

December 24, 2013

Mary E. Dalton
State Medicaid Director
Montana Department of Public Health and Human Services
P.O. Box 4210
Helena, MT 59604-4210

Dear Ms. Dalton:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) has approved a 3 year extension of the Montana Basic Medicaid for Able-Bodied Adults section 1115 demonstration (Project No. 11-W-00181/8) in order to preserve the coverage afforded to residents of Montana as the state continues to consider its coverage options. The Basic Medicaid for Able-Bodied Adults demonstration will continue to receive federal financial participation at the state's regular federal medical assistance percentage from January 1, 2014, through December 31, 2016.

Our approval of this demonstration is subject to the limitations specified in the enclosed list of waivers and expenditure authorities. The state may deviate from the Medicaid state plan requirements only to the extent those requirements have been specifically waived, or with respect to expenditure authorities, listed as not applicable to expenditures for demonstration populations and other services not covered under the state plan. In addition, this extension incorporates two changes to the program which allows the state to increase enrollment in the Waiver for Mental Health Services Plan program and include home infusion services under the demonstration, to the special terms and conditions (STCs).

This demonstration approval is conditional upon acceptance and compliance with the enclosed STCs defining the nature, character, and extent of anticipated federal involvement in the project. The award is subject to our receiving your written acknowledgement of the award and acceptance of these STCs and expenditure authorities within 30 days of the date of this letter.

Your project officer for this demonstration is Ms. Terri Fraser. She is available to answer any questions concerning your section 1115 demonstration. Ms. Fraser's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Division of State Demonstrations and Waivers
7500 Security Boulevard, Mailstop S2-01-16
Baltimore, MD 21244-1850
Telephone: (410) 786-5573
Email: Terri.Fraser@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Fraser and to Mr. Richard Allen, Associate Regional Administrator in our Denver Regional Office. Mr. Allen's contact information is as follows:

Centers for Medicare & Medicaid Services
1600 Broadway, Suite 700
Denver, CO 80202-4367
Telephone: (303) 844-1370
Email: Richard.Allen@cms.hhs.gov

If you have questions regarding this correspondence, please contact Mr. Eliot Fishman, Director, Children and Adults Health Programs Group, Center for Medicaid & CHIP Services, at (410) 786-5647. We look forward to continuing to work with you and your staff.

Sincerely,

/s/

Cindy Mann
Director

Enclosures

cc: Richard Allen, Associate Regional Administrator, Region VIII
Cindy Smith, CMCHO

**CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER LIST**

NUMBER: 11-W-00181/8 - Title XIX
TITLE: Montana Basic Medicaid for Able-Bodied Adults
AWARDEE: Montana Department of Public Health and Human Services

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived in the following list shall apply to the demonstration project under title XIX of the Social Security Act (the Act) from January 1, 2014, through December 31, 2016. In addition, these waivers may only be implemented consistent with the approved special terms and conditions (STCs).

MEDICAID TITLE XIX REQUIREMENTS WAIVED FOR MEDICAID STATE PLAN GROUPS

1. Amount, Duration, and Scope of Services and Comparability **Section 1902(a)(10)(B)**

To the extent necessary to enable the state to offer a reduced benefit package, a different benefit package, or cost-effective alternative benefit packages to populations affected by the demonstration.

2. Home Health Services **Section 1902(a)(10)(D)**

To the extent necessary to enable the state not to offer the medical equipment component of the home health benefit to populations affected by the demonstration.

3. Freedom of Choice **Section 1902(a)(23)(A)**

To enable the state to restrict freedom of choice of provider for populations affected by the demonstration, through the use of mandatory enrollment in managed care entities (primary care case management or nurse first advice line) for the receipt of applicable demonstration covered services. And to enable the state to mandate managed care enrollment for any individual in the populations affected by the demonstration who is an Indian as defined in section 4(c) of the Indian Health Care Improvement Act of 1976 (25 U.S.C. 1603(c)).

**CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY**

NUMBER: 11-W-00181/8 - Title XIX

TITLE: Montana Basic Medicaid for Able-Bodied Adults

AWARDEE: Montana Department of Public Health and Human Services

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the state for the items identified below, which are not otherwise included as expenditures under section 1903, shall, for the period of this demonstration extension, be regarded as expenditures under the state's Medicaid title XIX state plan. These expenditure authorities and *not applicables* are effective January 1, 2014, through December 31, 2016.

The following expenditure authorities shall enable Montana to implement this section 1115 demonstration.

1. Expenditures Related to Waiver for Mental Health Services Plan Program (WMHSP) Expansion Population

Expenditures for coverage of health care services for no more than 2000 individuals aged 18 through 64, with incomes at or below 150 percent of the federal poverty level (FPL), who have been diagnosed with a severe disabling mental illness of schizophrenia, bipolar disorder, or major depression, and who, at the time of their initial enrollment were receiving a limited mental health services benefit package through enrollment in the state-financed Mental Health Service Plan Program, but are otherwise ineligible for Medicaid.

MEDICAID REQUIREMENTS NOT APPLICABLE TO THE DEMONSTRATION ELIGIBLE POPULATION

Waivers that are extended to the Able-Bodied Adults will also be extended to the WMHSP as *not applicables*. All other requirements of the Medicaid statute will be applicable to those individuals who are made eligible for services solely by virtue of the demonstration project, for which, under the expenditure authority listed above, the state will receive federal financial participation in its expenditures, except those requirements specified below:

1. Reasonable Promptness (enrollment limit) Section 1902(a)(8)

To enable the state to maintain enrollment up to the designated enrollment limit for the WMHSP population.

2. Retroactive Eligibility Section 1902(a)(34)

To permit the state not to offer retroactive eligibility to WMHSP individuals.

Demonstration Period: January 1, 2014, through December 31, 2016

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS (STCs)

NUMBER: 11-W-00181/8

TITLE: Montana Basic Medicaid for Able-Bodied Adults

AWARDEE: Montana Department of Public Health and Human Services

DEMONSTRATION PERIOD: January 1, 2014, through December 31, 2016

I. PREFACE

The following are the special terms and conditions (STCs) for Montana’s Basic Medicaid for Able Bodied Adults section 1115 demonstration program (hereinafter referred to as “demonstration”) for the demonstration under section 1115(a) of the Social Security Act (the Act) for the period of January 1, 2014, through December 31, 2016. The parties to this agreement are the Montana Department of Public Health and Human Services (“state”) and the Centers for Medicare & Medicaid Services (“CMS”). All requirements of the Medicaid and CHIP programs expressed in law, regulation and policy statement, not expressly waived or made not applicable in the list of Waivers and Expenditure authorities, shall apply to the demonstration project.

The STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and the state’s obligations to CMS during the life of the demonstration. The STCs are effective as of the approval letter’s date, unless otherwise specified. Amendment requests, correspondence, documents, reports, and other materials that are submitted for review or approval shall be directed to the CMS Central Office Project Officer and the Regional Office state representative at the addresses shown on the award letter. All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below. The STCs are effective the date of approval through December 31, 2016.

The STCs have been arranged into the following subject areas:

- I. PREFACE
- II. PROGRAM DESCRIPTION AND OBJECTIVES
- III. GENERAL PROGRAM REQUIREMENTS
- IV. ELIGIBILITY
- V. BENEFITS
- VI. ENROLLMENT
- VII. COST SHARING
- VIII. DELIVERY SYSTEMS
- IX. GENERAL REPORTING REQUIREMENTS
- X. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX
- XI. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION
- XII. EVALUATION OF THE DEMONSTRATION
- XIII. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION
EXTENSION

ATTACHMENT A

ATTACHMENT B

II. PROGRAM DESCRIPTION AND OBJECTIVES

The Montana Basic Medicaid for Able-Bodied Adults (Basic Medicaid) is a statewide section 1115 demonstration administered by the Montana Department of Public Health and Human Services (the state). The Basic Medicaid program began in 1996, under the authority of an 1115 welfare reform waiver referred to as Families Achieving Independence in Montana (FAIM). Under FAIM, Montana provided for all mandatory Medicaid benefits and a limited collection of

optional services to approximately 8,500 able-bodied adults (aged 21 through 64 and neither pregnant nor disabled), eligible under the State plan because they are parents and/or caretaker relatives of dependent children at or below the state standard of need (i.e., otherwise eligible for Medicaid under section 1925 or 1931 of the Social Security Act). The FAIM welfare reform waiver expired on January 31, 2004, and was replaced (without change) by a section 1115 Medicaid demonstration, which was approved for the period of February 1, 2004, through January 31, 2009. The demonstration was continued through a series of Temporary Extensions through November 30, 2010.

On January 25, 2008, Montana proposed to renew the Basic Medicaid for Able-Bodied Adults demonstration for eligible parents and caretaker adults eligible under the State plan, and in subsequent communications proposed to use demonstration savings generated through the use of a limited service delivery network and the elimination of certain benefits to expand eligibility. On July 30, 2009, and August 13, 2010, the state submitted revised proposals to CMS. Under the revised proposals, demonstration savings are used to provide Medicaid-like coverage to up to 800 individuals, aged 18 through 64, with incomes at or below 150 percent of the federal poverty level (FPL), who have been diagnosed with a severe disabling mental illness (SDMI) of schizophrenia, bipolar disorder, or major depression, and who would not otherwise be eligible for Medicaid benefits. Prior to enrollment in the section 1115 demonstration under the Waiver for Mental Health Service Plan (WMHSP), these individuals received a very limited mental health benefit through enrollment in a state-financed Mental Health Service Plan (SMHSP).

On the basis of the state's July 30, 2009, and August 13, 2010, proposals, CMS approved the extension of the Basic Medicaid demonstration under authority of section 1115(a) of the Social Security Act (the Act). The demonstration was renewed three years, December 1, 2010 through December 31, 2013.

On October 31, 2013, Montana submitted a completed application for a renewal of the demonstration. The state proposed to extend its demonstration with some changes which include increasing enrollment in the WMHSP from 800 to 2000 individuals and include home infusion services which are services that were previously excluded under the benefits package in the demonstration.

III. GENERAL PROGRAM REQUIREMENTS

- 1. Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.
- 2. Compliance with Medicaid and Children's Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in law, regulation, and policy statement not expressly waived or identified as not applicable in the waiver and expenditure authority documents of which these terms and conditions are part, must apply to the demonstration.

- 3. Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy directive, come into compliance with any changes in Federal law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.
- 4. Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**
 - a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.
 - b. If mandated changes in the federal law require state legislation, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.
- 5. State Plan Amendments.** The state will not be required to submit title XIX or title XXI state plan amendments for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required, except as otherwise noted in these STCs.
- 6. Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Social Security Act (the Act). The state must not implement changes to these elements without prior approval by CMS. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in paragraph 7 below.
- 7. Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required reports and other deliverables in a timely fashion according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:

- a. An explanation of the public process used by the state, consistent with the requirements of paragraph 12, to reach a decision regarding the requested amendment;
- b. A data analysis which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current federal share “with waiver” and “without waiver” status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the “with waiver” expenditure total as a result of the proposed amendment, which isolates (by eligibility group) the impact of the amendment;
- c. An up-to-date CHIP allotment neutrality worksheet, if necessary;
- d. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and
- e. If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

8. Extension of the Demonstration. If the state intends to request demonstration extensions under sections 1115(e) or 1115(f), the state must observe the timelines contained in those statute provisions. Otherwise, no later than 12 months prior to the expiration date of the demonstration, the chief executive officer of the state must submit to CMS either a demonstration extension request or a transition and phase-out plan consistent with the requirements of paragraph 9.

As part of the demonstration extension request, the state must provide documentation of compliance with the public notice requirements outlined in paragraph 14, as well as include the following supporting documentation:

- a. Demonstration Summary and Objectives. The state must provide a narrative summary of the demonstration project, reiterate the objectives set forth at the time the demonstration was proposed, and provide evidence of how these objectives have been met as well as future goals of the program. If changes are requested, a narrative of the changes requested along with the objective of the change and desired outcomes must be included.
- b. Special Terms and Conditions (STCs). The state must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address duplicate areas, the STCs need not be documented a second time.

- c. Waiver and Expenditure Authorities. The state must provide a list along with a programmatic description of the waivers and expenditure authorities that are being requested in the extension.
 - d. Quality. The state must provide summaries of External Quality Review Organization (EQRO) reports, managed care organization (MCO) and state quality assurance monitoring, and any other documentation of the quality of care provided under the demonstration.
 - e. Compliance with the Budget Neutrality Agreement. The state must provide financial data (as set forth in the current STCs) demonstrating the State's detailed and aggregate, historical and projected budget neutrality status for the requested period of the extension as well as cumulatively over the lifetime of the demonstration. CMS will work with the state to ensure that Federal expenditures under the extension of this project do not exceed the Federal expenditures that would otherwise have been made. In addition, the state must provide up-to-date responses to the CMS Financial Management standard questions.
 - f. Draft on Evaluation Status and Findings. The state must provide a narrative summary of the evaluation design, status including evaluation activities and findings to date, and plans for evaluation activities during the expansion period. The narrative is to include, but not be limited to, describing the hypotheses being tested and any results available. The state must report interim research and evaluation findings for key research questions as a condition of renewal.
 - g. Compliance with Transparency Requirements at 42 CFR §431.412. As part of the demonstration extension requests the state must provide documentation of compliance with the transparency requirements 42 CFR §431.412 and the public notice and tribal consultation requirements outlined in STC 14, as well as include the following supporting documentation:
 - i. *Demonstration Summary and Objectives*. The state must provide a summary of the demonstration project, reiterate the objectives set forth at the time the demonstration was proposed and provide evidence of how these objectives have been met as well as future goals of the program. If changes are requested, a narrative of the changes being requested along with the objective of the change and desired outcomes must be included.
 - ii. *Special Terms and Conditions*. The state must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address any of the following areas, they need not be documented a second time.
 - iii. *Waiver and Expenditure Authorities*. The state must provide a list along with a programmatic description of the waivers and expenditure authorities that are being requested in the extension.
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- iv. *Quality.* The State must provide summaries of External Quality Review Organization (EQRO) reports, managed care organization (MCO), state quality assurance monitoring and quality improvement activities, and any other documentation of the quality of care provided under the demonstration.
- v. *Compliance with the Budget Neutrality.* The state must provide financial data (as set forth in the current STCs) demonstrating that the state has maintained and will maintain budget neutrality for the requested period of extension. CMS will work with the state to ensure that federal expenditures under the extension of this project do not exceed the federal expenditures that would otherwise have been made. In doing so, CMS will take into account the best estimate of President's budget and historical trend rates at the time of the extension.
- vi. *Interim Evaluation Report.* The state must provide an evaluation report reflecting the hypotheses being tested and any results available.
- vii. *Demonstration of Public Notice 42 CFR §431.408.* The state must provide documentation of the state's compliance with public notice process as specified in 42 CFR §431.408 including the post-award public input process described in 42 CFR §431.420(c) with a report of the issues raised by the public during the comment period and how the state considered the comments when developing the demonstration extension application.

9. Demonstration Transition and Phase Out. The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

- a. *Notification of Suspension or Termination.* The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit its notification letter and a draft transition and phase-out plan to CMS no less than six (6) months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation State Plan Amendment. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment and how the state incorporated the received comment into the revised phase-out plan.
- b. *Plan approval.* The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.

- c. **Transition and Phase-out Plan Requirements.** The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility prior to the termination of the program for the affected beneficiaries including any individuals on demonstration waiting lists, and ensure ongoing coverage for those beneficiaries determined eligible for ongoing coverage, as well as any community outreach activities including community resources that are available.
- d. **Transition and Phase-out Procedures.** The state must comply with all notice requirements found in 42 CFR §431.206, §431.210, and §431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §431.220 and §431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category. 42 CFR section 435.916.
- e. **Exemption from Public Notice Procedures 42.CFR Section 431.416(g).** CMS may expedite the federal and state public notice requirements in the event it determines that the objectives of title XIX and XXI would be served or under circumstances described in 42 CFR section 431.416(g).
- f. **Federal Financial Participation (FFP):** If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

10. CMS Right to Terminate or Suspend. CMS may suspend or terminate the demonstration (in whole or in part) at any time before the date of expiration, whenever it determines following a hearing that the state has materially failed to comply with the terms of the project. CMS will promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date.

11. Finding of Non-Compliance. The state does not relinquish its rights to challenge the CMS finding that the state materially failed to comply.

12. Withdrawal of Waiver Authority. CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is

limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

13. Adequacy of Infrastructure. The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

14. Public Notice, Tribal Consultation, and Consultation with Interested Parties. The state must continue to comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) and the tribal consultation requirements pursuant to section 1902(a)(73) of the Act as amended by section 5006(e) of the Recovery and Reinvestment Act of 2009. In states with federally recognized Indian tribes, Indian health programs, and / or Urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any waiver proposal, amendment, and / or renewal of this demonstration. In the event that the state conducts additional consultation activities consistent with these requirements prior to the implementation, documentation of these activities will be provided to CMS.

15. Federal Financial Participation. No federal matching funds for expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter.

IV. ELIGIBILITY

16. Eligibility Criteria. Mandatory and optional Medicaid state plan populations derive their eligibility through the Medicaid state plan, and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan, except as expressly waived and as described in these STCs. The demonstration affects the Basic Medicaid for Able Bodied Adults population, as defined below, and provides for coverage of an expansion population for individuals with certain disabling mental illnesses..

17. The section 1115 demonstration affects the following eligibility groups

18. a. Eligibility Group under the State plan:

a. Able Bodied Adults. Individuals who are eligible as Family Medicaid or Transitional Medicaid under sections 1925 and 1931 of the Act, are age 21 through 64, and who are not pregnant or disabled.

b. Demonstration Group: Waiver for Mental Health Services Plan Program (WMHSP) Enrollees - Individuals aged 18 through 64, with incomes at or below 150 percent of the FPL, who have been diagnosed with a severe disabling mental illness of schizophrenia, bipolar disorder, or major depression, who at the time of their enrollment were receiving a limited mental health services benefit package

through enrollment in the state-financed Mental Health Service Plan (SMHSP), but are otherwise ineligible for Medicaid benefits.

V. BENEFITS

18. Benefits for Able Bodied Adults and WMHSP Enrollees. All individuals enrolled in the demonstration will receive all Medicaid state plan services excluding: audiology, dental and denturist, medical equipment, eyeglasses, optometry and ophthalmology for routine eye exams, personal care services, and hearing aids. Effective January 1, 2014, home infusion will be a covered service.

19. Allowances / Special Circumstances. Coverage for the excluded services may be provided under the following circumstances:

- a. Services may be pre-approved by the state in cases of emergency or when essential to obtain or maintain employment. When this occurs, the state will make available associated records upon request by CMS. Examples of emergency circumstances include, but are not limited to coverage for emergency dental situations, medical conditions of the eye (e.g., annual dilated eye exams for individuals with diabetes or other medical conditions), and certain medical supplies (e.g., diabetic supplies, prosthetic supplies, oxygen).
- b. Services are age-appropriate EPSDT services.

20. Changes to the State Plan Benefits or to Other Demonstrations Integrated with the Able-Bodied Demonstration.

- a. During each monthly monitoring call, the state will discuss with CMS (Central and Regional Offices) proposed state plan amendments (SPAs) or changes to other waivers/demonstrations (e.g., PASSPORT To Health), which are integrated with the Able-Bodied demonstration and would impact the demonstration enrollees. The discussion would include the intent of the amendment; anticipated programmatic and fiscal impacts; and intended submission and implementation dates.
- b. CMS reserves the right to require the state to submit an amendment if it is determined that it is warranted.

21. Cost-Effective Insurance. When a WMHSP-eligible individual has access to cost-effective health coverage through a cost-effective group health plan, the state may obtain benefits for the individual by providing premium assistance to the individual for this purpose in accord with the state plan for the provision of alternative cost effective coverage authorized for state plan eligible populations under section 1906 of the Act.

VI. ENROLLMENT

22. General Requirements

- a. Unless otherwise specified in these STCs, all processes for eligibility, enrollment, redeterminations, terminations, appeals, etc. must comply with federal law and regulations governing Medicaid and CHIP.
- b. Any individual who is denied eligibility in any health coverage program authorized under this demonstration must receive a notice from the state that gives the reason for denial, and includes information about the individual's right to appeal.
- c. The state will adhere to the demonstration population enrollment limits presented in section IV *Eligibility*.

23. Enrollment of Able Bodied Adults. Upon determination of Medicaid eligibility, Able-Bodied Adults (as defined in paragraph 17(a)) will be enrolled in the demonstration. Enrollment for this population will not be capped.

24. Imposing WMHSP Waiver Enrollment Limit and Lifting Enrollment Limit. Upon approval of these STCs, the state will facilitate enrollment of up to 2000 eligible individuals into the WMHSP demonstration population. With 30 days prior notice, the state may impose an enrollment cap upon the WMHSP demonstration population of less than 2000 in order to phase in enrollment and remain under the budget neutrality limit/ceiling for expenditures established for the demonstration. The state must submit an amendment to this demonstration in order to increase WMHSP enrollment above 2000 slots.

25. Prioritization for WMHSP Waiver Enrollment. The state will enroll individuals into the WMHSP program using the following process:

- a. The individual meets the financial and clinical eligibility criteria established for the SMHSP program, and is enrolled in the SMHSP program.
- b. Priority of SMHSP enrolled individuals being moved into the WMSHP demonstration will be based upon a current primary diagnosis of schizophrenia. At the state's discretion, available slots in the demonstration will then be open to eligible individuals with bipolar disorder. The state may then open enrollment of any remaining slots to individuals with a diagnosis of major depression.
- c. To initially phase in enrollment, or at such time as the number of eligible individuals exceeds the number of available slots, the state will use a computer based random drawing to select the individuals (based on priority of diagnosis established in subparagraph b) to fill the available statewide slots.

26. Enrollment into PASSPORT to Health, Enhance Primary Care Case Management, and Nurse First. The state may enroll demonstration-eligibles into the PCCMs and Nurse First Advice Line. By cross-reference, the enrollment, benefits, and cost sharing in

the associated CMS-approved state plan in place as of the effective date of these STCs will apply to this demonstration.

VII. COST-SHARING

27. Cost-sharing. All demonstration-enrolled individuals will be subject to the Medicaid cost-sharing requirements as set forth in the state plan.

VIII. DELIVERY SYSTEMS

28. Freedom of Choice of Health Care Providers. Individuals enrolled in the demonstration:

- a. May also be enrolled in the PASSPORT to HEALTH Managed Care Program and/or the Enhanced Primary Case Management Program, which are Montana Medicaid's primary care case management (PCCM) programs. Under the PCCM programs, Medicaid clients are required to choose one primary care provider and develop an ongoing relationship that provides a "medical home." With some exceptions, all services to PCCM program enrollees must be provided or approved by the individual's primary care provider.
- b. Who are not enrolled in the Montana PCCM programs may receive a covered benefit from any provider participating with the Montana Medicaid program.
- c. Who are enrolled in the Nurse First Nurse First Advice Line may receive covered benefits from the one Disease Management Organization.

29. Delivery System of a Cost-Effective Insurance Plan. Demonstration-enrolled individuals receiving services through a cost-effective insurance plan will receive plan-covered services through the delivery systems provided by their respective insurance plan and additional services as necessary to ensure access to the full benefit package otherwise available. All additional services may be obtained from any physical or mental health provider participating with the Montana Medicaid program.

IX. GENERAL REPORTING REQUIREMENTS

30. General Financial Requirements. The state must comply with all general financial requirements under title XIX set forth in this section.

31. Reporting Requirements Relating to Budget Neutrality. The state shall comply with all reporting requirements for monitoring budget neutrality as set forth in section XI. The state must submit any corrected budget neutrality data upon request.

32. Compliance with Managed Care Reporting Requirements. The state will comply with all applicable managed care regulation at 42 CFR 438 *et seq* for demonstration-eligible individuals enrolled in the PCCM program. A status update on the PCCM,

including a discussion of recent developments, problems encountered and steps taken to resolve them, must be included in each Annual Report.

33. Monitoring Calls. CMS shall schedule monthly conference calls with the state to ascertain progress and issues related to implementation of the MHSP component of the demonstration. Once start-up issues and concerns are resolved (at approximately 6 months post-implementation), the state and CMS may resume quarterly monitoring calls. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Areas to be addressed include, but are not limited to, health care delivery, enrollment, quality of care, access, benefits, audits, lawsuits, financial reporting and budget neutrality issues, progress on evaluations, state legislative developments, and any demonstration amendments, concept papers or state plan amendments the state is considering submitting. The state and CMS shall discuss quarterly expenditure reports submitted by the state for purposes of monitoring budget neutrality. CMS shall update the state on any amendments or concept papers under review as well as federal policies and issues that may affect any aspect of the demonstration. The state and CMS shall jointly develop the agenda for the calls.

34. Quarterly Progress Reports. The state must submit progress reports in accordance with the guidelines in Attachment A no later than 60 days following the end of each quarter. The intent of these reports is to present the state's analysis and the status of the various operational areas. These quarterly reports must include, but not be limited to:

- a. An updated budget neutrality monitoring spreadsheet;
- b. A discussion of events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including, but not limited to: approval and contracting with new plans, benefits, enrollment and disenrollment, grievances, quality of care, access, health plan contract compliance and financial performance that is relevant to the demonstration, pertinent legislative or litigation activity, and other operational issues;
- c. Action plans for addressing any policy, administrative, or budget issues identified;
- d. Quarterly enrollment reports for demonstration-eligibles, that include the member months and end of quarter, point-in-time enrollment for each demonstration population, and other statistical reports listed in Attachment A; and
- e. Evaluation activities and interim findings.

35. Transition Plan. The state is required to prepare, and incrementally revise a Transition Plan consistent with the provisions of the ACA for individuals enrolled in the demonstration, including how the state plans to coordinate the transition of these individuals to a coverage option available under the ACA without interruption in coverage to the maximum extent possible. The state must submit progress updates included in each quarterly report. The state will revise the Transition Plan as needed.

36. Annual Report. In lieu of the fourth quarter report, the state must submit an annual report. The state must submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, interim evaluation findings, and policy and administrative difficulties and solutions in the operation of the demonstration. The state must submit the draft annual report no later than 120 days after the close of the demonstration year (DY). Within 30 days of receipt of comments from CMS, a final annual report must be submitted.

X. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

37. Quarterly Expenditure Reports for Title XIX. The state must provide quarterly expenditure reports using Form CMS-64 to separately report total expenditures for services provided through this demonstration under section 1115 authority that are subject to budget neutrality. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS shall provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section IX.

38. Expenditures Subject to the Title XIX Budget Neutrality Expenditure Limit. All expenditures for health care services for demonstration participants (as defined in section IV above) are subject to the budget neutrality expenditure limit.

39. Accounting for Enrollment and Expenditures of Demonstration Populations. All enrollment and expenditures of Able-Bodied Adults and WMHSP individuals enrolled in the PCCM PASSPORT to Health and the Nurse First Disease Management programs will be attributable to this demonstration and reported in accord with section IX, X, and XI. The enrollment and expenditures of Able-Bodied Adults and WMHSP individuals enrolled in these programs will not be included in the state's 1915(b) reports.

40. Reporting Expenditures Subject to the Title XIX Budget Neutrality Expenditure Limit. The following describes the reporting of expenditures subject to the budget neutrality expenditure limit:

- a. **Use of Waiver Forms.** In order to track expenditures under this demonstration, the state must report demonstration expenditures through the Medicaid and Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the state Medicaid Manual (SMM). All demonstration expenditures claimed under the authority of title XIX of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration Project Number (11-W-00181/8) assigned by CMS.
- b. **Reporting By Date of Service.** In each quarter, demonstration expenditures (including prior period adjustments) must be totaled and reported on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver by demonstration Year (DY). The

DY for which expenditures are reported is identified using the project number extension (a 2-digit number appended to the demonstration Project Number). Expenditures are to be assigned to DYs on the basis of date of service. The date of service for premium or premium assistance payments is identified as the DY that accounts for the larger share of the coverage period for which the payment is made. DY 1 will correspond to the period of February 1, 2004 through January 31, 2005, DY 2 with the period of February 1, 2005 through January 31, 2006, and so on.

- c. **Waiver Name.** For each demonstration quarter, separate Forms CMS-64.9 Waiver and/or 64.9P Waiver must be completed to report expenditures for the following demonstration populations. The waiver names to be used to identify these separate Forms CMS-64.9 Waiver and/or 64.9P Waiver appear in bold following the colon. Expenditures should be allocated to these forms based on the guidance provided in these STCs.
- i. **Demonstration Population 1: Able-Bodied Adults**—Eligibility Group (EG) consists of parent / caretaker relative adults whose Medicaid eligibility derives from their status as an optional Medicaid population under section 1925 or 1931 of the Act – counted in the “with” and “without” waiver calculations.
 - ii. **Demonstration Population 2: WMHSP** —EG consists of enrolled WMHSP adults who are only eligible with section 1115 demonstration authority (Title XIX demonstration-eligible expansion population) – counted only in the “with” waiver calculations.
- d. **Premiums and Cost Sharing Adjustments.** Premiums and other applicable cost-sharing contributions that are collected by the state from enrollees under the demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet Line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, premium and cost-sharing collections (both total computable and federal share) should also be reported separately by DY on the Form CMS-64 Narrative, and divided into subtotals corresponding to the eligibility groups (EGs) from which collections were made. In the calculation of expenditures subject to the budget neutrality expenditure limit, premium collections applicable to demonstration populations shall be offset against expenditures. These section 1115 premium collections will be included as a manual adjustment (decrease) to the demonstration’s actual expenditures on a quarterly basis.
- e. **Cost Settlements.** For monitoring purposes, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any cost settlements not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the state Medicaid

Manual.

