to indicate which benefit packages you are proposing to provide to the various populations included in your HIFA demonstration.

1. Mandatory Populations

❑ The benefit package specified in the Medicaid State Plan as of the date of the HIFA application.

☑ Other: *ABD Waiver Population*

MEG 2) ABD Waiver Population additional benefits *- individuals receive Standard Medicaid benefits package through the State Plan. Waiver covers dental treatment services above the $1,125 State Plan dental treatment cap.*

2. Optional populations included in the existing Medicaid State Plan

☑ The same coverage provided under the State's approved Medicaid State Plan.

MEG 2) ABD Waiver Population additional benefits*– individuals receive Standard Medicaid benefits package through the State Plan. Waiver covers dental treatment services above the $1,125 State Plan dental treatment cap.*

❑ The benefit package for the health insurance plan that is offered by an HMO and has the largest commercial, non-Medicaid enrollment in the State.

❑ The standard Blue Cross Blue Shield preferred provider option service benefit pan that is described in, and offered to Federal employees under 5 U.S.C. 8903(1). (Federal Employees Health Benefit Plan (FEHBP))

❑ A health benefits coverage plan that is offered and generally available to State employees.

❑ A benefit package that is actuarially equivalent to one of those listed above.

❑ Secretary approved coverage. (The proposed benefit package is described in Attachment D.)

Note: For Secretary approved coverage, benefit packages must include these basic services: inpatient and outpatient hospital services, physicians surgical and medical services, laboratory and x-ray services, well-baby and well-child care, including age appropriate immunizations.

3. SCHIP populations, if they are to be included in the HIFA demonstration

States with approved SCHIP plans may provide the benefit package specified in Medicaid State Plan, or may choose another option specified in Title XXI. (If the State is proposing to change its existing SCHIP State Plan as part of implementing a HIFA demonstration, a corresponding plan amendment must be submitted.) SCHIP coverage will consist of:

❑ The same coverage provided under the State's approved Medicaid State Plan.

❑ The benefit package for the health insurance plan that is offered by an HMO and has the largest commercial, non-Medicaid enrollment in the State.

❑ The standard Blue Cross Blue Shield preferred provider option service benefit plan that is described in, and offered to Federal employees under 5 U.S.C. 8903(1). (Federal Employees Health Benefit Plan (FEHBP))

❑ A health benefits coverage plan that is offered and generally available to State employees

❑ A benefit package that is actuarially equivalent to one of those listed above

❑ Secretary approved coverage.

Note: For Secretary approved coverage, benefit packages must include these basic services: inpatient and outpatient hospital services, physicians surgical and medical services, laboratory and x-ray services, well-baby and well-child care, including age appropriate immunizations.

4. New optional populations to be covered as a result of the HIFA demonstration

☑ The same coverage provided under the State's approved Medicaid State Plan.

MEG 2) ABD Waiver Population *– individuals receive Standard Medicaid benefits package through the State Plan. Waiver covers dental treatment services above the $1,125 State Plan dental treatment cap.*

- ❑ The benefit package for the health insurance plan that is offered by an HMO and has the largest commercial, non-Medicaid enrollment in the State.
- ❑ The standard Blue Cross Blue Shield preferred provider option service benefit plan that is described in, and offered to Federal employees under 5 U.S.C. 8903(1). (Federal Employees Health Benefit Plan (FEHBP)).
- ❑ A health benefits coverage plan that is offered and generally available to State employees
- ❑ A benefit package that is actuarially equivalent to one of those listed above.
- ❑ Secretary approved coverage. (The proposed benefit packages are described in Attachment D.)

Note: For Secretary approved coverage, benefit packages must include these basic services: inpatient and outpatient hospital services, physicians surgical and medical services, laboratory and x-ray services, well-baby and well-child care, including age appropriate immunizations.

5. Expansion Populations

States have flexibility in designing the benefit package, however, the benefit package must be comprehensive enough to be consistent with the goal of increasing the number of insured persons in the State. The benefit package for this population must include a basic primary care package, which means health care services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician.

With this definition states have flexibility to tailor the individual definition to adapt to the demonstration intervention and may establish limits on the types of providers and the types of services. Please check the services to be included:

- ❑ Inpatient
- ❑ Outpatient
- ❑ Physician's surgical and medical services
- ❑ Laboratory and x-ray services
- ❑ Pharmacy
- ❑ A benefit package that is actuarially equivalent to one of those listed above—

Other (please specify). Please include a description of any Secretary approved coverage or flexible expansion benefit package as Attachment C to your proposal. Please include a discussion of whether different benefit packages will be available to different expansion populations.

MEG 1) MHSP Waiver Population– Standard Medicaid Benefit

Through this renewal, coverage will be the Standard Medicaid benefits package. See Attachment C Benefit Package Descriptions.

MEG 2) ABD Waiver Population additional benefits *- individuals receive Standard Medicaid benefits package through the State Plan. Waiver covers dental treatment services above the $1,125 State Plan dental treatment cap.*

F. <u>Coverage Vehicle</u>

Please check the coverage vehicle(s) for all applicable eligibility categories in the chart below (check multiple boxes if more than one coverage vehicle will be used within a category):

Figure III. Coverage Vehicle

Eligibility Category	Fee-For-Service	Medicaid or SCHIP Managed Care	Private Health Insurance Coverage	Group Health Plan Coverage	Other (specify)	***Comments***
MEG 1) MHSP Waiver Population	√	***Standard Medicaid Benefit***	√*	√*	***N/A***	√***Individuals have the Standard Medicaid benefit unless the individual is able to obtain Employer Sponsored Health Care or Private Health Insurance through the Montana Medicaid HIPP Program.***
MEG 2) ABD Waiver Population	√	***Standard Medicaid Benefit*** ***Dental Treatment Services above $1,125***	√*	√*	***N/A***	

Please include a detailed description of any private health insurance coverage options as Attachment D in your proposal. Detailed descriptions of private health insurance coverage options are included in Attachment D.

G. Private Health Insurance Coverage Options

Coordination with private health insurance coverage is an important feature of a HIFA demonstration. One way to achieve this goal is by providing premium assistance or "buying into" employer-sponsored insurance policies. Description of additional activities may be provided in Attachment D to the State's application for a HIFA demonstration. If the State is employing premium assistance, please use the section below to provide details.

☑ As part of the demonstration, the State will be providing premium assistance for private health insurance coverage under the demonstration. Provide the information below for the relevant demonstration population(s):

- *If individuals from the Waiver for Additional Services and Population have the opportunity to obtain employer sponsored insurance or private insurance, if cost effective, the Waiver will pay the full premium payment. See Attachment D Private and Public Health Insurance Coverage Options Including Premium Assistance.*

The State elects to provide the following coverage in its premium assistance program: (Check all applicable and describe benefits and wraparound arrangements, if applicable, in Attachment D to the proposal if necessary. If the State is offering different arrangements to different populations, please explain in Attachment D.)

- ❑ The same coverage provided under the State's approved Medicaid plan.
- ❑ The same coverage provided under the State's approved SCHIP plan.

- ❑ The benefit package for the health insurance plan that is offered by an HMO, and has the largest commercial, non-Medicaid enrollment in the State.
- ❑ The standard Blue Cross Blue Shield preferred provider option service benefit plan that is described in, and offered to Federal employees under 5 U.S.C. 8903(1). (Federal Employees Health Benefit Plan (FEHBP)).
- ❑ A health benefits coverage plan that is offered and generally available to State employees.
- ❑ A benefit package that is actuarially equivalent to one of those listed above (please specify).
- ❑ Secretary-Approved coverage.
- ❑Other coverage defined by the State. (A copy of the benefits description must be included in Attachment D.)
- ❑ The State assures that it will monitor aggregate costs for enrollees in the premium assistance program for private health insurance coverage to ensure that costs are not significantly higher than costs would be for coverage in the direct coverage program. (A description of the Monitoring Plan will be included in Attachment D.)
- ☑ The State assures that it will monitor changes in employer contribution levels or the degree of substitution of coverage and be prepared to make modifications in its premium assistance program. (Description will be included as part of the Monitoring Plan.)
  The State will monitor employer contributions levels. See Attachment F Additional Detail Regarding Measuring Progress Toward Reducing The Rate Of Insurance.

H. <u>Cost Sharing</u>

Please check the cost sharing rules for all applicable eligibility categories in the chart below:

Figure IV. MEG Cost Sharing

Eligibility Category	Nominal Amounts Per Regulation	Up to 5 Percent of Family Income	State Defined
MEG 1) MHSP Waiver Population ***MEG 2) ABD Waiver Population***	√ ***Existing 1115 Waiver, Standard Medicaid Benefit***	***N/A***	√* ***If cost effective, Medicaid will pay premium assistance, cost share, coinsurance for Employer Sponsored Health Care or Private Health Insurance (and provides wrap around coverage). Individual is responsible for Medicaid cost share only.***

Any State defined cost sharing must be described in Attachment E. In addition, if cost sharing limits will differ for participants in a premium assistance program or other private health insurance coverage option, the limits must be specified in detail in Attachment E to your proposal. *See Attachment E Cost Sharing Limits.*

VI. ACCOUNTABILITY AND MONITORING

Please provide information on the following areas:

1. Insurance Coverage

The rate of uninsurance in Montana as of 2015 for all individuals of the total population was 13 percent.

Insured	*87%*
• *Military/VA*	*3%*
• *Medicare (Excludes Part A only)*	*15%*
• *Means tested insurance*	*9%*
o *Medicaid/CHIP*	*13%*
• *Employer-based*	*47%*
• *Non group*	*9%*
• *Unable to determine type*	*3%*
Uninsured	*13%*

Note: Respondents can have more than one type of health insurance.

Indicate the data source used to collect the insurance information presented above (the State may use different data sources for different categories of coverage, as appropriate):

☑ The Current Population Survey
❑ Other National Survey (please specify)
❑ State Survey (please specify)
❑ Administrative records (please specify)
❑ Other (please specify)

Adjustments were made to the Current Population Survey or another national survey.

❑ Yes ☑ No

If yes, a description of the adjustments must be included in Attachment F.

A State Survey was used.

❑Yes ☑ No

If yes, provide further details regarding the sample size of the survey and other important design features in Attachment F. If a State Survey is used, it must continue to be administered through the life of the demonstration so that the State will be able to evaluate the impact of the demonstration on coverage using comparable data

2. State Coverage Goals and State Progress Reports

The goal of the HIFA demonstration is to reduce the uninsured rate. For example, if a State was providing Medicaid coverage to families, a coverage goal could be that the State expects the uninsured rate for families to decrease by 5 percent. Please specify the State's goal for reducing the uninsured rate:

The U.S. Census Bureau data indicates Montana's overall uninsured rate is 13 percent. The Waiver for Additional Services and Population will allow Montana to continue benefits for up to 3,000 MHSP Waiver individuals and furnish health care benefits for Montanans who are currently uninsured or underinsured. Secondly, the Waiver will continue to cover individuals determined categorically eligible for ABD for dental treatment services above the Medicaid State Plan cap of $1,125. Lastly, the Waiver will continue to provide12-month continuous eligibility for non-expansion Medicaid-covered individuals whose eligibility is based on MAGI.

Attachment F must include the State's Plan to track changes in the uninsured rate and trends in sources of insurance as listed above. States should monitor whether there are unintended consequences of the demonstration such as high levels of substitution of private coverage and major decreases in employer contribution levels. (See the attached Special Terms and Conditions.)

☑ Annual progress reports will be submitted to CMS six months after the end of each demonstration year which provide the information described in this plan for monitoring the uninsured rate and trends in sources of insurance coverage. States are encouraged to develop performance measures related to issues such as access to care, quality of services provided, preventative care, and enrollee satisfaction. The performance plan must be provided in Attachment F.
See Attachment F for Montana's Evaluation Design.

VII. PROGRAM COSTS

A requirement of HIFA demonstrations is that they not result in an increase in Federal costs compared to costs in the absence of the demonstration. Please submit expenditure data as Attachment G to your proposal. For your convenience, a sample worksheet for submission of base year data is included as part of the application packet.

The base year will be trended forward according to one of the growth rates specified below. Please designate the preferred option:

❑ Medical Care Consumer Price Index, published by the Bureau of Labor Statistics. (Available at http://stats.bls.gov/ .) The Medical Care Consumer Price Index will only be offered to States proposing statewide demonstrations under the HIFA initiative. If the State chooses this option, it will not be used to submit detailed historical data.

☑ Medicaid-specific growth rate. States choosing this option should submit five years of historical data for the eligibility groups included in the demonstration proposal for assessment by CMS staff, with quantified explanations of trend anomalies. A sample worksheet for submission of this information is included with this application package. The policy for trend rates in HIFA demonstrations is that trend rates are the lower of State specific history or the President's Budget Medicaid baseline for the eligibility groups covered by a State's proposal. This option will lengthen the review time for a State's HIFA proposal because of the data generation and assessment required to establish a State specific trend factor.
See trend rate information in Attachment G Budget Worksheets.

VIII. WAIVERS AND EXPENDITURE AUTHORITY REQUESTED

A. Waivers

The following waivers are requested pursuant to the authority of section 1115(a)(1) of the Social Security Act (Please check all applicable.)

Title XIX:

❑ Statewideness 1902(a)(1)

To enable the State to phase in the operation of the demonstration.

The Waiver will be available to qualified participants statewide from the date of implementation.
☑Amount, Duration, and Scope (1902(a)(10)(B)
To permit the provision of different benefit packages to different populations in the demonstration. Benefits (i.e. amount, duration, and scope) may vary by individual based on eligibility category.
MEG 2) ABD Waiver Population additional benefits *– individuals receive Standard Medicaid benefits package through the State Plan. Waiver covers dental treatment services above the $1,125 State Plan dental treatment cap.*
❑ Freedom of Choice 1902(1)(23)
To enable the State to restrict the choice of provider.

Title XXI:
❑ Benefit Package Requirements 2103
To permit the State to offer a benefit package that does not meet the requirements of section 2103.
❑ Cost Sharing Requirements 2103(e)
To permit the State to impose cost sharing in excess of statutory limits.

B. <u>Expenditure Authority</u>
Expenditure authority is requested under Section 1115(a)(2) of the Social Security Act to allow the following expenditures (which are not otherwise included as expenditures under Section 903 or Section 2105) to be regarded as expenditures under the State's Title XIX or Title XXI plan.

Note: Checking the appropriate box(es) will allow the State to claim Federal Financial Participation for expenditures that otherwise would not be eligible for Federal match.
☑Expenditures to provide services to populations not otherwise eligible to be covered under the Medicaid State Plan.
MEG 1) MHSP Waiver Population.

MEG 2) ABD Waiver Population additional benefits *– individuals receive Standard Medicaid benefits package through the State Plan. Waiver covers dental treatment services above the $1,125 State Plan dental treatment cap; costs are a pass through.*

❑ Expenditures related to providing ___ months of guaranteed eligibility to demonstration participants.
❑ Expenditures related to coverage of individuals for whom cost-sharing rules not otherwise allowable in the Medicaid program apply.
Title XXI:
❑ Expenditures to provide services to populations not otherwise eligible under a State child health plan.
❑ Expenditures that would not be payable because of the operation of the limitations at 2105(c)(2) because they are not for targeted low-income children.

