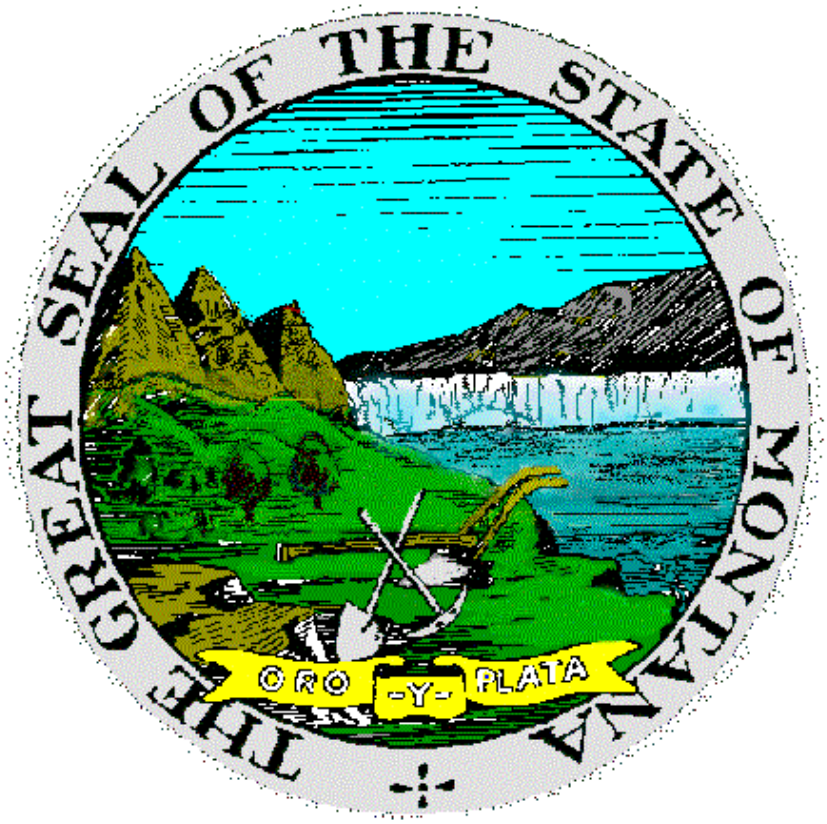

MONTANA DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

Mary E. Dalton, State Medicaid Director

Section 1115 Basic Medicaid Waiver Amendment

November 15, 2015 Submittal

Effective January 1, 2016

MONTANA

1115 BASIC MEDICAID WAIVER AMENDMENT

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SECTION 1115 BASIC MEDICAID WAIVER
DEMONSTRATION AMENDMENT EXECUTIVE SUMMARY

This Demonstration Waiver will further the objectives of the Medicaid program by expanding Medicaid coverage to a vulnerable population, adults with Severe Disabling Mental Illness. By aligning the Basic Medicaid benefit with Standard Medicaid, Montanans with Severe Disabling Mental Illness served under this waiver will gain access to significant health care benefits. Adoption of continuous eligibility will ensure better access to care and continuity of services for members and increase administrative efficiency of the Montana Medicaid Program.

Montana requests CMS approval of an Amendment to our Section 1115 Montana Basic Medicaid Waiver. This Waiver Amendment is a companion to the recently approved Medicaid Health and Economic Livelihood Partnership (HELP) Program 1115 Waiver and the Alternative Benefit Plans, eligibility, copayment and service state plan amendments that we are submitting to effectuate Medicaid Expansion. Two of the populations currently served under the Basic Waiver are covered elsewhere and no longer require coverage under this Basic Waiver vehicle. We are asking for this Amendment to the Basic Waiver to be approved by January 1, 2016, to coincide with the rest of Medicaid Expansion in Montana.