- i. **Prescription Drug Rebates.** Prescription drug rebates were not included in the original PMPM for Able-Bodied Adults. While the state collects prescription drug rebates on this population and the WMHSP population, the state does not include such rebates in the expenditure reports either as a credit or as an offset of prescription drug expenditures. This process will continue for the extension of the demonstration covered by these special terms and conditions.

An amendment would be necessary should the state wish to attribute a portion of the Prescription Drug Rebate to expenditures for populations included in the Basic demonstration. The amendment would need to include a rebasing the PMPM costs to include prescription drug costs and a proposed methodology for assigning a portion of prescription drug rebates to the demonstration, in a way that reasonably reflects the actual rebate-eligible utilization of the demonstration population, and which reasonably identifies prescription drug rebate amounts with DYs. Consistent with section 1115 demonstrations, the use of the methodology is subject to the approval in advance by the CMS Regional Office, and changes to the methodology must also be approved in advance by the Regional Office. The portion of prescription drug rebates assigned to the demonstration using the approved methodology will be reported on the appropriate Forms CMS-64.9 Waiver for the demonstration, and not on any other CMS-64.9 form (to avoid double-counting). Each rebate amount must be distributed as state and federal revenue consistent with the federal matching rates under which the claim was paid.

- ii. **Federally Qualified Health Center Settlement Expenses.** Within 60 days of this award, the state must propose to the CMS Regional Office a methodology for identifying the portion of any FQHC settlement expenses that should be reported as demonstration expenditures because of a linkage between settlement payments to FQHCs and use of FQHC services by demonstration participants. Once the methodology is approved by the Regional Office, the state will reported the amounts of FQHC settlement payments identified on the appropriate Forms CMS-64.9 and 64.9P Waiver.
- iii. **Indian Health Services.** The following rules govern reporting of Indian Health Service (IHS) expenditures subject to the 100 percent federal matching for Able-Bodied Adults and WMHSP eligibles.
 1. Because IHS expenditures were excluded from the original calculation of the without-waiver PMPM costs estimates for Able-Bodied Adults, the state must report IHS expenditures for Able-Bodied Adults on forms CMS-64.9 Waiver and 64.9P Waiver,

under waiver name “IHS” and with project number extension “NA.” This is an exception to the instructions for reporting Able-Bodied Adults’ expenditures in subparagraphs (b) through (d) above.

2. Because IHS expenditures for WMHSP eligibles are costs not otherwise matchable, they are necessarily demonstration expenditures. For this reason, the state must report these expenditures on forms CMS-64.9 Waiver and 64.9P Waiver under waiver name “WMHSP Adults,” following the instructions in subparagraphs (b) through (d).

41. Title XIX Administrative Costs. Administrative costs will not be subject to the budget neutrality expenditure limit, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration. All such administrative costs will be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver, using waiver name “Montana Basic Medicaid for Able-Bodied Adults.”

42. Claiming Period. All claims for expenditures subject to the budget neutrality expenditure limit (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

43. Standard Medicaid Funding Process. The standard Medicaid funding process shall be used during the demonstration. The state must estimate matchable Medicaid expenditures on the quarterly form CMS-37. In addition, the estimate of matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality agreement must be separately reported by quarter for each FFY on the form CMS-37.12 for both the medical assistance program and administrative costs. CMS shall make federal funds available based upon the state’s estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

44. Extent of Title XIX FFP for the Demonstration. Subject to CMS approval of the source(s) of the non-federal share of funding, CMS shall provide FFP at the applicable federal matching rates for the demonstration as a whole as outlined below, subject to the limits described in Section IX:

- a. Administrative costs, including those associated with the administration of the demonstration;
- b. Net expenditures and prior period adjustments, made under approved expenditure authorities, with dates of service during the operation of the demonstration

45. Sources of Non-Federal Share. The state certifies that the source of non-federal share of funds for the demonstration is state/local monies. The state further certifies that such funds shall not be used as the non-federal share for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with title XIX of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

- a. CMS shall review the sources of the non-federal share of funding for the demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.
- b. The state shall provide information to CMS regarding all sources of the non-federal share of funding for any amendments that impact the financial status of the program.
- c. Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the state as demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the state and/or local government to return and/or redirect any portion of the Medicaid or demonstration payments. This confirmation of Medicaid and demonstration payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes (including health care provider-related taxes, fees, and business relationships with governments that are unrelated to Medicaid or the demonstration and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid or demonstration payment.

46. Maintenance of Effort for the WMHSP Population. In order to expand the Able-Bodied section 1115 demonstration to include up to 2000 individuals who are not otherwise Medicaid eligible, Montana must provide the same level of state funding (referred to as Maintenance of Effort (MOE)) for the continued provision of health services to this population.

- a. **WMHSP Claiming.**
 - i. During state fiscal year (SFY) 2009, the state's expenditures for health benefits provided to the over 3,400 individuals in the state-only MHSP program was \$8,860,518.

- ii. The state must determine the total reported health benefit expenditures for WMHSP enrolled individuals for each SFY, and in each annual report provide assurance to CMS that state expenditures for WMHSP and MHSP will be maintained at the SFY 2009 level.
- iii. The state is not eligible to claim the increased FFP established under the American Recovery and Reinvestment Act of 2009 for the WMHSP population.
- iv. The state is not eligible to claim the increased FFP established under the Affordable Care Act for this WMHSP population.

47. Monitoring the Demonstration. The state will provide CMS with information to effectively monitor the demonstration, upon request, in a reasonable timeframe.

XI. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

48. Limit on Title XIX Funding. The state shall be subject to a limit on the amount of federal title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit is determined by using a per capita cost method. The budget neutrality expenditure targets are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. Actual expenditures subject to the budget neutrality expenditure limit shall be reported by the state using the procedures described in paragraph 39.

49. Risk. The state assures that the demonstration expenditures do not exceed the level of expenditures had there been no demonstration.

- a. The state will be at risk for the per capita cost (as determined by the method described in this Section) for Medicaid eligibles in the following eligibility group(s): “Able-Bodied Adults,” but not for the number of individuals enrolled in the group(s). By providing FFP for enrollees in the specified group(s), the state will not be at risk for changing economic conditions that impact enrollment levels.
- b. The state will be at risk, under this budget neutrality agreement, for both the number of enrollees as well as the per capita cost for the following expansion populations enrolled in the demonstration: enrolled WMHSP individuals.

50. Budget Neutrality Expenditure Limit. The following describes how the annual budget neutrality expenditure limits are determined:

- a. For each DY of the budget neutrality agreement, an annual target is calculated as the projected per member per month (PMPM) cost for Able-Bodied Adults times the actual number of member months (reported by the state in accordance with paragraph 33)

- b. Member months for WMHSP eligibles are not used for calculation of the budget neutrality expenditure limit.
- c. The following table gives the projected PMPM costs for the calculation described in paragraph 50(a) by DY.

Table 1: Historical PMPM Costs for Determining the Budget Neutrality Ceiling

	DY 1 PMPM	DY 2 PMPM	DY 3 PMPM	DY 4 PMPM	DY 5 PMPM
Able-Bodied Adults	\$294.21	\$316.87	\$341.27	\$367.54	\$395.84

Table 2: Projected PMPM Costs for Determining the Budget Neutrality Ceiling

	DY 6 PMPM (2/1/09 – 1/31/10)	DY 7 PMPM* (2/1/10 – 1/31/11)	DY 8 PMPM (2/1/11 – 1/31/12)	DY 9 PMPM (2/1/12 – 1/31/13)	DY 10 PMPM (2/1/13 – 12/31/13)
Able-Bodied Adults	\$426.32 7.7%	\$459.15 7.7%	\$481.73 6.3%	\$512.08 6.3%	\$544.34 6.3%
		\$453.18 6.3%			

	DY 11 PMPM (1/1/14 - 12/31/14)	DY 12 PMPM (1/1/15 – 12/31/15)	DY 13 PMPM (1/1/16 – 12/31/16)
Able-Bodied Adults	\$571.56 5.0%	\$600.14 5.0%	\$630.15 5.0%

- d. The budget neutrality expenditure limit is the federal share of the annual PMPM limits for the demonstration period, and represents the maximum amount of FFP that the state may receive for title XIX expenditures during the demonstration period, as described in paragraph X.3. The budget neutrality expenditure limit is

equal to the sum of all of the subcomponents described in (a)(1) above for all DYs, times the composite federal share (defined in (e) below).

- e. The composite federal share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period, as reported through the MBES/CBES and summarized on Schedule C by total computable demonstration expenditures for the same period as reported on the same forms. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of composite federal share may be developed and used through the same process or through an alternative mutually agreed upon method.

51. Future Adjustments to the Budget Neutrality Expenditure Limit. CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under this demonstration. CMS reserves the right to make adjustments to the budget neutrality expenditure limit if any health care-related tax that was in effect during the base year with respect to the provision of services covered under this demonstration, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care-related tax provisions of section 1903(w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

52. Enforcement of Budget Neutrality. CMS shall enforce budget neutrality over the life of the demonstration rather than on an annual basis. However, if the state exceeds the calculated cumulative target limit by the percentage identified below for any of the DYs, the state shall submit a corrective action plan to CMS for approval.

Year	Cumulative target definition	Percentage
DY 1	DY 1 budget neutrality cap	+8.0 percent
DY 2	DYs 1 and 2 combined budget neutrality limit	+3.0 percent
DY 3	DYs 1 through 3 combined budget neutrality limit	+1.0 percent
DY 4	DYs 1 through 4 combined budget neutrality limit	+0.5 percent
DY 5	DYs 1 through 5 combined budget neutrality limit	0 percent
DY 6	DYs 1 through 6 combined budget neutrality limit	+2.5 percent
DY 7	DYs 1 through 7 combined budget neutrality limit	+0.75 percent
DY 8	DYs 1 through 8 combined budget neutrality limit	0 percent
DY 9	DYs 1 through 9 combined budget neutrality limit	+2.5 percent
DY 10	DYs 1 through 10 combined budget neutrality limit	+.75 percent
DY 11	DYs 1 through 11 combined budget neutrality limit	0 percent
DY 12	DYs 1 through 12 combined budget neutrality limit	0 percent

53. Exceeding Budget Neutrality. If the budget neutrality expenditure limit has been exceeded at the end of this demonstration period, the excess federal funds shall be

returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.

XII. EVALUATION OF THE DEMONSTRATION

- 54. Submission of Draft Evaluation Design.** The state must submit to CMS for approval a draft evaluation design for an overall evaluation of the demonstration no later than 120 days after the effective date of the demonstration. At a minimum, the draft design must include a discussion of the goals and objectives set forth in Section II of these STCs, as well as the specific hypotheses that are being tested. The draft design must discuss the outcome measures that will be used in evaluating the impact of the demonstration during the period of approval. It shall discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the demonstration must be isolated from other initiatives occurring in the state. The draft design must identify whether the state will conduct the evaluation, or select an outside contractor for the evaluation.
- 55. Inclusion of the WMHSP Population into the Evaluation Design.** The state will submit an addendum to the Draft Evaluation Design previously submitted for the Montana Basic Medicaid for Able-Bodied Adults demonstration. The revised Draft Evaluation Design that incorporates the WMHSP addendum will be submitted to CMS for approval no later than 60 days after CMS's approval of the WMHSP program.
- 56. Interim Evaluation Reports.** In the event the state requests to extend the demonstration beyond the current approval period under the authority of section 1115(a), (e), or (f) of the Act, the state must submit an interim evaluation report as part of the state's request for each subsequent renewal.
- 57. Final Evaluation Design and Implementation.** CMS will provide comments on the draft evaluation design within 60 days of receipt, and the state shall submit a final design within 60 days after receipt of CMS comments. The state must implement the evaluation design and submit its progress in each of the quarterly and annual progress reports. The state must submit to CMS a draft of the evaluation report within 120 days after expiration of the demonstration. CMS must provide comments within 60 days after receipt of the report. The state must submit the final evaluation report within 60 days after receipt of CMS comments.
- 58. Final Evaluation Report.** The state must submit to CMS a draft of the evaluation report within 120 days after expiration of the demonstration. CMS must provide comments within 60 days after receipt of the report. The state must submit the final evaluation report within 60 days after receipt of CMS' comments.
- 59. Cooperation with Federal Evaluators.** Should CMS undertake an independent evaluation of any component of the demonstration, the state shall cooperate fully with

CMS or the independent evaluator selected by CMS. The state shall submit the required data to CMS or the contractor.

XIII. HEALTH INFORMATION TECHNOLOGY

60. Health Information Technology (Health IT). The State will use HIT to link services and core providers across the continuum of care to the greatest extent possible. The State is expected to achieve minimum standards in foundational areas of HIT and to develop its own goals for the transformational areas of HIT use.

- a. Health IT: Arkansas must have plans for health IT adoption for providers. This will include creating a pathway (and/or a plan) to adoption of certified EHR technology and the ability to exchange data through the State’s health information exchanges. If providers do not currently have this technology, there must be a plan in place to encourage adoption, especially for those providers eligible for the Medicare and Medicaid EHR Incentive Program.
- b. The State must participate in all efforts to ensure that all regions (e.g., counties or other municipalities) have coverage by a health information exchange. Federal funding for developing HIE infrastructure may be available, per State Medicaid Director letter #11-004, to the extent that allowable costs are properly allocated among payers. The State must ensure that all new systems pathways efficiently prepare for 2014 eligibility and enrollment changes.
- c. All requirements must also align with Arkansas’ State Medicaid HIT Plan and other planning efforts such as the ONC HIE Operational Plan.

XIV. T-MSIS REQUIREMENTS

61. On August 23, 2013, a State Medicaid Director Letter entitled, “Transformed Medicaid Statistical Information System (T-MSIS) Data”, was released. It states that all States are expected to demonstrate operational readiness to submit T-MSIS files, transition to T-MSIS, and submit timely T-MSIS data by July 1, 2014. Among other purposes, these data can support monitoring and evaluation of the Medicaid program in Arkansas against which the premium assistance demonstration will be compared.

Should the MMIS fail to maintain and produce all federally required program management data and information, including the required T-MSIS, eligibility, provider, and managed care encounter data, in accordance with requirements in the State Medicaid Manual Part 11, FFP may be suspended or disallowed as provided for in federal regulations at 42 CFR 433 Subpart C, and 45 CFR Part 95.

XV. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION EXTENSION

STC	Deliverable
Within 30 days of the date	state acceptance of demonstration Waivers, STCs, and

of award	Expenditure Authorities (approval letter)
In compliance with paragraph 54.	Submit Draft Design for Final Evaluation Report
Within 60 days of the date of award (paragraph 55).	Submit the WMHSP addendum to the Draft Evaluation Design
Monthly Deliverables	Deliverable
In compliance with paragraph 33 .	Monitoring Call
In compliance with paragraph 47.	Monthly Enrollment Report
Quarterly Due 60 days after the end of each quarter, except the 4th quarter	Deliverable
In compliance with paragraph 34.	Quarterly Progress Reports
In compliance with paragraph 34.d.	Quarterly Enrollment Reports
In compliance with section 37.	Quarterly Expenditure Reports
Annual Due 60 days after the end of the 4th quarter	Deliverable
In compliance with paragraph 36.	Draft and Final Annual Reports (Annual Progress Reports and Annual Expenditure Reports)
Other	Deliverable
In compliance with paragraph 35.	Submit a Transition Plan
120 days after expiration of the demonstration per paragraph 58.	Submit Draft Final Evaluation Report
Within 60 days after receipt of CMS comments per paragraph 58.	Submit Final Evaluation Report

ATTACHMENT A

QUARTERLY REPORT FORMAT AND CONTENT

Under Section VII, paragraph XX, the state is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the state. A complete quarterly progress report must include an updated budget neutrality monitoring workbook.

NARRATIVE REPORT FORMAT:

Title Line One – Montana Basic Section 1115 Medicaid Demonstration

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Example:

Demonstration Year: 1 (January 1, 2010 – December 31, 2010)

Federal Fiscal Quarter: 01/01/2010 – 03/31/2010

Introduction

Information describing the goal of the demonstration, what it does, and key dates of approval/operation. (This should be the same for each report.)

Enrollment Information

Please complete the following table that outlines all enrollment activity under the demonstration. The state should indicate “N/A” where appropriate. If there was no activity under a particular enrollment category, The state should indicate that by “0”.

Enrollment Count

Note: Enrollment counts should be person counts, not member months.

Demonstration Populations (as hard coded in the CMS 64)	Current Enrollment (last day of quarter)	Newly Enrolled in Current Quarter	Disenrolled in Current Quarter
Able-Bodied Adults			
WMHSP Adults			
<ul style="list-style-type: none">Schizophrenia			
<ul style="list-style-type: none">Bipolar Disorder			
<ul style="list-style-type: none">Major Depression			

Member Month Reporting

Enter the member months for the quarter.

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
Able-Bodied Adults				
WMHSP Adults				
• Schizophrenia				
• Bipolar Disorder				
• Major Depression				

Outreach/Innovative Activities:

Summarize outreach activities and/or promising practices for the current quarter.

Operational/Policy Developments/Issues:

Identify all significant program developments/issues/problems that have occurred in the current quarter, including, but not limited to, approval and contracting with new plans, benefit changes, and legislative activity.

Financial/Budget Neutrality Developments/Issues:

Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS-64 reporting for the current quarter. Identify the state’s actions to address these issues. Specifically, provide an update on the progress of implementing the corrective action plan.

Consumer Issues:

A summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences.

Quality Assurance/Monitoring Activity:

Identify any quality assurance/monitoring activity in current quarter.

Status of Benefits and Cost Sharing:

Provide update regarding any changes to benefits or cost sharing during the quarter.

Demonstration Evaluation:

Discuss progress of evaluation design and planning.

Enclosures/Attachments:

Identify by title any attachments along with a brief description of what information the document contains.

State Contact(s):

Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise.

Date Submitted to CMS:



MONTANA DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

Mary E. Dalton, State Medicaid Director

Section 1115 Basic Medicaid Waiver Renewal

June 28, 2013 Submittal

Effective February 1, 2014

MONTANA
1115 BASIC MEDICAID WAIVER RENEWAL
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SECTION 1115 BASIC MEDICAID WAIVER DEMONSTRATION AMENDMENT RENEWAL EXECUTIVE SUMMARY

The State of Montana, Department of Public Health and Human Services (DPHHS), requests to renew the existing section 1115 Basic Medicaid Waiver. The waiver will continue to provide Basic Medicaid coverage, which was originally designed in 1996 to replicate a basic health plan benefit as a welfare reform waiver, for Able Bodied Adults. Montana will use the generated Federal waiver savings to provide Basic Medicaid coverage for up to 2,000 individuals with schizophrenia, bi-polar disorder, and major depressive disorder. These 2,000 individuals were previously eligible for the State-funded program known as the Mental Health Services Plan Program (MHSP). MHSP participants received a limited mental health and pharmacy benefit and no physical health benefit.

Waiver Renewal:

This renewal requests to continue the 1115 Basic Medicaid Waiver as currently operated with the following notable changes: add 1,200 MHSP Waiver individuals (for a total of 2,000); update the diagnosis codes for schizophrenic disorder, bipolar disorder and major depressive disorder; add major depressive disorder as a waiver diagnosis; include home infusion as a covered service; update the waiver population PMPM and cost data; include the CMS approved evaluation design; and update general waiver language.

Public Notice:

A Tribal Consultation letter was sent on May 15, 2013. A public notice was published in newspapers on May 19, 2013. On May 20, 2013 a public notice was mailed electronically to individuals who have expressed interest in Medicaid Administrative Rule changes. Beginning on May 20, 2013, information regarding the Basic Medicaid Renewal was posted on the DPHHS website, which included the CMS 1115 waiver website link, current evaluation design and goals, our public notice process, the public input process, invitations and details to two public meetings, the application with noted changes, and minutes to the public meetings. A public meeting was held on May 23, 2013 at the Mental Health Oversight Advisory Council in Helena, Montana and a public meeting was held on May 24, 2014 in Billings, Montana. The latter meeting was broadcast as a WebEx so people around the State could participate. A memo to the Health Advisory Committee, the Montana Health Coalition, was emailed on May 29, 2013. A presentation was made on to the Children, Families, Health and Human Services Interim Committee on June 25, 2013. These public notice items may be found at <http://medicaidprovider.hhs.mt.gov/waiver/index.shtml>.

Waiver Populations:

This Section 1115 Basic Medicaid Waiver renewal amends the December 2010 approved waiver. This amendment includes about 8,800 Able Bodied Adults under Section 1931 and 1925 of the Act, who are not pregnant, aged, blind or disabled, with incomes at or below 33% of the Federal Poverty Level (FPL), as described in the current Basic Medicaid Waiver. This renewal requests to increase the number of individuals referred to as "MHSP Waiver" from "up to 800 individuals" to "up to 2,000" individuals. Previously, these individuals qualified for the State only Mental Health Services Plan Program, had schizophrenia or bipolar disorder, were at least 18 years of age, and who were a resident of Montana with incomes at or below 150% FPL. Montana requests to add individuals with major depressive disorder as a waiver diagnosis. MHSP Waiver individuals with schizophrenia will be enrolled first, to reach the estimated 467 total individuals with schizophrenia. The remaining waiver openings will be filled through a computer based random drawing, first with individuals who have bipolar disorder, then major

depressive disorder, until we reach 2000 total individuals. Montana will continually analyze waiver sustainability.

This renewal of the Basic Medicaid Waiver will allow Montana to continue Basic Medicaid benefits for about 8,800 Able Bodied Adults and for 800 individuals with schizophrenia and bipolar disorder. The renewal will offer Basic Benefits to an additional 1,200 MHSP Waiver individuals, which includes both physical and mental benefits, for (up to) 2,000 Montanans who, without the Basic Medicaid Waiver, have a very limited mental health only benefit through the State only Mental Health Services Plan.

Basic Medicaid Benefit and Excluded Services:

The Basic package is the Full Medicaid benefit, with the following medical services generally excluded: audiology, dental and denturist, durable medical equipment, eyeglasses, optometry and ophthalmology for routine eye exams, personal care services, and hearing aids. Under the original 1996 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.

Basic Medicaid Allowances/Special Circumstances:

DPHHS recognizes there may be situations where the excluded services are necessary as in an emergency or when essential for employment. Coverage for the excluded services may be provided at the State's discretion in cases of emergency or when essential to obtain or maintain employment. Examples of emergency circumstances include, but are not limited to, coverage for emergency dental situations, medical conditions of the eye, which include but are 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 will provide approval to the provider, and make associated records available upon CMS request.

Employer Sponsored Insurance or Private Health Insurance:

Currently, 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 the analysis is considered cost effective, Medicaid pays the client's premium, cost share, deductibles, and wrap around services. The Medicaid client is only responsible for the Medicaid cost share. This benefit is available to the Basic Medicaid Waiver population in the same manner.

Basic Medicaid Cost Share:

All waiver individuals age 21 and older will pay nominal cost share for Basic Medicaid benefits; individuals younger than age 21 do not pay cost share for Basic Medicaid benefits.

Figure I. Montana’s Amendment Population Summary

Able Bodied Adults = Mandatory MHSP Waiver = Expansion			Funding Source		Benefit Package		Cost Sharing	
Demonstration Population	Number of Clients	Financial Eligibility	Current	Proposed	Current	Proposed	Current	Proposed
1) Able Bodied Adults Act Sections 1925 and 1931 Mandatory 8,800 33% FPL	8,800 Not Capped	Section 1925 or 1931(b)	Title XIX and State match	No change	Basic Medicaid Services	No change	Same as State Plan Medicaid	No change
2) MHSP Waiver Expansion 800 150% FPL	2,000 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 2) MHSP Waiver. Federal Spending: Budget Neutrality Surplus from the existing 1115 Basic Medicaid Waiver will be used to cover MEG 2) MHSP Waiver.	Limited Mental Health Benefits, up to \$425 Mental Health Prescription Drugs, PACT, and 72 Hour Services.	Basic 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 prescription drug.	Basic Medicaid is minimal, the same as State Plan Full Medicaid. Employer Sponsored or Private Health Insurance would vary depending on the plan.

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. We have projected State and Federal expenditures for DY11 (2/14 – 1/15) – DY13 (2/16 – 1/17) and can sustain these populations through January 2017.

The accumulated Federal Basic Medicaid Waiver savings from DY1 – DY9, February 1, 2004 through January 31, 2013 is estimated at \$80 million. (Providers have 365 days from date of service to file claims.) The total February 2014 through January 2017 State and Federal cost for 2,000 MHSP Waiver individuals is estimated at \$89,401,241 and \$59,103,161 Federal, and \$30,298,081 State.

Figure V. State and Federal Waiver Benefit Costs:

	2/2014 -1/2015	2/2015 -1/2016	2/2016 -1/2017	Renewal Total
	DY11	DY12	DY13	
Cumulative Federal Variance	\$84,947,227	\$71,393,386	\$50,462,914	\$50,462,914
Federal Variance	\$4,731,207	\$5,040,628	\$2,125,180	\$109,566,075
Total Federal and State MHSP Waiver Benefit Costs	\$26,400,000	\$28,126,560	\$34,874,681	\$89,401,241
Total Federal Waiver Benefit Costs	\$17,453,040	\$18,594,469	\$23,055,652	\$59,103,161
Total State Waiver Benefit Costs	\$8,946,960	\$9,532,091	\$11,819,030	\$30,298,081

Reporting:

The Basic Medicaid Waiver’s goal is to continue to provide Basic Medicaid coverage, which was originally designed in 1996 to replicate a basic health plan benefit as a welfare reform waiver, for Able Bodied Adults. Montana will use the generated Federal waiver savings to provide Basic Medicaid coverage for up to 2,000 individuals with schizophrenia, bi-polar disorder, and major depressive disorder. These 2,000 individuals were previously eligible for the State-funded program known as the Mental Health Services Plan Program (MHSP). MHSP participants received a limited mental health and pharmacy benefit and no physical health benefit. We will study the effectiveness of our objectives through the described data measurements and reports to CMS. See Figure VII. Waiver Reporting Deliverables.

Conclusion:

Currently, individuals enrolled in the State only Mental Health Services Plan have a limited mental health benefit, a \$425 mental health prescription drug benefit, but no physical health care. MHSP individuals often have physical health care complications that go untreated until emergent care is needed or they reach a level of disability. MHSP Waiver Montanans served under this Section 1115 Basic Medicaid Waiver will greatly reduce their out-of-pocket costs and gain access to significant health care benefits. Without granting approval of the Section 1115 Basic Medicaid Waiver renewal request, Montana will not be able to provide an expanded health care benefit package.

I. BASIC MEDICAID WAIVER HISTORY

Basic Medicaid Wavier 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 Wavier 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. The Basic Medicaid Waiver is a type of health care reform; it resembles a basic health plan benefit. Optional excluded (to the defined eligibility group) services will be preserved for elderly, disabled or pregnant Medicaid beneficiaries. The 1115 Basic Medicaid Waiver is a replica of the welfare reform in the area of limited optional services under Medicaid. The Department updated the list of standards, and criteria and continued using the term Basic Medicaid as the providers and the consumers are familiar with it.

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, 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. This waiver renewal will be submitted prior to June 30, 2013, effective February 2014.

II. GENERAL DESCRIPTION OF PROGRAM

This Section 1115 Basic Medicaid Waiver renewal request, scheduled to begin on February 1, 2014, will continue to provide health care coverage to approximately 8,800 (current average) Able Bodied Adults and up to 800 MHSP Waiver individuals. It will also provide coverage for an additional 1,200 MHSP Waiver individuals, residents of the State of Montana, with Basic Medicaid health care benefit for a total of 10,800 lives covered.

Montana will phase-in MHSP Waiver individuals each month until we reach 2,000 individuals. We will enroll all of the individuals with schizophrenia, and as many individuals with bipolar disorder and major depressive disorder until we reach 2,000 enrolled individuals.

Since MHSP Waiver individuals do not currently have health care benefits, this demonstration will allow us to provide benefits while studying our goals and data measurements without risking budget neutrality. The following are descriptions of the existing Able Bodied Adult population and the proposed MHSP Waiver population.

- MEG 1) *Able Bodied Adults***
Able Bodied Adults under both Sections 1925 and 1931 of the Act
Age 21-64, Not Disabled or Pregnant

33% FPL
8,800 (current average) Individuals (Not Capped)
Mandatory Population

MEG 2) MHSP Waiver
Mental Health Services Plan (MHSP) Individuals
Age 18-64
150% FPL
2,000 Individuals (Capped)
Expansion Population

Funding:

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

Able Bodied Adults:

State Funds: State legislature appropriated funding at the current FMAP rate.

Federal Funds: New Federal matching Medicaid funds for the mandatory population at the current FMAP rate.

MHSP Waiver:

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.

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.

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

- *MEG 1) Able Bodied Adults*

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

- *MEG 2) 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)

Section 1931 Families (Limited to adults between 21 and 64 under Section 1925 or 1931 of the Act who are Able Bodied Adults (neither pregnant or disabled) and who are parents and/or caretaker relatives of dependent children.)