If additional waivers or expenditure authority are desired, please include a detailed request and justification and Attachment H to the proposal.

Figure V. Waivers and Expenditure Authority Requested

	MEG 1) MHSP Waiver Population	***MEG 2) ABD Waiver Population***
XIX. Amount, Duration, and Scope (1902(a)(10)(B) – Applied to Services	*N/A*	√
XIX. Retroactive Eligibility 1902(a)(34)	√	*N/A*
XIX. Expenditures to provide services to populations not otherwise eligible to be covered under the Medicaid State Plan.	√	*N/A*

IX. ATTACHMENTS

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

☑ Attachment A: Discussion of how the State will ensure that covering individuals above 200 percent of poverty under the waiver will not induce individuals with private health insurance coverage to drop their current coverage. *There is no income ceiling for ABD populations, as they have medically needy coverage. It is possible for ABD individuals who have standard Medicaid benefits to have income in excess of 150% FPL.*

☑ Attachment B: Detailed description of expansion populations included in the demonstration.

☑ Attachment C: Benefit package description.

☑ Attachment D: Detailed description of private health insurance coverage options, including premium assistance if applicable.

☑ Attachment E: Detailed discussion of cost sharing limits.

☑ Attachment F: Additional detail regarding measuring progress toward reducing the rate of insurance.

☑ Attachment G: Budget worksheets.

❑ Attachment H: Additional waivers or expenditure authority request and justification. *No additional expenditure authority or Waivers are requested at this time, other than those listed in the chart, IV. Waivers and Expenditure Authority Requested.*

X. SIGNATURE

7/15/2016
Date

Mary E. Dalton, Montana State Medicaid Director
Name of Authorizing State Official (Typed)

ATTACHMENT A - *DISCUSSION - HOW THE STATE WILL ENSURE COVERING INDIVIDUALS ABOVE 200% FPL*

There is no income ceiling for ABP populations, as they have medically needy coverage. It is possible for ABD individuals who have standard Medicaid benefits to have income in excess of 150 percent FPL.

ATTACHMENT B - DETAILED DESCRIPTION OF EXPANSION POPULATIONS

Mental Health Services Plan (MHSP) - State Only Program

The MHSP is a State only program for low-income adults, age 18 and up, who have a SDMI. The program currently provides a limited mental health benefit, a related mental health pharmacy benefit of up to $425, PACT Services, and 72 Hour Presumptive Eligibility services. Approximately one-third of the MHSP individuals have other insurance coverage. The number of people enrolled in State only MHSP is limited by current legislative appropriations. State only MHSP beneficiaries are not eligible for Medicaid services because they do not meet the income and resource Medicaid eligibility requirements. The income limit for State only MHSP is less than or equal to 150 percent FPL and there is no asset or resource test. The State only MHSP is a discretionary program that is not required by State or Federal law. As a result, people eligible for the State only MHSP do not have legal entitlement to services. The Addictive and Mental Disorders Division administers the State only MHSP within the funding levels appropriated by the legislature. There is no physical health benefit offered by the State only MHSP.

State Only Mental Health Services Plan Program Eligibility:

1. *The individual must have a SDMI, as determined by a licensed mental health professional through an assessment of diagnosis, functional impairment, and duration of illness.*
2. *The individual must have a family income equal to or less than 150 percent FPL. All State only MHSP financial eligibility determinations will be made by Department staff. Determinations do not include an asset or resource test.*
3. *The individual must be ineligible for Medicaid as determined by the Department.*
4. *The individual must be at least 18 years of age.*

In some circumstances, an individual with a SDMI does not meet the SSI/Medicaid criteria for being disabled. The functional criteria for the MHSP SDMI are less strict that the SSI/SSDI criteria. Social Security focuses primarily on the ability to work. Also, many individuals with severe mental illness have co-occurring substance abuse or chemical dependency disorders, which make it harder to "prove" that the mental illness is not caused or exacerbated by the co-occurring disorder for SSI/SSDI.

For those MHSP individuals not enrolled in the Waiver, the State will continue to provide the State only MHSP benefit using State only dollars. The Waiver will enroll up to 3,000 of those qualified MHSP Waiver individuals.

MHSP Waiver Population Participation Criteria:

Individuals age 18 or older, with SDMI who qualify for or are enrolled in the State-financed MHSP or the Waiver for Additional Services and Population, but are otherwise ineligible for Medicaid benefits <u>and</u> 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).*

Waiver Eligibility Determination:
MHSP Waiver eligibility determinations and management of the MHSP Waiver waiting list will be completed by Department staff. Eligibility is accomplished through the CHIMES eligibility system.

MHSP Waiver Enrollment:
Montana will phase-in MHSP Waiver qualified individuals with SDMI each month until we reach 3,000 individuals. We estimate the PMPM is about $650 for individuals with SDMI.

ABD Waiver Population
Individuals receive Standard Medicaid benefits package through the State Plan. The Waiver covers dental treatment services above the $1,125 State Plan dental treatment cap.

ATTACHMENTS C - BENEFIT PACKAGE DESCRIPTIONS

MEG 1) MHSP Waiver Expansion Population
Up to 3,000 MHSP Waiver individuals at one time will be served by the Waiver for Additional Services and Populations and will receive the Standard Medicaid benefit. There is no lifetime maximum benefit for MHSP individuals.

MEG 2) ABD Waiver Population – Optional Population
Individuals receive the Standard Medicaid benefits package through the State Plan. Waiver covers dental treatment services above the $1,125 State Plan dental treatment cap.

ATTACHMENT D - PRIVATE AND PUBLIC HEALTH INSURANCE COVERAGE OPTIONS INCLUDING PREMIUM ASSISTANCE

Medicaid pays for employer sponsored health insurance or private insurance when it is cost effective. Most individuals are referred to the Medicaid Health Insurance Premium Payments (HIPP) Program when applying for Medicaid. All individuals 18 years of age and older are required to be referred to HIPP. Other referrals come from the Office of Public Assistance. Individuals or case managers also call if an individual has an opportunity for employer sponsored health benefits or private health insurance. We have a cost effectiveness tool, which can assess the medical condition of the patient.

Medicaid Health Insurance Premium Payments System (HIPPS):
The Health Insurance Premium Payment Program allows Medicaid funds to be used to pay for private health insurance coverage when it is cost effective to do so. The system used to determine and track eligibility is the Health Insurance Premium Payments System (HIPPS). The goals of the program are to:

- *Provide access to health care for Montanans through payment of health insurance premiums with Medicaid funds.*
- *Control costs to the Medicaid program by payment of health insurance premiums.*
- *Provide prompt and accurate monthly reimbursement of premiums.*

Referrals for the HIPPS Program, for people with access to health insurance, are generated electronically by the case workers. Anyone who is 18 years or age or older on any Medicaid Program is required to be referred.
The HIPPS Program gathers information from the referred individual and the employer to complete a cost effectiveness analysis.

The cost effectiveness analysis process reviews the annual premium amount, deductible amount, and administrative cost, all Medicaid eligible members, age, and annual medical cost. This information is compared to the cost under Medicaid for similar individuals.

Insurance premium payment is considered cost effective if the total premium costs and Medicaid costs are within $200 of the calculation. A second method used is to review the potential for a high cost medical need. If the member has an urgent or ongoing medical condition with the probability of high cost, the HIPPS Program can be used.

HIPPS reimburses for the following health plans:

- *Group Plans - available through an employer*
- *COBRA Plans - a continuation of the current health insurance plan*
- *Individual Health Plans*
- *Student Health Plan - through the college*
- *COBRA 75 - employer must have at least 75 employees & member does not have to be on Medicaid.*

ATTACHMENT E - COST SHARING LIMITS

Waiver Individuals Subject To Cost Share:
All Waiver for Additional Services and Populations individuals age 21 and older pay cost share for the Standard Medicaid benefit. Individuals age 20 and younger do not pay cost share.

Medicaid Cost Share Amounts and Exempt Services:
Cost share amounts and exemptions from cost share are aligned with the Montana Medicaid State Plan.

ATTACHMENT F: ADDITIONAL DETAIL REGARDING MEASURING PROGRESS TOWARD REDUCING THE RATE OF UNINSURANCE

Attachment F is Montana's currently approved Waiver for Additional Services and Population evaluation design. Upon receiving Waiver approval, Special Terms and Conditions from CMS, Montana will revise the evaluation design if necessary.

ATTACHMENT F:
Evaluation Design

Montana evaluated the effectiveness of the Waiver for Additional Services and Population with this 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.

Waiver for Additional Services and Populations Goal:

Montana's goal is to continue to provide Standard Medicaid coverage to individuals with SDMI utilizing previously, generated Federal Waiver savings from the previously titled Basic Medicaid Waiver. By increasing from the Basic Medicaid benefit to Standard Medicaid, Montanans served under this Waiver greatly reduced their out-of-pocket costs and gained access to significant health care benefits. Continuing to cover ABD Dental Treatment Services above the $1,125 State Plan dental treatment cap, allows this population to receive unlimited dental care.

Waiver for Additional Services and Populations Hypotheses for the MHSP Group:

1. *The Waiver will provide Standard Medicaid coverage;*
2. *The Waiver will improve access to care, utilization of services, and quality of care; and*
3. *The Waiver will improve health status.*

Objectives:

- ***Objective One: Examine and measure utilization, access and expenditures for the MHSP population.***
    - *Measure One: Compare and contrast medical service utilization and service costs for MHSP Waiver members with Medicaid members for the major service components such as inpatient, outpatient, clinic, prescription drugs, physician services, specialty providers, emergency, and dental services;*
    - *Measure Two: Compare annual prescription drugs costs for the MHSP group for the year prior to the Waiver while on the State funded MHSP Program with the demonstration Waiver years;*
    - *Measure Three: Measure the percentage of the MHSP population who have a primary care provider (PCP); and*
    - *Measure Four: Measure the number and percentage of the MHSP population that access specialty care.*

- ***Objective Two: Examine, through ongoing participant surveys, the MHSP Waiver population perception of their health status, access to and quality of health care.***
    - *Measure One: Determine, through MHSP ongoing participant surveys, participants' perceptions of their general physical and mental health;*
    - *Measure Two: Determine, through MHSP ongoing participant surveys, participants' perceptions of access to care; and*
    - *Measure Three: Determine, through MHSP ongoing participant surveys, participants' perceptions of quality of care.*

Waiver for Additional Services and Populations Hypotheses for the ABD Group:

1. *The Waiver will cover dental treatment services above the $1,125 State Plan cap, allowing the eligible ABD population unlimited dental treatment services.*

Objectives:

- *Objective One: Examine and measure dental treatment service expenditures above the $1,125 State Plan cap for the ABD population.*
    - *Measure One: Measure the number and percentage of the ABD population that access dental treatment services; and*

- *Measure Two: Analyze claims and measure the expenditures for the ABD population over the dental treatment services $1,125 State Plan cap.*

National and State Uninsured or Underinsured Data Sources Used For Reporting:
The following are National and State organizations that offer information regarding demographics, insured, underinsured, and uninsured information. Montana will use these sites, among other sites, to analyze the above objectives and measures.

1. ***BRFSS*** *- The Behavioral Risk Factor Surveillance System (BRFSS) is the primary source of State-based information on the health risk behaviors among primarily adult populations. BRFSS is administered by the DPHHS Public Health and Safety Division. Phone surveys are conducted annually with an intended sample size of 6,000 (with a typical response rate of 50%). After 2007, BRFSS survey's included State-added questions related to health care coverage and utilization for adults and children. The BRFSS results (including responses to the State-added health care coverage questions) are available to review through year 2014. (http://dphhs.mt.gov/publichealth/brfss)*
2. ***KIDS COUNT*** *– Montana KIDS COUNT data is located at the Bureau of Business and Economic Research (BBER) at the University of Montana. Montana KIDS COUNT is a statewide effort to identify the status and well-being of Montana children by collecting data about them and publishing an annual data book. (http://bber.umt.edu)*
3. ***Kaiser Foundation*** *- The Kaiser Family Foundation is a non-profit, private operating foundation focusing on major health care issues. The Foundation serves as non-partisan source of health facts, information and analysis. State health facts include demographics, health status, health coverage and uninsured, health costs and budgets, managed care, providers and service use, Medicaid, SCHIP and Medicare. (http://statehealthfacts.org)*
4. ***US Census Bureau and Current Population Survey*** *– US Census Report on income, poverty and health insurance coverage in the United States. This site includes the Current Population Survey (CPS) Report, released annually in August of each year. This is the official source of national health insurance statistics, with State-by-State annual estimates of health insurance coverage. (http://www.census.gov /)*
5. ***Medical Expenditure Panel Survey*** *- US Census Bureau and Medical Expenditure Panel Survey. Is a national data source on employer based health insurance conducted via a survey of private business establishments and government employers. This survey is released annually in the summer. (http://meps.ahrq.gov)*
6. ***Montana Area Health Education Center*** *- The Montana Area Health Education Center (AHEC) and Office of Rural Health are located at Montana State University. The mission of AHEC is to improve the supply and distribution of health care professionals, with an emphasis on primary care, through community/academic educational partnership, to increase access to quality health care. The Office of Rural Health has as its mission: collecting and disseminating information within the State; improving recruitment and retention of health professionals into rural health areas; providing technical assistance to attract more Federal, State and foundation funding health and coordinating rural health interests and activities across the State. (http://healthinfo.montana.edu)*
7. ***USDA Economic Research Services*** *- The USDA Economic Research Services prepares State fact sheets on population, income, education, employment reported separately by rural and urban areas. (http://www.usda.gov/wps/portal/usda/usdahome?contentid=ERS_Agency_Splash.xml)*

8. ***Labor Statistics*** *– Montana Department of Labor and Industry, Research and Analysis Bureau provides information regarding employment, unemployment, wages, prevailing wages, injuries and illnesses, and other labor information. (http://wsd.dli.mt.gov/service/rad.asp)*

Figure VI. Waiver Reporting Deliverables:

	State	***CMS***	***State and/or CMS***
Operational Protocol	*The State shall prepare one protocol documents a single source for the Waiver policy and operating procedures.*	*N/A*	*N/A*
Draft Evaluation Design	*The State shall submit a draft evaluation design within 120 days from the demonstration award.*	*CMS will provide comments within 60 days.*	*The State shall submit the final report prior to the expiration date of this demonstration.*
Protocol Change	*Submit protocol change in writing 60 days prior to the date of the change implementation.*	*CMS will make every effort to respond to the submission in writing within 30 days of the submission receipt.*	*CMS and the State will make efforts to ensure that each submission is approved within sixty days from the date of CMS's receipt of the original submission.*
Quarterly Waiver Reports	*Quarterly progress reports due 60 days after the end of each quarter. Due:* *April 1 for November - January* *June 29 for February - April* *September 29 for May – July* *December 30 for August – October*	*N/A*	*N/A*
Annual Report	*Annual progress report drafts due 120 days after the end of each demonstration year, which include uninsured rates, effectiveness of HIFA approach, impact on employer coverage, other contributing factors, other performance measure progress.*	*N/A*	*N/A*
Phase-out Demonstration Plan	*The State will submit a phase-out plan six months prior to initiating normal phase-out activities.*	*N/A*	*N/A*
Draft Demonstration Evaluation Report	*Submit to CMS 120 days before demonstration ends.*	*Will provide comments within 60 days of receipt of report.*	*The State shall submit the final report prior to the expiration date of the demonstration.*

ATTACHMENT G - BUDGET WORKSHEETS

Budget Summary:

The accumulated Federal Section 1115 Montana Medicaid savings February 1, 2004, through January 31, 2016, is estimated at $96,001,859. (Providers have 365 days from date of service to file claims.) The renewal Federal fiscal impact is estimated at $75,605,400 from February 1, 2017, through January 31, 2022.

