DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850

State Demonstrations Group

November 7, 2024

Rebecca de Camara
111 North Sanders, PO Box 4210
Helena, MT 59604

Dear Director de Camara:

The Centers for Medicare & Medicaid Services (CMS) completed its review of the Waiver for Additional Services and Populations Summative Evaluation Report, which is required by the Special Terms and Conditions (STCs), specifically STC #5 "Final Evaluation Report" of Montana's section 1115 demonstration, "Waiver for Additional Services and Populations" (Project No:11-W-00181/8). This Summative Evaluation Report covers the period from January 2018 through December 2022. CMS determined that the Evaluation Report, submitted on June 26, 2024, is in alignment with the CMS-approved Evaluation Design and the requirements set forth in the STCs, and therefore, approves the state's Waiver for Additional Services and Populations Summative Evaluation Report.

The Waiver for Additional Services and Populations Summative Evaluation Report addresses the research hypotheses aligned with the demonstration's goals and presents descriptive trends to evaluate the demonstration. The report indicates that the demonstration continues to provide coverage for medically necessary medical care to eligible Montanans. The report demonstrated decreased utilization of emergency department and inpatient mental health services for the Mental Health Services Plan population. The Parent Caretaker Relative population also had a decline in utilization of emergency department visits. Finally, the Aged, Blind and Disabled population experienced consistent utilization of dental services through the demonstration period. We look forward to collaborating with the state on the Evaluation Design for the new demonstration period, which we expect will allow for a fuller assessment of the demonstration.

In accordance with STC # 5, the approved Final Summative Evaluation Report may now be posted to the state's Medicaid website within 30 days. CMS will also post the Final Evaluation Report on Medicaid.gov.

We look forward to our continued partnership on the Montana's Waiver for Additional Services and Populations section 1115 demonstration. If you have any questions, please contact your CMS demonstration team.

Sincerely,

Danielle Daly -S

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Date: 2024.11.07 05:09:33 -05'00'

Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

cc: Tobias Griffin, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

Montana Section 1115 Waiver for Additional Services and Populations (WASP) Demonstration

Summative Evaluation Report

Demonstration Reporting Period:
Demonstration Year 15 – 19
January 1, 2018 – December 31, 2022

Submitted June 30, 2024

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Executive Summary

Montana's Waiver for Additional Services and Populations (WASP) Demonstration, formally known as the Basic Medicaid Waiver, has remained a positive source of Medicaid coverage since the program's inception in 1996. The following report is an overview and analysis of the demonstration's approval period from January 1, 2018, through December 31, 2022.

During this time period, the WASP waiver had three populations covered under it: Mental Health Services Plan (MHSP), Aged, Blind, and Disabled (ABD), and Parent Caretaker Relative (PCR). The majority of the analysis for this report will focus on the MHSP population as they receive the greatest benefits from the waiver.

The populations will be analyzed separately, and data will be provided to align with the CMS approved Evaluation Design. The waiver will also be explained in terms of changes it has endured and it will be discussed on a more macro level with successes, challenges, and recommendations for future waiver considerations.

Initial findings for the MHSP population show a consistent, although minimal, decline in members as well as overall utilization. The PCR population data contains some flaws due to issues experienced during the public health emergency (PHE) and changing deprivation codes for certain members which will be discussed in depth later in this report. The ABD populations principal results show a steady decline in member counts but an increase in overall service utilization.

The WASP waiver has experienced numerous changes over the course of its existence with many changes being in this reporting period alone. The recommendations for future considerations and for other states are included in this report despite being somewhat limited due to the particular benefits offered and the finite number of members eligible for WASP services.

General Background Information

General History

Montana's WASP Demonstration has been active since 1996 and continues to provide beneficial services to Montana residents today. 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.

Originally, the Basic Program included medical services provided to able-bodied adults (neither pregnant nor disabled) and who were parents and/or caretaker relatives of dependent children, eligible for Medicaid under Sections 1925 or 1931 of the Social Security Act. The Basic Program was operated under a Section 1115 Waiver, offering all mandatory services and a reduced package of Medicaid optional services through a fee-for-service delivery. Amount, duration, and scope of services, under Section 1902(a)(10)(B) of the Act were waived, enabling Montana to carry out the 1115 demonstration.