MEG) 1 Able Bodied Adults

- Age 21-64, Not Disabled or Pregnant*
- 33% FPL*
- 8,800 Individuals (Not Capped)*

- 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 2) MHSP Waiver
 - Qualified State Only Mental Health Services Plan (MHSP) Individuals*
 - Not otherwise Medicaid eligible*
 - Age 18-64*
 - 150% FPL*
 - 2,000 Individuals (Capped)*

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 2) MHSP Waiver will be capped at 2,000 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 2,000. Since our PMPM for the MHSP Waiver group is estimated, we will study the sustainability of 2,000 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:

o **MEG 1) Able Bodied Adults – Basic Medicaid Benefit:**

Basic Medicaid services are a reduced benefit of optional services as described in the existing Basic Medicaid 1115 Waiver for Able Bodied Adults. 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 would generally not have coverage for the list of excluded services.

The Basic package is 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, 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.

Allowances/Special Circumstances:

The Department recognizes there may be situations where the excluded services are necessary as in an emergency or when essential for employment. Coverage for the excluded services may be provided at the State's discretion in cases of emergency or when essential to obtain or maintain employment. Examples of emergency circumstances include, but are not limited to, coverage for emergency dental situations, medical conditions of the eye, which include but are 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 will provide approval to the provider, and make associated records available upon CMS request.

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 2) MHSP Waiver – Basic Medicaid Benefit

MHSP Waiver is an expanded population and will have the Basic Medicaid benefit, which has been approved in the existing 1115 Basic Medicaid Waiver for Able Bodied Adults. This is a reduced benefit of optional services, described as Basic Medicaid services above for the mandatory MEG 1) Able Bodied Adults. See Attachment C Benefit Package Descriptions.

F. Coverage Vehicle

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 II. 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>
Mandatory Population <i>MEG 1) Able Bodied Adults</i>	√	<i>Basic Medicaid Benefit</i>	√*	√*		<i>√*Individuals have the Basic Medicaid benefit unless the individual is able to obtain Employer Sponsored Health Care or Private Health Insurance through the Montana Medicaid HIPP Program.</i>
New HIFA Expansion <i>MEG 2) MHSP Waiver</i>	√	<i>Basic Medicaid Benefit</i>	√*	√*		

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 MEG 2) 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 III. MEG Cost Sharing

Eligibility Category	Nominal Amounts Per Regulation	Up to 5 Percent of Family Income	State Defined
Mandatory <i>MEG 1) Basic Medicaid for Able Bodied Adults</i>	√ <i>Existing 1115 Waiver, Basic Medicaid Benefit</i>		√* <i>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.</i>
New HIFA Expansion <i>MEG 2) MHSP Waiver</i>			

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 2011 for all individuals of the total population was 24 percent.

<i>Insured</i>	<i>80%</i>
• <i>Medicare and VA insurance</i>	<i>17%</i>
• <i>Means tested insurance</i>	<i>9%</i>
○ <i>Medicaid</i>	<i>5%</i>
○ <i>CHIP</i>	<i>4%</i>
• <i>Employer-based</i>	<i>49%</i>
• <i>Direct purchase (includes limited coverage)</i>	<i>7%</i>
• <i>Unable to determine type</i>	<i>3%</i>
<i>Uninsured</i>	<i>20%</i>
• <i>Tribal Health Service</i>	<i>4%</i>

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

IHS is not considered insurance and Medicaid pays prior to IHS.

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 24 percent. The Basic Medicaid Waiver would allow Montana to continue benefits for 8,800 Able Bodied Adults, 800 MHSP Waiver individuals and furnish health care benefits up to 1,200 Montanans who are currently uninsured.

The Basic Medicaid Waiver would provide health care to a total of 10,800 individuals. This expansion group is a very important population to insure, as they currently receive only a small \$425 pharmacy benefit and limited mental health services through the State funded Mental Health Services Plan Program.

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 2) 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 IV. Waivers and Expenditure Authority Requested

	<i>MEG 1) Able Bodied Adults</i>	<i>MEG 2) MHSP Waiver</i>
<i>XIX. Amount, Duration, and Scope (1902(a)(10)(B) – Applied to Services</i>	√	√
<i>XIX. Retroactive Eligibility 1902(a)(34)</i>		√
<i>XIX. Expenditures to provide services to populations not otherwise eligible to be covered under the Medicaid State Plan.</i>		√

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

Date

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

Signature of Authorizing State Official

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0848. The time required to complete this information collection is estimated to average 10 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850.

ATTACHMENT B - DETAILED DESCRIPTION OF EXPANSION POPULATIONS

MEG 1) Existing Waiver - Montana Basic Medicaid for Able Bodied Adults

Mandatory Population

On November 20, 1995, the State of Montana's welfare reform demonstration, entitled "Families Achieving Independence in Montana" (FAIM), was approved under the authority of Section 1115 of the Social Security Act (the Act). The demonstration was effective from February 1, 1996, through January 31, 2004. According to the State Medicaid Directors' Letter dated February 5, 1997, the State could not extend the Title XIX component of FAIM beyond the specified eight-year period. Any continuation of these Medicaid waivers would be subject to new terms and conditions, including a budget neutrality test and an evaluation.

Under the current Montana Basic Medicaid for Able Bodied Adults 1115 Waiver Number 11-00181/8, parents and/or caretaker relatives of dependent children, as described in Sections 1925 and 1931 of the Social Security Act, who are ages 21 to 64 and neither pregnant nor disabled, receive a limited package of Medicaid services. The Basic Medicaid Waiver currently has two populations; Family Medicaid, and Transitional Medicaid. The income limit for individuals qualifying for Family Medicaid is around 33 percent FPL. We indicate approximately 33 percent because Family Medicaid income is based on 1996 standards and is not an exact FPL. Transitional Medicaid has no qualifying income limit.

The Basic Medicaid Waiver was approved for a five-year period of February 1, 2004 through January 31, 2009. 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. A July 30, 2009 submittal requested only one population, MHSP Waiver, in addition to Able Bodied Adults. This amendment extension requested one additional expansion population, up to 800 MHSP Waiver individuals, and represented small changes from the July 30, 2009 application as a result of continuing conversations with CMS regarding the Basic Medicaid Waiver and was approved by CMS effective December 2010.

Able Bodied Waiver Participation Criteria:

- *Be eligible for Medicaid as Family Medicaid or Transitional Medicaid under 1931 or 1925 of the Act;*
 - *Be age 21 through 64; and*
 - *Be able bodied, not disabled, not pregnant.*

Waiver Eligibility Determination:

Eligibility determinations for Able Bodied Adults are processed by eligibility staff in the Public Assistance Bureau of the Human and Community Services Division. Eligibility is accomplished through the CHIMES eligibility system.

Enrollment:

As of January 31, 2013 8,800 individuals were enrolled in Basic Medicaid. Enrollment is not capped for Able Bodied Adults.

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 through 64, 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 receive other insurance. The number of people enrolled in the State only MHSP is limited by current legislative appropriations and not by a cap on the number of slots created by DPHHS. 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 waiver program staff. Determinations do not include an asset or resource test.*
- 3. The individual must be ineligible for Medicaid as determined by the Department's Public Assistance Bureau.*
- 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 than 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 2) 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 2,000 of those qualified MHSP Waiver individuals.

MHSP Waiver Participation Criteria:

- Be on or eligible for the Mental Health Services Plan;*
- Be otherwise ineligible for Medicaid;*
- Be at least 18 years of age;*
- Have incomes equal or less than 150% FPL (no resource test); and*
- Been determined to have a Severe Disabling Mental Illness (SDMI) by a licensed mental health professional. Including assessment of diagnosis, functional impairment, and duration of illness.*

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:

Starting in February 2014, Montana will phase-in MHSP Waiver individuals each month until we reach 2,000 individuals. We will enroll all of the individuals with schizophrenia, then bipolar disorder and as many individuals with major depression until we reach 2,000 enrolled individuals. We estimate the PMPM is about \$1,100 for those individuals with schizophrenia, bipolar disorder and major depressive disorder and we will analyze the data quarterly to maintain budget neutrality.

ATTACHMENTS C - BENEFIT PACKAGE DESCRIPTIONS

**MEG 1) Existing Waiver - Montana Basic Medicaid for Able Bodied Adults
Mandatory Population**

Under the current Montana Basic Medicaid for Able Bodied Adults 1115 demonstration, parents and/or caretaker relatives of dependent children, as described in Sections 1925 and 1931 of the Social Security Act, who are ages 21 to 64 and neither pregnant nor disabled, receive a limited package of Medicaid services called Basic Medicaid. There is not a lifetime maximum benefit for Able Bodied Adults.

**MEG 2) MHSP Waiver
Expansion Population**

Up to 2,000 MHSP Waiver individuals at one time will be served by the Basic Medicaid health care benefit. There is not a lifetime maximum benefit for MHSP individuals.

Basic Medicaid Benefit and Excluded Services:

The Basic package is 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, 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.

Basic Medicaid Allowances/Special Circumstances:

DPHHS recognizes there may be situations where the excluded services are necessary as in an emergency or when essential for employment. Coverage for the excluded services may be provided at the State's discretion in cases of emergency or when essential to obtain or maintain employment. Examples of emergency circumstances include, but are not limited to, coverage for emergency dental situations, medical conditions of the eye, which include but are 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 will provide approval to the provider, and make associated records available upon CMS request.

Delivery System: *The delivery system for Basic Medicaid benefits is through MMIS and is fee-for-service. The delivery system will vary for employer sponsored or private health care plan and premium assistance payments are made through the Medicaid Health Insurance Premium Payments Program.*

Employer Sponsored or Private Health Insurance Benefit:

If a Basic Medicaid Waiver enrolled individual becomes employed and is offered an employer sponsored health care plan, or is otherwise able to obtain a private health insurance plan, the individual will be referred to the Medicaid Health Insurance Premium Payments (HIPP) Program. Screening for the HIPP Program is a Medicaid process that happens at the time of Medicaid application, or change in insurance status, for those applicants age 18 and older.

For those Able Bodied Adults currently in the Basic Medicaid Waiver, if the HIPP analysis is cost effective, the beneficiary only pays Medicaid cost share if the service has not been billed by the third party. Medicaid pays any premium assistance, cost share, coinsurance, deductibles and the beneficiary has Medicaid wrap around benefits. This HIPP Program benefit will now include the MHSP Waiver population. See Attachment D Private and Public Health Insurance Coverage Options Including Premium Assistance for HIPP Program information.

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 (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 HIPP Program 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 referred individual or the parent must answer the questions on the HIPP questionnaire (449 form). It is important to have the form filled out accurately and completely so the State can ascertain whether or not it would be cost effective to the Medicaid Program to pay for the insurance versus Medicaid claims. Completing this form and sending in all insurance information within 10 days is part of the Medicaid eligibility process.

The HIPP program will send letters to the referred individual and the employer seeking the needed information to complete a cost effective analysis. It is imperative that the information be returned by the date stated in the letter.

The cost effective analysis process reviews the annual premium amount, deductible amount, administrative cost, all Medicaid eligible clients, age, and annual medical cost.

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 client has an urgent or ongoing medical condition with the probability of high cost, the HIPP Program can be used.

HIPP 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 & client does not have to be on Medicaid.*

Once notified of their status for HIPP, the client must comply with the information and instructions sent by the HIPP Program before the deadline date. This can include:

- *A request to fax/send receipts, bank statements, pay stubs, etc.*
- *If the client needs to enroll on their insurance, they will need to show proof of enrollment. If the client needs to enroll on COBRA, the client needs to fill out COBRA paperwork, make a copy and send or fax the copy and send the original to COBRA. Payment can be made directly to the COBRA administrator or the recipient can pay the premium and send in the receipt for reimbursement.*

ATTACHMENT E - COST SHARING LIMITS

Cost Sharing Limits – Basic Medicaid Benefit:

MEG 1) Able Bodied Adults and MEG 2) MHSP Waiver individuals will receive the Basic Medicaid benefit.

Waiver Individuals Subject To Cost Share:

All Basic Medicaid Waiver individuals age 21 and older will pay nominal cost share for the Basic Medicaid benefit.

Individuals Not Subject To Cost Share:

All Basic Medicaid Waiver individuals who are pregnant, age 20 and under, or live in a skilled nursing, intermediate care facility, or other medical institution do not pay cost share. Medicaid clients who also have Medicare or another insurance are exempt from cost sharing only when the service is allowed by Medicare or paid by the other insurance and Medicaid is the secondary payer. No enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, shall be imposed against a Native American who is furnished a service directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services.

Medicaid Cost Share Exempt Services:

Basic Medicaid services also follow Medicaid rules regarding exemption from cost share. Affected providers or services exempt from cost sharing include: emergency services, hospice, personal assistance, home dialysis attendant, home and community based waiver services, non-emergency medical transportation, eyeglasses purchased by the Medicaid Program under a volume purchasing arrangement, EPSDT services, independent laboratory and x-ray services, and family planning services.

Medicaid Cost Share Amount:

The cost share amount for individuals in the Basic Medicaid Waiver is the same cost share amount specified in the State Plan for Montana Medicaid.

Figure VI. Medicaid Cost Sharing

Cost Share	Maximum
<i>\$1 - \$5 office visits, x-rays \$1 - \$5 prescription drugs \$100 inpatient hospital stay \$1 - \$5 outpatient hospital visit \$5 in state outpatient surgery \$0 emergencies, family planning, hospice, dialysis, transportation, eyeglasses though volume purchasing agreement, immunizations, nursing homes, respiratory therapy, home and community waiver services.</i>	<i>\$25 prescription monthly maximum</i>

Cost Sharing Limits – Employer Sponsored or Private Health Insurance Benefit:

Able Bodied Adults and MHSP Waiver individuals who participate in an employer sponsored plan or a private health insurance plan could experience varied cost share amounts. These Basic Medicaid Waiver individuals will be subject to cost sharing rules of the insurance plan in which they enroll. These individuals are subject to Medicaid cost share only if the individual is enrolled in an employer sponsored or private health insurance plan and the third party did not bill Medicaid. Medicaid pays all other cost share, deductibles, and coinsurance. The Basic Medicaid Waiver will pay the full cost of the premium, with no limit. See Attachment D: Private and Public Health Insurance Coverage Options Including Premium Assistance for a full description of employer sponsored or private health insurance benefit.

**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 evaluation design from December 2010 through January 2017. We took a baseline survey of the 800 MHSP Waiver individuals in the summer of 2012 and will survey the MHSP Waiver population again in December 2013 and again in December 2017 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 continue 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 Mental Health and Services Plan (MHSP) group.

Basic Medicaid Waiver Hypotheses for the MHSP Group:

1. *The waiver will provide basic coverage.*
2. *The waiver will improve access to care, utilization of services, and quality of care.*
3. *The waiver will improve the 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 participants with Medicaid recipients 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 it's 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 VII. Waiver Reporting Deliverables:

	<i>State</i>	<i>CMS</i>	<i>State and/or CMS</i>
Operational Protocol	<i>The State shall prepare one protocol documents a single source for the waiver policy and operating procedures.</i>		
Draft Evaluation Design	<i>The State shall submit a draft evaluation design within 120 days from the demonstration award.</i>	<i>CMS will provide comments within 60 days.</i>	<i>The State shall submit the final report prior to the expiration date of this demonstration.</i>
Protocol Change	<i>Submit protocol change in writing 60 days prior to the date of the change implementation.</i>	<i>CMS will make every effort to respond to the submission in writing within 30 days of the submission receipt.</i>	<i>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.</i>
Quarterly Waiver Reports	<i>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</i>		
Annual Report	<i>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.</i>		
Phase-out Demonstration Plan	<i>The State will submit a phase-out plan six months prior to initiating normal phase-out activities.</i>		
Draft Demonstration Evaluation Report	<i>Submit to CMS 120 days before demonstration ends.</i>	<i>Will provide comments 60 days of receipt of report.</i>	<i>The State shall submit the final report prior to the expiration date of the demonstration.</i>

ATTACHMENT G - BUDGET WORKSHEETS

Budget Summary:

The accumulated Federal Basic Medicaid Waiver savings from DY1 – DY9, February 1, 2004 through January 31, 2013 is estimated at \$80 million. (Providers have 365 days from date of service to file claims.) The total February 2014 through January 2017 State and Federal cost for 2,000 MHSP Waiver individuals is estimated at \$89,401,241 and \$59,103,161 Federal, and \$30,298,081 State.

Figure XI. State and Federal Waiver Benefit Costs:

	<i>2/2014 - 1/2015</i>	<i>2/2015 - 1/2016</i>	<i>2/2016 - 1/2017</i>	<i>Renewal Total</i>
	<i>DY11</i>	<i>DY12</i>	<i>DY13</i>	
MEG 1) 8,800 Able Bodied Adults Benefit Expenditures				
<i>Federal</i>	\$18,923,086	\$20,160,655	\$21,479,162	\$60,562,903
<i>State</i>	\$9,551,198	\$10,175,847	\$10,841,347	\$30,568,392
Total State & Federal	\$28,474,284	\$30,336,502	\$32,320,509	\$91,131,295
MEG 2) 2,000 MHSP Waiver Benefit Expenditures				
<i>Federal</i>	\$17,453,040	\$18,594,469	\$23,055,652	\$59,103,161
<i>State</i>	\$8,946,960	\$9,532,091	\$11,819,030	\$30,298,081
Total State & Federal	\$26,400,000	\$28,126,560	\$34,874,681	\$89,401,241
Waiver Total Benefits MEGS 1) 8,800 Able Bodied Adults and 2) 2,000 MHSP Waiver				
<i>Federal</i>	\$36,376,125	\$38,755,124	\$44,534,814	\$119,666,064
<i>State</i>	\$18,498,158	\$19,707,938	\$22,660,377	\$60,866,473
Total State & Federal	\$54,874,284	\$58,463,062	\$67,195,191	\$180,532,536

Attached Budget Worksheets:

1) Quarterly Budget Neutrality Worksheets:

I. Calculation of Budget Neutrality Limit (Without Waiver Ceiling)

Presents the Federal funds, budget neutrality limit calculation for DY1 - DY9.

II. Waiver Costs & Variance from Budget Neutrality Limit (Federal Funds)

Presents the budget neutrality limit and the actual and projected Federal benefit expenditures side by side and the resulting budget neutrality variance.

III. Summary By Demonstration Year and Cumulatively (Federal Funds)

Presents actual Federal benefits spending DY1 – DY9.

2) **Figure VIII. Budget Worksheet:**

Presents variance, expenditures, budget neutrality cap, PMPM, by total Federal and State, Federal only and State only MEG activity for MEG 1) Able Bodied Adults and MEG 2) MHSP Waiver for DY1 – DY 13.

3) **State Maintenance of Effort**

Presents the State only Mental Health Services Plan Program budget and services for individuals remaining on the State only program and MHSP Waiver individuals for DY11 – DY13.

Trending Rates Used in the BN Calculation Schedules:

Expenditures:

- *The Basic Medicaid Waiver BN PMPM Cap is trended at 6.3% for DY11 – DY13.*
- *Enrollment for Able Bodied Adults and MHSP Waiver populations are trended at the following: 2012 – 2013 3.94%, 2013 – 2014 4.17%, 2014 – 2015 3.76%, and 2015 – 2016 3.49%.*
- *Benefit expenditures are trended at 8% for 2009 – 2010, 5% for 2010 – 2011, 9% 2011 – 2012, 5.08% 2012 – 2013, and 6.54% 2013 – 2014.*

FMAP:

- *Regular FMAP was used but Montana is requesting 100% FMAP for the MHSP Waiver population.*

Member Months:

- *June 2010 flat enrollment of 8,800 was used for DY11 – DY13.*
- *MHSP Waiver enrollment is phase-in to reach 2,000 individuals.*

PMPM Cost Basis Explanation:

The PMPM for the MHSP Waiver population is figured at \$1,100 on February 2014.

Excluded Basic Medicaid Services:

Since this population will have Basic Medicaid coverage, the excluded Basic Medicaid Services were excluded from this PMPM cost. Basic Medicaid provides mandatory services and a limited Medicaid benefit package of optional services. The optional medical services generally excluded under “Basic Medicaid,” including provider type are: audiology (08), dental (18) and denturist (43), durable medical equipment (20), eyeglasses (47), optometric (21), optician (22), and ophthalmology (27) (18 specialty) for routine eye exams, personal care services (12), and hearing aids (09). DPHHS recognizes there may be situations where the excluded services are necessary as in an emergency or when essential for employment. Coverage for the excluded services may be provided at the State’s discretion in cases of emergency or when essential to obtain or maintain employment. Examples of emergency circumstances include, but are not limited to coverage for emergency dental situations, medical conditions of the eye, which include but are 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 will provide approval to the provider, and make associated records available upon CMS request.

Other Excluded Provider Types:

In addition to the excluded Basic Medicaid services above, the following provider types and expenditures were excluded for the PMPM calculation as we do not anticipate expenditures in the following categories:

- EPSDT (04)
- Home and Community Based Waiver Services (28)
- Nutrition (35)
- Schools (45)
- QMB Chiropractic (50)
- *Note, individuals age 18 – 20 will be served in the MHSP waiver population, but expenses for EPSDT were excluded as the data showed the cost of the (04) provider type, for this age group in regular Medicaid with an SDMI diagnosis, is under \$1,000. Drug rebates are excluded from the MHSP Waiver PMPM calculation and IHS expenses are included per CMS. Drug rebates and IHS expenses are excluded from the Basic Medicaid Able Bodied calculation per CMS.

Hierarchy of Diagnosis:

The hierarchy of MHSP Waiver slots will be filled with eligible individuals who have primary diagnosis of schizophrenia, bipolar disorder, and major depression.

Schizophrenia:

The average monthly cost of individuals, with a primary diagnosis of schizophrenia for regular Medicaid, minus the above explained Basic Medicaid services and the additional excluded services is \$1,100. The primary diagnoses for schizophrenia are:

- 295.10 Schizophrenia, Disorganized Type
- 295.20 Schizophrenia, Catatonic Type
- 295.30 Schizophrenia, Paranoid Type
- 295.40 Schizophreniform Disorder
- 295.60 Schizophrenia, Residual Type
- 295.70 Schizoaffective Disorder
- 295.90 Schizophrenia, Undifferentiated Type
- 293.81 Schizophrenia with Delusions
- 293.82 Schizophrenia with Hallucinations
- 297.1 Delusional Disorder
- 297.3 Shared Psychotic Disorder

Schizophrenia

Average PMPM cost for individuals with schizophrenia:	\$1,100
Average yearly costs of existing adult Medicaid recipient with schizophrenia: 467 Individuals x \$1,100 = \$513,700 x 12 = \$6,164,400	\$6,164,400
Average monthly costs of existing adult Medicaid recipient with schizophrenia: 467 Individuals x \$1,100 = \$513,700	\$513,700

Bipolar Disorder:

The average monthly cost of individuals, with a primary diagnosis of bipolar disorder for regular Medicaid, minus the above explained Basic Medicaid services and the additional excluded services is \$1,100. The primary diagnoses for bipolar disorder are:

- 296.42 Bipolar I Disorder, Most Recent Episode Manic, Moderate
- 296.43 Bipolar I Disorder, Most Recent Episode Manic, Severe Without Psychotic Features
- 296.44 Bipolar I Disorder, Most Recent Episode Manic, Severe With Psychotic Features

- 296.52 Bipolar I Disorder, Most Recent Episode Depressed, Moderate
- 296.53 Bipolar I Disorder, Most Recent Episode Depressed, Severe Without Psychotic Features
- 296.54 Bipolar I Disorder, Most Recent Episode Depressed, Severe With Psychotic Features
- 296.62 Bipolar I Disorder, Most Recent Episode Mixed, Moderate
- 296.63 Bipolar I Disorder, Most Recent Episode Mixed, Severe Without Psychotic Features
- 296.64 Bipolar I Disorder, Most Recent Episode Mixed, Severe With Psychotic Features
- 296.7 Bipolar I Disorder, Most Recent Episode Unspecified
- 296.89 Bipolar II Disorder

Bipolar Disorder

Average PMPM cost for individuals with bipolar disorder:	\$1,100
Average yearly costs of existing adult Medicaid recipient with bipolar disorder: 593 Individuals x \$1,100 = \$652,300 x 12 = \$7,827,600	\$7,827,600
Average monthly costs of existing adult Medicaid recipient with bipolar disorder: 593 Individuals x \$1,100 = \$652,300	\$652,300

Major Depression:

The average monthly cost of individuals, with a primary diagnosis of major depression for regular Medicaid, minus the above explained Basic Medicaid services and the additional excluded services is \$1,100. The primary diagnoses for major depression are:

- 296.22 Major Depressive Disorder, Single Episode, Moderate
- 296.23 Major Depressive Disorder, Single Episode, Severe Without Psychotic Features
- 296.24 Major Depressive Disorder, Single Episode, Severe With Psychotic Features
- 296.32 Major Depressive Disorder, Recurrent, Moderate
- 296.33 Major Depressive Disorder, Recurrent, Severe Without Psychotic Features
- 296.34 Major Depressive Disorder, Recurrent, Severe With Psychotic Features

Major Depressive Disorder

Average PMPM cost for individuals with major depressive disorder:	\$1,100
Average yearly costs of existing adult Medicaid recipient with major depressive disorder: 940 Individuals x \$1,100 x 12 = \$12,408,000	\$12,408,000
Average monthly costs of existing adult Medicaid recipient with major depressive disorder: 940 Individuals x \$1,100 = \$1,034,000	\$1,034,000

* Note: The average cost of all Medicaid individuals, with a primary diagnosis of SDMI for regular Medicaid, minus the above explained Basic Medicaid services and minus the additional Basic Medicaid excluded services is \$1,100.

MONTANA DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

Section 1115 Waiver for Health Care Reform

***Evaluation Report
February 2010 – December 2012***

October 31, 2013



Executive Summary

The Basic Medicaid Program has remained a positive source of Medicaid coverage since the program's inception in 1996. The Basic Program is comprised of mandatory Medicaid benefits and a collection of optional services available for emergencies and when necessary, for seeking and maintaining employment. These services are available to able-bodied adults (neither pregnant nor disabled) who are parents and/or caretaker relatives of dependent children. The most significant change has been adding up to 800 individuals with schizophrenia or bipolar disorder who qualify for the Basic Medicaid Waiver in December 2010.

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 are the medical services provided for Able-Bodied Adults (neither pregnant nor disabled) and who are parents and/or caretaker relatives of dependent children, eligible for Medicaid under Sections 1925 or 1931 of the Social Security Act. The Basic Program is operated under a Section 1115 waiver, offers 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 are waived enabling Montana to carry out the 1115 demonstration.

In February 1996, Montana implemented its state-specific welfare reform program known as Families Achieving Independence in Montana (FAIM). This sweeping change involved the cash assistance, food stamp, and Medicaid programs that were administered on the federal side by several agencies under multiple statutes. As part of welfare reform, Montana obtained a Section 1115 waiver, approved in February 1996. On October 23, 2003, the Department submitted an 1115 waiver application to CMS requesting approval to continue the Basic Medicaid Program. CMS approved the waiver application on January 29, 2004 for a five-year period from February 1, 2004 through January 31, 2009. Terms of the request and the approval were consolidated into an Operational Protocol document as of February 2005. The waiver structure has remained constant throughout the life of the Basic Program. The State must submit a quarterly Basic Medicaid report as one of the Operational Protocol conditions.

A HIFA proposal was submitted on June 27, 2006. 1115 Basic Medicaid Waiver amendments were submitted on March 23, 2007 and January 28, 2008 requesting seven new optional and expansion populations. Tribal Consultation was completed on December 14, 2007. As a result of discussions with CMS, Montana submitted a revised 1115 Basic Medicaid Waiver amendment on June 6, 2008 requesting four new populations. On July 30, 2009 and August 6, 2010 submittals requested only one population, MHSP Waiver 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.

Department of Public Health and Human Services

Richard Opper is the Department Director 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 continue 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 Mental Health and Services Plan (MHSP) group.

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 Excluded Services

The Basic package is the Full Medicaid benefit, with the following medical services generally excluded under Basic Medicaid: audiology, dental and dentist, 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 recognizes there may be situations where the excluded services are necessary as in an emergency or when essential for employment. Coverage for the excluded services may be provided at the State's discretion in cases of emergency or when essential to obtain or maintain employment. Examples of emergency circumstances include, but are not limited to, coverage for emergency dental situations, medical conditions of the eye, which include but are 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 will provide approval to the provider, and make associated records available upon CMS request. Medicaid manuals contain Basic information and are found on the Department site at <http://medicaidprovider.hhs.mt.gov/index.shtml>.

The *General Information for Providers, Medicaid and Other Medical Assistance Programs*, is found at <http://medicaidprovider.hhs.mt.gov/pdf/general.pdf>, which explains Basic Medicaid eligibility to providers in section 3.1 and publishes the list of covered Basic services in Appendix A-1. Basic Medicaid emergency and Essentials for Employment Program covered service information is also included in specific provider manuals like, *Dental and Denturist*, found in sections 1.1 and 1.3. Charts of dental covered procedure codes, beginning in section 1.4, also list the Basic coverage limits.

Medicaid provider training is offered several times a year and Basic Medicaid billing, policies, and procedures are included. Providers, when inquiring about client eligibility, receive eligibility information including whether a person is receiving Full or Basic Medicaid regardless of the various eligibility

methods of Faxback, Voice Response, or when contacting the Office of Public Assistance, the Department, or Montana Medicaid’s Provider Relations.