Figure VII. State and Federal Waiver Benefit Costs:

	2/2017 - 1/2018	*2/2018 - 1/2019*	*2/2019- 1/2020*	*2/2020- 1/2021*	*2/2021- 1/2022*	*5 Year Renewal Total*
	DY 14	***DY 15***	***DY 16***	***DY 17***	***DY 18***	
MEG 1) 3,000 MHSP Waiver Benefit Expenditures						
Federal	*$15,121,080*	*$15,121,080*	*$15,121,080*	*$15,121,080*	*$15,121,080*	*$75,605,400*
State	*$8,278,920*	*$8,278,920*	*$8,278,920*	*$8,278,920*	*$8,278,920*	*$41,394,600*
Total State & Federal	*$23,400,000*	*$23,400,000*	*$23,400,000*	*$23,400,00*	*$23,400,000*	*$117,000,000*
All Waiver Federal	*$15,121,080*	*$15,121,080*	*$15,121,080*	*$15,121,080*	*$15, 121,080*	*$75,605,400*
All Waiver State	*$8,278,920*	*$8,278,920*	*$8,278,920*	*$8,278,920*	*$8,278,920*	*$41,394,600*
All Waiver Total Federal and State	*$23,400,000*	*$23,400,000*	*$23,400,000*	*$23,400,000*	*$23,400,000*	*$117,000,000*

Trending Rates Used in the BN Calculation Schedules:

Expenditures:

- *The five-year total Renewal Federal fiscal impact is estimated at $75,605,400.*

Member Months:

- *MHSP Waiver population enrollment is phase-in to reach 3,000 individuals.*

MHSP Waiver Population and ABD Waiver Population PMPM Cost Basis Explanation:

The PMPM for the MHSP Waiver population was figured at $650 in December 2015.
The PMPM for the ABD Waiver population was figured at $86 in June 2016.

MHSP Waiver Population:

The average monthly cost of individuals, with a primary diagnosis of SDMI is $650.

SDMI

Average PMPM *cost for individuals with SDMI:*	*$650*
Average yearly *costs of existing adult Medicaid recipient with SDMI:* *3,000 individuals x $650 x 12*	*$23,400,000*
Average monthly *costs of existing adult Medicaid recipient with SDMI:* *3,000 individuals x $650*	*$1,950,000*

Hierarchy of Diagnosis:

The hierarchy of MHSP Waiver slots will be filled with eligible individuals who have primary diagnosis of Schizophrenia Spectrum, Bipolar Related Disorders, Major Depressive Disorders, and then all MHSP Program individuals with SDMI.

ABD Waiver Population:

The average monthly cost of individuals with dental expenditures over the $1,125 dental treatment services cap is $86; costs are a pass through.

ABD

Average PMPM *costs for individuals with ABD:*	*$86*
Average yearly *costs of existing adult Medicaid recipient with ABD over $1,125 dental cap:821 individuals x $86 x 12*	*$847,272*
Average monthly *costs of existing adult Medicaid recipient with ABD over $1,125 dental cap: 821 x $86*	*$70,606*

Attached Budget Worksheets:

1) ***Figure IX. Waiver for Additional Services and Populations Projections***
   Presents variance, expenditures, budget neutrality cap, PMPM, by total Federal and State, Federal only and State only MEG activity for MEG 1) MHSP Waiver and for MEG 2) ABD Waiver for DY1 – DY18.

2) ***Figure X. Calculation of Budget Neutrality Limit***
   Presents the calculation of budget neutrality limit.

3) ***Figure XI. State Maintenance of Effort***
   Presents the State only Mental Health Services Plan Program budget for individuals remaining on the State only program and the ABD Service Dental Plan.

MONTANA DPHHS
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Department of Public Health & Human Services

Department of Public Health and Human Services

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Steve Bullock, Governor

Richard H. Opper, Director

Date: March 16, 2016

To: Montana Health Coalition

From: Mary E. Dalton, State Medicaid Director

Subject: Montana Medicaid Waiver Renewal

We are pleased to invite comment from the Montana Health Coalition members regarding the renewal of the Montana Medicaid Section 1115 Waiver for Additional Services and Populations (formerly known as the Basic Waiver).

On or before April 29, 2016, the Department of Public Health and Human Services (DPHHS) will submit a renewal request for the current Section 1115 Waiver for Additional Services and Populations to the Centers for Medicare and Medicaid Services for approval. This waiver will be effective January 1, 2017, through December 31, 2019. The waiver renewal includes: 1) up to 3,000 individuals below 150% of the Federal Poverty Level with Severe Disabling Mental Illness who are not otherwise eligible for Medicaid; 2) individuals who are categorically eligible for Medicaid as Aged, Blind, or Disabled who are eligible for an enhanced Dental Treatment Services package; and 3) all non-expansion Medicaid-covered individuals whose eligibility is based on modified adjusted gross income who will receive a 12 month continuous eligibility period. Two separate public meetings to solicit comment on this renewal will be held.

The first public meeting will be on March 31, 2016, 9 a.m., at 1400 Broadway, Room C205, Helena, Montana 59601. To join the audio portion of the WebEx, call 1-877-668-4490 (806 032 202 access code); and access the internet presentation at http://dphhs.mt.gov/MontanaHealthCarePrograms/BasicMedicaid/BasicMedicaid1115Waiver.

The second meeting will be held April 5, 2016, 11 a.m. at 2121B Rosebud Drive, Billings, Montana 59102. To join the audio portion of the WebEx call 1-877-668-4490 (805 214 313 access code); access the internet presentation at the above website and view waiver renewal materials. Public comments on the Section 1115 Waiver for Additional Services and Populations renewal may be submitted until midnight **April 15**, 2016.

You may direct your comments to Mary Eve Kulawik, Medicaid State Plan Amendment and Waiver Coordinator, at (406) 444-2584 or mkulawik@mt.gov; or Director's Office, PO Box 4210, Helena, MT 59604-4210.

Thank you for your continued commitment to the Medicaid program.

Section 1115 Montana Waiver for Additional Services and Populations Renewal

Public Input Notice Schedule

*Waiver Renewal Submittal: May 31, 2016 or after

The 1115 Waiver for Additional Services and Population renewal submission requests a 5-year renewal to the currently approved demonstration waiver, effective January 1, 2017, through December 31, 2021.

Task	Days Prior to Waiver Submittal	Due Date	Comments
Newspaper Public Notice	30 days	3/16/2016	Published in three major newspapers.
Post Pre-Submission Materials to the DPHHS Website	30 days	3/16/2016	Post redline application, public notice, public notice meetings and WebEx information, tribal letter, and MT Health Coalition Memo.
Post Public Meeting to DPHHS Meeting Calendar	30 days	3/16/2016	Post public meeting call/WebEx information, agendas and handouts.
Montana Health Coalition Letter	30 days	3/16/2016	Sent and posted on the DPHHS website on 3/16/2016.
Tribal Consultation Letter	28 days	3/16/2016	Sent and posted on the DPHHS website on 3/16/2016.
Electronic Mailing List	30 days	3/31/2016	Sent on 3/31/2016.
Conduct 2 Public Meetings	20 days	3/31 - Helena 4/5 - Billings	WebEx hosted on March 31, 2016, 9 a.m., at 1400 Broadway, Room C205, Helena, MT 59601. To join the audio portion of the WebEx call 1-877-668-4490, (805 163 895 access code) and access the internet presentation at http://dphhs.mt.gov/MontanaHealthcarePrograms/Medicaid/Medicaid1115Waiver. The second meeting will be held April 5, 2016, 11 a.m. at 2121B Rosebud Dr., Billings, MT 59102. To join the audio portion of the WebEx call 1-877-668-4490, (805 214 313 access code); access the internet presentation at the above website and view waiver renewal materials.
Post Public Notice Meeting Minutes to DPHHS Website	After meetings are held	4/8/2016	Posted meeting minutes, handouts, attendees, and meeting recordings 4/8/2016.
Public Comments Due	30 days from public	5/14/2016	Summarize and evaluate comments.

	notice/ 60 days for MCA		
CMS Waiver Submission	Date submission is to be sent	5/31/2016 or after	Must be mailed and submitted electronically, must contain: • cover letter, waiver application, • 508 ADA compliant 1115 waiver application, • budget neutrality spreadsheets, • public notice schedule, • tribal and public comment summaries, • public meeting information: handouts, agendas, minutes, list of attendees, • Montana Children, Families, Health, and Human Services Interim Committee, • tribal consultation, • full public notice, • newspaper affidavits, • proof of electronic mailing, and • draft evaluation plan.
Post Submission Materials to the DPHHS Website	After submitted to CMS	5/31/2016 or after	Post all submission materials on the DPHHS Website.
CMS Sends Written Receipt Confirmation	Within 15 days receipt of completed package	6/14/2016 or after	Receipt starts CMS 30 day public notice process.

MONTANA DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

Section 1115 Waiver for Additional Services and Populations (formerly Basic Medicaid)

Evaluation Report
February 2014 – January 2016

July 15, 2016

Executive Summary
The Basic Medicaid Program 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.

Basic Medicaid Demonstration History
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 comprised of 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, offered 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, DPHHS submitted an 1115 Waiver application to Centers for Medicare and Medicaid Services (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 has remained constant throughout the life of the Basic Program. The State submits quarterly and annual Basic Medicaid reports as one of the Operational Protocol conditions.

A Health Insurance Flexibility and Accountability (HIFA) proposal was submitted on June 27, 2006. Amendments to the 1115 Basic Medicaid Waiver 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. On July 30, 2009 and August 6, 2010, submittals requested only one population, Waiver Mental Health Services Plan (WMHSP) individuals, in addition to Able-Bodied Adults. CMS approved the Waiver extension and the request to insure the additional WMHSP population, effective December 1, 2010. The WMHSP population included those individuals age 18 through 64, with incomes at or below 150 percent of the Federal Poverty Level (FPL), who have been diagnosed with severe disabling mental illness (SDMI) of schizophrenia or bipolar disorder. Priority enrollment was based on a current diagnosis of schizophrenia and a secondary population of individuals with bipolar disorder.

The Basic Medicaid Waiver renewal was submitted in June, 2013, and approved by CMS effective January 1, 2014. The renewal included raising the enrollment cap from "up to 800" to "up to 2,000"; added a random drawing to include the SDMI diagnosis of Major Depressive disorder as the third priority population; and home infusion as a covered service.

In June 2014, Montana submitted an amendment to the Section 1115 Basic Medicaid Waiver, 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 Mental Health Service Plan (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; updated the diagnosis codes for Schizophrenia spectrum, Bipolar Related disorders, Major Depressive disorders, and then all remaining SDMI 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 WMSHP 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.

On November 16, 2015, effective January 1, 2016, Montana submitted an amendment, to remove the Able-Bodied Adult population, remove Medicaid Expansion SDMI population eligible for State Plan, which gives MHSP Waiver population Standard Medicaid benefits, and close the Basic Medicaid 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 provides a 12-month continuous eligibility period for all non-expansion Medicaid-covered individuals whose eligibility is based on modified adjusted gross income (MAGI). Overall, this amendment will re-finance state funds by utilizing federal funds.

On March 7, 2016, effective March 1, 2016, an Amendment was submitted 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.

Department of Public Health and Human Services
Richard Opper is the Director of DPHHS and Mary E. Dalton is the State Medicaid Director. The Montana Medicaid Program consists of the following Divisions: Health Resources Division, Disability Services Division, Addictive and Mental Disorders Division, Child and Family Services Division, Senior and Long Term Care Division, Quality Assurance Division, Human and Community Services Division, and the Public Health and Safety Division. Medicaid eligibility is determined in the Human and Community Services Division.

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

Section 1115 Basic Medicaid Waiver Goal
Montana's goal is to provide Basic Medicaid coverage, originally designed to replicate a basic health plan benefit as a Welfare Reform Waiver, for Able-Bodied Adults while using the generated Federal Waiver savings to provide Basic coverage for the previously uninsured WMHSP.

Basic 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 Basic Medicaid unless specified in the Waiver.

Basic Medicaid Benefit Excluded Services (February 1, 1996 - January 1, 2016)
The Basic package was the Full Medicaid benefit, with the following medical services generally excluded under Basic Medicaid: audiology, dental and denturist, durable medical equipment, eyeglasses, optometry and ophthalmology for routine eye exams, personal care services, home infusion and hearing aids. Under the FAIM Waiver, these services were excluded to align with the basic medical coverage of a work-related insurance program. That is, an employed individual who is insured under a work-related insurance policy would not have coverage for the list of excluded services.

Emergencies and Essentials for Employment Program
DPHHS recognized there may be situations where the excluded services were necessary as in an emergency or when essential for employment. Coverage for the excluded services was provided at the State's discretion in cases of emergency or when essential to obtain or maintain employment. Examples of emergency circumstances included, but were not limited to, coverage for emergency dental situations, medical conditions of the eye, which included but were not limited to annual dilated eye exams for individuals with diabetes or other medical conditions, and certain medical supplies such as diabetic supplies, prosthetic devices and oxygen. In these situations, the State provided approval to the provider, and made associated records available upon CMS request. Medicaid manuals contained Basic information, which could be found on the DPHHS site at http://medicaidprovider.mt.gov/providertype.

The *General Information for Providers, Medicaid and Other Medical Assistance Programs*, is found at http://medicaidprovider.mt.gov.

Medicaid provider training was offered several times a year and Basic Medicaid billing, policies, and procedures were included. Providers, when inquiring about members eligibility, receive eligibility information including whether a person was receiving Full or Basic Medicaid regardless of the various eligibility methods of Faxback, Voice Response, Web Portal or when contacting the Office of Public Assistance, DPHHS, or Montana Medicaid's Provider Relations.

Medicaid members received a post card informing them the Montana Medicaid and Healthy Montana Kids Plus Member Guide was available online or they could request a hard copy by contacting the member Help Line; the Montana Medicaid and Healthy Montana Kids Plus Member Guide can be found at: http://dphhs.mt.gov/MontanaHealthcarePrograms/Welcome/MembersServices. A chart of Medicaid covered benefits was published with additional service details. Members received education and information regarding Full and Basic Medicaid services through the Montana Medicaid Help Line. The provider community and individuals who were affected by the 1115 Waiver were accustom to the provisions of the Waiver.

Standard Medicaid Benefit (January 1, 2016 – present)
All Medicaid members are eligible for Standard Medicaid services if medically necessary. Covered services include, but are not limited to, audiology services, clinic services, community health centers

services, dental services, doctor visits, hospital services, immunizations, Indian Health Services, laboratory services, mental health services, Nurse First services, nursing facility, occupational therapy, pharmacy, public health clinic services, substance dependency services, tobacco cessation, transportation, vision services, well-child checkups, and x-rays.