The proposed amendment, effective January 1, 2016, requests to:

- *Remove able-bodied adults from the waiver;*
- *Remove individuals under age 65 with Severe Disabling Mental Illness who are not covered by or eligible for Medicare and who are between 0-138% of the modified adjusted gross income (MAGI) income level;*
- *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) or the Basic Medicaid waiver, but are otherwise ineligible for Medicaid benefits <u>and</u> 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).*
- *Reduce the MHSP wavier enrollment cap from 6,000 to 3,000;*
- *Align 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*
- *Adopt a 12-month continuous eligibility period for all non-expansion Medicaid-covered individuals whose eligibility is based on modified adjusted gross income (MAGI).*

The amendment will also update the waiver budget neutrality and general waiver language.

Public Notice:
A Tribal Consultation letter was sent on August 19, 2015. Beginning on November 16, 2015, information regarding the Basic Medicaid Amendment was posted on the DPHHS website, which includes: our public notice process, an invitation and details to the public meeting, and the application with noted changes. A public meeting is scheduled for December 2, 2015, in Helena, Montana; the public meeting will be broadcast as a WebEx so people around the State can participate. A memo to the Montana Health Coalition was mailed electronically on November 18, 2015. A public notice will be published in

newspapers on November 22, 2015. These public notice items may be found at http://dphhs.mt.gov/MontanaHealthcarePrograms/BasicMedicaid/BasicMedicaid1115Waiver.

Waiver Populations:
This Demonstration will:

- *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) or the Basic Medicaid waiver, 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 modified adjusted gross income (MAGI).*

A notice to members who will no longer be eligible for the Basic Medicaid Waiver effective January 1, 2016, will be sent in mid-December, 2015.

Basic Medicaid Waiver Benefit:
Through this amendment, coverage for the Basic Medicaid Waiver will be aligned with the Standard Medicaid benefits package. The following previously excluded basic benefits are included in Standard Medicaid benefit: audiology, dental and denturist, durable medical equipment (DME), eyeglasses, optometry and ophthalmology for routine eye exams, personal care services, and hearing aids.

A notice to members who will begin receiving Standard Medicaid benefits on January 1, 2016, will be sent in mid-December, 2015.

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.

Basic Medicaid Waiver Cost Share:
All waiver individuals age 21 and older pay Standard Medicaid cost share for Medicaid benefits; individuals younger than age 21 do not pay cost share.

Figure I. Montana's Basic Waiver Amendment Population Summary

MHSP Waiver = Expansion			*Funding Source*		*Benefit Package*		*Cost Sharing*	
Demonstration Population	***Number of Members***	***Financial Eligibility***	***Current***	***Proposed***	***Current***	***Proposed***	***Current***	***Proposed***

1) MHSP Waiver *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 Maintenance 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 1115 Basic 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 DBT services, $12 generic and $17 non generic, up to $425 mental health pres-cription drug.*	*Standard Medicaid State Plan Cost Share*

Federal and State Basic Medicaid Waiver 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 February 1, 2016 – January 31, 2017 is $1,950,000 and we can sustain these populations through December 31, 2017.

Figure II. State and Federal Waiver Benefit Costs:

	2/2016 -1/2017	***2/2017 -1/2018***	***Amendment Total***
	DY13	***DY14***	
Cumulative Federal Variance	*$135,307,283*	*$134,047,193*	*$134,047,193*
Federal Variance	*($1,260,090)*	*($1,260,090)*	*($2,520,180)*
Total Federal and State MHSP Waiver Benefit Costs	*$1,950,000*	*$1,950,000*	*$54,483,314*
Total Federal MHSP Waiver Benefit Costs	*$1,260,090*	*$1,260,090*	*$36,295,635*
Total State MHSP Waiver Benefit Costs	*$689,910*	*$689,910*	*$18,187,679*

Reporting:
The Basic Medicaid Waiver's goal is to continue to provide healthcare coverage to adults with Severe Disabling Mental Illness. Montana will use the generated Federal waiver savings from the previously

approved Basic Medicaid Waiver to provide Medicaid coverage for up to 3,000 MHSP Waiver individuals. We will study the effectiveness of our objectives through the described data measurements and reports to CMS. See Figure VII. Waiver Reporting Deliverables.

Conclusion:
By increasing the Basic Medicaid benefit to Standard Medicaid, Montanans served under this waiver will greatly reduce their out-of-pocket costs and gain access to significant health care benefits.