Individuals on Medicaid are given a copy of the Medicaid Health Insurance Services, “*Member Guide*,” found at: <http://medicaidprovider.hhs.mt.gov/pdf/medinfo.pdf>. A chart of Medicaid covered benefits is published on page 19. Clients receive education and information regarding Full and Basic Medicaid services through the Montana Medicaid Hotline. The provider community and individuals who are affected by the 1115 waiver are accustomed to the provisions of the waiver.

Basic Medicaid Population

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

Basic Medicaid Population DY7 Average - December 2012 Average		
	February 2010 – January 2011 DY7 Average	December 2012 Average
Family Medicaid	78.75%	72.49%
Transitional Medicaid	21.12%	18.45%
WMHSP Schizophrenia	0.55%	3.89%
WMHSP Bipolar Disorder	0%	5.17%

Basic and Full Medicaid Enrollment DY7 Average – December 2012

In DY7 a quarterly average of 9,063 individuals (8,768 in December 2012) were enrolled in Basic Medicaid. Of the 27,070 (28,855 in December 2012) all Medicaid individuals, age 21-64, 33.68% (30.38% in December 2012) were Basic Medicaid.

Basic and Full Medicaid Enrollment DY7 Average – December 2012 Average		
	February 2010 – January 2011 DY7 Average	December 2012 Average
Basic Medicaid Enrollment	9,063	8,768
Full Medicaid Enrollment (Age 21-64)	27,070	28,855

Full (Age 21-64) and Basic Medicaid Gender, Ethnic and Race DY7 Average – December 2012

Basic Medicaid was 69.07% (67.93% in December 2012) predominately female as compared to 64.14% (64.49% in December 2012) females for all Medicaid in the 21-64 age group. Males in Full Medicaid are 6.71% (3.65% in December 2012) less than the Basic population. The American Indian quarterly average for Basic is 33.26% (27.60% in December 2012), which is 11.91% (9.60% in December 2012) more than the Full Medicaid average of 21.35% (18% in December 2012).

Basic Medicaid Gender, Ethnic and Race DY7 Average – December 2012 Average		
	February 2010 – January 2011 DY7 Average	December 2012 Average
Gender		
Female	69.07%	67.93%
Male	30.93%	32.06%
Ethnic and Race (Plus Any Other)		
Hispanic of Any Race	3.24%	4.85%
White	66.10%	70.70%
American Indian/AK	33.26%	27.60%
Other: African American, Asian, Pacific Islander	1.20%	1.44%

Full Medicaid Gender, Ethnic and Race (Age 21-64) DY7 Average – December 2012 Average		
	February 2010 – January 2011 DY7 Average	December 2012 Average
Gender		
Female	64.14%	64.29%
Male	36.12%	35.71%
Ethnic and Race (Plus Any Other)		
Hispanic of Any Race	2.49%	2.50%
White	77.73%	78.11%
American Indian/AK	21.35%	18.00%
Other	1.18%	1.29%

	BN Limit	CMS-64 Waiver Costs	Annual Variance	Cumulative BN Limit	Cumulative CMS-64 Waiver Costs	Cumulative Variance
DY7 February 2010 - January 2011	\$39,180,273	\$25,888,909	\$13,291,364	\$200,211,559	\$145,722,183	\$54,489,376
DY8 February 2011 - January 2012	\$36,485,101	\$22,792,736	\$11,918,669	\$236,696,660	\$170,288,615	\$66,408,045
DY9 February 2012 - January 2012	\$35,725,873	\$16,445,819	\$14,201,474	\$272,422,532	\$191,813,014	\$80,609,518

Section 1115 Montana Basic Medicaid Waiver Survey Summary

On July 31, 2012, the Department distributed 787 surveys with a pre-paid return envelope to WMHSP Waiver individuals, those individuals with schizophrenia or bipolar disorder, to establish a base line. A ticket for a chance to win a \$50 gift certificate to grocery store of their choice was included in the survey. The survey was due August 17, 2012. Reminder flyers were mailed to the mental health centers. The Department received 209 surveys.

A summary of the data is as follows:

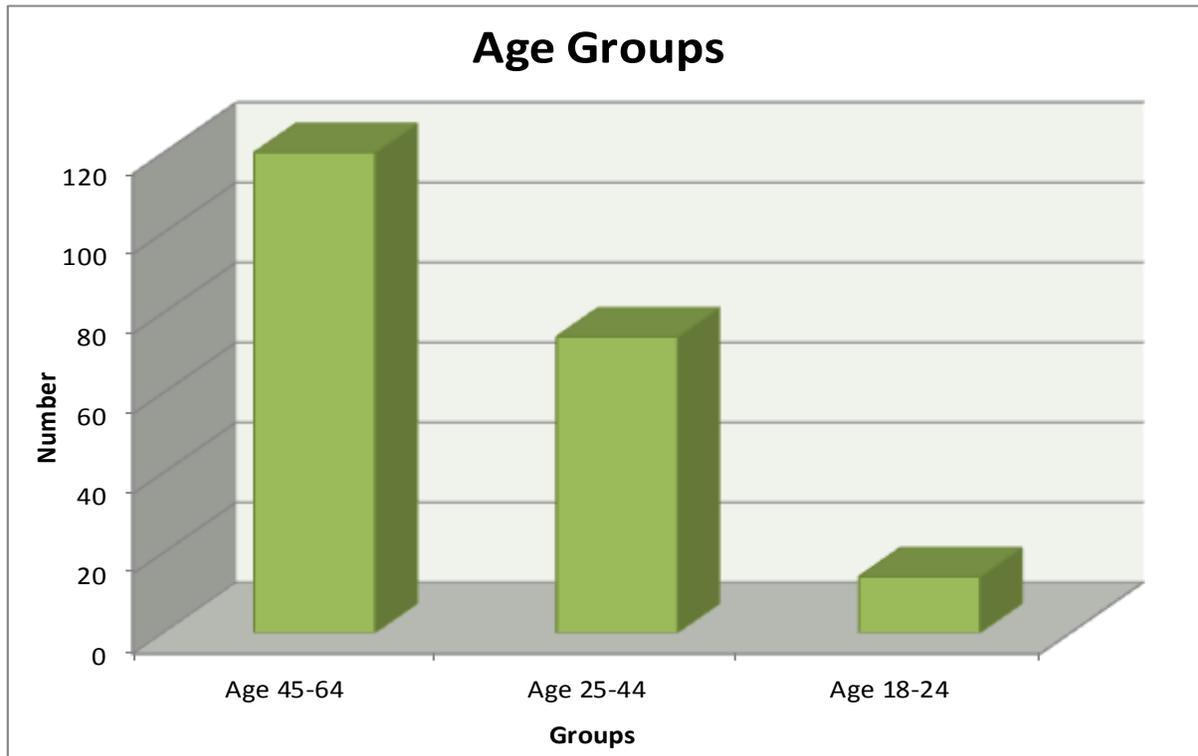
- 50% stated they did understand their Basic Medicaid benefits.
- 86% have a main doctor for physical health.
- 44% have seen a doctor in past month, while 44% in the past year.
- 52% were female.
- 89% were Caucasian, 7% Native American and 4% Hispanic.
- 73% were not employed.
- 39% consider their health fair, 30% good, and 12% poor.
- 41% believe their general health has improved since receiving the Basic Medicaid benefits.
- 94% have had mental or physical health care in the last three months.
- In the last three months, 31% could get an appointment within one week, 22% within a day, and 17% within two weeks.
- In the last three months, 47% always felt their doctor spent time listening to their concerns; 31% felt their doctor usually listened to them.
- In the last three months, 29% could receive an appointment with their doctor for mental health, 20% within a day, 19% within two weeks, and 13% over two weeks.
- In the past three months when they needed to see a doctor for physical or mental health but could not because of cost, 66% said no.
- 78% believe that in the past three months they could access physical or mental health care services when needed. *See the attached Detailed Analysis Reports for additional information.

Contact Information

Jo Thompson, Bureau Chief, Health Resources Division
Mary E. Dalton, State Medicaid Director

(406) 444-4146
(406) 444-4084

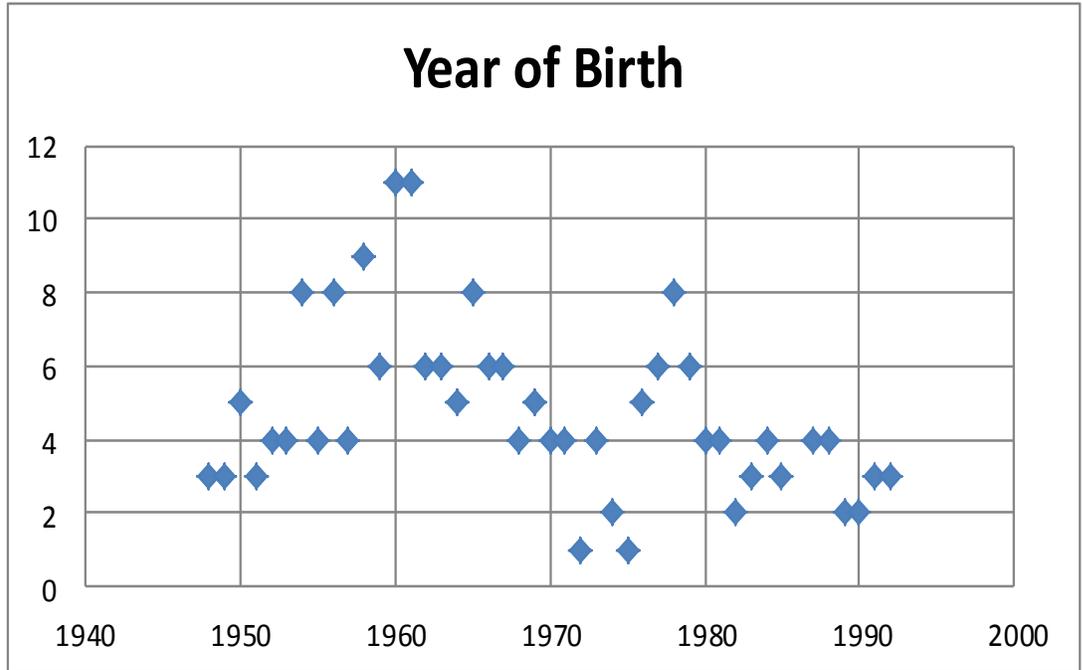
Basic Medicaid Survey Results—August 2012



Age 45-64	120
Age 25-44	74
Age 18-24	14

Basic Medicaid Survey Results—August 2012

1948	3
1949	3
1950	5
1951	3
1952	4
1953	4
1954	8
1955	4
1956	8
1957	4
1958	9
1959	6
1960	11
1961	11
1962	6
1963	6
1964	5
1965	8
1966	6
1967	6
1968	4
1969	5
1970	4
1971	4
1972	1
1973	4
1974	2
1975	1
1976	5
1977	6
1978	8
1979	6
1980	4
1981	4
1982	2
1983	3
1984	4
1985	3
1987	4
1988	4
1989	2
1990	2
1991	3
1992	3



Basic Medicaid Waiver for MHSP Population

Basic Medicaid will be provided for up to 800 State Only MHSP individuals who qualify for the Basic Medicaid Waiver. MHSP individuals who meet waiver qualifications receive Basic benefits for 12 months of continuous eligibility without reporting monthly changes of income and resources. The Basic package is 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.

Qualifications include: Meet the State Only MHSP eligibility, have a primary clinical diagnosis of schizophrenia or bipolar disorder; are ages 18-64; are Montana residents (individuals must provide citizenship and identification documentation); have incomes at or below 150% FPL; and are not otherwise qualified for Medicaid.

Quotes from individuals receiving the Basic Medicaid Waiver:

“If it wasn’t for Medicaid, I couldn’t make doctor visits and medications cost a lot for the meds I take.”

“I cannot express how much this help has meant to me, I am able to get ALL my prescriptions – not having to choose which is most important. Thank you.”

“Montana has taken excellent care of me, much thanks for saving my LIFE.”

“Medicaid saved me and made me able to get my mental health taken care of after losing my job because of getting sick and hospitalized – THANK YOU!”

“Being able to receive basic Medicaid I have put my health as my first priority now.”

“I am very satisfied with how fortunate I am to live here in such a wonderful place.”

Condensed Item Analysis Report

How well do you understand your Basic Medicaid benefit? (Like the kinds of benefits you can receive and what type of doctors/health professionals you can see.)

Response	Frequency	Percent	Mean: 1.63
Very well	27	12.92	<div style="width: 12.92%; height: 15px; background-color: blue;"></div>
Well	77	36.84	<div style="width: 36.84%; height: 15px; background-color: blue;"></div>
Not well at all	105	50.24	<div style="width: 50.24%; height: 15px; background-color: blue;"></div>
Missing	0	0.00	<div style="width: 0%; height: 15px; background-color: blue;"></div>

Do you have a main doctor (who provides physical health care)

Response	Frequency	Percent	Mean: 1.13
Yes	180	86.12	<div style="width: 86.12%; height: 15px; background-color: blue;"></div>
No	28	13.40	<div style="width: 13.40%; height: 15px; background-color: blue;"></div>
Missing	1	0.48	<div style="width: 0%; height: 15px; background-color: blue;"></div>

When did you last see a doctor for physical health care -

Response	Frequency	Percent	Mean: 1.72
within the last month	93	44.50	<div style="width: 44.50%; height: 15px; background-color: blue;"></div>
within the last year	92	44.02	<div style="width: 44.02%; height: 15px; background-color: blue;"></div>
within the last 2-4 years	17	8.13	<div style="width: 8.13%; height: 15px; background-color: blue;"></div>
within the last 5-10 years	4	1.91	<div style="width: 1.91%; height: 15px; background-color: blue;"></div>
over 10 years ago	3	1.44	<div style="width: 1.44%; height: 15px; background-color: blue;"></div>
Missing	0	0.00	<div style="width: 0%; height: 15px; background-color: blue;"></div>

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

Response	Frequency	Percent	Mean: -
Medicare	79	37.80	<div style="width: 37.80%; height: 15px; background-color: blue;"></div>
Veteran's	4	1.91	<div style="width: 1.91%; height: 15px; background-color: blue;"></div>
Private Health Insurance	4	1.91	<div style="width: 1.91%; height: 15px; background-color: blue;"></div>
Other please specify	14	6.70	<div style="width: 6.70%; height: 15px; background-color: blue;"></div>
No	109	52.15	<div style="width: 52.15%; height: 15px; background-color: blue;"></div>
Missing	3	1.44	<div style="width: 0%; height: 15px; background-color: blue;"></div>

Did you have a main doctor (who provides physical health care) before you received Basic Medicaid?

Response	Frequency	Percent	Mean: 1.35
Yes	136	65.07	<div style="width: 65.07%; height: 15px; background-color: blue;"></div>
No	72	34.45	<div style="width: 34.45%; height: 15px; background-color: blue;"></div>
Missing	1	0.48	<div style="width: 0%; height: 15px; background-color: blue;"></div>

What is your gender?

Response	Frequency	Percent	Mean: 1.52
male	101	48.33	<div style="width: 48.33%; height: 15px; background-color: blue;"></div>
female	108	51.67	<div style="width: 51.67%; height: 15px; background-color: blue;"></div>
Missing	0	0.00	<div style="width: 0%; height: 15px; background-color: blue;"></div>

Race and ethnicity

Response	Frequency	Percent	Mean: -
Hispanic/Latino	7	3.35	
Non-Hispanic/Latino	2	0.96	
White	185	88.52	
American Indian or Alaska Native	16	7.66	
Black or African American	1	0.48	
Asian	1	0.48	
Pacific Islander	0	0.00	
Unknown	2	0.96	
Missing	1	0.48	

Are you employed?

Response	Frequency	Percent	Mean: 1.73
Yes	55	26.32	
No	152	72.73	
Missing	2	0.96	

Would you say that in general your health now is?

Response	Frequency	Percent	Mean: 3.42
Excellent	7	3.35	
Very good	32	15.31	
Good	62	29.67	
Fair	81	38.76	
Poor	26	12.44	
Missing	1	0.48	

What is the highest year of school you completed?

Response	Frequency	Percent	Mean: 3.62
Grades 1 - 8	3	1.44	
Grades 9 - 11	11	5.26	
Grade 12 or GED	81	38.76	
1-3 years college/technical school	78	37.32	
4 years or more college/technical school	34	16.27	
Missing	2	0.96	

Where do you live?

Response	Frequency	Percent	Mean: 1.59
Own or rent your home	135	64.59	
Live with people friends or relatives	43	20.57	
Consider yourself homeless	7	3.35	
Other living arrangements	22	10.53	
Missing	2	0.96	

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

Response	Frequency	Percent	Mean: 1.92
Yes improved	86	41.15	
Stayed the same as if was before being on Basic Medicaid	59	28.23	
Not sure	52	24.88	
no gotten worse	9	4.31	
Missing	3	1.44	

Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?

Response	Frequency	Percent	Mean: 1.80
1-7 days	105	50.24	
8-13 days	29	13.88	
14 days or more	65	31.10	
Missing	10	4.78	

During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?

Response	Frequency	Percent	Mean: 1.52
None	51	24.40	
Not Sure	56	26.79	
Missing	102	48.80	

During the last 3 months, did you receive physical or mental health care from your doctor?

Response	Frequency	Percent	Mean: 1.06
Yes	191	91.39	
No	12	5.74	
Missing	6	2.87	

During the last 3 months, did you receive physical or mental health care at the emergency room?

Response	Frequency	Percent	Mean: 1.79
Yes	42	20.10	
No	160	76.56	
Missing	7	3.35	

Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?

Response	Frequency	Percent	Mean: 2.03
1-7 days	77	36.84	
8-13 days	42	20.10	
14 days or more	84	40.19	
Missing	6	2.87	

Have you had mental or physical health care in the last 3 months?

Response	Frequency	Percent	Mean: 1.05
Yes. Please complete the rest of the questions.	197	94.26	
No. You do not have to fill out the rest of the questions this survey is complete.	10	4.78	
Missing	2	0.96	

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

Response	Frequency	Percent	Mean: 1.89
Yes	23	11.00	
No	178	85.17	
Missing	8	3.83	

In the last 3 months, how quickly did or could you usually get an appt with your doctor for Physical health?

Response	Frequency	Percent	Mean: 2.40
Within one day	46	22.01	
Within one week	65	31.10	
Within two weeks	35	16.75	
Over two weeks	24	11.48	
Did not need an appointment	12	5.74	
Missing	27	12.92	

Was the time timeframe for getting an appt for physical health satisfactory?

Response	Frequency	Percent	Mean: 1.17
The above timeframe was satisfactory	73	34.93	
The above timeframe was not satisfactory	15	7.18	
Missing	121	57.89	

Was the above timeframe for getting an appt for mental health care satisfactory?

Response	Frequency	Percent	Mean: 1.24
The above timeframe was satisfactory	71	33.97	
The above timeframe was not satisfactory	22	10.53	
Missing	116	55.50	

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	Mean: 1.76
Always	99	47.37	
Usually	65	31.10	
Sometimes	29	13.88	
Never	5	2.39	
Haven't had health care in the last 3 months	4	1.91	
Missing	7	3.35	

In the last 3 months, how quickly did or could you usually get an appointment with your doctor for Mental health?

Response	Frequency	Percent	Mean: 2.39
Within one day	43	20.57	
Within one week	60	28.71	
Within two weeks	40	19.14	
Over two weeks	28	13.40	
Did not need an appointment	5	2.39	
Missing	33	15.79	

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

Response	Frequency	Percent	Mean: 1.96
Yes	39	18.66	
No	138	66.03	
Sometimes	15	7.18	
Haven't needed health care in the last 3 months	8	3.83	
Missing	9	4.31	

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	Mean: 1.86
Always	100	47.85	
Usually	56	26.79	
Sometimes	27	12.92	
Never	12	5.74	
Haven't had health care in the last 3 months	7	3.35	
Missing	7	3.35	

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	Mean: 1.21
Yes	163	77.99	
No	36	17.22	
Haven't needed health care in the last 3 months	3	1.44	
Missing	7	3.35	

If yes, how often do you take your medication as prescribed?

Response	Frequency	Percent	Mean: 1.13
Every day	172	82.30	
More than half the time	5	2.39	
Less than half the time	3	1.44	
Never	4	1.91	
Missing	25	11.96	

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	Mean: -
My doctor does not live in my community	33	15.79	
I need a specialist that does not live in my community	30	14.35	
I live outside a community	20	9.57	
Haven't had health care in the last 3 months	26	12.44	
Missing	115	55.02	

In the last 3 months, have you been prescribed physical or mental health medication by your doctor?

Response	Frequency	Percent	Mean: 1.89
No	22	10.53	
Yes	180	86.12	
Missing	7	3.35	

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

Response	Frequency	Percent	Mean: 1.62
10 miles or less	130	62.20	
11-30 miles	39	18.66	
31-100 miles	16	7.66	
101 miles or more	4	1.91	
Haven't had health care in the last 3 months	10	4.78	
Missing	10	4.78	

Have you received Medicaid travel reimbursement for these trips in the last 3 months?

Response	Frequency	Percent	Mean: 2.17
Yes	3	1.44	
No	145	69.38	
Some trips	3	1.44	
Haven't had health care in the last 3 months	14	6.70	
Missing	44	21.05	

Detailed Item Analysis Report

How well do you understand your Basic Medicaid benefit? (Like the kinds of benefits you can receive and what type of doctors/health professionals you can see.) Mean: 1.63

Response	Value	Frequency	Percent	Graph
Very well	3.00	27	12.92	
Well	2.00	77	36.84	
Not well at all	1.00	105	50.24	
Total Valid		209	100.00	

In addition to Basic Medicaid, do you have other kinds of health care coverage? Mean: -

Response	Value	Frequency	Percent	Graph
Medicare	1.00	79	37.80	
Veteran's	2.00	4	1.91	
Private Health Insurance	3.00	4	1.91	
Other please specify	4.00	14	6.70	
No	5.00	109	52.15	
Total Valid		206	98.56	
Missing		3	1.44	
Total		209	100.00	

Do you have a main doctor (who provides physical health care)

Mean: 1.13

Response	Value	Frequency	Percent	Graph
Yes	1.00	180	86.12	
No	2.00	28	13.40	
Total Valid		208	99.52	
Missing		1	0.48	
Total		209	100.00	

Did you have a main doctor (who provides physical health care) before you received Basic Medicaid?

Mean: 1.35

Response	Value	Frequency	Percent	Graph
Yes	1.00	136	65.07	
No	2.00	72	34.45	
Total Valid		208	99.52	
Missing		1	0.48	
Total		209	100.00	

When did you last see a doctor for physical health care -

Mean: 1.72

Response	Value	Frequency	Percent	Graph
within the last month	1.00	93	44.50	
within the last year	2.00	92	44.02	
within the last 2-4 years	3.00	17	8.13	
within the last 5-10 years	4.00	4	1.91	
over 10 years ago	5.00	3	1.44	
Total Valid		209	100.00	

What is your gender?

Mean: 1.52

Response	Value	Frequency	Percent	Graph
male	1.00	101	48.33	
female	2.00	108	51.67	
Total Valid		209	100.00	

Race and ethnicity

Mean: -

Response	Value	Frequency	Percent	Graph
Hispanic/Latino	1.00	7	3.35	
Non-Hispanic/Latino	2.00	2	0.96	
White	3.00	185	88.52	
American Indian or Alaska Native	4.00	16	7.66	
Black or African American	5.00	1	0.48	
Asian	6.00	1	0.48	
Pacific Islander	7.00	0	0.00	
Unknown	8.00	2	0.96	
Total Valid		208	99.52	
Missing		1	0.48	
Total		209	100.00	

What is the highest year of school you completed?

Mean: 3.62

Response	Value	Frequency	Percent	Graph
Grades 1 - 8	1.00	3	1.44	
Grades 9 - 11	2.00	11	5.26	
Grade 12 or GED	3.00	81	38.76	
1-3 years college/technical school	4.00	78	37.32	
4 years or more college/technical school	5.00	34	16.27	
Total Valid		207	99.04	
Missing		2	0.96	
Total		209	100.00	

Are you employed?

Mean: 1.73

Response	Value	Frequency	Percent	Graph
Yes	1.00	55	26.32	
No	2.00	152	72.73	
Total Valid		207	99.04	
Missing		2	0.96	
Total		209	100.00	

Where do you live?

Mean: 1.59

Response	Value	Frequency	Percent	Graph
Own or rent your home	1.00	135	64.59	
Live with people friends or relatives	2.00	43	20.57	
Consider yourself homeless	3.00	7	3.35	
Other living arrangements	4.00	22	10.53	
Total Valid		207	99.04	
Missing		2	0.96	
Total		209	100.00	

Would you say that in general your health now is?

Mean: 3.42

Response	Value	Frequency	Percent	Graph
Excellent	1.00	7	3.35	
Very good	2.00	32	15.31	
Good	3.00	62	29.67	
Fair	4.00	81	38.76	
Poor	5.00	26	12.44	
Total Valid		208	99.52	
Missing		1	0.48	
Total		209	100.00	

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

Mean: 1.92

Response	Value	Frequency	Percent	Graph
Yes improved	1.00	86	41.15	
Stayed the same as if was before being on Basic Medicaid	2.00	59	28.23	
Not sure	3.00	52	24.88	
no gotten worse	4.00	9	4.31	
Total Valid		206	98.56	
Missing		3	1.44	
Total		209	100.00	

Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?

Mean: 1.80

Response	Value	Frequency	Percent	Graph
1-7 days	1.00	105	50.24	
8-13 days	2.00	29	13.88	
14 days or more	3.00	65	31.10	
Total Valid		199	95.22	
Missing		10	4.78	
Total		209	100.00	

Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good? Mean: 2.03

Response	Value	Frequency	Percent	Graph
1-7 days	1.00	77	36.84	
8-13 days	2.00	42	20.10	
14 days or more	3.00	84	40.19	
Total Valid		203	97.13	
Missing		6	2.87	
Total		209	100.00	

During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation? Mean: 1.52

Response	Value	Frequency	Percent	Graph
None	1.00	51	24.40	
Not Sure	2.00	56	26.79	
Total Valid		107	51.20	
Missing		102	48.80	
Total		209	100.00	

Have you had mental or physical health care in the last 3 months?

Mean: 1.05

Response	Value	Frequency	Percent	Graph
Yes. Please complete the rest of the questions.	1.00	197	94.26	
No. You do not have to fill out the rest of the questions this survey is complete.	2.00	10	4.78	
Total Valid		207	99.04	
Missing		2	0.96	
Total		209	100.00	

During the last 3 months, did you receive physical or mental health care from your doctor?

Mean: 1.06

Response	Value	Frequency	Percent	Graph
Yes	1.00	191	91.39	
No	2.00	12	5.74	
Total Valid		203	97.13	
Missing		6	2.87	
Total		209	100.00	

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

Mean: 1.89

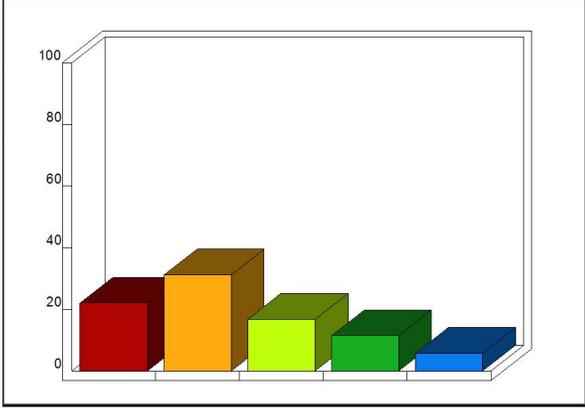
Response	Value	Frequency	Percent	Graph
Yes	1.00	23	11.00	
No	2.00	178	85.17	
Total Valid		201	96.17	
Missing		8	3.83	
Total		209	100.00	

During the last 3 months, did you receive physical or mental health care at the emergency room?

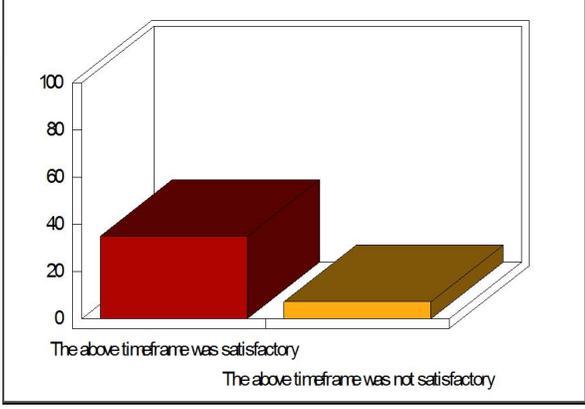
Mean: 1.79

Response	Value	Frequency	Percent	Graph
Yes	1.00	42	20.10	
No	2.00	160	76.56	
Total Valid		202	96.65	
Missing		7	3.35	
Total		209	100.00	

In the last 3 months, how quickly did or could you usually get an appt with your doctor for Physical health? Mean: 2.40

Response	Value	Frequency	Percent	Graph
Within one day	1.00	46	22.01	
Within one week	2.00	65	31.10	
Within two weeks	3.00	35	16.75	
Over two weeks	4.00	24	11.48	
Did not need an appointment	5.00	12	5.74	
Total Valid		182	87.08	
Missing		27	12.92	
Total		209	100.00	

Was the time timeframe for getting an appt for physical health satisfactory? Mean: 1.17

Response	Value	Frequency	Percent	Graph
The above timeframe was satisfactory	1.00	73	34.93	
The above timeframe was not satisfactory	2.00	15	7.18	
Total Valid		88	42.11	
Missing		121	57.89	
Total		209	100.00	

In the last 3 months, how quickly did or could you usually get an appointment with your doctor for Mental health?