Basic Medicaid Population

Individuals on Basic Medicaid included Able Bodied Adults who were not pregnant, not blind, under age 65, and not disabled or receiving SSI. These were individuals eligible for Basic Medicaid under the designation of Family Medicaid and Transitional Medicaid.

Basic Medicaid Population DY11 Average - DY12 Average		
	February 2014 – January 2015 DY11 Average	**February 2015 - January 2016 DY12 Average**
Family Medicaid	78%	64%
Transitional Medicaid	11%	14%
WMHSP Schizophrenia	3%	3%
WMHSP Bipolar Disorder	5%	5%
WHMSP Major Depressive Disorder	4%	6%
WMHSP Post-Traumatic Stress Disorder	N/A	0%
WHMSP Anxiety Disorder	N/A	1%
WMHSP Borderline Personality Disorder	N/A	0%
***WHMSP Other**	0%	0%

*The WMHSP Other category covers diagnoses for personality disorders, mood disorders, and other psychotic disorders that do not fall under Schizophrenia spectrum, Bipolar spectrum, Major Depressive disorders, Anxiety disorders, Post-Traumatic Stress disorder, and Borderline Personality disorder.

Basic and Full Medicaid Enrollment DY11 Average – DY12 Average

In DY11, a quarterly average of 13,751 members were enrolled in Basic Medicaid; compared to 37,264 members were enrolled in Full Medicaid. In DY12, Basic Medicaid members increased 11% and Full Medicaid enrollment increased 13%.

Basic and Full Medicaid Enrollment DY11 Average – DY12 Average		
	February 2014 – January 2015 DY11 Average	**February 2015 – January 2016 DY12 Average**
Basic Medicaid Enrollment	13,751	15,406
Full Medicaid Enrollment (Age 21-64)	37,264	43,000

Full (Age 21-64) and Basic Medicaid Gender, Ethnic and Race DY11 Average – DY12 Average
In DY11, Basic Medicaid was 68% predominately female; compared to 67% females for Full Medicaid in the 21-64 age group. In DY12, Basic Medicaid was 69% predominately female; compared to 67% females for Full Medicaid in the 21-64 age group. In DY11, Basic Medicaid was 31% males; compared to 33% males in Full Medicaid. In DY12, Basic Medicaid was 31% males; compared to 33% males in Full Medicaid. In DY11, the American Indian average for Basic Medicaid was 24% and 21% for DY12, which is averaged at 5% more than the Full Medicaid for both demonstration years.

Basic Medicaid Gender, Ethnic and Race DY11 Average – DY12 Average		
	February 2014 – January 2015 DY11 Average	**February 2015 – January 2016 DY12 Average**
Gender		
Female	68%	69%
Male	32%	31%
Ethnic and Race (Plus Any Other)		
Hispanic of Any Race	3%	3%
White	72%	75%
American Indian/AK	24%	21%
Other: African American, Asian, Pacific Islander	1%	1%

Full Medicaid Gender, Ethnic and Race (Age 21-64) DY11 Average – DY12 Average		
	February 2014 – January 2015 DY11 Average	**February 2015 – January 2016 DY12 Average**
Gender		
Female	67%	67%
Male	38%	33%
Ethnic and Race (Plus Any Other)		
Hispanic of Any Race	3%	3%
White	78%	79%
American Indian/AK	17%	18%
Other: African American, Asian, Pacific Islander	1%	1%

DY11 and DY12 Expenditures by Provider Type for the Top Ten Providers

PROV PAY TO TYPE	DY11 2/1/2014 to 1/31/2015 Total	DY11 Percent of Total	DY12 2/2/2015 to 1/31/2016 Total	DY12 Percent of Total
PHARMACY	$15,577,346	22.97%	$18,200,068	21.45%
HOSPITAL - OUTPATIENT	$8,781,209	12.95%	$10,938,572	12.89%
HOSPITAL - INPATIENT	$8,395,117	12.38%	$10,652,854	12.56%
CRITICAL ACCESS HOSPITAL	$7,621,233	11.24%	$9,894,454	11.66%
GROUP/CLINIC	$6,133,363	9.04%	$8,920,625	10.51%
INDIAN HEALTH SERVICES	$3,397,037	5.01%	$3,832,689	4.52%
CASE MANAGEMENT - MENTAL HEALTH	$2,749,773	4.05%	$3,367,153	3.97%
MENTAL HEALTH CENTER	$2,732,549	4.03%	$3,324,322	3.92%
PHYSICIAN	$2,194,593	3.24%	$2,375,586	2.80%
FEDERALLY QUALIFIED HEALTH CENTER	$1,568,458	2.31%	$1,938,614	2.29%
Grand Total	**$67,824,110**	**88.77%**	**$84,839,915**	**86.57%**

Top ten provider types averages 87.67% of total costs.

Section 1115 Montana Basic Medicaid Waiver
Primary Survey Findings

In October, 2015, DPHHS mailed 2,760 surveys to all currently enrolled WMHSP individuals. As in the previous survey, completed in 2012, a drawing for $50 gift certificate to a grocery store of their choice was provided as an incentive to complete and return the survey in the pre-paid envelope by November 15. In all, 26% of the surveys were returned (705), which was comparable to the 2012 return rate (26.5%).

The survey addressed six different components, which are: General Coverage, Demographics, Health Status, Access to Health Care, Quality of Health Care, and Travel to Healthcare. The 2012 survey data was intended as a baseline. Five percent of the 2015 surveys were second-time respondents; the remaining 672 surveys (95% of the returned 2015 surveys) were first-time respondents. Comparison of results showed; members reported a greater understanding of their benefits, reported a greater percentage had seen their physician for their physical health in the past month, reported a smaller percentage where there were zero days in which poor physical or mental health kept them from doing their usual activities, and reported a greater percentage of members receiving Medicaid travel reimbursement to see specialists outside of their community. Additionally, all the 2015 responses are compared with the 2012 responses, which are included in the findings under the Baseline Comparison heading.

Primary findings from the 2015 survey data are below. Additional details are provided in the attached Detailed Analysis Report.

General Coverage:

- More than half (55%) said they understood their Basic Medicaid benefits well or very well; 45% said they did not understand their benefits well at all (Q1).
- Two-thirds (66%) did not have additional coverage; 28% had Medicare in addition to Medicaid (Q2).
- 84% currently indicated having a primary physician for physical health while only 58% had a primary physician prior to receiving Basic Medicaid (a 31% increase) (Q3+Q4).
- Half (50%) had seen a physician for physical healthcare within the past month, while an additional 40% (280) last saw their physician within the past 2-12 months. Ten percent had last seen a physician two or more years ago (Q5).

Demographics:

- Race, ethnicity, gender and age of the respondents reflected that of publically funded adult mental health members in Montana, but with an underrepresentation of American Indians (3% of survey respondents vs. 6.6%); however, five percent of the respondents categorized as having more than one race most often were of American Indian/Alaska Native descent (Q6-Q8).
- 38% had completed high school and an additional 49% of the sample had attended college (Q9); the percent who had attended college was not representative of publically funded adult mental health clients in Montana (which was reported to be 22% in 2015).
- One-fourth (26%) were employed (Q10), 66% owned or rented a home (Q11), and four percent considered themselves homeless (Q11) (including some who lived with others in their home).

Health Status:

- 44% considered their general health to be good, very good, or excellent; 36% fair; and 19% poor (Q12).
- 38% believed their general health had *improved* since receiving the Basic Medicaid benefits; 30% believed it had stayed the same; 10% felt their health had gotten worse; and 22% were not sure (Q13).
- Members presented themselves as being healthier physically than mentally:
    - 34% said their *physical* health was not good for 14 or more days out of the past 30 days (Q14), while 51% said their *mental* health was not good for 14 or more days out of the past 30 days (Q15).
    - Similarly, 51% said their *physical* health was *not* good for just 0-7 days out of the past 30 days (Q14), while only 29% said their *mental* health was *not* good for just 0-7 days out of the past 30 days (Q15).
- When asked the number of days, in the past 30 days, that poor physical *or* mental health kept them from doing their usual activities, 16% said zero days; 17% said 1-7 days; nine percent said 8-13 days; 20% said 14-20 days; and 20% said 21-30 days (Q16).
- Most (91%) said they had received mental or physical health care in the last three months, and 88% had received care from their physician (Q17-Q18).
- In the last three months, 23% received physical or mental health care at the Emergency Room, and 11% were hospitalized (Q19-Q20).

Access to Health Care:

- For *physical* care in the last three months, 19% could get an appointment with their physician within one day, 43% within a week, 22% within two weeks, and 16% greater than two weeks. For physical care in general, 83% found their wait-time to be satisfactory. (Q21)
- Members had to wait longer for mental health care than physical care for wait-times that exceeded one day: 19% could get an appointment with their mental health physician within one day, 34% within a week, 24% within two weeks, and 23% greater than two weeks. For mental care in general, 71% found their wait-time to be satisfactory, which was a 12% lower satisfaction rate than that for physical appointment wait-times. (Q21). (Satisfaction rates and comments suggest that some members may have felt they needed to be seen for mental health care more often than the once-a-week appointments they were given.)
- For those who had to wait *over* two weeks for an appointment, 53% found the wait-time to be unsatisfactory for physical care, and 54% found the wait-time to be unsatisfactory for mental care (Q21).
- For those who were able to get an appointment *within* two weeks, 24% found the wait-time unsatisfactory for physical care and 23% found the wait-time unsatisfactory for mental care (Q21).
- When asked if they were unable to see a physician for physical or mental health care in the past three months because of *cost*, 72% said no, and 28% said yes or sometimes (Q22). One member said, “No, I have Medicaid.” Some members commented that $4-$5 co-pays for appointments and

medications are not always affordable; others said that medication is cheaper, and that without Medicaid they would not be able to afford physicians, specialists, and needed procedures.

Quality of Health Care:

- The majority (81%) felt their physician always or usually spent enough time listening to their concerns, answering their physical and mental health questions, and explaining their medical conditions, treatment options and medications; 16% felt their physician sometimes spent enough time; and three percent said their physician never spent enough time with them (Q23-Q24). Comments suggested that the amount of time spent listening varied from provider to provider, and that specialists tended to spend less time than Primary Care Providers (PCPs), therapists, or case managers.
- The majority (70%) said that in the past three months they were able to get all the physical and mental health care services they thought they needed (Q25). One member said, "Medicaid has helped me a lot. I have been very sick and out of work and seeing a lot of physicians."
- In the comments, three percent of respondents expressed a desire for dental coverage, some of them with dire needs; and two percent expressed a need for vision care. (Fortunately, both dental and vision will be covered for nearly all these members when they move from Basic Medicaid to Standard Medicaid in January, 2016.)
- 88% were prescribed medication, and 94% of respondents said they take their medication as prescribed every day (Q26).

Travel to Health Care:

- Two-thirds (64%) traveled no more than 20 miles roundtrip for healthcare; 17% traveled 22-60 miles; 15% traveled 62-200 miles; and five percent traveled 202 or more roundtrip miles (Q27).
- The most common reason for traveling outside one's community for healthcare was to see a specialist (45%); 37% said their physician did not live in their community; and 18% traveled outside their community for health care because they did not live in a large enough community (Q28).
- Only 12% received Medicaid travel reimbursement; 88% did not. One member who asked for information on travel reimbursement wrote, "A roundtrip to the physician is over 200 miles—and in a pickup. Have missed many appointments." Three percent of respondents requested travel reimbursement information or said they were unaware of travel reimbursement coverage; another ten members asked for assistance with transportation (Q29).

Baseline Comparison

Although only 33, 2015 surveys were returned by members who had also completed the 2012 baseline survey; we can still compare the responses between the three years. Comparing the averaged responses of the 705 members in 2015 with the averaged responses of the 209 members who returned the 2012 surveys, we find:

- A greater percentage of Waiver members understood their Basic Medicaid benefits well or very well in 2015 than in 2012 (55% vs. 50%).

- A smaller percentage of members had *Medicare* in addition to Medicaid in 2015 compared to 2012 (28% vs. 38%); and a greater percent did *not* have additional coverage in 2015 compared to 2012 (66% vs. 52%).
- A greater percent of 2015 members had seen their physician for *physical* health care within the last month compared to the 2012 respondents (50% vs. 45%).
- A greater percent of 2015 members felt their general health was *poor* compared to the 2012 respondents (19% vs. 12%).
- A greater percent of 2015 members felt their general health had gotten *worse* since being on the Basic Medicaid Waiver compared to the 2012 respondents (10% vs.4%).
- A greater percent of 2015 members said their *mental* health was not good for *14 days or more days* out of the past 30 compared to the 2012 respondents (51% vs. 40%).
- A smaller percent of 2015 members said there were zero days in which poor physical *or* mental health kept them from doing their usual activities (16% vs. 24% in 2012).
- The *same* percent of 2015 members were hospitalized overnight in the last three months for physical or mental health as the 2012 respondents (11% each).
- A smaller percent of 2015 members were able to get a *physical* health care appointment within one day compared to 2012 respondents (19% vs. 27%).*
- A smaller percent of 2015 members were able to get a *mental* health care appointment within one day compared to 2012 respondents (19% vs. 25%).*
- A greater percent of 2015 members had to wait over two weeks to get a *mental* health care appointment compared to 2012 respondents (23% vs. 16%).*
- A greater percent of 2015 members were *dissatisfied with the wait-time for mental health* services compared to 2012 respondents (29% vs. 24%); likewise, fewer 2015 members were *satisfied* with the mental health wait-time (71% vs. 76% in 2012).*
- A smaller percent of 2015 members said their physician never spends enough time explaining their medical condition, treatment options and medications compared to 2012 respondents (3% vs. 6%).
- *12% fewer* 2015 members felt they were able to get all of the physical or mental health care services they needed compared to 2012 respondents (70% vs. 82%). Likewise, a greater percent of 2015 members said they were *not* able to get all the health care services they needed (30% vs. 18%).*
- A greater percent of 2015 members said the reason they needed to travel was to see a specialist outside their community (45% vs. 36% in 2012).*
- A greater percent of 2015 members received Medicaid travel reimbursement compared to 2012 respondents (12% vs. 4%).*

<u>Comments of Appreciation:</u>

- Fifty-four members (8%) took the initiative to express appreciation for their Medicaid services in the Comments section. One member summed up the comments of many others when stating,

"Since I have had Medicaid, I have finally been able to get the medical and mental help so desperately needed. Thank you."

*2012 percent adjusted to exclude those not needing an appointment in the past three months to allow for equitable comparison with 2015.