I. BASIC MEDICAID WAIVER HISTORY

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 severe disabling mental illnesses was submitted on June 30, 2014, and became effective August 1, 2014.

This amendment submitted on November 15, 2015 with an effective date of January 1, 2016 proposes to:

- *Remove able-bodied adults from the waiver;*
- *Remove individuals under age 65 with Severe Disabling Mental Illness who are not covered by or eligible for Medicare and who are between 0-138% of the modified adjusted gross income (MAGI) income level;*

- *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) or the Basic Medicaid waiver, 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).*
- *Align 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*
- *Adopt a 12-month continuous eligibility period for all non-expansion Medicaid-covered individuals whose eligibility is based on modified adjusted gross income (MAGI).*

II. GENERAL DESCRIPTION OF PROGRAM

This Section 1115 Basic Medicaid Waiver amendment request, scheduled to begin on January 1, 2016, will provide health care coverage to up to 3,000 MHSP Waiver individuals and will increase the Basic benefit package to align it with the Standard Medicaid package provided through the Montana Medicaid State Plan. It will also provide a 12-month continuous eligibility period for all non-expansion Medicaid covered individuals whose eligibility is based on modified adjusted gross income (MAGI).

The following is a description of the Basic Waiver MHSP Waiver population.

MEG 1) MHSP Waiver – Expansion Population

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) or the Basic Medicaid waiver, 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).*

Funding:

See Figure I. Montana's Amendment Population Summary for Federal and State funding.

MHSP Waiver Population:

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 1115 Basic Medicaid Waiver surplus budget neutrality savings.*

Continuous Eligibility Population:

Funding consistent with CMS guidance provided in a State Medicaid Director Letter of 2/21/2014.

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, a 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. Upper Income Limit:

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

150 percent of the Federal Poverty Level will be the upper limit for individuals in:

- *MEG 1) MHSP Waiver*

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
❑ 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
❑ 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 an 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
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) or the Basic Medicaid waiver, 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).*

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 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 Waiver individuals each month until we reach the goal of 3,000. Since our PMPM for the MHSP Waiver group is estimated, we will 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. <u>Benefit Package:</u>

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:

2. Optional populations included in the existing Medicaid State Plan

❑ 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 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.
- ❑ 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 – Standard Medicaid Benefit

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

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)	***<u>Comments</u>***
						√***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.
New HIFA Expansion ***MEG 1) MHSP Waiver***	√	***Standard Medicaid Benefit***	√*	√*		

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. <u>Private Health Insurance Coverage Options</u>

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 MEG1) MHSP Waiver 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. Cost Sharing

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
New HIFA Expansion ***MEG 1) MHSP Waiver***	√ ***Existing 1115 Waiver, Standard Medicaid Benefit***		√* ***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. <u>State Coverage Goals and State Progress Reports</u>

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 Basic Medicaid Waiver would 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.

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.
❑ 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. Expenditure Authority

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.***
❑ 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
XIX. Amount, Duration, and Scope (1902(a)(10)(B) – Applied to Services		
XIX. Retroactive Eligibility 1902(a)(34)		√
XIX. Expenditures to provide services to populations not otherwise eligible to be covered under the Medicaid State Plan.		√

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. ***No individuals above 150 percent FPL will be covered by the waiver.***

☑ 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

11-15-15
Date

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

ATTACHMENT B - DETAILED DESCRIPTION OF EXPANSION POPULATIONS

Mental Health Services Plan (MHSP) - State Only Program

The Mental Health Services Plan (MHSP) is a State only program for low-income adults, age 18 and up, who have a Severe Disabling Mental Illness (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. 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 Severe Disabling Mental Illness (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.

MEG 1) MHSP Waiver

Expansion Population

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 Participation Criteria:

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) or the Basic Medicaid Waiver, 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).*

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 all qualified individuals with SDMI each month until we reach 3,000 individuals. We estimate the PMPM is about $650 for individuals with SDMI.

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 Basic Medicaid Waiver and will receive Standard Medicaid benefit. There is no lifetime maximum benefit for MHSP individuals.

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 access the medical condition of the patient.