Mean: 2.39

Response	Value	Frequency	Percent	Graph
Within one day	1.00	43	20.57	
Within one week	2.00	60	28.71	
Within two weeks	3.00	40	19.14	
Over two weeks	4.00	28	13.40	
Did not need an appointment	5.00	5	2.39	
Total Valid		176	84.21	
Missing		33	15.79	
Total		209	100.00	

Was the above timeframe for getting an appt for mental health care satisfactory?

Mean: 1.24

Response	Value	Frequency	Percent	Graph
The above timeframe was satisfactory	1.00	71	33.97	
The above timeframe was not satisfactory	2.00	22	10.53	
Total Valid		93	44.50	
Missing		116	55.50	
Total		209	100.00	

Was there a time in the past 3 months when you needed to see a doctor for physical or mental health but could not because of cost? Mean: 1.96

Response	Value	Frequency	Percent	Graph	
Yes	1.00	39	18.66		
No	2.00	138	66.03		
Sometimes	3.00	15	7.18		
Haven't needed health care in the last 3 months	4.00	8	3.83		
Total Valid					200
Missing				9	4.31
Total				209	100.00

In the last 3 months, has your doctor spent enough time listening to your concerns and answering your mental or physical health questions? Mean: 1.76

Response	Value	Frequency	Percent	Graph	
Always	1.00	99	47.37		
Usually	2.00	65	31.10		
Sometimes	3.00	29	13.88		
Never	4.00	5	2.39		
Haven't had health care in the last 3 months	5.00	4	1.91		
Total Valid				202	96.65
Missing				7	3.35
Total				209	100.00

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?

Mean: 1.86

Response	Value	Frequency	Percent	Graph
Always	1.00	100	47.85	
Usually	2.00	56	26.79	
Sometimes	3.00	27	12.92	
Never	4.00	12	5.74	
Haven't had health care in the last 3 months	5.00	7	3.35	
Total Valid		202	96.65	
Missing		7	3.35	
Total		209	100.00	

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?

Mean: 1.21

Response	Value	Frequency	Percent	Graph
Yes	1.00	163	77.99	
No	2.00	36	17.22	
Haven't needed health care in the last 3 months	3.00	3	1.44	
Total Valid		202	96.65	
Missing		7	3.35	
Total		209	100.00	

In the last 3 months, have you been prescribed physical or mental health medication by your doctor?

Mean: 1.89

Response	Value	Frequency	Percent	Graph
No	1.00	22	10.53	
Yes	2.00	180	86.12	
Total Valid		202	96.65	
Missing		7	3.35	
Total		209	100.00	

If yes, how often do you take your medication as prescribed?

Mean: 1.13

Response	Value	Frequency	Percent	Graph
Every day	1.00	172	82.30	
More than half the time	2.00	5	2.39	
Less than half the time	3.00	3	1.44	
Never	4.00	4	1.91	
Total Valid		184	88.04	
Missing		25	11.96	
Total		209	100.00	

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

Mean: 1.62

Response	Value	Frequency	Percent	Graph
10 miles or less	1.00	130	62.20	
11-30 miles	2.00	39	18.66	
31-100 miles	3.00	16	7.66	
101 miles or more	4.00	4	1.91	
Haven't had health care in the last 3 months	5.00	10	4.78	
Total Valid		199	95.22	
Missing		10	4.78	
Total		209	100.00	

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)?

Mean: -

Response	Value	Frequency	Percent	Graph
My doctor does not live in my community	1.00	33	15.79	
I need a specialist that does not live in my community	2.00	30	14.35	
I live outside a community	3.00	20	9.57	
Haven't had health care in the last 3 months	4.00	26	12.44	
Total Valid		94	44.98	
Missing		115	55.02	
Total		209	100.00	

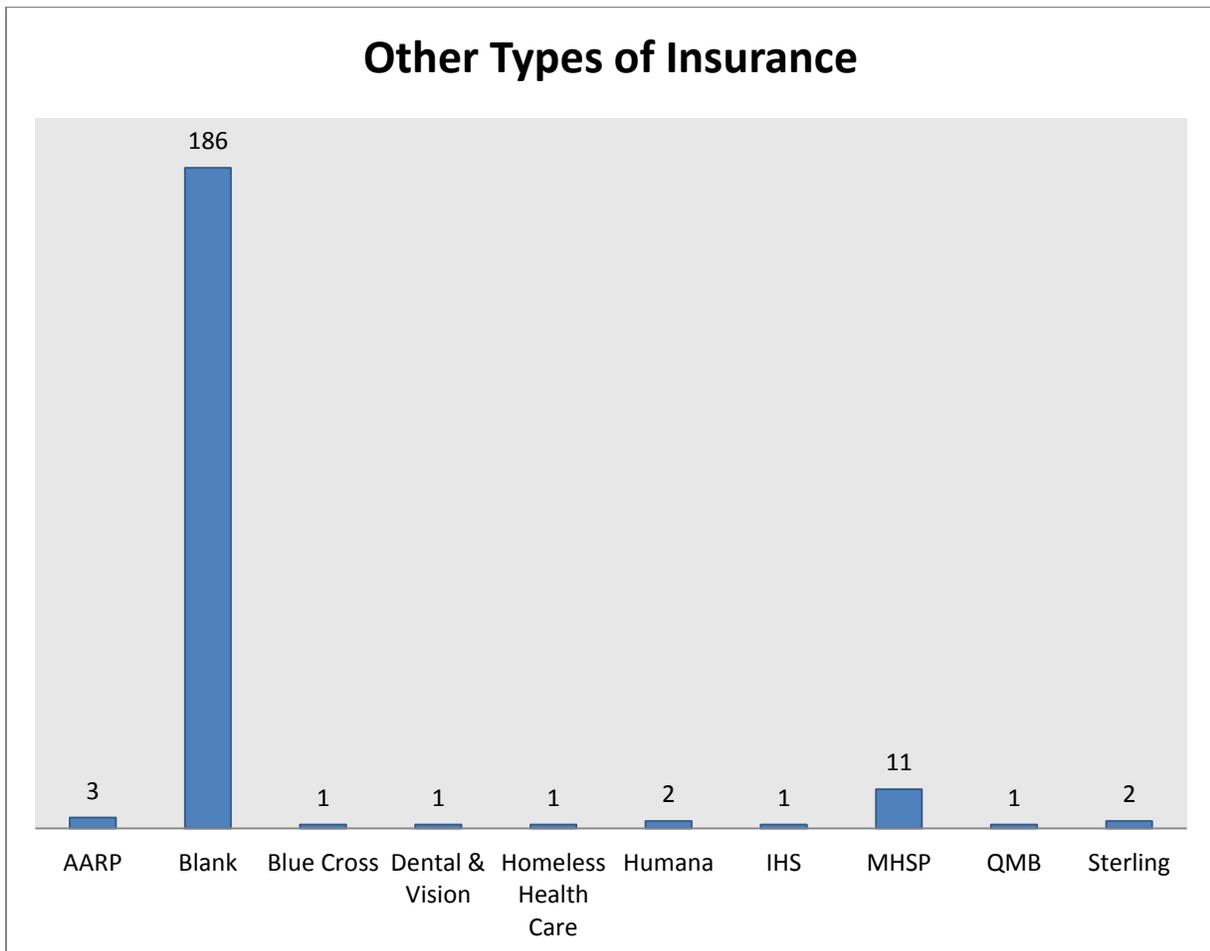
Have you received Medicaid travel reimbursement for these trips in the last 3 months?

Mean: 2.17

Response	Value	Frequency	Percent	Graph
Yes	1.00	3	1.44	
No	2.00	145	69.38	
Some trips	3.00	3	1.44	
Haven't had health care in the last 3 months	4.00	14	6.70	
Total Valid		165	78.95	
Missing		44	21.05	
Total		209	100.00	

Basic Medicaid Survey Results – August 2012

AARP	3
Blank	186
Blue Cross	1
Dental & Vision	1
Homeless Health Care	1
Humana	2
IHS	1
MHSP	11
QMB	1
Sterling	2



Item Analysis Graph Report

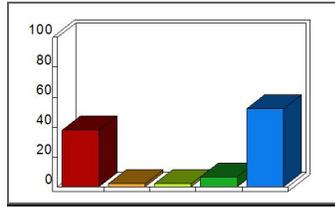
Q1



Mean: 1.63

Response	Percent
Very well	12.92
Well	36.84
Not well at all	50.24

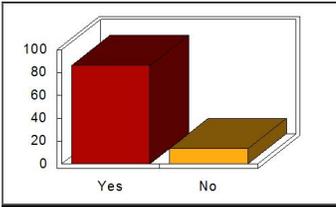
Q2



Mean: -

Response	Percent
Medicare	37.80
Veteran's	1.91
Private Health Insurance	1.91
Other please specify	6.70
No	52.15

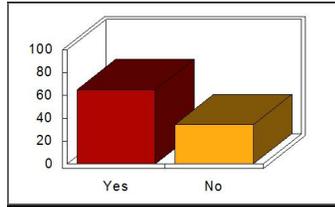
Q3



Mean: 1.13

Response	Percent
Yes	86.12
No	13.40

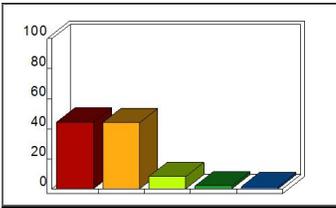
Q4



Mean: 1.35

Response	Percent
Yes	65.07
No	34.45

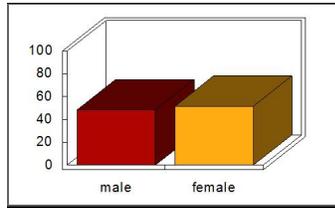
Q5



Mean: 1.72

Response	Percent
within the last month	44.50
within the last year	44.02
within the last 2-4 years	8.13
within the last 5-10 years	1.91
over 10 years ago	1.44

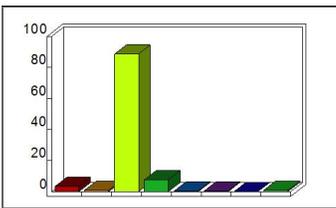
Q6



Mean: 1.52

Response	Percent
male	48.33
female	51.67

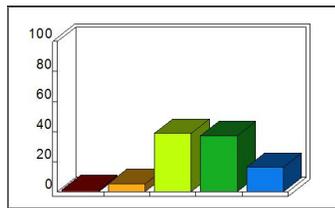
Q8



Mean: -

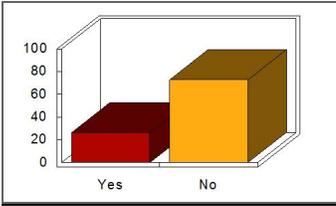
Response	Percent
Hispanic/Latino	3.35
Non-Hispanic/Latino	0.96
White	88.52
American Indian or Alaska Native	7.66
Black or African American	0.48
Asian	0.48
Pacific Islander	0.00
Unknown	0.96

Q9



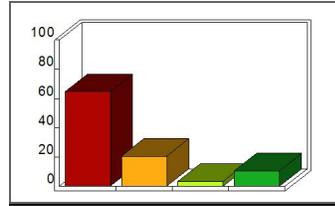
Mean: 3.62

Response	Percent
Grades 1 - 8	1.44
Grades 9 - 11	5.26
Grade 12 or GED	38.76
1-3 years college/technical school	37.32
4 years or more college/technical school	16.27

Q10

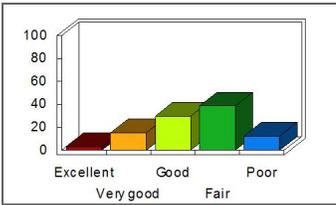
Mean: 1.73

Response	Percent
Yes	26.32
No	72.73

Q11

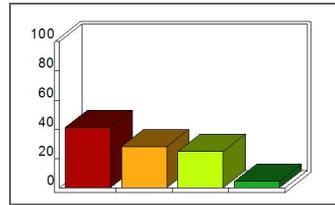
Mean: 1.59

Response	Percent
Own or rent your home	64.59
Live with people friends or relatives	20.57
Consider yourself homeless	3.35
Other living arrangements	10.53

Q12

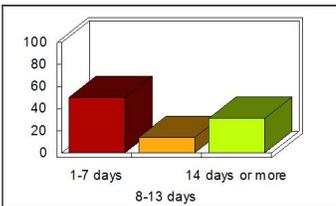
Mean: 3.42

Response	Percent
Excellent	3.35
Very good	15.31
Good	29.67
Fair	38.76
Poor	12.44

Q13

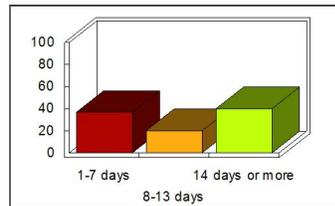
Mean: 1.92

Response	Percent
Yes improved	41.15
Stayed the same as if was before being on Basic Medicaid	28.23
Not sure	24.88
no gotten worse	4.31

Q14

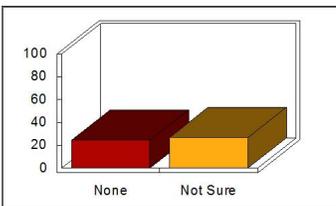
Mean: 1.80

Response	Percent
1-7 days	50.24
8-13 days	13.88
14 days or more	31.10

Q15

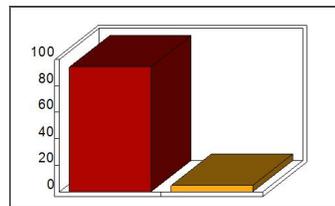
Mean: 2.03

Response	Percent
1-7 days	36.84
8-13 days	20.10
14 days or more	40.19

Q16a

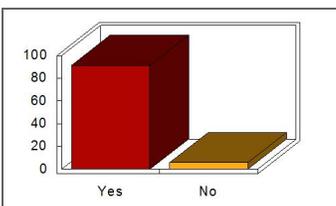
Mean: 1.52

Response	Percent
None	24.40
Not Sure	26.79

Q17

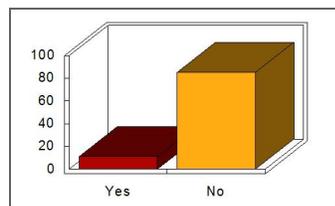
Mean: 1.05

Response	Percent
Yes. Please complete the rest of the questions.	94.26
No. You do not have to fill out the rest of the questions this survey is complete.	4.78

Q18

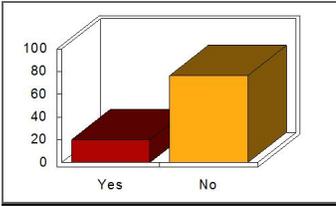
Mean: 1.06

Response	Percent
Yes	91.39
No	5.74

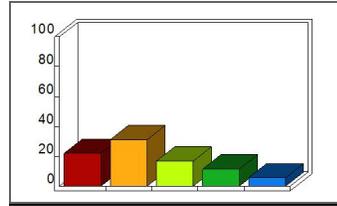
Q19

Mean: 1.89

Response	Percent
Yes	11.00
No	85.17

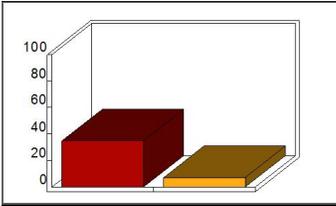
Q20

Mean: 1.79

Q21P

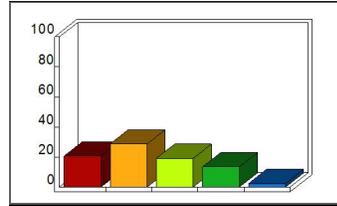
Mean: 2.40

Response	Percent
Within one day	22.01
Within one week	31.10
Within two weeks	16.75
Over two weeks	11.48
Did not need an appointment	5.74

Q21Pa

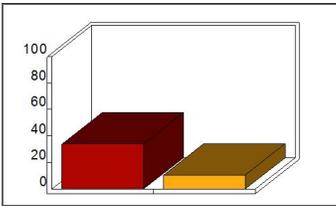
Mean: 1.17

Response	Percent
The above timeframe was satisfactory	34.93
The above timeframe was not satisfactory	7.18

Q21M

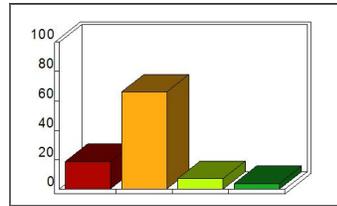
Mean: 2.39

Response	Percent
Within one day	20.57
Within one week	28.71
Within two weeks	19.14
Over two weeks	13.40
Did not need an appointment	2.39

Q21Ma

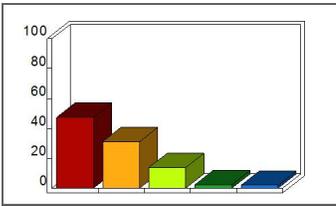
Mean: 1.24

Response	Percent
The above timeframe was satisfactory	33.97
The above timeframe was not satisfactory	10.53

Q22

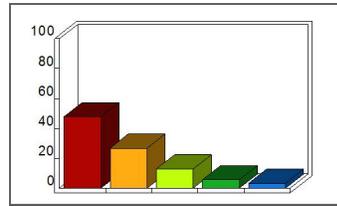
Mean: 1.96

Response	Percent
Yes	18.66
No	66.03
Sometimes	7.18
Haven't needed health care in the last 3 months	3.83

Q23

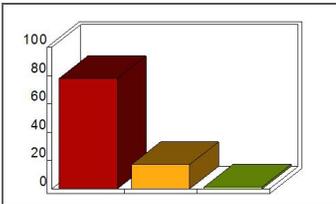
Mean: 1.76

Response	Percent
Always	47.37
Usually	31.10
Sometimes	13.88
Never	2.39
Haven't had health care in the last 3 months	1.91

Q24

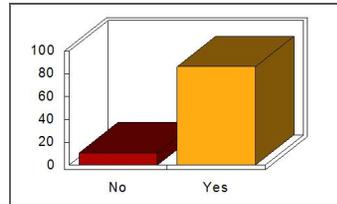
Mean: 1.86

Response	Percent
Always	47.85
Usually	26.79
Sometimes	12.92
Never	5.74
Haven't had health care in the last 3 months	3.35

Q25

Mean: 1.21

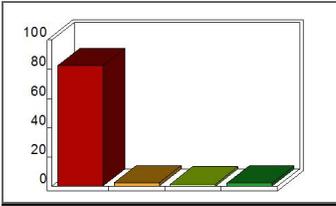
Response	Percent
Yes	77.99
No	17.22
Haven't needed health care in the last 3 months	1.44

Q26a

Mean: 1.89

Response	Percent
No	10.53
Yes	86.12

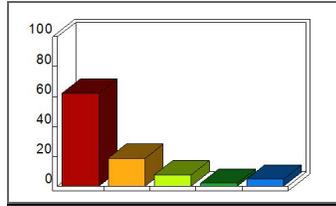
Q26b



Mean: 1.13

Response	Percent
Every day	82.30
More than half the time	2.39
Less than half the time	1.44
Never	1.91

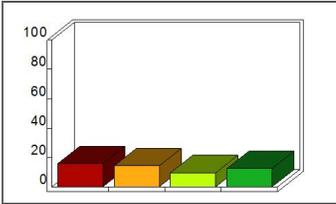
Q27



Mean: 1.62

Response	Percent
10 miles or less	62.20
11-30 miles	18.66
31-100 miles	7.66
101 miles or more	1.91
Haven't had health care in the last 3 months	4.78

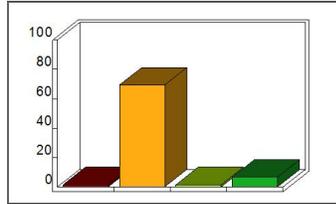
Q28



Mean: -

Response	Percent
My doctor does not live in my community	15.79
I need a specialist that does not live in my community	14.35
I live outside a community	9.57
Haven't had health care in the last 3 months	12.44

Q29



Mean: 2.17

Response	Percent
Yes	1.44
No	69.38
Some trips	1.44
Haven't had health care in the last 3 months	6.70

MONTANA DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

Section 1115 Waiver for Health Care Reform

***Evaluation Report
February 2010 – December 2012***

October 31, 2013



Executive Summary

The Basic Medicaid Program has remained a positive source of Medicaid coverage since the program's inception in 1996. The Basic Program is comprised of mandatory Medicaid benefits and a collection of optional services available for emergencies and when necessary, for seeking and maintaining employment. These services are available to able-bodied adults (neither pregnant nor disabled) who are parents and/or caretaker relatives of dependent children. The most significant change has been adding up to 800 individuals with schizophrenia or bipolar disorder who qualify for the Basic Medicaid Waiver in December 2010.

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 are the medical services provided for Able-Bodied Adults (neither pregnant nor disabled) and who are parents and/or caretaker relatives of dependent children, eligible for Medicaid under Sections 1925 or 1931 of the Social Security Act. The Basic Program is operated under a Section 1115 waiver, offers 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 are waived enabling Montana to carry out the 1115 demonstration.

In February 1996, Montana implemented its state-specific welfare reform program known as Families Achieving Independence in Montana (FAIM). This sweeping change involved the cash assistance, food stamp, and Medicaid programs that were administered on the federal side by several agencies under multiple statutes. As part of welfare reform, Montana obtained a Section 1115 waiver, approved in February 1996. On October 23, 2003, the Department submitted an 1115 waiver application to CMS requesting approval to continue the Basic Medicaid Program. CMS approved the waiver application on January 29, 2004 for a five-year period from February 1, 2004 through January 31, 2009. Terms of the request and the approval were consolidated into an Operational Protocol document as of February 2005. The waiver structure has remained constant throughout the life of the Basic Program. The State must submit a quarterly Basic Medicaid report as one of the Operational Protocol conditions.

A HIFA proposal was submitted on June 27, 2006. 1115 Basic Medicaid Waiver amendments were submitted on March 23, 2007 and January 28, 2008 requesting seven new optional and expansion populations. Tribal Consultation was completed on December 14, 2007. As a result of discussions with CMS, Montana submitted a revised 1115 Basic Medicaid Waiver amendment on June 6, 2008 requesting four new populations. On July 30, 2009 and August 6, 2010 submittals requested only one population, MHSP Waiver 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.

Department of Public Health and Human Services

Richard Opper is the Department Director 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 continue 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 Mental Health and Services Plan (MHSP) group.

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 Excluded Services

The Basic package is the Full Medicaid benefit, with the following medical services generally excluded under Basic Medicaid: audiology, dental and dentist, 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 recognizes there may be situations where the excluded services are necessary as in an emergency or when essential for employment. Coverage for the excluded services may be provided at the State's discretion in cases of emergency or when essential to obtain or maintain employment. Examples of emergency circumstances include, but are not limited to, coverage for emergency dental situations, medical conditions of the eye, which include but are 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 will provide approval to the provider, and make associated records available upon CMS request. Medicaid manuals contain Basic information and are found on the Department site at <http://medicaidprovider.hhs.mt.gov/index.shtml>.

The *General Information for Providers, Medicaid and Other Medical Assistance Programs*, is found at <http://medicaidprovider.hhs.mt.gov/pdf/general.pdf>, which explains Basic Medicaid eligibility to providers in section 3.1 and publishes the list of covered Basic services in Appendix A-1. Basic Medicaid emergency and Essentials for Employment Program covered service information is also included in specific provider manuals like, *Dental and Denturist*, found in sections 1.1 and 1.3. Charts of dental covered procedure codes, beginning in section 1.4, also list the Basic coverage limits.

Medicaid provider training is offered several times a year and Basic Medicaid billing, policies, and procedures are included. Providers, when inquiring about client eligibility, receive eligibility information including whether a person is receiving Full or Basic Medicaid regardless of the various eligibility

methods of Faxback, Voice Response, or when contacting the Office of Public Assistance, the Department, or Montana Medicaid’s Provider Relations.

Individuals on Medicaid are given a copy of the Medicaid Health Insurance Services, “*Member Guide*,” found at: <http://medicaidprovider.hhs.mt.gov/pdf/medinfo.pdf>. A chart of Medicaid covered benefits is published on page 19. Clients receive education and information regarding Full and Basic Medicaid services through the Montana Medicaid Hotline. The provider community and individuals who are affected by the 1115 waiver are accustomed to the provisions of the waiver.

Basic Medicaid Population

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

Basic Medicaid Population DY7 Average - December 2012 Average		
	February 2010 – January 2011 DY7 Average	December 2012 Average
Family Medicaid	78.75%	72.49%
Transitional Medicaid	21.12%	18.45%
WMHSP Schizophrenia	0.55%	3.89%
WMHSP Bipolar Disorder	0%	5.17%

Basic and Full Medicaid Enrollment DY7 Average – December 2012

In DY7 a quarterly average of 9,063 individuals (8,768 in December 2012) were enrolled in Basic Medicaid. Of the 27,070 (28,855 in December 2012) all Medicaid individuals, age 21-64, 33.68% (30.38% in December 2012) were Basic Medicaid.

Basic and Full Medicaid Enrollment DY7 Average – December 2012 Average		
	February 2010 – January 2011 DY7 Average	December 2012 Average
Basic Medicaid Enrollment	9,063	8,768
Full Medicaid Enrollment (Age 21-64)	27,070	28,855

Full (Age 21-64) and Basic Medicaid Gender, Ethnic and Race DY7 Average – December 2012

Basic Medicaid was 69.07% (67.93% in December 2012) predominately female as compared to 64.14% (64.49% in December 2012) females for all Medicaid in the 21-64 age group. Males in Full Medicaid are 6.71% (3.65% in December 2012) less than the Basic population. The American Indian quarterly average for Basic is 33.26% (27.60% in December 2012), which is 11.91% (9.60% in December 2012) more than the Full Medicaid average of 21.35% (18% in December 2012).

Basic Medicaid Gender, Ethnic and Race DY7 Average – December 2012 Average		
	February 2010 – January 2011 DY7 Average	December 2012 Average
Gender		
Female	69.07%	67.93%
Male	30.93%	32.06%
Ethnic and Race (Plus Any Other)		
Hispanic of Any Race	3.24%	4.85%
White	66.10%	70.70%
American Indian/AK	33.26%	27.60%
Other: African American, Asian, Pacific Islander	1.20%	1.44%

Full Medicaid Gender, Ethnic and Race (Age 21-64) DY7 Average – December 2012 Average		
	February 2010 – January 2011 DY7 Average	December 2012 Average
Gender		
Female	64.14%	64.29%
Male	36.12%	35.71%
Ethnic and Race (Plus Any Other)		
Hispanic of Any Race	2.49%	2.50%
White	77.73%	78.11%
American Indian/AK	21.35%	18.00%
Other	1.18%	1.29%

	BN Limit	CMS-64 Waiver Costs	Annual Variance	Cumulative BN Limit	Cumulative CMS-64 Waiver Costs	Cumulative Variance
DY7 February 2010 - January 2011	\$39,180,273	\$25,888,909	\$13,291,364	\$200,211,559	\$145,722,183	\$54,489,376
DY8 February 2011 - January 2012	\$36,485,101	\$22,792,736	\$11,918,669	\$236,696,660	\$170,288,615	\$66,408,045
DY9 February 2012 - January 2012	\$35,725,873	\$16,445,819	\$14,201,474	\$272,422,532	\$191,813,014	\$80,609,518

Section 1115 Montana Basic Medicaid Waiver Survey Summary

On July 31, 2012, the Department distributed 787 surveys with a pre-paid return envelope to WMHSP Waiver individuals, those individuals with schizophrenia or bipolar disorder, to establish a base line. A ticket for a chance to win a \$50 gift certificate to grocery store of their choice was included in the survey. The survey was due August 17, 2012. Reminder flyers were mailed to the mental health centers. The Department received 209 surveys.