Contact Information

Holly Mook, Medicaid Program Officer (406) 444-6868
Mary E. Dalton, State Medicaid Director (406) 444-4084

2015 Basic Medicaid Survey~Detailed Item Analysis Report

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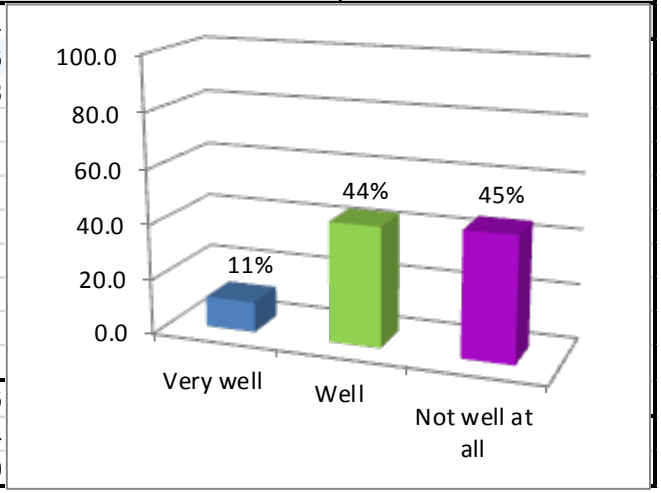
GENERAL COVERAGE:

Q1. How well do you understand your Basic Medicaid benefit?

Response	Frequency	Percent
Very well	78	11.1
Well	306	43.6
Not well at all	318	45.3
Total Valid	702	99.6
No Response	3	0.4
Total	705	100.0

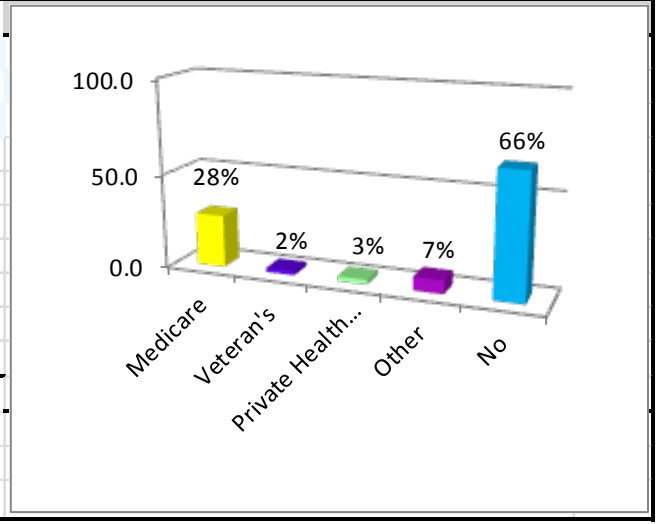
Graph



Q2. In addition to Basic Medicaid, do you have other kinds of health care coverage?

Response	Frequency	Percent
Medicare	192	27.7
Veteran's	15	2.2
Private Health Insurance	17	2.5
Other	49	7.1
No	454	65.5
Total Valid	693	98.3
No Response	12	1.7
Multiple Responses	-34	-4.8
Total	705	100.0

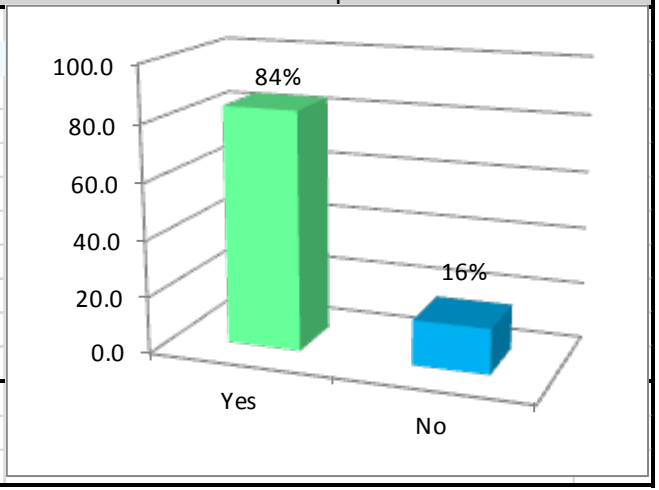
Graph



Q3. Do you have a main doctor who provides physical health care?

Response	Frequency	Percent
Yes	590	84.0
No	112	16.0
Total Valid	702	99.6
No Response	3	0.4
Total	705	100.0

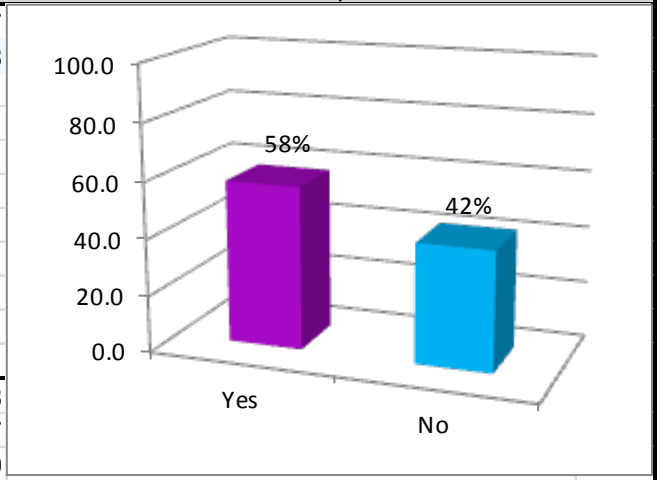
Graph



Q4. Did you have a main doctor for physical health care before you received Basic Medicaid?

Response	Frequency	Percent
Yes	400	57.7
No	293	42.3
Total Valid	693	98.3
No Response	12	1.7
Total	705	100.0

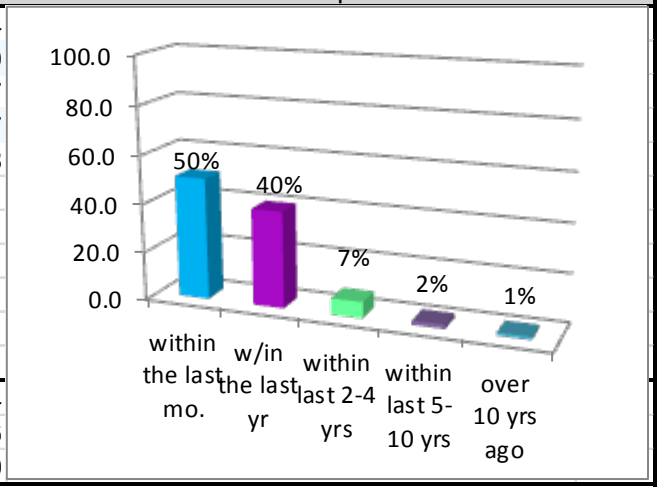
Graph



Q5. When did you last see a doctor for physical healthcare?

Response	Frequency	Percent
within the last mo.	353	50.4
w/in the last yr	280	39.9
within last 2-4 yrs	47	6.7
within last 5-10 yrs	12	1.7
over 10 yrs ago	9	1.3
Total Valid	701	99.4
No Response	4	0.6
Total	705	100.0

Graph

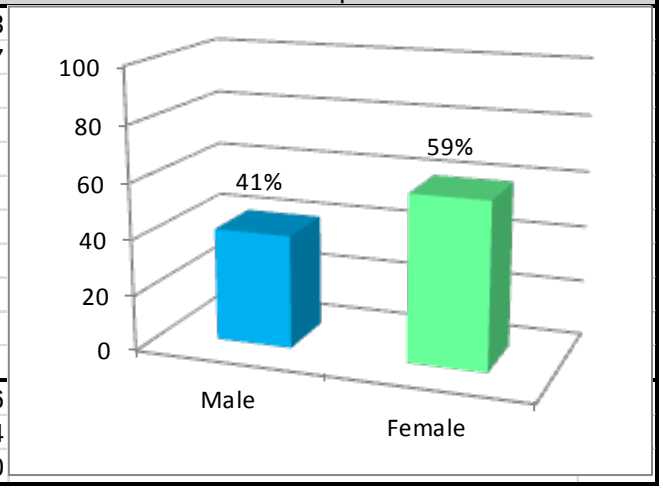


DEMOGRAPHICS:

Q6. Gender

Response	Frequency	Percent
Male	285	40.5983
Female	417	59.4017
Total Valid	702	99.6
No Response	3	0.4
Total	705	100.0

Graph

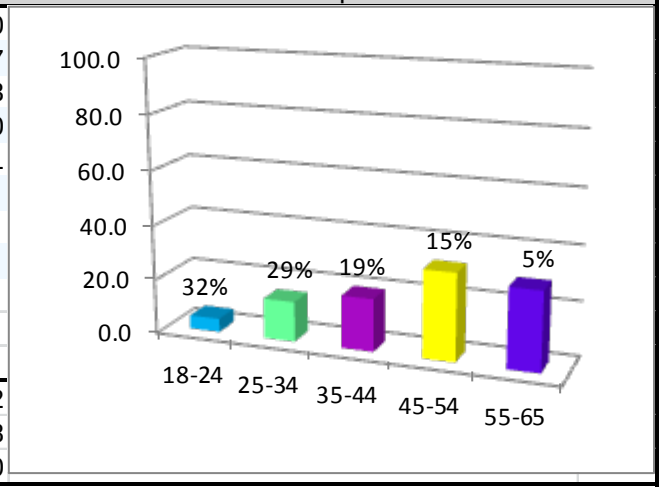


Q7. Age

Average Age: 46

Response	Frequency	Percent
18-24	34	5.0
25-34	101	14.7
35-44	132	19.3
45-54	219	32.0
55-65	199	29.1
Total Valid	685	97.2
No Response	20	2.8
Total	705	100.0

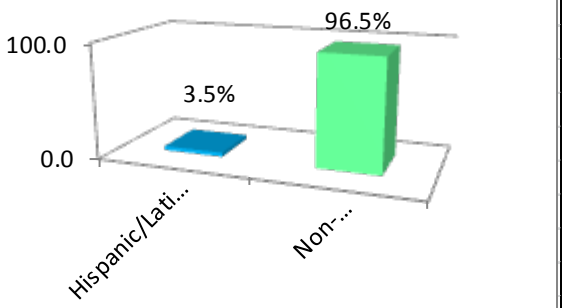
Graph



Q8a. Ethnicity

Response	Frequency	Percent
Hispanic/Latino	25	3.5
Non-Hispanic/Latino	680	96.5
Total	705	100.0

Graph

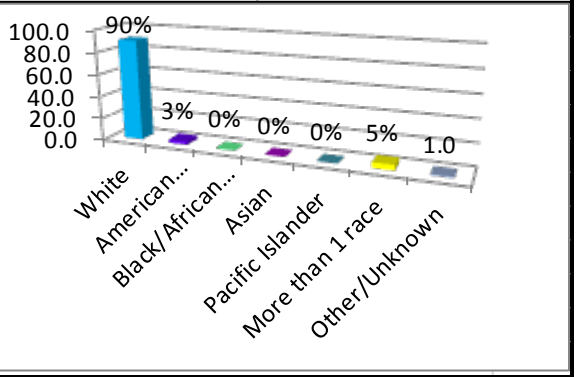


Note: Non-Hispanic includes no response

Q8b. Race

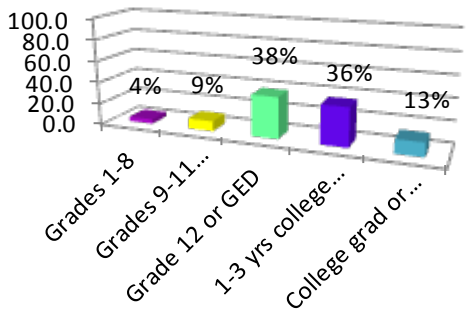
Response	Frequency	Percent
White	624	90.0
American Indian/Alaskan Native	22	3.2
Black/African American	3	0.4
Asian	2	0.3
Pacific Islander	1	0.1
More than 1 race	34	4.9
Other/Unknown	7	1.0
Total Valid	693	98.2979
No Response	11	1.56028
Invalid Response	1	0.14184
Total	705	100.0

Graph



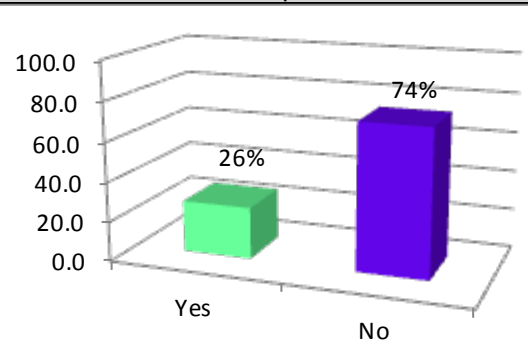
Q9. What is the highest year of school you completed?

Response	Frequency	Percent	Graph
Grades 1-8	29	4.1	
Grades 9-11 some highschool	65	9.3	
Grade 12 or GED	266	38.1	
1-3 yrs college or technical school	249	35.6	
College grad or tech school graduate	90	12.9	
Total Valid	699	99.15	
No Response	6	0.85	
Total	705	100.0	



Q10. Are you employed?

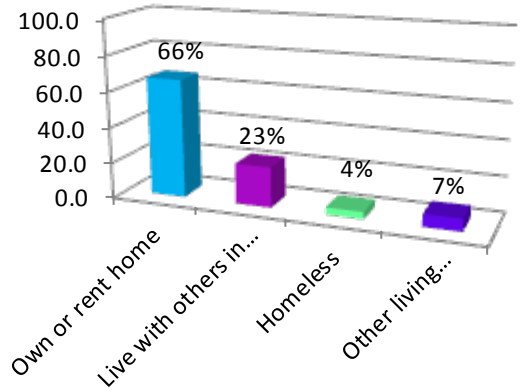
Response	Frequency	Percent	Graph
Yes	182	26.19	
No	513	73.81	
Total Valid	695	98.58	
No Response	9	1.28	
Invalid Response	1	0.14	
Total	705	100.0	



Q11. Housing status

Response	Frequency	Percent
Own or rent home	461	66.3
Live with others in their home	157	22.6
Homeless	28	4.0
Other living arrangements	49	7.1
Total Valid	695	98.6
No Response	10	1.4
Total	705	100.0

Graph

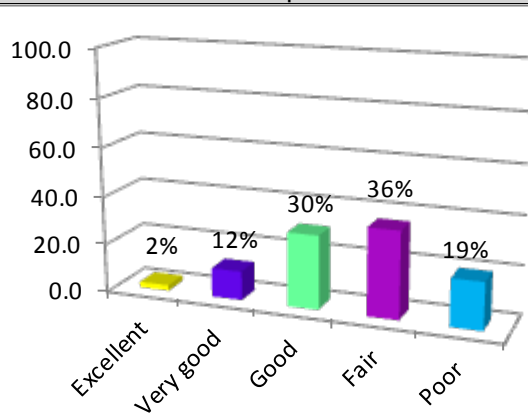


HEALTH STATUS:

Q12. Would you say your general health status now is:

Response	Frequency	Percent
Excellent	16	2.3
Very good	84	12.0
Good	213	30.4
Fair	251	35.9
Poor	136	19.4
Total Valid	700	99.3
No Response	5	0.7
Total	705	100.0

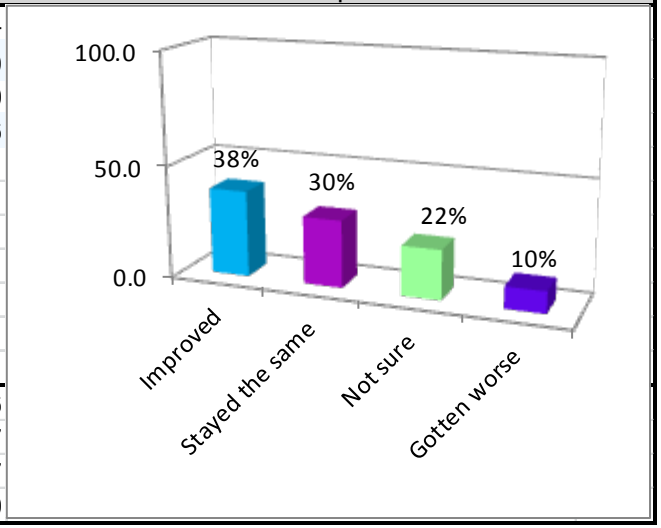
Graph



Q13. Do you think your general health has improved since you have been on the Basic Medicaid Waiver?