In February 1996, Montana implemented its state-specific welfare program known as Families Achieving Independence in Montana (FAIM). This sweeping change involved modifications to cash assistance, food stamps, and Medicaid programs. As part of welfare reform, Montana obtained a Section 1115 waiver, approved in February 1996. On October 23, 2003, the DPHHS submitted an 1115 waiver application to CMS requesting approval to continue the Basic Medicaid Program through the 1115 waiver. CMS approved this request for an additional five-year period from February 1, 2004, through January 31, 2009. The waiver structure remained consistent throughout this time.

In 2010, Montana submitted, and CMS approved the addition of the Mental Health Service Plan (MHSP) population. These included individuals with the Severe Disabling Mental Illness (SDMI) diagnosis of schizophrenia or bipolar disorder. This population was included in the waiver due to the limited benefits and services for persons suffering from severe mental health conditions at the time.

In 2014, CMS approved a renewal to the Basic Medicaid Waiver that also included raising the enrollment cap of the MHSP population from "up to 800" to "up to 2000" and added additional criteria for the MHSP population to include the clinical diagnosis of major depressive disorder. This change also added home infusion as a covered service. The enrollment cap for the MHSP population was again increased in 2014 from "up to 2,000" to "up to 6,000" and the eligible diagnoses codes were also updated to be more inclusive of additional SDMI diagnoses. This amendment also updated the evaluation design, Federal Poverty Level (FPL), and budget neutrality information.

Changes that directly impacted this waiver's services were precipitated by the implementation of Medicaid expansion through another 1115 waiver, called the Health and Economic Livelihood Partnership (HELP) Plan. Due to Medicaid expansion, many Basic Medicaid/WASP Program members became eligible for Montana Medicaid. At the same time, significant changes were made to the Basic Program/WASP Program.

Effective January 1, 2016, Montana submitted an amendment to remove the able-bodied adult population, remove the SDMI population eligible for expansion, give the MHSP population the Standard Medicaid benefit, and close the Basic Program benefit. This amendment proposed to cover individuals aged 18 or older, with SDMI who qualify for or are enrolled in the state financed MHSP but are otherwise ineligible for Medicaid benefits and either: (1) have income 0-138% of the FPL and are eligible for or enrolled in Medicare; or (2) have income 139-150% of the FPL regardless of Medicare status. The MHSP waiver enrollment cap was reduced from 6,000 to 3,000. The amendment provided for a 12-month continuous eligibility period for all non-expansion Medicaid covered individuals whose eligibility is based on modified adjusted gross income (MAGI). This amendment aligned the Basic Medicaid benefit package with the Standard Medicaid benefit package.

On March 1, 2016, an amendment was submitted that proposed to change the name of the waiver to Section 1115 Montana Waiver for Additional Services and Populations and cover individuals

determined categorically eligible for ABD for dental treatment services above the Medicaid State Plan cap, as a pass-through cost.

After Montana's Legislative Session, Montana requested an amendment to the WASP Demonstration to discontinue the PCR population, as directed by the Legislature. This additional amendment, effective March 30, 2022, removed expenditure authority for the twelve-month continuous eligibility for the PCR population and also removed historical references to cost sharing and copayments for all demonstration enrollees. However, due to the PHE provisions of the continuous enrollment requirement under section 6008(b)(3) of the Families First Coronavirus Response Act (FFCRA), the PCR population continued to receive twelve-month continuous eligibility into 2023. An application to extend this waiver for five years, with no changes to the prior approved authorities, was approved December 15, 2022. This report will cover the WASP demonstration approval period of January 1, 2018, through December 31, 2022 (DY15 – DY19).

Evaluation Overview

In 2020, while in the midst of the COVID -19 pandemic, CMS informed Montana that the WASP Medicaid Demonstration Evaluation Design draft was long overdue. This design draft, due 120 days after approval of the extension, had been due on May 1, 2018. It is believed that changes in staffing at both CMS and the State of Montana contributed to this oversight. On August 19, 2020, CMS provided Montana with recommendations for developing an evaluation design draft with a suggested due date 60-days following.

In prior years, the approved WASP Evaluation Designs had been limited to the MHSP population only. For this demonstration period, CMS requested the other two populations: Aged, Blind, and Disabled (ABD) and Parent & Caretaker Relatives (PCR) be included in the evaluation design draft. This presented some barriers to Montana. Since the MHSP population of the WASP is under the oversight of the Behavioral Health and Developmental Disabilities Division (BHDD) of DPHHS, this division has been responsible for the evaluation plan and reports, whereas the Health Resources Division (HRD) has been responsible for the monitoring reports.