A summary of the data is as follows:

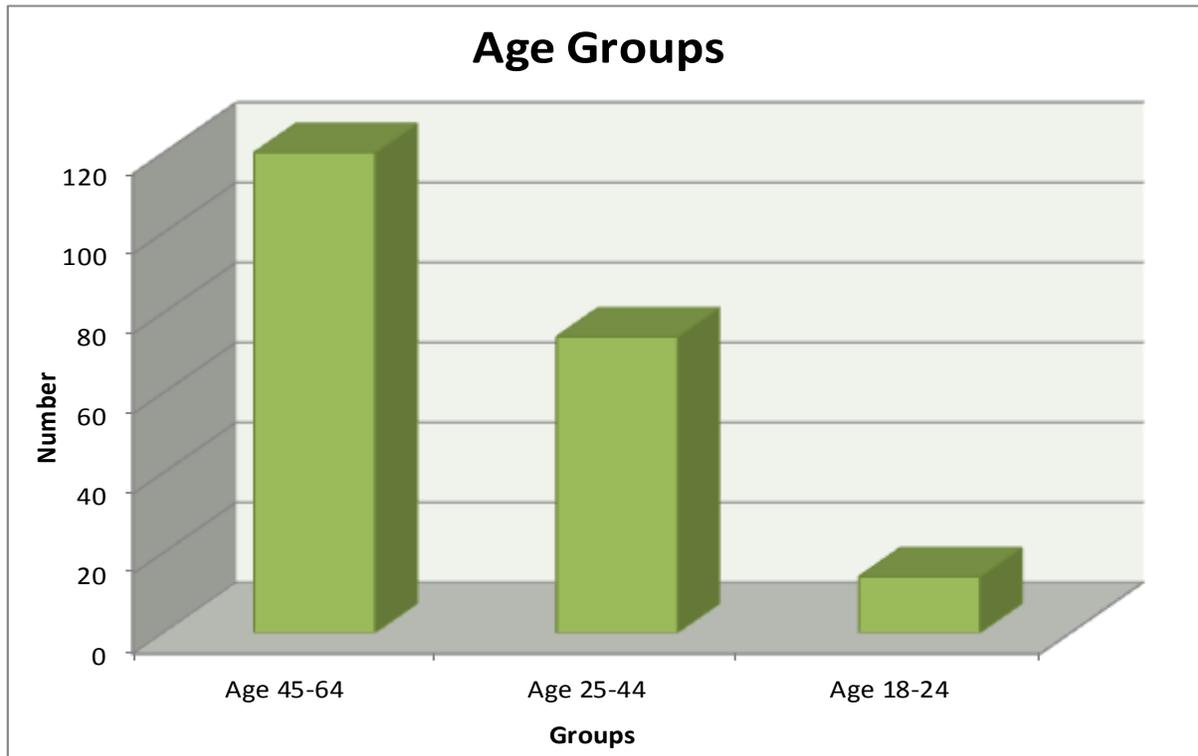
- 50% stated they did understand their Basic Medicaid benefits.
- 86% have a main doctor for physical health.
- 44% have seen a doctor in past month, while 44% in the past year.
- 52% were female.
- 89% were Caucasian, 7% Native American and 4% Hispanic.
- 73% were not employed.
- 39% consider their health fair, 30% good, and 12% poor.
- 41% believe their general health has improved since receiving the Basic Medicaid benefits.
- 94% have had mental or physical health care in the last three months.
- In the last three months, 31% could get an appointment within one week, 22% within a day, and 17% within two weeks.
- In the last three months, 47% always felt their doctor spent time listening to their concerns; 31% felt their doctor usually listened to them.
- In the last three months, 29% could receive an appointment with their doctor for mental health, 20% within a day, 19% within two weeks, and 13% over two weeks.
- In the past three months when they needed to see a doctor for physical or mental health but could not because of cost, 66% said no.
- 78% believe that in the past three months they could access physical or mental health care services when needed. *See the attached Detailed Analysis Reports for additional information.

Contact Information

Jo Thompson, Bureau Chief, Health Resources Division
Mary E. Dalton, State Medicaid Director

(406) 444-4146
(406) 444-4084

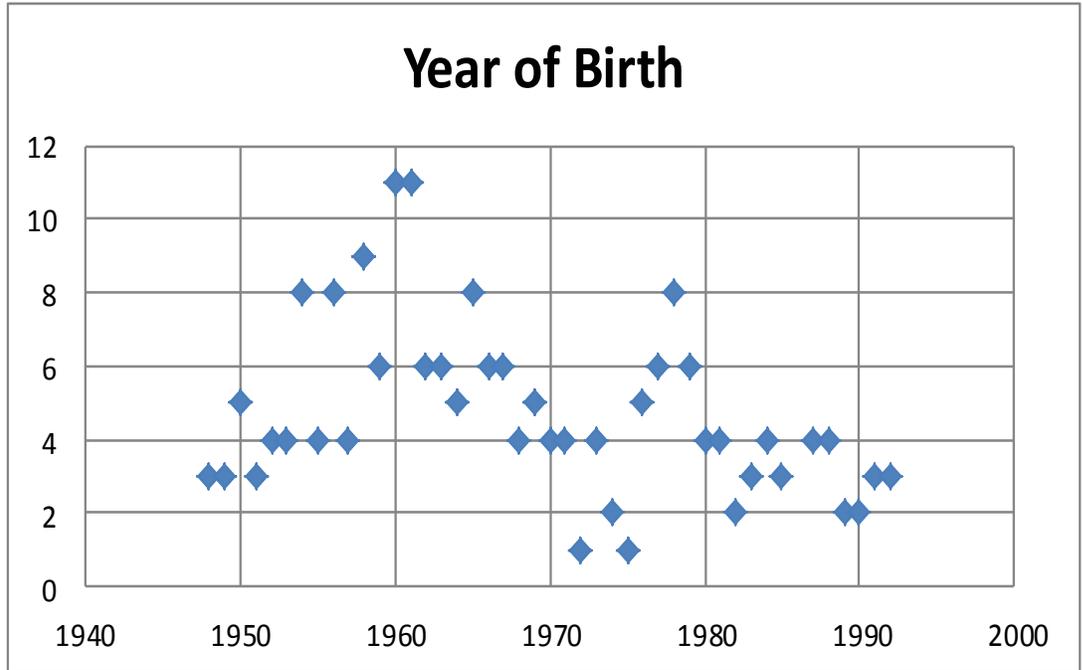
Basic Medicaid Survey Results—August 2012



Age 45-64	120
Age 25-44	74
Age 18-24	14

Basic Medicaid Survey Results—August 2012

1948	3
1949	3
1950	5
1951	3
1952	4
1953	4
1954	8
1955	4
1956	8
1957	4
1958	9
1959	6
1960	11
1961	11
1962	6
1963	6
1964	5
1965	8
1966	6
1967	6
1968	4
1969	5
1970	4
1971	4
1972	1
1973	4
1974	2
1975	1
1976	5
1977	6
1978	8
1979	6
1980	4
1981	4
1982	2
1983	3
1984	4
1985	3
1987	4
1988	4
1989	2
1990	2
1991	3
1992	3



Basic Medicaid Waiver for MHSP Population

Basic Medicaid will be provided for up to 800 State Only MHSP individuals who qualify for the Basic Medicaid Waiver. MHSP individuals who meet waiver qualifications receive Basic benefits for 12 months of continuous eligibility without reporting monthly changes of income and resources. The Basic package is 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.

Qualifications include: Meet the State Only MHSP eligibility, have a primary clinical diagnosis of schizophrenia or bipolar disorder; are ages 18-64; are Montana residents (individuals must provide citizenship and identification documentation); have incomes at or below 150% FPL; and are not otherwise qualified for Medicaid.

Quotes from individuals receiving the Basic Medicaid Waiver:

“If it wasn’t for Medicaid, I couldn’t make doctor visits and medications cost a lot for the meds I take.”

“I cannot express how much this help has meant to me, I am able to get ALL my prescriptions – not having to choose which is most important. Thank you.”

“Montana has taken excellent care of me, much thanks for saving my LIFE.”

“Medicaid saved me and made me able to get my mental health taken care of after losing my job because of getting sick and hospitalized – THANK YOU!”

“Being able to receive basic Medicaid I have put my health as my first priority now.”

“I am very satisfied with how fortunate I am to live here in such a wonderful place.”

Condensed Item Analysis Report

How well do you understand your Basic Medicaid benefit? (Like the kinds of benefits you can receive and what type of doctors/health professionals you can see.)

Response	Frequency	Percent	Mean: 1.63
Very well	27	12.92	<div style="width: 12.92%; height: 15px; background-color: blue;"></div>
Well	77	36.84	<div style="width: 36.84%; height: 15px; background-color: blue;"></div>
Not well at all	105	50.24	<div style="width: 50.24%; height: 15px; background-color: blue;"></div>
Missing	0	0.00	<div style="width: 0%; height: 15px; background-color: blue;"></div>

Do you have a main doctor (who provides physical health care)

Response	Frequency	Percent	Mean: 1.13
Yes	180	86.12	<div style="width: 86.12%; height: 15px; background-color: blue;"></div>
No	28	13.40	<div style="width: 13.40%; height: 15px; background-color: blue;"></div>
Missing	1	0.48	<div style="width: 0%; height: 15px; background-color: blue;"></div>

When did you last see a doctor for physical health care -

Response	Frequency	Percent	Mean: 1.72
within the last month	93	44.50	<div style="width: 44.50%; height: 15px; background-color: blue;"></div>
within the last year	92	44.02	<div style="width: 44.02%; height: 15px; background-color: blue;"></div>
within the last 2-4 years	17	8.13	<div style="width: 8.13%; height: 15px; background-color: blue;"></div>
within the last 5-10 years	4	1.91	<div style="width: 1.91%; height: 15px; background-color: blue;"></div>
over 10 years ago	3	1.44	<div style="width: 1.44%; height: 15px; background-color: blue;"></div>
Missing	0	0.00	<div style="width: 0%; height: 15px; background-color: blue;"></div>

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

Response	Frequency	Percent	Mean: -
Medicare	79	37.80	<div style="width: 37.80%; height: 15px; background-color: blue;"></div>
Veteran's	4	1.91	<div style="width: 1.91%; height: 15px; background-color: blue;"></div>
Private Health Insurance	4	1.91	<div style="width: 1.91%; height: 15px; background-color: blue;"></div>
Other please specify	14	6.70	<div style="width: 6.70%; height: 15px; background-color: blue;"></div>
No	109	52.15	<div style="width: 52.15%; height: 15px; background-color: blue;"></div>
Missing	3	1.44	<div style="width: 0%; height: 15px; background-color: blue;"></div>

Did you have a main doctor (who provides physical health care) before you received Basic Medicaid?

Response	Frequency	Percent	Mean: 1.35
Yes	136	65.07	<div style="width: 65.07%; height: 15px; background-color: blue;"></div>
No	72	34.45	<div style="width: 34.45%; height: 15px; background-color: blue;"></div>
Missing	1	0.48	<div style="width: 0%; height: 15px; background-color: blue;"></div>

What is your gender?

Response	Frequency	Percent	Mean: 1.52
male	101	48.33	<div style="width: 48.33%; height: 15px; background-color: blue;"></div>
female	108	51.67	<div style="width: 51.67%; height: 15px; background-color: blue;"></div>
Missing	0	0.00	<div style="width: 0%; height: 15px; background-color: blue;"></div>

Race and ethnicity

Response	Frequency	Percent	Mean: -
Hispanic/Latino	7	3.35	
Non-Hispanic/Latino	2	0.96	
White	185	88.52	
American Indian or Alaska Native	16	7.66	
Black or African American	1	0.48	
Asian	1	0.48	
Pacific Islander	0	0.00	
Unknown	2	0.96	
Missing	1	0.48	

Are you employed?

Response	Frequency	Percent	Mean: 1.73
Yes	55	26.32	
No	152	72.73	
Missing	2	0.96	

Would you say that in general your health now is?

Response	Frequency	Percent	Mean: 3.42
Excellent	7	3.35	
Very good	32	15.31	
Good	62	29.67	
Fair	81	38.76	
Poor	26	12.44	
Missing	1	0.48	

What is the highest year of school you completed?

Response	Frequency	Percent	Mean: 3.62
Grades 1 - 8	3	1.44	
Grades 9 - 11	11	5.26	
Grade 12 or GED	81	38.76	
1-3 years college/technical school	78	37.32	
4 years or more college/technical school	34	16.27	
Missing	2	0.96	

Where do you live?

Response	Frequency	Percent	Mean: 1.59
Own or rent your home	135	64.59	
Live with people friends or relatives	43	20.57	
Consider yourself homeless	7	3.35	
Other living arrangements	22	10.53	
Missing	2	0.96	

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

Response	Frequency	Percent	Mean: 1.92
Yes improved	86	41.15	
Stayed the same as if was before being on Basic Medicaid	59	28.23	
Not sure	52	24.88	
no gotten worse	9	4.31	
Missing	3	1.44	

Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?

Response	Frequency	Percent	Mean: 1.80
1-7 days	105	50.24	
8-13 days	29	13.88	
14 days or more	65	31.10	
Missing	10	4.78	

During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?

Response	Frequency	Percent	Mean: 1.52
None	51	24.40	
Not Sure	56	26.79	
Missing	102	48.80	

During the last 3 months, did you receive physical or mental health care from your doctor?

Response	Frequency	Percent	Mean: 1.06
Yes	191	91.39	
No	12	5.74	
Missing	6	2.87	

During the last 3 months, did you receive physical or mental health care at the emergency room?

Response	Frequency	Percent	Mean: 1.79
Yes	42	20.10	
No	160	76.56	
Missing	7	3.35	

Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?

Response	Frequency	Percent	Mean: 2.03
1-7 days	77	36.84	
8-13 days	42	20.10	
14 days or more	84	40.19	
Missing	6	2.87	

Have you had mental or physical health care in the last 3 months?

Response	Frequency	Percent	Mean: 1.05
Yes. Please complete the rest of the questions.	197	94.26	
No. You do not have to fill out the rest of the questions this survey is complete.	10	4.78	
Missing	2	0.96	

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

Response	Frequency	Percent	Mean: 1.89
Yes	23	11.00	
No	178	85.17	
Missing	8	3.83	

In the last 3 months, how quickly did or could you usually get an appt with your doctor for Physical health?

Response	Frequency	Percent	Mean: 2.40
Within one day	46	22.01	
Within one week	65	31.10	
Within two weeks	35	16.75	
Over two weeks	24	11.48	
Did not need an appointment	12	5.74	
Missing	27	12.92	

Was the time timeframe for getting an appt for physical health satisfactory?

Response	Frequency	Percent	Mean: 1.17
The above timeframe was satisfactory	73	34.93	
The above timeframe was not satisfactory	15	7.18	
Missing	121	57.89	

Was the above timeframe for getting an appt for mental health care satisfactory?

Response	Frequency	Percent	Mean: 1.24
The above timeframe was satisfactory	71	33.97	
The above timeframe was not satisfactory	22	10.53	
Missing	116	55.50	

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	Mean: 1.76
Always	99	47.37	
Usually	65	31.10	
Sometimes	29	13.88	
Never	5	2.39	
Haven't had health care in the last 3 months	4	1.91	
Missing	7	3.35	

In the last 3 months, how quickly did or could you usually get an appointment with your doctor for Mental health?

Response	Frequency	Percent	Mean: 2.39
Within one day	43	20.57	
Within one week	60	28.71	
Within two weeks	40	19.14	
Over two weeks	28	13.40	
Did not need an appointment	5	2.39	
Missing	33	15.79	

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

Response	Frequency	Percent	Mean: 1.96
Yes	39	18.66	
No	138	66.03	
Sometimes	15	7.18	
Haven't needed health care in the last 3 months	8	3.83	
Missing	9	4.31	

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	Mean: 1.86
Always	100	47.85	
Usually	56	26.79	
Sometimes	27	12.92	
Never	12	5.74	
Haven't had health care in the last 3 months	7	3.35	
Missing	7	3.35	

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	Mean: 1.21
Yes	163	77.99	
No	36	17.22	
Haven't needed health care in the last 3 months	3	1.44	
Missing	7	3.35	

If yes, how often do you take your medication as prescribed?

Response	Frequency	Percent	Mean: 1.13
Every day	172	82.30	
More than half the time	5	2.39	
Less than half the time	3	1.44	
Never	4	1.91	
Missing	25	11.96	

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	Mean: -
My doctor does not live in my community	33	15.79	
I need a specialist that does not live in my community	30	14.35	
I live outside a community	20	9.57	
Haven't had health care in the last 3 months	26	12.44	
Missing	115	55.02	

In the last 3 months, have you been prescribed physical or mental health medication by your doctor?

Response	Frequency	Percent	Mean: 1.89
No	22	10.53	
Yes	180	86.12	
Missing	7	3.35	

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

Response	Frequency	Percent	Mean: 1.62
10 miles or less	130	62.20	
11-30 miles	39	18.66	
31-100 miles	16	7.66	
101 miles or more	4	1.91	
Haven't had health care in the last 3 months	10	4.78	
Missing	10	4.78	

Have you received Medicaid travel reimbursement for these trips in the last 3 months?

Response	Frequency	Percent	Mean: 2.17
Yes	3	1.44	
No	145	69.38	
Some trips	3	1.44	
Haven't had health care in the last 3 months	14	6.70	
Missing	44	21.05	

Detailed Item Analysis Report

How well do you understand your Basic Medicaid benefit? (Like the kinds of benefits you can receive and what type of doctors/health professionals you can see.) Mean: 1.63

Response	Value	Frequency	Percent	Graph
Very well	3.00	27	12.92	
Well	2.00	77	36.84	
Not well at all	1.00	105	50.24	
Total Valid		209	100.00	

In addition to Basic Medicaid, do you have other kinds of health care coverage? Mean: -

Response	Value	Frequency	Percent	Graph
Medicare	1.00	79	37.80	
Veteran's	2.00	4	1.91	
Private Health Insurance	3.00	4	1.91	
Other please specify	4.00	14	6.70	
No	5.00	109	52.15	
Total Valid		206	98.56	
Missing		3	1.44	
Total		209	100.00	

Do you have a main doctor (who provides physical health care)

Mean: 1.13

Response	Value	Frequency	Percent	Graph
Yes	1.00	180	86.12	
No	2.00	28	13.40	
Total Valid		208	99.52	
Missing		1	0.48	
Total		209	100.00	

Did you have a main doctor (who provides physical health care) before you received Basic Medicaid?

Mean: 1.35

Response	Value	Frequency	Percent	Graph
Yes	1.00	136	65.07	
No	2.00	72	34.45	
Total Valid		208	99.52	
Missing		1	0.48	
Total		209	100.00	

When did you last see a doctor for physical health care -

Mean: 1.72

Response	Value	Frequency	Percent	Graph
within the last month	1.00	93	44.50	
within the last year	2.00	92	44.02	
within the last 2-4 years	3.00	17	8.13	
within the last 5-10 years	4.00	4	1.91	
over 10 years ago	5.00	3	1.44	
Total Valid		209	100.00	

What is your gender?

Mean: 1.52

Response	Value	Frequency	Percent	Graph
male	1.00	101	48.33	
female	2.00	108	51.67	
Total Valid		209	100.00	

Race and ethnicity

Mean: -

Response	Value	Frequency	Percent	Graph
Hispanic/Latino	1.00	7	3.35	
Non-Hispanic/Latino	2.00	2	0.96	
White	3.00	185	88.52	
American Indian or Alaska Native	4.00	16	7.66	
Black or African American	5.00	1	0.48	
Asian	6.00	1	0.48	
Pacific Islander	7.00	0	0.00	
Unknown	8.00	2	0.96	
Total Valid		208	99.52	
Missing		1	0.48	
Total		209	100.00	

What is the highest year of school you completed?

Mean: 3.62

Response	Value	Frequency	Percent	Graph
Grades 1 - 8	1.00	3	1.44	
Grades 9 - 11	2.00	11	5.26	
Grade 12 or GED	3.00	81	38.76	
1-3 years college/technical school	4.00	78	37.32	
4 years or more college/technical school	5.00	34	16.27	
Total Valid		207	99.04	
Missing		2	0.96	
Total		209	100.00	

Are you employed?

Mean: 1.73

Response	Value	Frequency	Percent	Graph
Yes	1.00	55	26.32	
No	2.00	152	72.73	
Total Valid		207	99.04	
Missing		2	0.96	
Total		209	100.00	

Where do you live?

Mean: 1.59

Response	Value	Frequency	Percent	Graph
Own or rent your home	1.00	135	64.59	
Live with people friends or relatives	2.00	43	20.57	
Consider yourself homeless	3.00	7	3.35	
Other living arrangements	4.00	22	10.53	
Total Valid		207	99.04	
Missing		2	0.96	
Total		209	100.00	

Would you say that in general your health now is?

Mean: 3.42

Response	Value	Frequency	Percent	Graph
Excellent	1.00	7	3.35	
Very good	2.00	32	15.31	
Good	3.00	62	29.67	
Fair	4.00	81	38.76	
Poor	5.00	26	12.44	
Total Valid		208	99.52	
Missing		1	0.48	
Total		209	100.00	

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

Mean: 1.92

Response	Value	Frequency	Percent	Graph
Yes improved	1.00	86	41.15	
Stayed the same as if was before being on Basic Medicaid	2.00	59	28.23	
Not sure	3.00	52	24.88	
no gotten worse	4.00	9	4.31	
Total Valid		206	98.56	
Missing		3	1.44	
Total		209	100.00	

Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?

Mean: 1.80

Response	Value	Frequency	Percent	Graph
1-7 days	1.00	105	50.24	
8-13 days	2.00	29	13.88	
14 days or more	3.00	65	31.10	
Total Valid		199	95.22	
Missing		10	4.78	
Total		209	100.00	

Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good? Mean: 2.03

Response	Value	Frequency	Percent	Graph
1-7 days	1.00	77	36.84	
8-13 days	2.00	42	20.10	
14 days or more	3.00	84	40.19	
Total Valid		203	97.13	
Missing		6	2.87	
Total		209	100.00	

During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation? Mean: 1.52

Response	Value	Frequency	Percent	Graph
None	1.00	51	24.40	
Not Sure	2.00	56	26.79	
Total Valid		107	51.20	
Missing		102	48.80	
Total		209	100.00	

Have you had mental or physical health care in the last 3 months?

Mean: 1.05

Response	Value	Frequency	Percent	Graph
Yes. Please complete the rest of the questions.	1.00	197	94.26	
No. You do not have to fill out the rest of the questions this survey is complete.	2.00	10	4.78	
Total Valid		207	99.04	
Missing		2	0.96	
Total		209	100.00	

During the last 3 months, did you receive physical or mental health care from your doctor?

Mean: 1.06

Response	Value	Frequency	Percent	Graph
Yes	1.00	191	91.39	
No	2.00	12	5.74	
Total Valid		203	97.13	
Missing		6	2.87	
Total		209	100.00	

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

Mean: 1.89

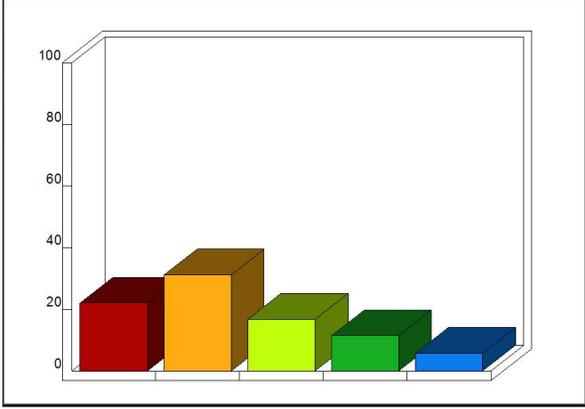
Response	Value	Frequency	Percent	Graph
Yes	1.00	23	11.00	
No	2.00	178	85.17	
Total Valid		201	96.17	
Missing		8	3.83	
Total		209	100.00	

During the last 3 months, did you receive physical or mental health care at the emergency room?

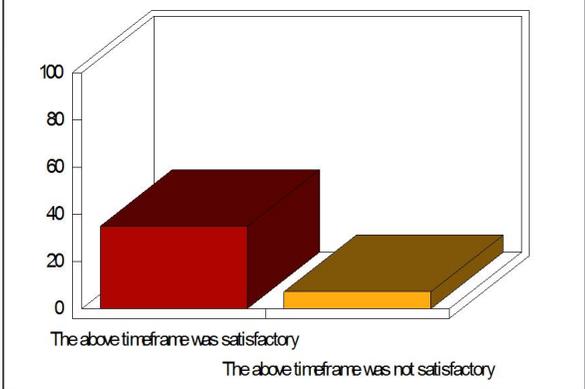
Mean: 1.79

Response	Value	Frequency	Percent	Graph
Yes	1.00	42	20.10	
No	2.00	160	76.56	
Total Valid		202	96.65	
Missing		7	3.35	
Total		209	100.00	

In the last 3 months, how quickly did or could you usually get an appt with your doctor for Physical health? Mean: 2.40

Response	Value	Frequency	Percent	Graph
Within one day	1.00	46	22.01	
Within one week	2.00	65	31.10	
Within two weeks	3.00	35	16.75	
Over two weeks	4.00	24	11.48	
Did not need an appointment	5.00	12	5.74	
Total Valid		182	87.08	
Missing		27	12.92	
Total		209	100.00	

Was the time timeframe for getting an appt for physical health satisfactory? Mean: 1.17

Response	Value	Frequency	Percent	Graph
The above timeframe was satisfactory	1.00	73	34.93	
The above timeframe was not satisfactory	2.00	15	7.18	
Total Valid		88	42.11	
Missing		121	57.89	
Total		209	100.00	

In the last 3 months, how quickly did or could you usually get an appointment with your doctor for Mental health?

Mean: 2.39

Response	Value	Frequency	Percent	Graph
Within one day	1.00	43	20.57	
Within one week	2.00	60	28.71	
Within two weeks	3.00	40	19.14	
Over two weeks	4.00	28	13.40	
Did not need an appointment	5.00	5	2.39	
Total Valid		176	84.21	
Missing		33	15.79	
Total		209	100.00	

Was the above timeframe for getting an appt for mental health care satisfactory?

Mean: 1.24

Response	Value	Frequency	Percent	Graph
The above timeframe was satisfactory	1.00	71	33.97	
The above timeframe was not satisfactory	2.00	22	10.53	
Total Valid		93	44.50	
Missing		116	55.50	
Total		209	100.00	

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

Mean: 1.96

Response	Value	Frequency	Percent	Graph
Yes	1.00	39	18.66	
No	2.00	138	66.03	
Sometimes	3.00	15	7.18	
Haven't needed health care in the last 3 months	4.00	8	3.83	
Total Valid		200	95.69	
Missing		9	4.31	
Total		209	100.00	

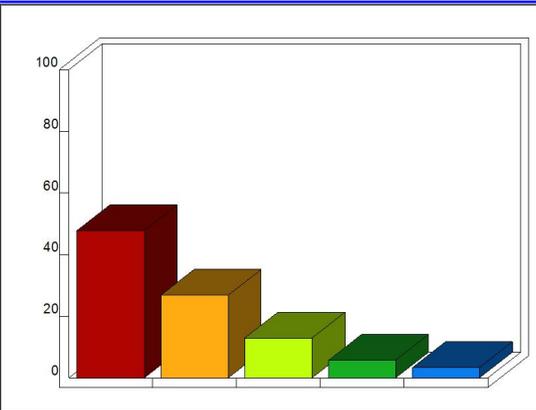
In the last 3 months, has your doctor spent enough time listening to your concerns and answering your mental or physical health questions?

Mean: 1.76

Response	Value	Frequency	Percent	Graph
Always	1.00	99	47.37	
Usually	2.00	65	31.10	
Sometimes	3.00	29	13.88	
Never	4.00	5	2.39	
Haven't had health care in the last 3 months	5.00	4	1.91	
Total Valid		202	96.65	
Missing		7	3.35	
Total		209	100.00	

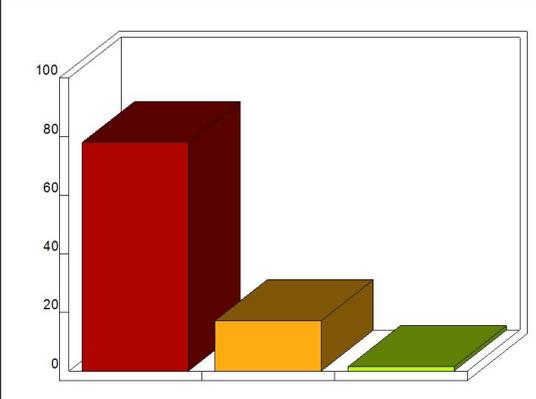
In the last 3 months, has your doctor spent enough time explaining your medical condition, treatment options and medications with you for physical or mental health?

Mean: 1.86

Response	Value	Frequency	Percent	Graph
Always	1.00	100	47.85	
Usually	2.00	56	26.79	
Sometimes	3.00	27	12.92	
Never	4.00	12	5.74	
Haven't had health care in the last 3 months	5.00	7	3.35	
Total Valid		202	96.65	
Missing		7	3.35	
Total		209	100.00	

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?

Mean: 1.21

Response	Value	Frequency	Percent	Graph
Yes	1.00	163	77.99	
No	2.00	36	17.22	
Haven't needed health care in the last 3 months	3.00	3	1.44	
Total Valid		202	96.65	
Missing		7	3.35	
Total		209	100.00	

In the last 3 months, have you been prescribed physical or mental health medication by your doctor?

Mean: 1.89

Response	Value	Frequency	Percent	Graph
No	1.00	22	10.53	
Yes	2.00	180	86.12	
Total Valid		202	96.65	
Missing		7	3.35	
Total		209	100.00	

If yes, how often do you take your medication as prescribed?

Mean: 1.13

Response	Value	Frequency	Percent	Graph
Every day	1.00	172	82.30	
More than half the time	2.00	5	2.39	
Less than half the time	3.00	3	1.44	
Never	4.00	4	1.91	
Total Valid		184	88.04	
Missing		25	11.96	
Total		209	100.00	

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

Mean: 1.62

Response	Value	Frequency	Percent	Graph
10 miles or less	1.00	130	62.20	
11-30 miles	2.00	39	18.66	
31-100 miles	3.00	16	7.66	
101 miles or more	4.00	4	1.91	
Haven't had health care in the last 3 months	5.00	10	4.78	
Total Valid		199	95.22	
Missing		10	4.78	
Total		209	100.00	

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)?