Response	Frequency	Percent
Improved	267	38.4
Stayed the same	208	29.9
Not sure	153	22.0
Gotten worse	67	9.6
Total Valid	695	98.6
No Response	5	0.7
Invalid Response	5	0.7
Total	705	100.0

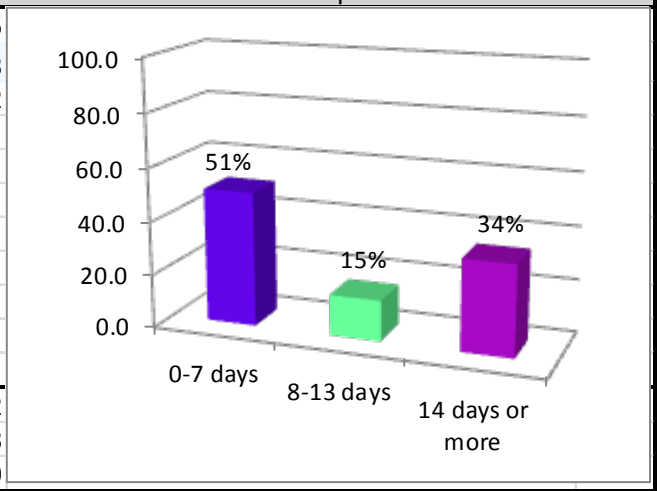
Graph



Q14. For how many days during the past 30 days was your physical health not good?

Response	Frequency	Percent
0-7 days	346	50.5
8-13 days	105	15.3
14 days or more	234	34.2
Total Valid	685	97.2
No Response	20	2.8
Total	705	100.0

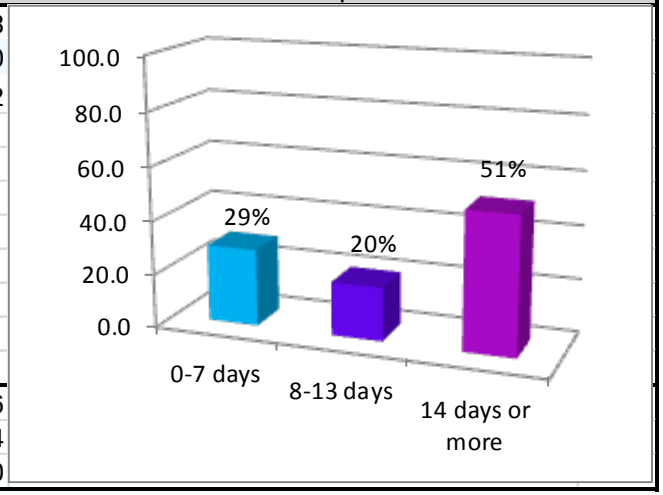
Graph



Q15. For how many days during the past 30 days was your mental health not good?

Response	Frequency	Percent
0-7 days	200	28.8
8-13 days	139	20.0
14 days or more	356	51.2
Total Valid	695	98.6
No Response	10	1.4
Total	705	100.0

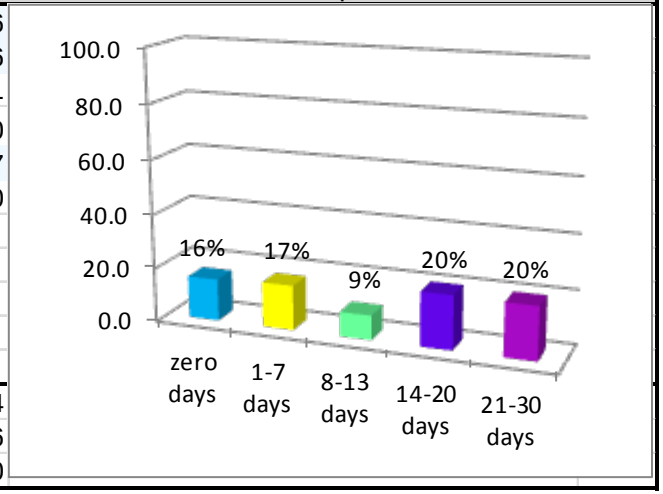
Graph



Q16. During the past 30 days, for how many days did poor physical or mental health keep you from doing your usual activities?

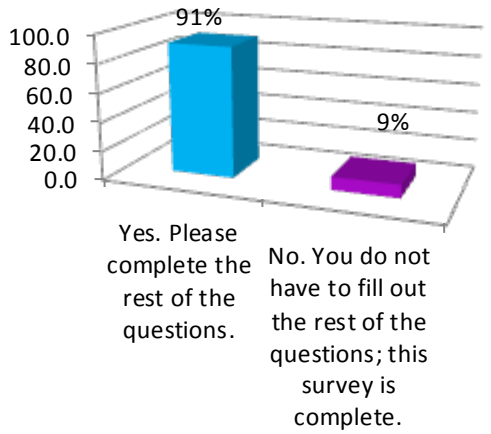
Response	Frequency	Percent
zero days	108	15.6
1-7 days	115	16.6
8-13 days	63	9.1
14-20 days	139	20.0
21-30 days	137	19.7
Not Sure	132	19.0
Total Valid	694	98.4
No Response	11	1.6
Total	705	100.0

Graph



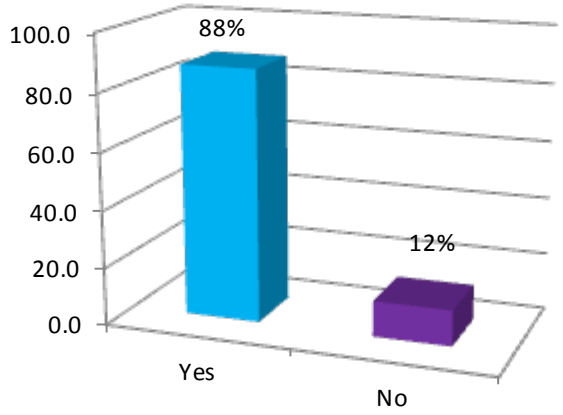
Q17. Have you had mental or physical healthcare in the last 3 months?			
Response		Frequency	Percent
Yes. Please complete the rest of the questions.		635	90.8
No. You do not have to fill out the rest of the questions; this survey is complete.		64	9.2
Total Valid		699	99.1
No Response		6	0.9
Total		705	100.0

Graph



Q18. During the last 3 months, did you receive physical or mental health care from your doctor?			
Response		Frequency	Percent
Yes		584	87.6
No		83	12.4
Total Valid		667	94.6
No Response		38	5.4
Total		705	100.0

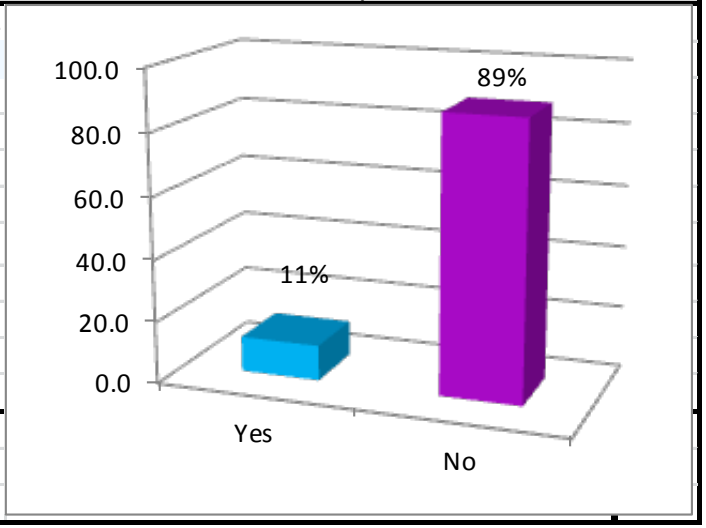
Graph



Q19. During the last 3 months, were you hospitalized for physical or mental health?

Response	Frequency	Percent
Yes	76	11.4
No	589	88.6
Total Valid	665	94.33
No Response	40	5.67
Total	705	100.0

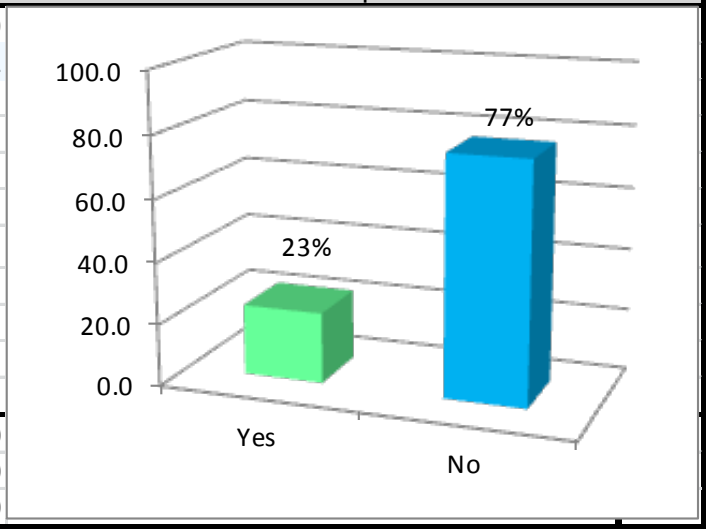
Graph



Q20. During the last 3 months, did you receive physical or mental healthcare at the emergency room?

Response	Frequency	Percent
Yes	152	22.9
No	511	77.1
Total Valid	663	94.0
No Response	42	6.0
Total	705	100.0

Graph

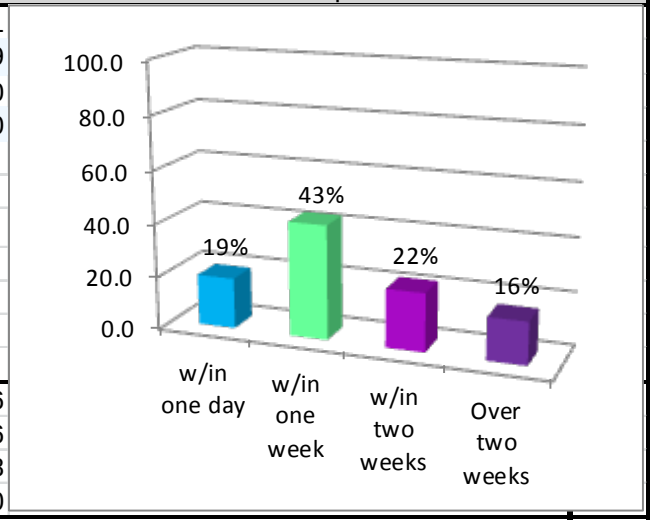


ACCESS TO HEALTH CARE:

Q21-P. In the last 3 months, how quickly did or could you usually get an appointment with your doctor for PHYSICAL healthcare?

Response	Frequency	Percent
w/in one day	112	19.1
w/in one week	252	42.9
w/in two weeks	129	22.0
Over two weeks	94	16.0
Total Valid	587	83.26
No Response	66	9.36
No appt needed	52	7.38
Total	705	100.0

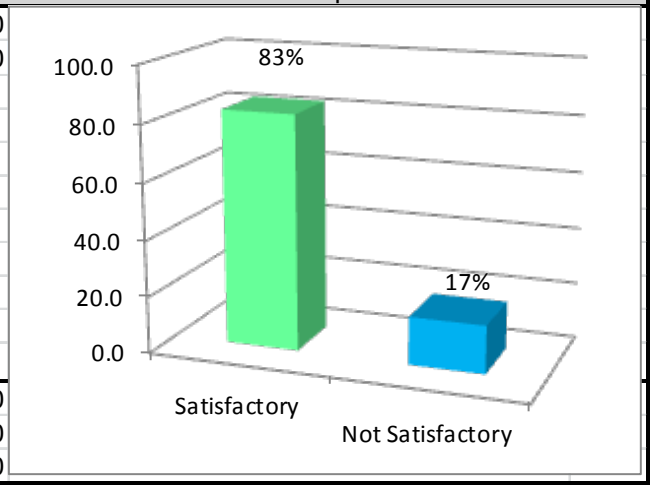
Graph



Q21-P2. Was the timeframe (above) for which you waited to receive an appointment for physical care satisfactory?

Response	Frequency	Percent
Satisfactory	229	83.0
Not Satisfactory	59	17.0
Total Valid	288	94.0
No Response	417	6.0
Total	705	100.0

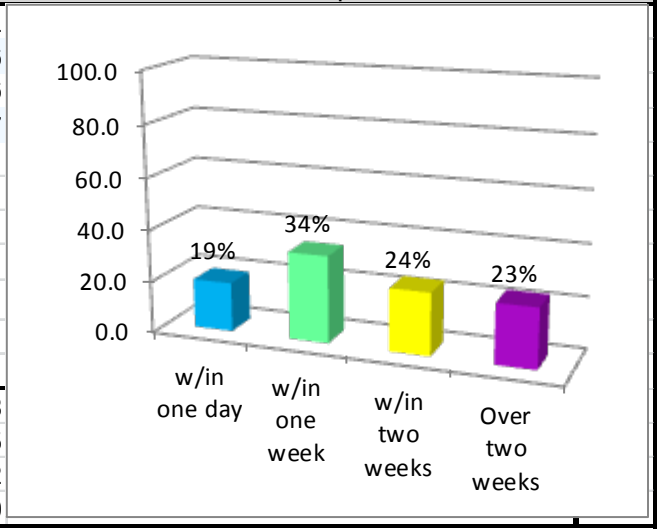
Graph



Q21-M. In the last 3 months, how quickly did or could you usually get an appointment with your doctor for MENTAL healthcare?

Response	Frequency	Percent
w/in one day	96	19.01
w/in one week	170	33.66
w/in two weeks	122	24.16
Over two weeks	117	23.17
Total Valid	505	71.63
No Response	159	22.55
No appt needed	41	5.82
Total	705	100.0

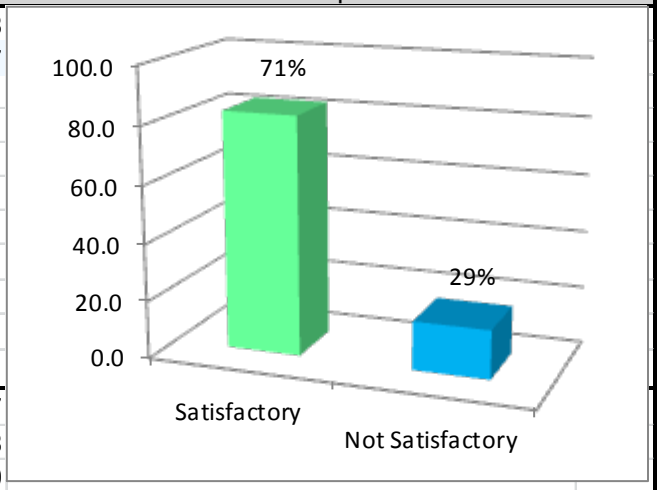
Graph



Q21-M2. Was the timeframe (above) for which you waited to receive an appointment for mental care satisfactory?