Medicaid Health Insurance Premium Payments System (HIPP):
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 Payment System (HIPP). 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 HIPP's 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

Cost Sharing Limits – Standard Medicaid Benefit:
MEG 1) MHSP Waiver individuals will receive the Standard Medicaid benefit.

Waiver Individuals Subject To Cost Share:
All individuals age 21 and older pay cost share for the Standard Medicaid benefit.

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 Basic Medicaid Waiver evaluation design. Upon receiving waiver approval, Special Terms and Conditions from CMS, Montana will revise the evaluation design if necessary. Montana will submit a final evaluation design within 60 days of receipt of CMS comments.

ATTACHMENT F:
Evaluation Design

Montana will evaluate the effectiveness of the Basic Medicaid Waiver with this CMS approved evaluation design from December 2010 through December 2017. We took a baseline survey of the 800 MHSP Waiver individuals in the summer of 2012 and then again in October 2015 to learn about participants' health status, access to health care, and quality of care. We will also identify lessons learned, unintended consequences, policy changes observed, and any recommendations going forward.

Basic Medicaid Waiver Goal
Montana's goal is to provide Standard Medicaid coverage to individuals with Severe Disabling Mental Illness utilizing previously, generated federal waiver savings from the Basic Medicaid Waiver. By increasing the Basic Medicaid benefit to Standard Medicaid, Montanans served under this waiver will greatly reduce their out-of-pocket costs and gain access to significant health care benefits.

Basic Medicaid Waiver 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.*

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 fund MHSP Program with the demonstration waiver years.*
    - *Measure Three: Measure the percentage of the MHSP population who have a primary care provider (PCP).*
    - *Measure Four: Measure the number and percentage of the MHSP population that access specialty care.*

- ***Objective Two: Examine, through participant surveys in 2012 and at waiver end, the new MHSP waiver population perception of their health status, access to and quality of health care.***
    - *Measure One: Determine, through MHSP participant baseline and waiver end surveys, participants' perceptions of their general physical and mental health.*
    - *Measure Two: Determine, through MHSP participant baseline and waiver end surveys, participants' perceptions of access to care.*
    - *Measure Three: Determine, through MHSP participant baseline and waiver end surveys, participants' perceptions of quality of care.*

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%). The 2007. 2008, and 2009 BRFSS survey's included State-added questions related to health care coverage for adults and children. The 2007 BRFSS results (including responses to the 10 State-added health care coverage questions) should be available in June 2008. (http://www.brfss.mt.gov/)*
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. (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. (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. (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. (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.*		
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*		
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.*		
Phase-out Demonstration Plan	*The State will submit a phase-out plan six months prior to initiating normal phase-out activities.*		
Draft Demonstration Evaluation Report	*Submit to CMS 120 days before demonstration ends.*	*Will provide comments 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 Basic Medicaid Waiver savings February 1, 2004 through September 30, 2013 is estimated at $74,079,143. (Providers have 365 days from date of service to file claims.) The two year amendment federal fiscal impact is estimated at $3,900,000 from February 1, 2016 through January 31, 2017.

Figure VII. State and Federal Waiver Benefit Costs:

	2/2016 -1/2017	***2/2017 -1/2018***	***2 Year Amendment Total***
	DY13	***DY14***	
MEG 1) 3,000 MHSP Waiver Benefit Expenditures			
Federal	*$1,260,090*	*$1,260,090*	*$2,520,180*
State	*$689,910*	*$689,910*	*$1,379,820*
Total State & Federal	*$1,950,000*	*$1,950,000*	*$3,900,000*

Trending Rates Used in the BN Calculation Schedules:

Expenditures:

- *The two year federal fiscal impact is estimated at $3,900,000 from January 1, 2016, through December 31, 2017.*

Member Months:

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

MHSP Population PMPM Cost Basis Explanation:

The PMPM for the MHSP Waiver population is figured at $650 in November 2015.

MHSP Waiver:

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 12*	*$36,000*

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.

Attached Budget Worksheets:

1) ***Figure IX. Basic Medicaid 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 for DY1 – DY14.

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 and services for individuals remaining on the State only program.