Mean: -

Response	Value	Frequency	Percent	Graph
My doctor does not live in my community	1.00	33	15.79	
I need a specialist that does not live in my community	2.00	30	14.35	
I live outside a community	3.00	20	9.57	
Haven't had health care in the last 3 months	4.00	26	12.44	
Total Valid		94	44.98	
Missing		115	55.02	
Total		209	100.00	

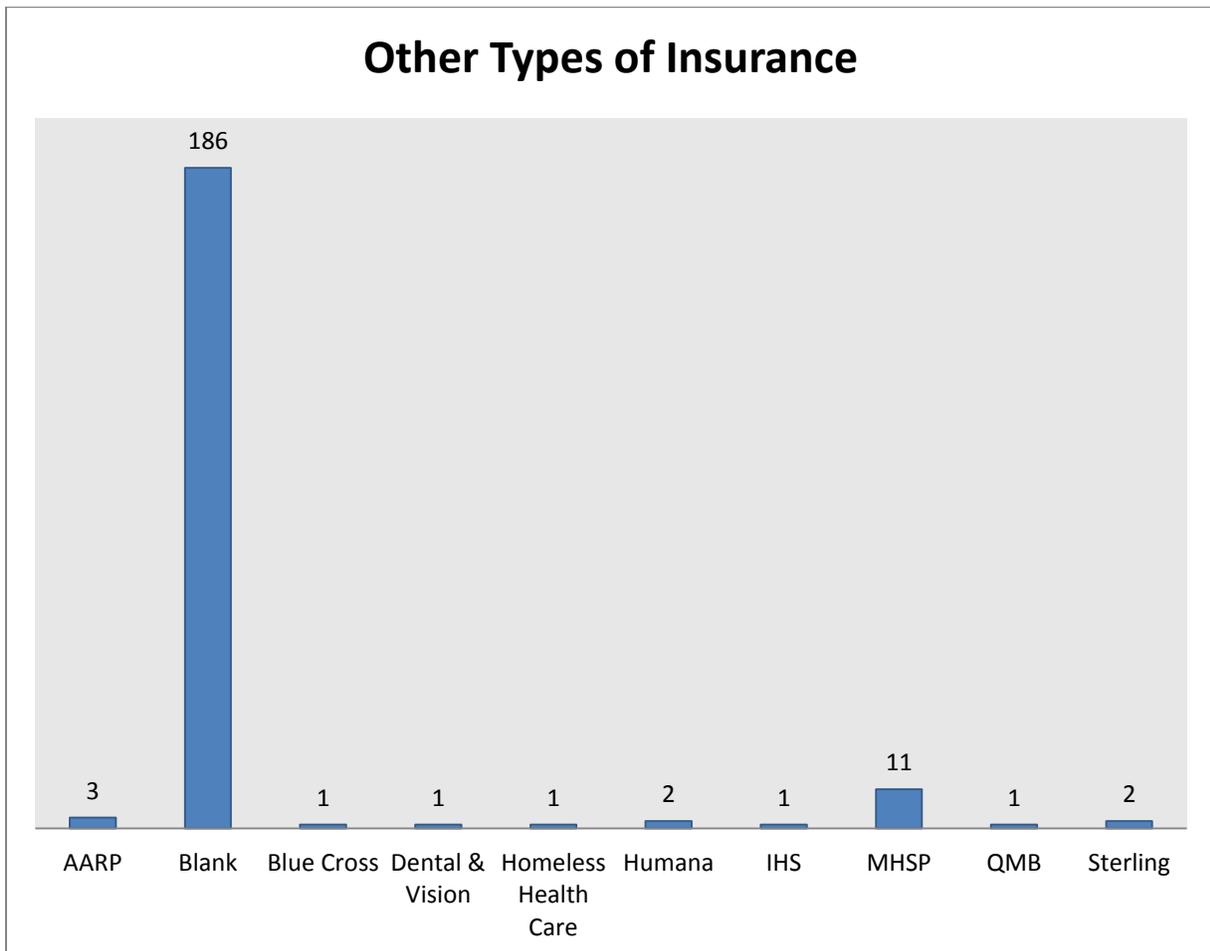
Have you received Medicaid travel reimbursement for these trips in the last 3 months?

Mean: 2.17

Response	Value	Frequency	Percent	Graph
Yes	1.00	3	1.44	
No	2.00	145	69.38	
Some trips	3.00	3	1.44	
Haven't had health care in the last 3 months	4.00	14	6.70	
Total Valid		165	78.95	
Missing		44	21.05	
Total		209	100.00	

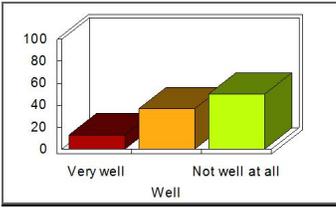
Basic Medicaid Survey Results – August 2012

AARP	3
Blank	186
Blue Cross	1
Dental & Vision	1
Homeless Health Care	1
Humana	2
IHS	1
MHSP	11
QMB	1
Sterling	2



Item Analysis Graph Report

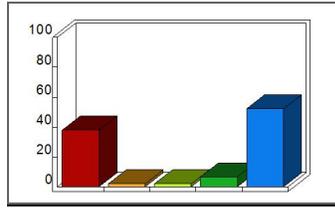
Q1



Mean: 1.63

Response	Percent
Very well	12.92
Well	36.84
Not well at all	50.24

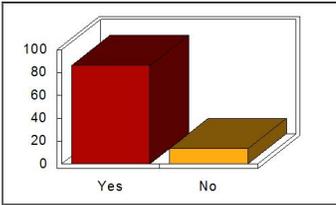
Q2



Mean: -

Response	Percent
Medicare	37.80
Veteran's	1.91
Private Health Insurance	1.91
Other please specify	6.70
No	52.15

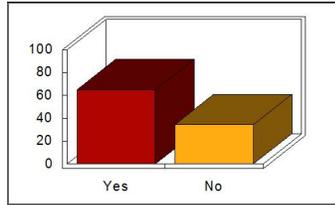
Q3



Mean: 1.13

Response	Percent
Yes	86.12
No	13.40

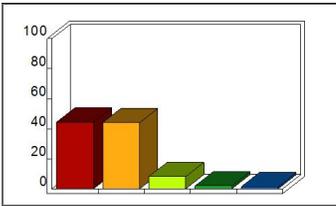
Q4



Mean: 1.35

Response	Percent
Yes	65.07
No	34.45

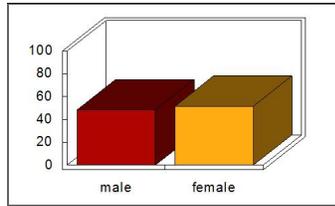
Q5



Mean: 1.72

Response	Percent
within the last month	44.50
within the last year	44.02
within the last 2-4 years	8.13
within the last 5-10 years	1.91
over 10 years ago	1.44

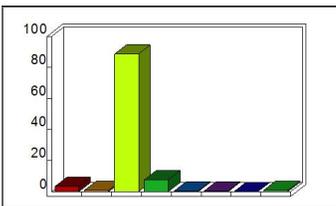
Q6



Mean: 1.52

Response	Percent
male	48.33
female	51.67

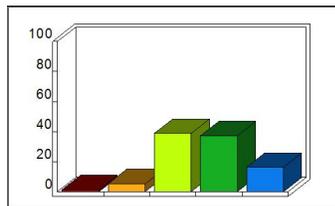
Q8



Mean: -

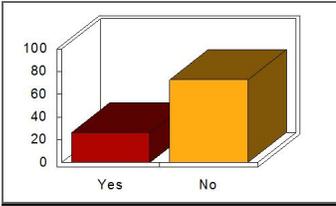
Response	Percent
Hispanic/Latino	3.35
Non-Hispanic/Latino	0.96
White	88.52
American Indian or Alaska Native	7.66
Black or African American	0.48
Asian	0.48
Pacific Islander	0.00
Unknown	0.96

Q9



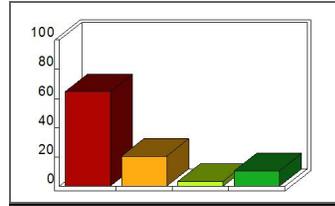
Mean: 3.62

Response	Percent
Grades 1 - 8	1.44
Grades 9 - 11	5.26
Grade 12 or GED	38.76
1-3 years college/technical school	37.32
4 years or more college/technical school	16.27

Q10

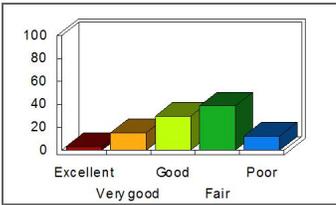
Mean: 1.73

Response	Percent
Yes	26.32
No	72.73

Q11

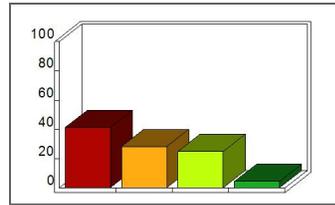
Mean: 1.59

Response	Percent
Own or rent your home	64.59
Live with people friends or relatives	20.57
Consider yourself homeless	3.35
Other living arrangements	10.53

Q12

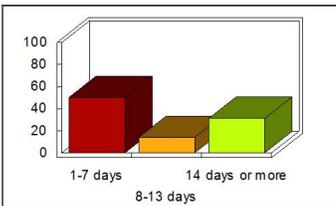
Mean: 3.42

Response	Percent
Excellent	3.35
Very good	15.31
Good	29.67
Fair	38.76
Poor	12.44

Q13

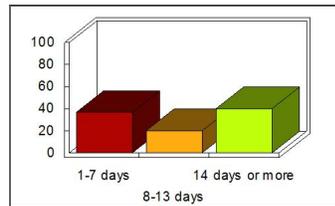
Mean: 1.92

Response	Percent
Yes improved	41.15
Stayed the same as if was before being on Basic Medicaid	28.23
Not sure	24.88
no gotten worse	4.31

Q14

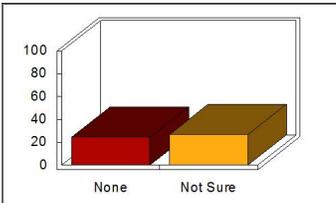
Mean: 1.80

Response	Percent
1-7 days	50.24
8-13 days	13.88
14 days or more	31.10

Q15

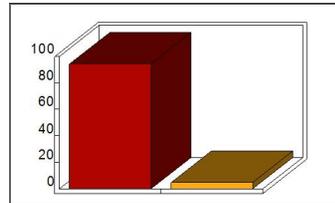
Mean: 2.03

Response	Percent
1-7 days	36.84
8-13 days	20.10
14 days or more	40.19

Q16a

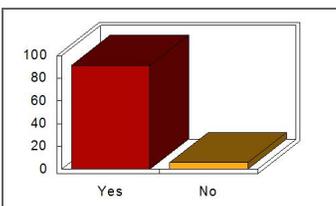
Mean: 1.52

Response	Percent
None	24.40
Not Sure	26.79

Q17

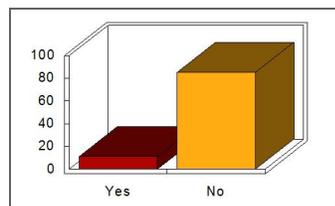
Mean: 1.05

Response	Percent
Yes. Please complete the rest of the questions.	94.26
No. You do not have to fill out the rest of the questions this survey is complete.	4.78

Q18

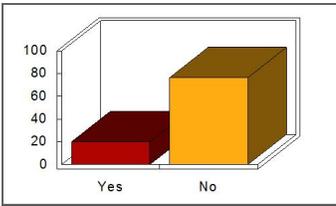
Mean: 1.06

Response	Percent
Yes	91.39
No	5.74

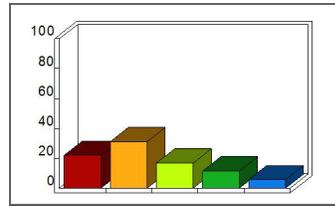
Q19

Mean: 1.89

Response	Percent
Yes	11.00
No	85.17

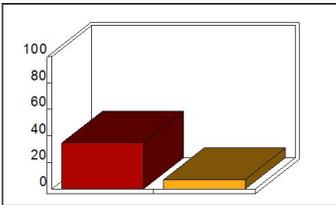
Q20

Mean: 1.79

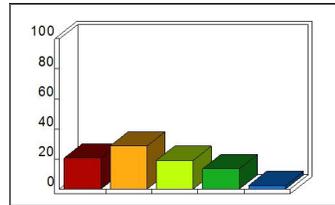
Q21P

Mean: 2.40

Response	Percent
Within one day	22.01
Within one week	31.10
Within two weeks	16.75
Over two weeks	11.48
Did not need an appointment	5.74

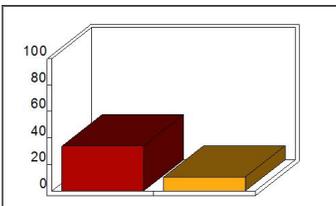
Q21Pa

Mean: 1.17

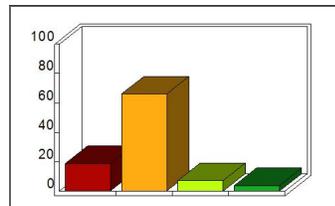
Q21M

Mean: 2.39

Response	Percent
Within one day	20.57
Within one week	28.71
Within two weeks	19.14
Over two weeks	13.40
Did not need an appointment	2.39

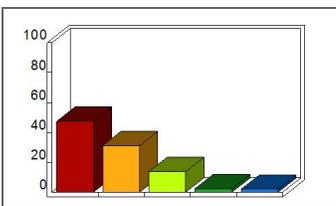
Q21Ma

Mean: 1.24

Q22

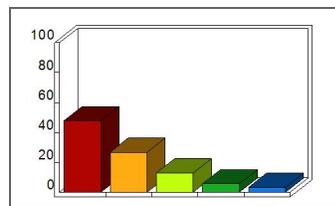
Mean: 1.96

Response	Percent
Yes	18.66
No	66.03
Sometimes	7.18
Haven't needed health care in the last 3 months	3.83

Q23

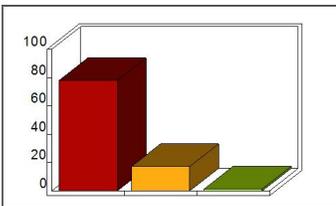
Mean: 1.76

Response	Percent
Always	47.37
Usually	31.10
Sometimes	13.88
Never	2.39
Haven't had health care in the last 3 months	1.91

Q24

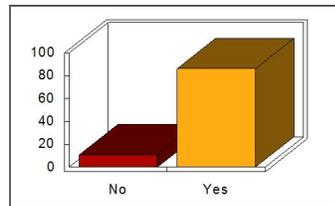
Mean: 1.86

Response	Percent
Always	47.85
Usually	26.79
Sometimes	12.92
Never	5.74
Haven't had health care in the last 3 months	3.35

Q25

Mean: 1.21

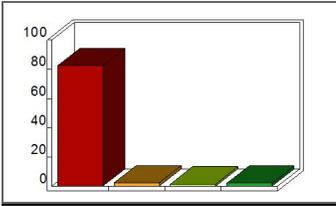
Response	Percent
Yes	77.99
No	17.22
Haven't needed health care in the last 3 months	1.44

Q26a

Mean: 1.89

Response	Percent
No	10.53
Yes	86.12

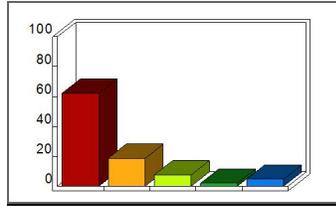
Q26b



Mean: 1.13

Response	Percent
Every day	82.30
More than half the time	2.39
Less than half the time	1.44
Never	1.91

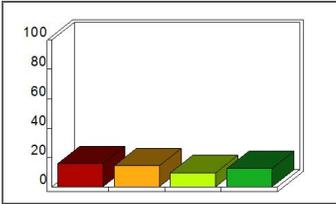
Q27



Mean: 1.62

Response	Percent
10 miles or less	62.20
11-30 miles	18.66
31-100 miles	7.66
101 miles or more	1.91
Haven't had health care in the last 3 months	4.78

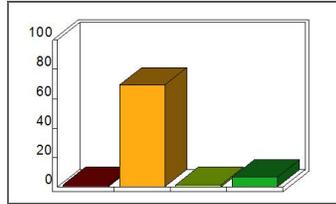
Q28



Mean: -

Response	Percent
My doctor does not live in my community	15.79
I need a specialist that does not live in my community	14.35
I live outside a community	9.57
Haven't had health care in the last 3 months	12.44

Q29



Mean: 2.17

Response	Percent
Yes	1.44
No	69.38
Some trips	1.44
Haven't had health care in the last 3 months	6.70



Administrator
Washington, DC 20201

NOV 24 2010

Ms. Mary E. Dalton
State Medicaid Director
Montana Department of Public Health and Human Services
P .O. Box 4210
Helena, MT 59604-421 0

Dear Ms. Dalton:

We are pleased to inform you that Montana's request to renew and amend its section 1115 Medicaid Demonstration project entitled Montana Basic Medicaid for Able-Bodied Adults (Basic Medicaid) has been approved as project number 11-W-00181/8 under the authority of section 1115(a) of the Social Security Act (the Act). The enclosed Special Terms and Conditions (STCs), waivers and expenditure authorities will be effective from December 1, 2010 through December 31, 2013.

The Centers for Medicare & Medicaid Services (CMS) is renewing Montana's statewide Basic Medicaid Demonstration, which began in 1996 under the authority of an 1115 welfare reform waiver referred to as families Achieving Independence in Montana (FAIM), and currently serves approximately 8,500 able-bodied adults. In addition, under the attached STCs, Federal financial participation will be available to enable the State to expand health care coverage by offering the Basic Medicaid benefit package to up to 800 individuals that have been diagnosed with a severe disabling mental illness of schizophrenia, bipolar disorder, or major depression. The approval to expand the Basic Medicaid Demonstration will enable the State to provide both physical and mental coverage to these vulnerable individuals in an effort to better stabilize their conditions.

Our approval of the Montana Basic Medicaid section 1115(a) Demonstration is limited to the extent of granting approval for the necessary expenditure authorities in the accompanying list and is conditioned upon compliance with the enclosed STCs. The STCs set forth in detail the nature, character, and extent of federal involvement in the Demonstration, and are effective immediately, unless otherwise specified. All the requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the enclosed expenditure authority list, shall apply to the Demonstration .

Page 2- Ms. Mary E. Dalton

Written notification to our office of your acceptance of this award must be received within 30 days after your receipt of this letter. Your project officer is Kelly Heilman. She is available to answer questions concerning this demonstration project. Her contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and State Operations
7500 Security Boulevard , S2-01-16
Baltimore, MD 21244-1850
Telephone: (410) 786- 1451
Facsimile: (410) 786-5882
E-mail: kelly.heilman@cms.hhs.gov

Official communications regarding program matters should be submitted simultaneously to Dr. Heilman, and to Mr. Richard Allen, Associate Regional Administrator in our Denver Regional Office. Mr. Allen's address is:

Centers for Medicare & Medicaid Services
Division of Medicaid & Children's Health Operations
Colorado State Bank Building
1 600 Broadway, Suite 700
Denver, CO 80202-4367

We extend our congratulations to you on the renewal, and we appreciate the State's cooperation throughout the review process. If you have additional questions, please contact Ms. Victoria Wachino, Director, Family and Children's Health Programs Group, Center for Medicaid and State Operations, at (410) 786-5647.

Sincerely,

/Donald M. Berwick/

Donald M. Berwick, M.D.

Encloures

cc:

Duane Preshinger, Montana Medicaid Systems Support Program Director
Jo Thompson, Montana Medicaid Analyst
Richard Allen, Associate Regional Administrator, CMS Denver Regional Office
Kelly Heilman, Health Insurance Specialist, CMS

**CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER LIST**

NUMBER: 11-W-00181/8 Title XIX
TITLE: Montana Basic Medicaid for Able-Bodied Adults
AWARDEE: Montana Department of Public Health and Human Services

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived in the following list or specified as *not applicable* to the expenditure authorities, shall apply to the demonstration project under title XIX of the Social Security Act (the Act) beginning December 1, 2010 through December 31, 2013. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs).

MEDICAID TITLE XIX REQUIREMENTS WAIVED FOR MEDICAID STATE PLAN GROUPS

1. Amount, Duration, and Scope of Services and Comparability Section 1902(a)(10)(B)

To the extent necessary to enable the State to offer a reduced benefit package, a different benefit package, or cost-effective alternative benefit packages to populations affected by the Demonstration.

2. Home Health Services Section 1902(a)(10)(D)

To the extent necessary to enable the State not to offer the medical equipment and home infusion component of the home health benefit to populations affected by the Demonstration.

3. Freedom of Choice Section 1902(a)(23)

To enable the State to restrict freedom of choice of provider for populations affected by the Demonstration, through the use of mandatory enrollment in managed care entities (Primary Care Case Management or Prepaid Ambulatory Health Plans) for the receipt of applicable Demonstration covered services. And to enable the States to mandate managed care enrollment for any individual in the populations affected by the Demonstration who is an Indian as defined in section 4(c) of the Indian Health Care Improvement Act of 1976 (25 U.S.C. 1603(c)).

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS (STCs)

NUMBER: 11-W-00181/8

TITLE: Montana Basic Medicaid for Able-Bodied Adults

AWARDEE: Montana Department of Public Health and Human Services

DEMONSTRATION PERIOD: February 1, 2009 through December 31, 2013

**Note: Temporary Extensions were granted under the same terms and conditions as the previous STCs for the period of February 1, 2009 through November 30, 2010.*

I. PREFACE

The following are the Special Terms and Conditions (STCs) for Montana’s Basic Medicaid for Able Bodied Adults section 1115 Demonstration program (hereinafter referred to as “Demonstration”) for the Demonstration under section 1115(a) of the Social Security Act (the Act) for the period of December 1, 2010 through December 31, 2013. The parties to this agreement are the Montana Department of Public Health and Human Services (“State”) and the Centers for Medicare & Medicaid Services (“CMS”). All requirements of the Medicaid and CHIP programs expressed in law, regulation and policy statement, not expressly waived or made not applicable in the list of Waivers and Expenditure authorities, shall apply to the Demonstration project.

The STCs set forth in detail the nature, character, and extent of Federal involvement in the Demonstration and the State’s obligations to CMS during the life of the Demonstration. The STCs are effective as of the approval letter’s date, unless otherwise specified. Amendment requests, correspondence, documents, reports, and other materials that are submitted for review or approval shall be directed to the CMS Central Office Project Officer and the Regional Office State Representative at the addresses shown on the award letter. All previously approved STCs, Waivers, and Expenditure Authorities are superseded by the STCs set forth below. This Demonstration extension is approved through December 31, 2013. The STCs have been arranged into the following subject areas:

- I. PREFACE
- II. PROGRAM DESCRIPTION AND OBJECTIVES
- III. GENERAL PROGRAM REQUIREMENTS
- IV. ELIGIBILITY
- V. BENEFITS
- VI. ENROLLMENT
- VII. COST SHARING
- VIII. DELIVERY SYSTEMS
- IX. GENERAL REPORTING REQUIREMENTS
- X. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX
- XI. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION
- XII. EVALUATION OF THE DEMONSTRATION
- XIII. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION EXTENSION

ATTACHMENT A
ATTACHMENT B

II. PROGRAM DESCRIPTION AND OBJECTIVES

The Montana Basic Medicaid for Able-Bodied Adults (Basic Medicaid) is a statewide section 1115 Demonstration administered by the Montana Department of Public Health and Human Services (the State). The Basic Medicaid program began in 1996, under the authority of an 1115 welfare reform waiver referred to as Families Achieving Independence in Montana (FAIM). Under FAIM, Montana provided all mandatory Medicaid benefits and a limited collection of optional services to approximately 8,500 able-bodied adults (aged 21 through 64 and neither pregnant nor disabled), who are parents and/or caretaker relatives of dependent children at or below the State Standard of Need (i.e., otherwise eligible for Medicaid under Sections 1925 or 1931 of the Social Security Act). The FAIM welfare reform waiver expired on January 31, 2004, and was replaced (without change) by a section 1115 Medicaid Demonstration, which was approved for the period of February 1, 2004 through January 31, 2009. The Demonstration was continued through a series of Temporary Extensions through November 30, 2010.

On January 25, 2008, Montana proposed to renew the Basic Medicaid for Able-Bodied Adults Demonstration for eligible parents and caretaker adults and in subsequent communications proposed to expand eligibility using demonstration savings. On July 30, 2009 and August 13, 2010, the State submitted revised proposals to CMS. Under the revised proposals, Demonstration savings are used to provide Medicaid-like coverage to up to 800 individuals, aged 18 through 64, with incomes at or below 150 percent of the Federal poverty level (FPL), who have been diagnosed with a severe disabling mental illness (SDMI) of schizophrenia, bipolar disorder, or major depression, and who would not otherwise be eligible for Medicaid benefits. Prior to enrollment in the section 1115 Demonstration, these individuals received a very limited mental health benefit through enrollment in a State-financed Mental Health Service Plan (MHSP).

On the basis of the State's July 30, 2009 and August 13, 2010 proposals, CMS approved the extension of the Basic Medicaid Demonstration under authority of section 1115(a) of the Social Security Act (the Act). The Demonstration will continue for the period of December 1, 2010 through December 31, 2013, and the following Special Terms and Conditions, waivers, and costs not otherwise matchable will apply.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The State must comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.
2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), must apply to the Demonstration.
3. **Changes in Medicaid Law, Regulation, and Policy.** The State must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in Federal law, regulation, or policy affecting the Medicaid program that occur during this Demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.
4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**
 - a. To the extent that a change in Federal law, regulation, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this Demonstration, the State must adopt, subject to CMS approval, a modified budget neutrality agreement for the Demonstration as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.
 - b. If mandated changes in the Federal law require State legislation, the changes must take effect on the day such State legislation becomes effective, or on the last day such legislation was required to be in effect under the law.
5. **State Plan Amendments.** The State will not be required to submit title XIX or title XXI State plan amendments for changes affecting any populations made eligible solely through the Demonstration. If a population eligible through the Medicaid State Plan is affected by a change to the Demonstration, a conforming amendment to the appropriate State Plan may be required, except as otherwise noted in these STCs.
6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, cost sharing, sources of non-Federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the Demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Social Security Act (the Act). The State must not implement changes to these elements without prior approval by CMS. Amendments to the Demonstration are not retroactive and FFP will

not be available for changes to the Demonstration that have not been approved through the amendment process set forth in paragraph 7 below.

7. **Amendment Process.** Requests to amend the Demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a Demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the State to submit required reports and other deliverables in a timely fashion according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:
 - a. An explanation of the public process used by the State, consistent with the requirements of paragraph 12, to reach a decision regarding the requested amendment;
 - b. A data analysis which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current Federal share “with waiver” and “without waiver” status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the “with waiver” expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;
 - c. An up-to-date CHIP allotment neutrality worksheet, if necessary;
 - d. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and
 - e. If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.
8. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the Demonstration (in whole or in part) at any time before the date of expiration, whenever it determines following a hearing that the State has materially failed to comply with the terms of the project. CMS will promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date.
9. **Finding of Non-Compliance.** The State does not relinquish its rights to challenge the CMS finding that the State materially failed to comply.
10. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS will promptly notify the State in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the State an opportunity to request a hearing to challenge CMS’ determination

prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

11. **Adequacy of Infrastructure.** The State must ensure the availability of adequate resources for implementation and monitoring of the Demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other Demonstration components.
12. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The State must continue to comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) and the tribal consultation requirements pursuant to section 1902(a)(73) of the Act as amended by section 5006(e) of the Recovery and Reinvestment Act of 2009. In States with Federally recognized Indian tribes, Indian health programs, and / or Urban Indian organizations, the State is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any waiver proposal, amendment, and / or renewal of this Demonstration. In the event that the State conducts additional consultation activities consistent with these requirements prior to the implementation, documentation of these activities will be provided to CMS.
13. **FFP.** No Federal matching funds for expenditures for this Demonstration will take effect until the effective date identified in the Demonstration approval letter.

IV. ELIGIBILITY

1. **Eligibility Criteria.** Mandatory and optional Medicaid State Plan populations derive their eligibility through the Medicaid State Plan, and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid State Plan, except as expressly waived and as described in these STCs. Able Bodied Adults, as defined below, are included in the Demonstration to generate savings for covering the expansion populations and to waive other specific programmatic requirements.
2. The section 1115 Demonstration affects the following Eligibility Groups:
 - a) **Able Bodied Adults.** Individuals who are eligible as Family Medicaid or Transitional Medicaid under sections 1925 and 1931 of the Social Security Act, are age 21 through 64, and who are not pregnant or disabled.

Waiver Montana Mental Health Services Plan (WMHSP) Enrollees. Individuals aged 18 through 64, with incomes at or below 150 percent of the Federal poverty level (FPL), who have been diagnosed with a severe disabling mental illness (SDMI) of schizophrenia, bipolar disorder, or major depression, who at the time of their enrollment were receiving a limited mental health services benefit package through enrollment in the State-financed Mental Health Service Plan (SMHSP), but are otherwise ineligible for Medicaid benefits.