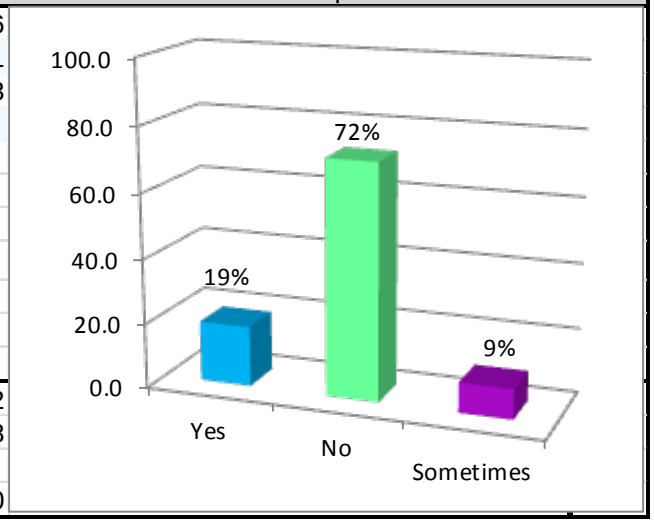
Response	Frequency	Percent
Satisfactory	221	71.3
Not Satisfactory	89	28.7
Total Valid	310	43.97
No Response	395	56.03
Total	705	100.0

Graph



Q22. Was there a time in the past 3 months when you needed to see a doctor for physical or mental healthcare but could not because of cost?

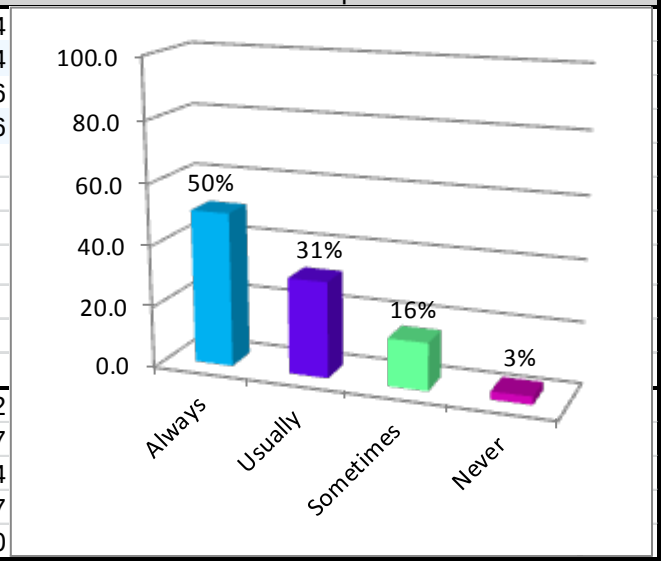
Response	Frequency	Percent	Graph
Yes	122	18.6	
No	474	72.1	
Sometimes	61	9.3	
Total Valid	657	94.2	
No Response	41	5.8	
Haven't need healthcare in last 3 months	7		
Total	705	100.0	



QUALITY OF HEALTH CARE:

Q23. In the last 3 months, has your doctor spent enough time listening to your concerns and answering your mental or physical health questions?

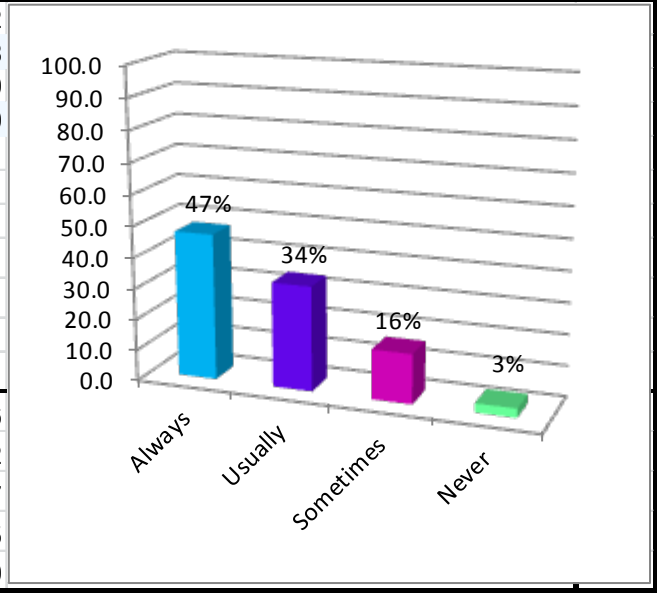
Response	Frequency	Percent	Graph
Always	324	50.4	
Usually	202	31.4	
Sometimes	100	15.6	
Never	17	2.6	
Total Valid	643	91.2	
No Response	40	5.7	
Invalid Responses	3	0.4	
Haven't had healthcare in the last 3 months	19	2.7	
Total	705	100.0	



Q24. In the last 3 months, has your doctor spent enough time explaining your medical condition, treatment options and medications with you for physical or mental health?

Response	Frequency	Percent
Always	303	47.2
Usually	217	33.8
Sometimes	103	16.0
Never	19	3.0
Total Valid	642	91.06
No Response	41	5.82
Invalid Response	4	0.57
Haven't had healthcare in the last 3 months	18.0	2.55
Total	705	100.0

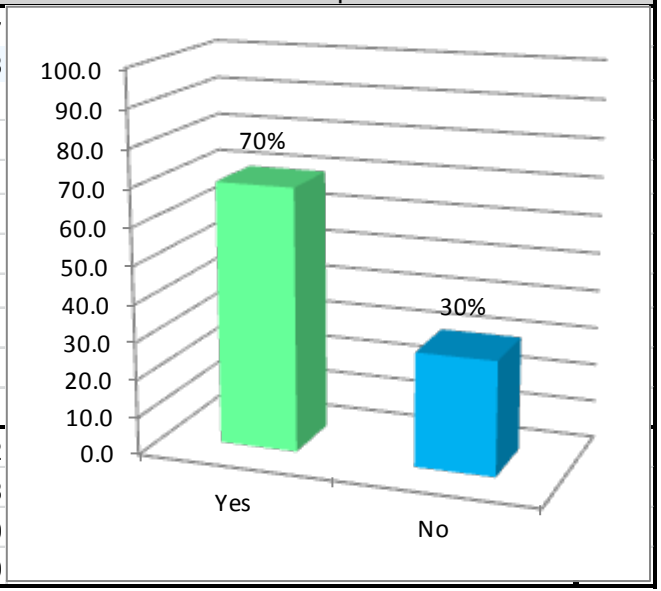
Graph

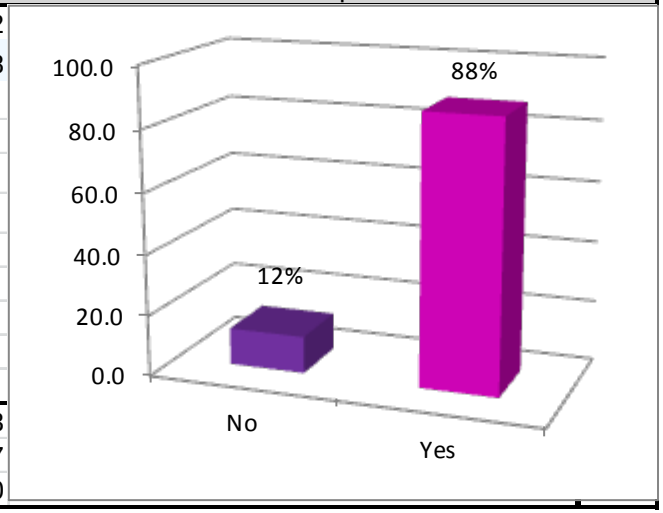


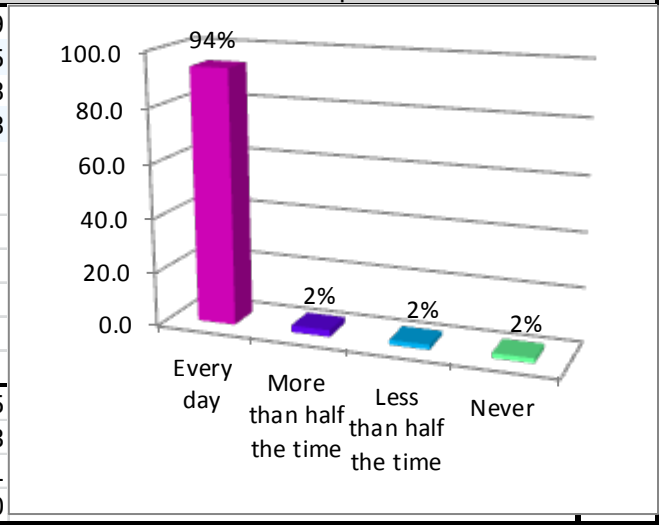
Q25. In the last 3 months, have you been able to get all of the physical or mental health care services that you thought you needed?

Response	Frequency	Percent
Yes	453	69.7
No	197	30.3
Total Valid	650	92.2
No Response	41	5.8
No healthcare in past 3 mo.	14	2.0
Total	705	100.0

Graph



Q26. In the last 3 months, have you been prescribed physical or mental health medication by your doctor?			Graph
Response	Frequency	Percent	
No	80	12.2	
Yes	578	87.8	
Total Valid	658	93.3	
No Response	47	6.7	
Total	705	100.0	

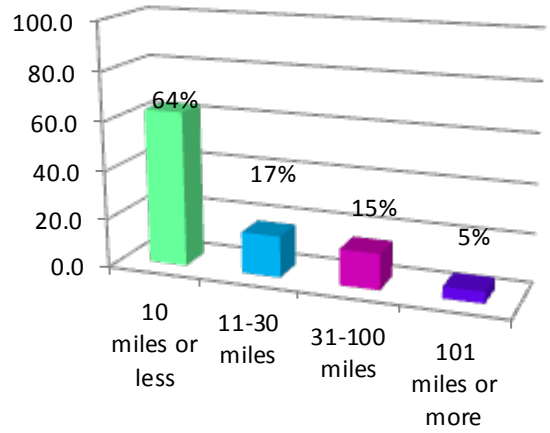
Q26b. If yes, how often do you take your medication as prescribed?			Graph
Response	Frequency	Percent	
Every day	566	93.9	
More than half the time	15	2.5	
Less than half the time	11	1.8	
Never	11	1.8	
Total Valid	603	85.5	
No Response	101	14.3	
Multiple Responses	1	0.1	
Total	705	100.0	

TRAVEL TO HEALTH CARE:

Q27. In the last 3 months, generally how far have you usually traveled each direction for your health care?

Response	Frequency	Percent
10 miles or less	401	63.5
11-30 miles	107	17.0
31-100 miles	93	14.7
101 miles or more	30	4.8
Total Valid	631	89.5
No Response	48	6.8
Multiple Responses	8	1.1
Haven't had health care in the last 3 months	18	2.6
Total	705	100.0

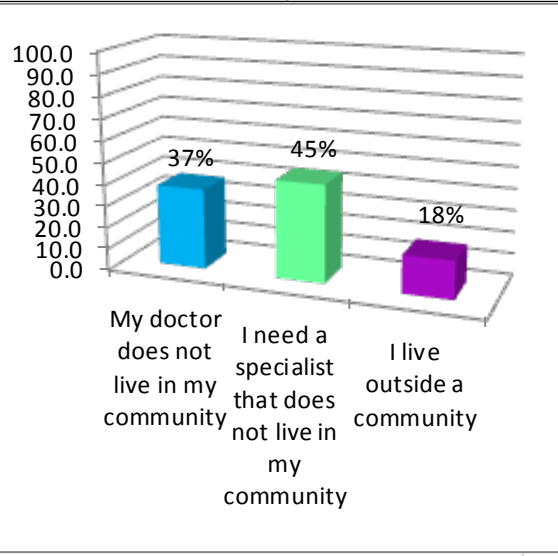
Graph



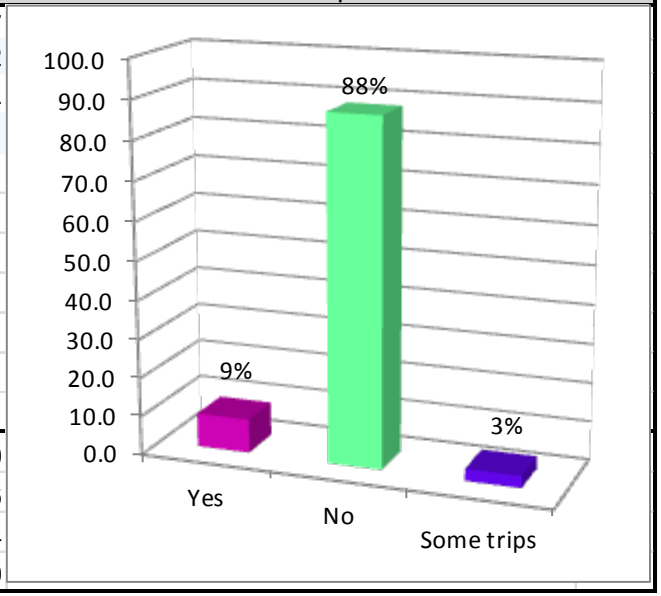
Q28. In the last 3 months, if you had to travel outside of your community, the reason you had to travel included (check all that apply):

Response	Frequency	Percent
My doctor does not live in my community	130	37.4
I need a specialist that does not live in my community	157	45.1
I live outside a community	61	17.5
Total Valid	348	45.0
No Response	350	45.3
Invalid Response	1	0.1
Haven't had health care in the last 3 months	74	9.6
Total	773	100.0

Graph



Q29. Have you received Medicaid travel reimbursement for these trips in the last 3 months?			
Response	Frequency	Percent	Graph
Yes	45	8.7	
No	454	88.2	
Some trips	16	3.1	
Total Valid	515	73.0	
No Response	152	21.6	
Haven't had health care in the last 3 months	38.0	5.4	
Total	705	100.0	