V. **BENEFITS**

1. **Benefits for Able Bodied Adults and WMHSP Enrollees.** All individuals enrolled in the Demonstration will receive all Medicaid State plan services excluding: audiology, dental and denturist, medical equipment, eyeglasses, optometry and ophthalmology for routine eye exams, personal care services, home infusion and hearing aids.
2. **Allowances / Special Circumstances.** Coverage for the excluded services may be provided:
 - a. At the State's discretion in cases of emergency or when essential to obtain or maintain employment. Examples of emergency circumstances include, but are not limited to coverage for emergency dental situations, medical conditions of the eye (e.g., annual dilated eye exams for individuals with diabetes or other medical conditions), and certain medical supplies (e.g., diabetic supplies, prosthetic supplies, oxygen). In these situations, the State will provide approval to the provider, and make associated records available upon CMS request; or
 - b. Are age-appropriate EPSDT services.
3. **Changes to the State Plan Benefits or to Other Demonstrations Integrated with the Able-Bodied Demonstration.**
 - a. During each Monthly Monitoring Call, the State will discuss with CMS (Central and Regional Offices) proposed State plan amendments (SPAs) or changes to other waivers/demonstrations (e.g., PASSPORT To Health), which are integrated with the Able-Bodied Demonstration and would impact the Demonstration enrollees. The discussion would include the intent of the amendment; anticipated programmatic and fiscal impacts; and intended submission and implementation dates.
 - b. CMS reserves the right to require the State to submit an amendment if it is determined that it is warranted.
4. **Cost-Effective Insurance.** When a WMHSP-eligible individual has access to cost-effective health coverage through a cost-effective group health plan, the State may obtain benefits for the individual by providing premium assistance to the individual for this purpose in accord with the State plan for the provision of alternative cost effective coverage authorized for State plan eligible populations under section 1906 of the Act.

VI. ENROLLMENT

1. General Requirements

- a. Unless otherwise specified in these STCs, all processes for eligibility, enrollment, redeterminations, terminations, appeals, etc. must comply with Federal law and regulations governing Medicaid and CHIP.
- b. Any individual who is denied eligibility in any health coverage program authorized under this Demonstration must receive a notice from the State that gives the reason for denial, and includes information about the individual's right to appeal.
- c. The State will adhere to the Demonstration population enrollment limits presented in Section IV *Eligibility*.

2. **Enrollment of Able Bodied Adults.** Upon determination of Medicaid eligibility, Able-Bodied Adults (as defined in section IV.3(a)) will be enrolled in the Demonstration. Enrollment for this population will not be capped.

3. **Imposing WMHSP Waiver Enrollment Limit and Lifting Enrollment Limit.** Upon approval of these STCs, the State will facilitate enrollment of up to 800 eligible individuals into the MHSP Demonstration population. With 30 days prior notice, the State may impose an enrollment cap upon the WMHSP Demonstration population of less than 800 in order to phase in enrollment and remain under the budget neutrality limit/ceiling for expenditures established for the Demonstration. The State must submit an amendment to this Demonstration in order to increase MHSP enrollment above 800 slots.

4. **Prioritization for WMHSP Waiver Enrollment.** The State will enroll individuals into the WMHSP program using the following process:

- a. The individual meets the financial and clinical eligibility criteria established for the State MHSP program, and is enrolled in the State MHSP program.
- b. Priority of State MHSP enrolled individuals being moved into the Demonstration will be based upon a current primary diagnosis of schizophrenia. At the State's discretion, available slots in the Demonstration will then be open to eligible individuals with bipolar disorder. The State may then open enrollment of any remaining slots to individuals with a diagnosis of major depression.
- c. To initially phase in enrollment, or at such time as the number of eligible individuals exceeds the number of available slots, the State will use a computer based random drawing to select the individuals (based on priority of diagnosis established in subparagraph b) to fill the available statewide slots.

5. **Enrollment into PASSPORT to Health, Enhance Primary Care Case Management, and Nurse First.** The State may enroll Demonstration-eligibles into the PCCMs and Nurse First Advice Line. By cross-reference, the enrollment, benefits, and cost sharing in the associated CMS-approved State plan in place as of the effective date of these STCs will apply to this Demonstration.

VII. COST SHARING

- 1. Cost Sharing.** All Demonstration-enrolled individuals will be subject to the Medicaid cost share requirements as set forth in the State Plan. Cost sharing for Demonstration-enrolled individuals enroll in a cost-effective insurance plan, will be in accord with Section V.4.

VIII. DELIVERY SYSTEMS

1. **Freedom of Choice of Health Care Providers.** Individuals enrolled in the Demonstration:
 - a. May also be enrolled in the PASSPORT to HEALTH Managed Care Program and/or the Enhanced Primary Case Management Program, which are Montana Medicaid's primary care case management (PCCM) programs. Under the PCCM programs, Medicaid clients are required to choose one primary care provider and develop an ongoing relationship that provides a "medical home." With some exceptions, all services to PCCM program enrollees must be provided or approved by the individual's primary care provider.
 - b. Who are not enrolled in the Montana PCCM programs may receive a covered benefit from any provider participating with the Montana Medicaid program.
 - c. Who are enrolled in the Nurse First Nurse First Advice Line may receive covered benefits from the one Disease Management Organization.
2. **Delivery System of a Cost-Effective Insurance Plan.** Demonstration-enrolled individuals receiving services through a cost-effective insurance plan will receive plan-covered services through the delivery systems provided by their respective insurance plan and additional services as necessary to ensure access to the full benefit package otherwise available. All additional services may be obtained from any physical or mental health provider participating with the Montana Medicaid program.

IX. GENERAL REPORTING REQUIREMENTS

1. **General Financial Requirements.** The State must comply with all general financial requirements under title XIX set forth in section IX.
2. **Reporting Requirements Relating to Budget Neutrality.** The State shall comply with all reporting requirements for monitoring budget neutrality as set forth in section XI. The State must submit any corrected budget neutrality data upon request.
3. **Compliance with Managed Care Reporting Requirements.** The State will comply with all applicable managed care regulation at 42 CFR 438 *et seq* for Demonstration-eligible individuals enrolled in the PCCM program. A status update on the PCCM, including a discussion of recent developments, problems encountered and steps taken to resolve them, must be included in each Annual Report.
4. **Monitoring Calls.** CMS shall schedule monthly conference calls with the State to ascertain progress and issues related to implementation of the MHSP component of the demonstration. Once start-up issues and concerns are resolved (at approximately 6 months post-implementation), the State and CMS may resume quarterly monitoring calls. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the Demonstration. Areas to be addressed include, but are not limited to, health care delivery, enrollment, quality of care, access, benefits, audits, lawsuits, financial reporting and budget neutrality issues, progress on evaluations, State legislative developments, and any Demonstration amendments, concept papers or State plan amendments the State is considering submitting. The State and CMS shall discuss quarterly expenditure reports submitted by the State for purposes of monitoring budget neutrality. CMS shall update the State on any amendments or concept papers under review as well as Federal policies and issues that may affect any aspect of the Demonstration. The State and CMS shall jointly develop the agenda for the calls.
5. **Quarterly Progress Reports.** The State must submit progress reports in accordance with the guidelines in Attachment A no later than 60 days following the end of each quarter. The intent of these reports is to present the State's analysis and the status of the various operational areas. These quarterly reports must include, but not be limited to:
 - a. An updated budget neutrality monitoring spreadsheet;
 - b. A discussion of events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including, but not limited to: approval and contracting with new plans, benefits, enrollment and disenrollment, grievances, quality of care, access, health plan contract compliance and financial performance that is relevant to the Demonstration, pertinent legislative or litigation activity, and other operational issues;
 - c. Action plans for addressing any policy, administrative, or budget issues identified;

- d. Quarterly enrollment reports for Demonstration-eligibles, that include the member months and end of quarter, point-in-time enrollment for each Demonstration population, and other statistical reports listed in Attachment A; and
 - e. Evaluation activities and interim findings.
6. **Transition Plan.** The State is required to prepare, and incrementally revise a Transition Plan consistent with the provisions of the ACA for individuals enrolled in the Demonstration, including how the State plans to coordinate the transition of these individuals to a coverage option available under the ACA without interruption in coverage to the maximum extent possible. The State must submit a draft to CMS by July 1, 2012, with progress updates included in each quarterly report. The State will revise the Transition Plan as needed.
7. **Annual Report.** In lieu of the fourth quarter report, the State must submit an annual report. The State must submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, interim evaluation findings, and policy and administrative difficulties and solutions in the operation of the Demonstration. The State must submit the draft annual report no later than 120 days after the close of the Demonstration Year (DY). Within 30 days of receipt of comments from CMS, a final annual report must be submitted.

X. GENERAL FINANCIAL REQUIREMENTS

1. **Quarterly Expenditure Reports for Title XIX.** The State must provide quarterly expenditure reports using Form CMS-64 to separately report total expenditures for services provided through this Demonstration under section 1115 authority that are subject to budget neutrality. This project is approved for expenditures applicable to services rendered during the Demonstration period. CMS shall provide FFP for allowable Demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section IX.
2. **Expenditures Subject to the Title XIX Budget Neutrality Expenditure Limit.** All expenditures for health care services for Demonstration participants (as defined in section IV above) are subject to the budget neutrality expenditure limit.
3. **Accounting for Enrollment and Expenditures of Demonstration Populations.** All enrollment and expenditures of Able-Bodied Adults and WMHSP individuals enrolled in the PCCM PASSPORT to Health and the Nurse First Disease Management programs will be attributable to this Demonstration and reported in accord with section IX, X, and XI. The enrollment and expenditures of Able-Bodied Adults and WMHSP individuals enrolled in these programs will not be included in the State's 1915(b) reports.
4. **Reporting Expenditures Subject to the Title XIX Budget Neutrality Expenditure Limit.** The following describes the reporting of expenditures subject to the budget neutrality expenditure limit:
 - a. **Use of Waiver Forms.** In order to track expenditures under this Demonstration, the State must report Demonstration expenditures through the Medicaid and Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual (SMM). All Demonstration expenditures claimed under the authority of title XIX of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the Demonstration Project Number (11-W-00181/8) assigned by CMS.
 - b. **Reporting By Date of Service.** In each quarter, Demonstration expenditures (including prior period adjustments) must be totaled and reported on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver by Demonstration Year (DY). The DY for which expenditures are reported is identified using the project number extension (a 2-digit number appended to the Demonstration Project Number). Expenditures are to be assigned to DYs on the basis of date of service. The date of service for premium or premium assistance payments is identified as the DY that accounts for the larger share of the coverage period for which the payment is made. DY 1 will correspond to the period of February 1, 2004 through January 31, 2005, DY 2 with the period of February 1, 2005 through January 31, 2006, and so on.

- c. **Waiver Name.** For each Demonstration quarter, separate Forms CMS-64.9 Waiver and/or 64.9P Waiver must be completed to report expenditures for the following Demonstration populations. The waiver names to be used to identify these separate Forms CMS-64.9 Waiver and/or 64.9P Waiver appear in bold following the colon. Expenditures should be allocated to these forms based on the guidance provided in these STCs.
- i. **Demonstration Population 1: Able-Bodied Adults**—Eligibility Group (EG) consists of parent / caretaker relative adults whose Medicaid eligibility derives from their status as an optional Medicaid population under section 1925 or 1931 of the Act – counted in the “with” and “without” waiver calculations.
- ii. **Demonstration Population 2: WMHSP** —EG consists of enrolled WMHSP adults who are only eligible with section 1115 Demonstration authority (Title XIX Demonstration-eligible expansion population) – counted only in the “with” waiver calculations.
- d. **Premiums and Cost Sharing Adjustments.** Premiums and other applicable cost-sharing contributions that are collected by the State from enrollees under the Demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet Line 9D, columns A and B. In order to assure that these collections are properly credited to the Demonstration, premium and cost-sharing collections (both total computable and Federal share) should also be reported separately by DY on the Form CMS-64 Narrative, and divided into subtotals corresponding to the eligibility groups (EGs) from which collections were made. In the calculation of expenditures subject to the budget neutrality expenditure limit, premium collections applicable to Demonstration populations shall be offset against expenditures. These section 1115 premium collections will be included as a manual adjustment (decrease) to the Demonstration’s actual expenditures on a quarterly basis.
- e. **Cost Settlements.** For monitoring purposes, cost settlements attributable to the Demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any cost settlements not attributable to this Demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual.
- i. **Prescription Drug Rebates.** Prescription drug rebates were not included in the original PMPM for Able-Bodied Adults. While the State collects prescription drug rebates on this population and the WMHSP population, the State does not include such rebates in the expenditure reports either as a credit or as an offset of prescription drug expenditures. This process will continue for the extension of the demonstration covered by these Special Terms and Conditions.

An amendment would be necessary should the State wish to attribute a portion of the Prescription Drug Rebate to expenditures for populations included in the Basic Demonstration. The amendment would need to include a rebasing the PMPM

costs to include prescription drug costs and a proposed methodology for assigning a portion of prescription drug rebates to the Demonstration, in a way that reasonably reflects the actual rebate-eligible utilization of the Demonstration population, and which reasonably identifies prescription drug rebate amounts with DYS. Consistent with section 1115 demonstrations, the use of the methodology is subject to the approval in advance by the CMS Regional Office, and changes to the methodology must also be approved in advance by the Regional Office. The portion of prescription drug rebates assigned to the Demonstration using the approved methodology will be reported on the appropriate Forms CMS-64.9 Waiver for the Demonstration, and not on any other CMS-64.9 form (to avoid double-counting). Each rebate amount must be distributed as State and Federal revenue consistent with the Federal matching rates under which the claim was paid.

- ii.* **Federally Qualified Health Center Settlement Expenses.** Within 60 days of this award, the State must propose to the CMS Regional Office a methodology for identifying the portion of any FQHC settlement expenses that should be reported as Demonstration expenditures because of a linkage between settlement payments to FQHCs and use of FQHC services by Demonstration participants. Once the methodology is approved by the Regional Office, the State will reported the amounts of FQHC settlement payments identified on the appropriate Forms CMS-64.9 and 64.9P Waiver.
- iii.* **Indian Health Services.** The following rules govern reporting of Indian Health Service (IHS) expenditures subject to the 100 percent Federal matching for Able-Bodied Adults and WMHSP eligibles.

 - 1. Because IHS expenditures were excluded from the original calculation of the without-waiver PMPM costs estimates for Able-Bodied Adults, the State must report IHS expenditures for Able-Bodied Adults on forms CMS-64.9 Waiver and 64.9P Waiver, under waiver name “IHS” and with project number extension “NA.” This is an exception to the instructions for reporting Able-Bodied Adults’ expenditures in subparagraphs (b) through (d) above.
 - 2. Because IHS expenditures for WMHSP eligibles are costs not otherwise matchable, they are necessarily demonstration expenditures. For this reason, the State must report these expenditures on forms CMS-64.9 Waiver and 64.9P Waiver under waiver name “WMHSP Adults,” following the instructions in subparagraphs (b) through (d).
- 5. **Title XIX Administrative Costs.** Administrative costs will not be subject to the budget neutrality expenditure limit, but the State must separately track and report additional administrative costs that are directly attributable to the Demonstration. All such administrative costs will be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver, using waiver name “Montana Basic Medicaid for Able-Bodied Adults.”

6. **Claiming Period.** All claims for expenditures subject to the budget neutrality expenditure limit (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the Demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the Demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 Demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.
7. **Standard Medicaid Funding Process.** The standard Medicaid funding process shall be used during the Demonstration. The State must estimate matchable Medicaid expenditures on the quarterly form CMS-37. In addition, the estimate of matchable Demonstration expenditures (total computable and Federal share) subject to the budget neutrality agreement must be separately reported by quarter for each FFY on the form CMS-37.12 for both the medical assistance program and administrative costs. CMS shall make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.
8. **Extent of Title XIX FFP for the Demonstration.** Subject to CMS approval of the source(s) of the non-Federal share of funding, CMS shall provide FFP at the applicable Federal matching rates for the Demonstration as a whole as outlined below, subject to the limits described in Section IX:
 - a. Administrative costs, including those associated with the administration of the Demonstration;
 - b. Net expenditures and prior period adjustments, made under approved Expenditure Authorities, with dates of service during the operation of the Demonstration
9. **Sources of Non-Federal Share.** The State certifies that the source of non-Federal share of funds for the Demonstration is State/local monies. The State further certifies that such funds shall not be used as the non-Federal share for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with title XIX of the Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.
 - a. CMS shall review the sources of the non-Federal share of funding for the Demonstration at any time. The State agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

- b. The State shall provide information to CMS regarding all sources of the non-Federal share of funding for any amendments that impact the financial status of the program.
- c. Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the State as Demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the State and/or local government to return and/or redirect any portion of the Medicaid or Demonstration payments. This confirmation of Medicaid and Demonstration payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes (including health care provider-related taxes, fees, and business relationships with governments that are unrelated to Medicaid or the Demonstration and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid or Demonstration payment.

10. **Maintenance of Effort for the WMHSP Population.** In order to expand the Able-Bodied section 1115 demonstration to include up to 800 individuals who are not otherwise Medicaid eligible, Montana must provide the same level of State funding (referred to as Maintenance of Effort (MOE)) for the continued provision of health services to this population.

a. **WMHSP Claiming.**

- 1. During State fiscal year (SFY) 2009, the State's expenditures for health benefits provided to the over 3,400 individuals in the State-only MHSP program was \$8,860,518.
- 2. The State must determine the total reported health benefit expenditures for WMHSP enrolled individuals for each SFY, and in each annual report provide assurance to CMS that State expenditures for WMHSP and MHSP will be maintained at the SFY 2009 level.
- 3. The State is not eligible to claim the increased FFP established under the American Recovery and Reinvestment Act of 2009 for the WMHSP population.

11. **Monitoring the Demonstration.** The State will provide CMS with information to effectively monitor the Demonstration, upon request, in a reasonable timeframe.

XI. MONITORING BUDGET NEUTRALITY

1. **Limit on Title XIX Funding.** The State shall be subject to a limit on the amount of Federal title XIX funding that the State may receive on selected Medicaid expenditures during the period of approval of the Demonstration. The limit is determined by using a per capita cost method. The budget neutrality expenditure targets are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire Demonstration. Actual expenditures subject to the budget neutrality expenditure limit shall be reported by the State using the procedures described in Section X.3.
2. **Risk.** The State assures that the demonstration expenditures do not exceed the level of expenditures had there been no demonstration.
 - a. The State will be at risk for the per capita cost (as determined by the method described in this Section) for Medicaid eligibles in the following eligibility group(s): “Able-Bodied Adults,” but not for the number of individuals enrolled in the group(s). By providing FFP for enrollees in the specified group(s), the State will not be at risk for changing economic conditions that impact enrollment levels.
 - b. The State will be at risk, under this budget neutrality agreement, for both the number of enrollees as well as the per capita cost for the following expansion populations enrolled in the demonstration: enrolled WMHSP individuals.
3. **Budget Neutrality Expenditure Limit.** The following describes how the annual budget neutrality expenditure limits are determined:
 - a. For each DY of the budget neutrality agreement, an annual target is calculated as the projected per member per month (PMPM) cost for Able-Bodied Adults times the actual number of member months (reported by the State in accordance with paragraph IX.4)
 - b. Member months for WMHSP eligibles are not used for calculation of the budget neutrality expenditure limit.
 - c. The following table gives the projected PMPM costs for the calculation described in paragraph XI.3(a) by DY.

Table 1: Historical PMPM Costs for Determining the Budget Neutrality Ceiling

	DY 1 PMPM	DY 2 PMPM	DY 3 PMPM	DY 4 PMPM	DY 5 PMPM
Able- Bodied Adults	\$294.21	\$316.87	\$341.27	\$367.54	\$395.84

Table 2: Projected PMPM Costs for Determining the Budget Neutrality Ceiling

	DY 6 PMPM (2/1/09 – 1/31/10)	DY 7 PMPM* (2/1/10 – 1/31/11)	DY 8 PMPM (2/1/11 – 1/31/12)	DY 9 PMPM (2/1/12 – 1/31/13)	DY 10 PMPM (2/1/13 – 12/31/13)
Able- Bodied Adults	\$426.32 7.7%	\$459.15 7.7%	\$481.73 6.3%	\$512.08 6.3%	\$544.34 6.3%
		\$453.18 6.3%			

* NOTE: The Demonstration was continued between February 1, 2009 and November 30, 2010 under “the same terms and conditions” meaning a 7.7% PMPM trend rate.

- d. The budget neutrality expenditure limit is the Federal share of the annual PMPM limits for the Demonstration period, and represents the maximum amount of FFP that the State may receive for title XIX expenditures during the Demonstration period, as described in paragraph X.3. The budget neutrality expenditure limit is equal to the sum of all of the subcomponents described in (a)(1) above for all DYs, times the Composite Federal Share (defined in (e) below).
 - e. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the State on actual demonstration expenditures during the approval period, as reported through the MBES/CBES and summarized on Schedule C by total computable Demonstration expenditures for the same period as reported on the same forms. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed upon method.
4. **Future Adjustments to the Budget Neutrality Expenditure Limit.** CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new Federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under this demonstration. CMS reserves the right to make adjustments to the budget neutrality expenditure limit if any health care-related tax that was in effect during the base year with respect to the provision of services

covered under this Demonstration, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care-related tax provisions of section 1903(w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

5. **Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality over the life of the Demonstration rather than on an annual basis. However, if the State exceeds the calculated cumulative target limit by the percentage identified below for any of the DYs, the State shall submit a corrective action plan to CMS for approval.

Year	Cumulative target definition	Percentage
DY 1	DY 1 budget neutrality cap	+8.0 percent
DY 2	DYs 1 and 2 combined budget neutrality limit	+3.0 percent
DY 3	DYs 1 through 3 combined budget neutrality limit	+1.0 percent
DY 4	DYs 1 through 4 combined budget neutrality limit	+0.5 percent
DY 5	DYs 1 through 5 combined budget neutrality limit	0 percent
DY 6	DYs 1 through 6 combined budget neutrality limit	+2.5 percent
DY 7	DYs 1 through 7 combined budget neutrality limit	+0.75 percent
DY 8	DYs 1 through 8 combined budget neutrality limit	0 percent
DY 9	DYs 1 through 9 combined budget neutrality limit	+2.5 percent
DY 10	DYs 1 through 10 combined budget neutrality limit	+.75 percent
DY 11	DYs 1 through 11 combined budget neutrality limit	0 percent
DY 12	DYs 1 through 12 combined budget neutrality limit	0 percent

6. **Exceeding Budget Neutrality.** If the budget neutrality expenditure limit has been exceeded at the end of this Demonstration period, the excess Federal funds shall be returned to CMS. If the Demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.

XII. EVALUATION OF THE DEMONSTRATION

1. **Submission of Draft Evaluation Design.** The State must submit to CMS for approval a draft evaluation design for an overall evaluation of the Demonstration no later than 120 days after the effective date of the Demonstration. At a minimum, the draft design must include a discussion of the goals and objectives set forth in Section II of these STCs, as well as the specific hypotheses that are being tested. The draft design must discuss the outcome measures that will be used in evaluating the impact of the Demonstration during the period of approval. It shall discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the Demonstration must be isolated from other initiatives occurring in the State. The draft design must identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation.
2. **Inclusion of the WMHSP Population into the Evaluation Design.** The State will submit an addendum to the Draft Evaluation Design previously submitted for the Montana Basic Medicaid for Able-Bodied Adults Demonstration. The revised Draft Evaluation Design that incorporates the WMHSP addendum will be submitted to CMS for approval no later than 60 days after CMS's approval of the WMHSP program.
3. **Interim Evaluation Reports.** In the event the State requests to extend the Demonstration beyond the current approval period under the authority of section 1115(a), (e), or (f) of the Act, the State must submit an interim evaluation report as part of the State's request for each subsequent renewal.
4. **Final Evaluation Design and Implementation.** CMS will provide comments on the draft evaluation design within 60 days of receipt, and the State shall submit a final design within 60 days after receipt of CMS comments. The State must implement the evaluation design and submit its progress in each of the quarterly and annual progress reports. The State must submit to CMS a draft of the evaluation report within 120 days after expiration of the Demonstration. CMS must provide comments within 60 days after receipt of the report. The State must submit the final evaluation report within 60 days after receipt of CMS comments.
5. **Final Evaluation Report.** The State must submit to CMS a draft of the evaluation report within 120 days after expiration of the Demonstration. CMS must provide comments within 60 days after receipt of the report. The State must submit the final evaluation report within 60 days after receipt of CMS' comments.
6. **Cooperation with Federal Evaluators.** Should CMS undertake an independent evaluation of any component of the Demonstration, The State shall cooperate fully with CMS or the independent evaluator selected by CMS. The State shall submit the required data to CMS or the contractor.

XIII. SCHEDULE OF DELIVERABLES FOR THE DEMONSTRATION EXTENSION PERIOD

STC	Deliverable
Within 30 days of the date of award	State acceptance of Demonstration Waivers, STCs, and Expenditure Authorities (approval letter)
In compliance with paragraph XII.1.	Submit Draft Design for Final Evaluation Report
Within 60 days of the date of award (paragraph XII.2).	Submit the WMHSP addendum to the Draft Evaluation Design
Monthly Deliverables	Deliverable
In compliance with paragraph IX.4.	Monitoring Call
In compliance with paragraph X.11.	Monthly Enrollment Report
Quarterly Due 60 days after the end of each quarter, except the 4th quarter	Deliverable
In compliance with paragraph IX.5.	Quarterly Progress Reports
In compliance with paragraph IX.5(d).	Quarterly Enrollment Reports
In compliance with section X.1.	Quarterly Expenditure Reports
Annual Due 60 days after the end of the 4th quarter	Deliverable
In compliance with paragraph IX.7.	Draft and Final Annual Reports (Annual Progress Reports and Annual Expenditure Reports)
Other	Deliverable
In compliance with paragraph IX.6, by July 1, 2012	Submit a Transition Plan
120 days after expiration of the demonstration per paragraph XII.5.	Submit Draft Final Evaluation Report
Within 60 days after receipt of CMS comments per paragraph XII.5.	Submit Final Evaluation Report

ATTACHMENT A

QUARTERLY REPORT FORMAT AND CONTENT

Under Section VII, paragraph XX, the State is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant Demonstration activity from the time of approval through completion of the Demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the State. A complete quarterly progress report must include an updated budget neutrality monitoring workbook.

NARRATIVE REPORT FORMAT:

Title Line One – Montana Basic Section 1115 Medicaid Demonstration

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Example:

Demonstration Year: 1 (January 1, 2010 – December 31, 2010)

Federal Fiscal Quarter: 01/01/2010 – 03/31/2010

Introduction

Information describing the goal of the Demonstration, what it does, and key dates of approval/operation. (This should be the same for each report.)

Enrollment Information

Please complete the following table that outlines all enrollment activity under the Demonstration. The State should indicate “N/A” where appropriate. If there was no activity under a particular enrollment category, The State should indicate that by “0”.

Enrollment Count

Note: Enrollment counts should be person counts, not member months.

Demonstration Populations (as hard coded in the CMS 64)	Current Enrollment (last day of quarter)	Newly Enrolled in Current Quarter	Disenrolled in Current Quarter
Able-Bodied Adults			
WMHSP Adults			
• Schizophrenia			
• Bipolar Disorder			
• Major Depression			

Member Month Reporting

Enter the member months for the quarter.

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
Able-Bodied Adults				
WMHSP Adults				
• Schizophrenia				
• Bipolar Disorder				
• Major Depression				

Outreach/Innovative Activities:

Summarize outreach activities and/or promising practices for the current quarter.

Operational/Policy Developments/Issues:

Identify all significant program developments/issues/problems that have occurred in the current quarter, including, but not limited to, approval and contracting with new plans, benefit changes, and legislative activity.

Financial/Budget Neutrality Developments/Issues:

Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS-64 reporting for the current quarter. Identify the State’s actions to address these issues. Specifically, provide an update on the progress of implementing the corrective action plan.

Consumer Issues:

A summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences.

Quality Assurance/Monitoring Activity:

Identify any quality assurance/monitoring activity in current quarter.

Status of Benefits and Cost Sharing:

Provide update regarding any changes to benefits or cost sharing during the quarter.

Demonstration Evaluation:

Discuss progress of evaluation design and planning.

Enclosures/Attachments:

Identify by title any attachments along with a brief description of what information the document contains.

State Contact(s):

Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise.

Date Submitted to CMS:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-01-16
Baltimore, Maryland 21244-1850



Children and Adults Health Programs Group

NOV 08 2013

Ms. Mary E. Dalton
State Medicaid Director
Montana Department of Public Health and Human Services
P.O. Box 4210
Helena, MT 50604-4210

Dear Ms. Dalton:

Thank you for your recent request to extend the state's Basic Medicaid for Able-Bodied Adults Section 1115 demonstration (11-W-00181/8). The Centers for Medicare & Medicaid Services (CMS) received your extension request on October 31, 2013. We have completed a preliminary review of the application and have determined that the state's extension request has met the requirements for a complete extension request as specified under section 42 CFR 431.412(c).

In accordance with Section 42 CFR 431.416(a), CMS acknowledges receipt of the state's extension request. The documents will be posted on [Medicaid.gov](http://medicaid.gov) and the comment period will last 30 days, as required under 42 CFR 431.416(b). The state's extension request is available at <http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html>.

We look forward to working with you and your staff, and are available to provide technical assistance as you revise the state's extension request. If you have additional questions or concerns, please contact your project officer Ms. Terri Fraser, Division of State Demonstrations and Waivers, at (410) 786-5573, or at terri.fraser@cms.hhs.gov.

Sincerely,


Diane T. Gerrits,
Director
Division of State Demonstrations and Waivers

cc: Eliot Fishman, Children and Adults Health Programs Group, CMCS
Richard Allen, Associate Regional Administrator, Region VIII
Cindy Smith, CMS Denver
Terri Fraser, CMCS