COMMENTS

Desperately need dental care
Didn't know I could get travel reimbursement, how does that work?
Can I get dental? They need to pull teeth and I need dentures on top.
Can I get travel reimbursement?
DENTAL ????
Dental?
Do not understand why I am not on full Medicaid. Cannot get OPA to give me help.
Does Medicaid expect to cover chiropractic services in the near future? Such coverage would help me financially, as Medicare doesn't pay 100%. Please mail me a booklet enumerating covered basic Medicaid services. Thank you.
Does my basic Medicaid cover eyes?
Don't know what this for. Have filled 3 of them out.
Had open heart aortic valve replacement on Oct 7th in Missoula. Was very satisfied with travel reimbursement.
How do I get assistance with transportation? Difficulty walking to get city bus. If I could solve this problem, I could be more independent and get to all my appointments
How do I get travel reimbursements for cost of travel to doctors?
I am in the process of changing doctors. My mental health care seems to be up in the air.
I am SICK of not being provided pain meds when it's a proven FACT that I need pain pills that work like Narco/Percocet/Oxycodone,
I am UPSET that no gastroenterologist could give me a colonoscopy for 5 WEEKS after my initial request. Nobody in Billings would do so. Either there's a severe lack of qualified enterologists, or almost no one takes Medicaid patients. UNACCEPTABLE!!
I appreciate the Medicaid. Would be great to have eye exams in the Basic.
I could use the groceries, I don't get help with food. Thanks. John B.
I didn't know I still had Medicaid
I do not have a Medicaid card
I do not have a Medicaid card! Also no Medicare cards.
I don't have vision or dental on my Medicaid not quite sure why. I need vision and dental but can't afford these services.
I don't know what Medicaid pays and not pays. And neither do my grandparents.
I don't see my MEDICAL doctor as often as needed because I can't pay the $4 co-pay which is required at the time of each visit. I have no income and they won't bill me.
I don't understand why chiropractic services are not covered. If I don't go every 1-2 weeks, I can't hardly handle the pain. I'm in constant pain anyway, but it helps enough for me to survive. I do "tens" therapy there, plus massage, too.
I got on Medicaid waiver 1st of February (THANK YOU)!! It's been difficult to get a colonoscopy. I'm 53 and I've asked my MD every month for 6 months now and still no appointment or procedure done. What's up with that?
I live in a small town and I want to know if the receptionists, nurses, billing staff, doctors, or any other employees in the doctors offices, clinics, hospitals, dentists, specialists, etc. can look into my records or Medicaid history and see any procedures, medications, or medical/mental issues I've had? Also; what do I do if I think my private information is being shared/leaked? Thank you.
I have absolutely no way transportation to get to a doctor/dentist or the mentality to make an appointment. I'm literally screwed mentally!
I just wish I could get more help in regards to my rotten teeth that need to be pulled and prepare for dentures. I don't have the money as 1/2 is given when dentures in Conrad are ordered. Balance is due upon completion.
I like and need the Medicaid badly but I can't travel outside of Montana to get further treatment.
I live in small town Montana, our quality of health care is limited, most I do not choose to use. I believe many health specialists have gotten lax and lazy. We can do better, we must.
I need a doctor close . My provider is in Boulder, MT. I have no way to get there.
I need dentures. I have NO top teeth and don't understand why that isn't covered by my Medicaid plan :(

I need glasses. My eyes have gotten worse to where I can't see. I get double vision when I drive and read.
I need medical work on my gums for periodontal disease & I can't get help because of cost - co-pay
I needed special equipment for a health condition and dental coverage for a tooth that right now is half missing. I can't get either one. I hope someday Medicaid and Medicare would cover these items. My quality of life would improve dramatically.
I pay $8.00 2 times a month for travel to mental health Glasgow, MT. May I please be reimbursed?
I really need some assistance for some dental work--don't have any fully intact molars left--Is becoming difficult to chew many foods and causes earaches and head aches--am worried about a low-grade infection entering my sinuses and brain area and can also lead to poor heart health and poor nutrition. Please contact me.
I should not have to be referred by a doctor to see another doctor and as far as Medicare, you should not turn down certain brands and say we need to try other but what doctor gives you.
I want to know if I can receive travel reimbursements to Mental Health. I drive 86 miles round trip.
I want to know why I haven't received travel monies to travel to my mental health/physical doctors
I wanted to see a specialist for my depression at Billings Clinic but was denied due to Medicaid.
I was told I was approved for Full Medicaid. I just want to know when my full Medicaid takes into effect. I want to be on the program where I can hire someone to clean my house and take care of me. I'm waiting for disability
I wish dental coverage were included to some extent, i.e., extractions, dentures if medically necessary.
I wish someone would help me fix my teeth!
I work and am a client at WMMH. I don't have a car and rely on public transport and agents from work.
I work with Voc Rehab & have 8 teeth; 4 that I can chew with. They will not help me with dentures & I want a note saying you won't either. I really need help in this area.
I would like more information on Medicaid travel reimbursement
I would like some information on travel reimbursement as I have missed doctor appts due to travel expense. Round tip to Dr's in Billings is a little over 200 miles-and in a pickup :(Have missed many appts.
I would like to find out if I can receive full insurance on my eyes and teeth. My teeth need to be pulled and to get dentures. Many infections. Cannot afford it.
I would like to talk about my medication
Ask about your help line-average recorded wait time 4 hrs with no ability for your call rep to answer or fix so 4 more hrs of wait.
I would like to try to get a liposuction done to help with my back problems.
I'd like to see a GP about my chronic back pain due to my childhood club foot, and see a counselor about my MDD and anxiety.
Info on BMHCG for medical and mental health all if possible, by mail please and thank you!
Information re: $ for travel would be helpful to get to and from my appts.
Is there a way I can get dental and vision help?
It is hard to get a second appointment.
It should be made clearer in the Medicaid guide that chiropractic is not covered for adults 21 and over. The language is very ambiguous.
Just information on Q1 Basic Medicaid Benefits. Thank you.
Just need to know what exactly my Medicaid covers (Drs, meds, dentist care)
Married woman don't receive the Medical like simple surgery or anything but basic even for hearing and eyes even for a month or 2, but if single or divorced they get it? Why. As I need surgery on right foot but can't?? Can't afford it?
Medicaid pretty good to me, if eyes, and hearing that would help.
Mental Health stated I should have full coverage Medicaid since I'm receiving SSI.
My doctor has ordered a procedure to be done on my neck over two months ago and we have still not gotten authorization or information as to how to proceed. We went through the diagnostic procedure and it was determined what was needed next and I am still waiting to hear anything.

I'm still confused as to what my Medicaid covers.
My main issue is my scoliosis. It's too expensive to travel so I don't get it taken care of.
My questions stem from confusion over what I understood to be a switch from Medicaid to Medicare (May 1, 2015), while in actuality I now appear to have both. I don't understand why the change was made, which program is responsible for covering what, or when further changes may occur. Once I understand those things, I'm sure I will have some more concrete questions. Thank you in advance.
Need Dental
Need help paying for Latuda mental pills
Need more help
Need more information on Basic Medicaid for physical health
Need psychologist & psychiatrist instead of counselor & nurse practitioner to properly handle my therapy and medicines. N.P. ignores what my neurobiologist and E.N.T. doctor recommend for anxiety and panic attacks. I'm suffering terribly.
Need vision care.
No dental coverage
No offense to the medical community...but I find too much unprofessional conduct.
Once approved for Medicaid, I continued my medical care at Pryor Indian Health Clinic. The 35-mile (one direction) drive has become an expensive hardship. I have been trying to change my healthcare provider to St. Vincent Healthcare in Billings, where I live. It has been very difficult to understand what Medicaid Montana needs me and my doctor to do for this to be accomplished. I called Crow Hospital to ask for help and they discouraged me from changing my provider. I am determined to change me provider to Billings, but it is taking much longer and requires excessive bureaucracy to accomplish.
Only issues I've had with healthcare is Work Comp not authorizing necessary care for injury. And Medicaid is picking up my mental health bill and medical caused by injury
Please contact me about emergency glasses [NOTE: client contacted on 12/21/15 to let her know that she will have Full MCD with eyeglass coverage beginning 1/1/16.]
Please help
Please, please help by talking to our congressmen, senators, legislatures in our state to expand our mental health facilities, staff and funding.
Q28-I did not know I could get travel reimbursement. My doctor is not outside my community but in another town fifteen miles each way. It would help me a lot if I could (get reimbursed) because it would take some stress away. Because I don't always know if I can get back to Kalispell the next week to get my medicine.
Q29? Do they have travel reimbursement? If so, I could use it! Thank you.
Question regarding travel reimbursement
Question, Does Medicaid pay for eye exams and glasses?
Send me a basic Medicaid benefit handbook
Should go to the dentist and eye doctor but these services are not covered
The main thing I need that Medicaid doesn't cover is more mental health therapy. I can only see therapist once per month and I need to see her once per week, often.
This program helps me a lot with dental and doctor visit. Thanks for being there. But Riverstone Health is trying to charge me with stuff they couldn't do.
Treating eating disorders as part of mental health should be recognized
Was unaware of the option for travel reimbursement
What is covered under Basic Medicaid? Is the day program at S.T.E.P. covered? Would transportation to work be covered?
Why don't I qualify for full benefits? I am on disability and Medicare. Please explain to me why I don't qualify.
Why is my Medicaid closing? I have testing to get done. Thank you!
Will need Medicaid. Have to fill out more paperwork, which overwhelms me.

Wish basic Medicaid would cover substance abuse treatment. What is the deal with travel reimbursements?
Without Medicaid I would not have been able to see the doctors I need. I need case management for mental health disability & have been unable to get one! Please help!
Workforce community does not care about one's mental health
Would like a card and Medicaid info.
Would like pamphlet that describes what services are covered by my basic Medicaid
Would like to learn more about my benefits and how to get help with travel costs
Dr's no longer look at you and take notes. They have their back to you, pecking out dictation that are not your words but their propagandized idea of what you mean.
I have had to borrow travel expenses from family to be able to visit with my doctor.
Once I needed a ride to mental health appt and my driving license was expired. Didn't have a job but I could only get a ride once. That's not fair.
If you've been with a doctor for more than 5 years and have to travel to them you should get paid for that trip that is only once a year.
I'm never quite certain what, and how much of my medical care (both physical and mental) is covered by Medicaid
Unable to receive mental health care due to owing $16.00 to my psychiatrist, she stopped seeing me for therapy. I have no income, and some co-pays are $5.00 for meds or doctor's visits and I can't pay them all.
I do wish dental care and eyeglasses/vision care were included. I need both.

*total dental expenditures

Without Waiver

Aged, Blind and Disabled	DY1	DY2	DY3	DY4	DY5	DY6	DY7	DY8
TOTAL EXPENDITURES								$ 6,166,693
ELIGIBLE MEMBER MONTHS								94,416
PMPM COST								$65.31

With Waiver

Aged, Blind, and Disabled	DY1	DY2	DY3	DY4	DY5	DY6	DY7	DY8
TOTAL EXPENDITURES								$ 6,166,693
ELIGIBLE MEMBER MONTHS								94,416
PMPM COST								$65.31

Without Waiver

Parents and other Caretaker Relatives- Continuous Eligbility	DY1	DY2	DY3	DY4	DY5	DY6	DY7	DY8
TOTAL EXPENDITURES								
ELIGIBLE MEMBER MONTHS								
PMPM COST								

With Waiver

Parents and other Caretaker relatives- Continuous Eligbility	DY1	DY2	DY3	DY4	DY5	DY6	DY7	DY8
TOTAL EXPENDITURES								
ELIGIBLE MEMBER MONTHS								
PMPM COST								

*DY 13 is an estimate

PROJECTIONS

*Starting in DY 13 dental expenditures are above the $1125 cap only

DY9	DY10	DY11	DY12	DY13	DY14	DY15	DY16
$ 6,136,315	$ 6,805,740	$ 7,254,981	$ 7,418,875	$ 849,863	$ 849,863	$ 849,863	$ 849,863
98,700	105,120	108,072	112,224	9,852	9,852	9,852	9,852
$62.17	$64.74	$67.13	$66.11	$86.26	$86.26	$86.26	$86.26

DY9	DY10	DY11	DY12	DY13	DY14	DY15	DY16
$ 6,136,315	$ 6,805,740	$ 7,254,981	$ 7,418,875	$ 849,863	$ 849,863	$ 849,863	$ 849,863
98,700	105,120	108,072	112,224	9,852	9,852	9,852	9,852
$62.17	$64.74	$67.13	$66.11	$86.26	$86.26	$86.26	$86.26

DY9	DY10	DY11	DY12	DY13	DY14	DY 15	DY 16
				$ 73,049,832	$ 81,697,841	$ 83,029,516	$ 84,382,897
				181,716	184,678	187,688	190,748
				$402	$442	$442	$442

DY9	DY10	DY11	DY12	DY13	DY14	DY 15	DY 16
				$ 73,049,832	$ 81,697,841	$ 83,029,516	$ 84,382,897
				181,716	184,678	187,688	190,748
				$402	$442	$442	$442

Notes:
*PMPM including increase in expenditures for those members who were previou
*member months trend rate is 1.63% per year
*expense trend rate is 1% per year

DY17	DY18	Total
$ 849,863	$ 849,863	**$ 38,881,782**
9,852	9,852	
$86.26	$86.26	

DY17	DY18	DY18
$ 849,863	$ 849,863	**$ 38,881,782**
9,852	9,852	
$86.26	$86.26	

DY 17	DY 18	DY18
$ 85,758,338	$ 87,156,199	**$ 495,074,621**
193,857	197,016.59	
$442	$442	

DY 17	DY 18	DY18
$ 85,758,338	$ 87,156,199	**$ 495,074,621**
193,857	197,017	
$442	$442	

ısly only receiving basic services

FIGURE XI. STATE MAINTENANCE OF EFFORT

p s			2/17-1/18 DY 14		2/18-1/19 DY 15		2/19-1/20 DY 16		2/20-1/21 DY 17		2/21-1/22 DY 18	Type of Assistance
Without Waiver												
Mental Health Services Plan - State Only Program Budget	*Total Recipients*		*3,000*		*3,000*		*3,000*		*3,000*		*3,000*	*MHSP State Only Program Assistance = Limited Mental Health Benefits, $425 Rx,*
	State Funds		*$1,000,000*		*$1,000,000*		*$1,000,000*		*$1,000,000*		*$1,000,000*	*MHSP State General Fund.*
ABD Service Dental Treament Services Over State Plan Annual Limit	*Total Recipients*		821		821		821		821		821	
	State Funds		*$300,682*		*$300,682*		*$300,682*		*$300,682*		*$300,682*	*No dental treatment beyond the state plan annu*
With Waiver												
	Total Recipients		*3,000*		*3,000*		*3,000*		*3,000*		*3,000*	
MEG 1) MHSP Waiver	*State Funds*		*$689,910*		*$689,910*		*$689,910*		*$689,910*		*$689,910*	*Waiver for Medicaid Additional Services and Populations = Medicaid Benefit*
MEG 2) ABD Waiver -with Waiver	*Total Recipients*		*821*		*821*		*821*		*821*		*821*	*ABD Dental Treatment Services over the $1,125*
	State Funds		*$300,682*		*$300,682*		*$300,682*		*$300,682*		*$300,682*	
State Only Funds Total			*$990,592*		*$990,592*		*$990,592*		*$990,592*		*$990,592*	

**State Funds-State Only General Funds or State Special Revenue (Tobacco Tax Revenue)*
MHSP State Funds to cover MHSP Waiver benefits
5/23/2016
*** The Aged, Blind, and Disabled dental expenses above $1,125 is considered a pass through and not listed as a cost towards budget neutrality.*

MONTANA DPHHS
Healthy People. Healthy Communities.
Department of Public Health & Human Services

Department of Public Health and Human Services

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Steve Bullock, Governor

Richard H. Opper, Director

Section 1115 Montana Waiver for Additional Services and Populations Renewal Comments and Responses

There were no public comments received for the Section 1115 Montana Waiver for Additional Services and Populations Renewal.