Additionally, HRD struggled with how to evaluate the very limited benefit the WASP offers to the ABD and PCR populations. WASP offers the ABD population only dental treatment services above the State Plan established dental treatment cap. WASP offers the PCR population a 12-month continuous eligibility period only.

Weeks of discussion and clarification followed, while both CMS and Montana were enmeshed in COVID-19 pandemic responses. By late November 2020, CMS provided direction to Montana on how to proceed with the draft evaluation design giving minimal attention to measuring and evaluating effects on the ABD and PCR populations.

The prior evaluation, completed by BHDD evaluated the effectiveness of the WASP MHSP population only, with a CMS approved evaluation design from December 2010 through December 2017. A key element of this evaluation was a satisfaction survey. A baseline survey of

the then 800 MHSP individuals was completed in the summer of 2012, and then a follow-up survey was conducted in October 2015. BHDD did not complete a new survey of the WASP MHSP population until September 2019 and this survey information differed from the 2015 survey. Because of this, Montana chose demonstration year (DY) 16, 2019, as the baseline year for the MHSP population survey on our evaluation design.

In early December 2020, CMS and Montana agreed upon a January 8, 2021, due date for the draft evaluation design. Montana encouraged a brief delay and was granted two more weeks of grace but submitted the draft evaluation design on January 13, 2021. CMS approved the draft evaluation design on April 5, 2021. The evaluation design specific to the PCR and ABD covered populations reflect on five years of data providing information for interpretation. Montana's complete findings and analysis of those findings are included in this report.

This Summative Evaluation Report is the analysis of the previously discussed design for the Demonstration Years 15-19. The brevity of the evaluation period for the Mental Health Services Plan (MHSP) population combined with the overall chaotic healthcare period of the COVID-19 federal public health emergency (PHE) makes it difficult to draw many clear conclusions from the information obtained for this report.

Evaluation Questions and Hypotheses

Demonstration Objectives and Goals

The goal of the WASP Demonstration mirrors the state's Medicaid goal. That is to assure medically necessary medical care is available to all eligible Montanans within available funding resources. This also aligns with the objectives of Titles XIX and XXI.

The three populations covered under WASP differ significantly from each other and the benefit each population derives from inclusion in WASP also differ. The MHSP population receives the broadest service package and is therefore the principle focus of the evaluation design and therefore this report.

The information obtained for the analyses of the populations covered under WASP include survey responses for the MHSP population and claims data specific to the populations over the defined period of time. Providers are given a 365-day period for claims submission from time of services, making complete data obtained from processed claims subject to a one-year lag time. This lag time causes the annual reports to have analyses that are not completely up to date for the reporting period. For this summative evaluation, all claims' data have been received for this reporting period.

MHSP Population

The goal of WASP for the MHSP population is threefold. The goals include (1) access to mental health care, (2) utilization of mental health care, and (3) mental health outcomes for individuals aged 18 or older, with Sever Disabling Mental Illness (SDMI) who qualify for, or are enrolled in,

the Section 1115 WASP by providing coverage to receive Standard Medicaid benefits for mental health services.

The three research questions used to seek understanding of how the provision of Standard Medicaid benefit coverage for the MHSP population of WASP impacts the three goals listed above. The evaluation design and research questions enable an understanding of the impact of WASP on the MHSP population by hypothesizing that the provision of Standard Medicaid benefits will enable the MHSP population to receive timely and appropriate mental health care, including community-based mental health care services and psychotropic prescription drug services, that improved their mental health outcomes by reducing the MHSP population's utilization of emergency rooms, crisis facilities, inpatient behavioral health units, and the Montana State Hospital for mental health care.

Evaluation Questions

1. How does the provision of Standard Medicaid benefits coverage for WASP enrollees impact their access to covered services?
2. How does the provision of Standard Medicaid benefits coverage for WASP enrollees impact utilization of covered services?
3. How does the provision of Standard Medicaid benefits coverage impact health care outcomes in the WASP population?

Evaluation Hypotheses

1. Access to care will improve for members of the WASP population who receive Standard Medicaid benefits for mental health services.
2. Utilization of community-based mental health services and psychotropic prescription drug services will increase.
3. Utilization of emergency department services for mental health services and admission to crisis stabilization facilities, inpatient psychiatric facilities, and the Montana State Hospital will decrease for members of the WASP population who receive Standard Medicaid benefits for mental health services.

MHSP Goal

Improve access to mental health care, improve utilization of mental health care and improve mental health outcomes for individuals aged 18 or older, with Severe Disabling Mental Illness (SDMI) who qualify for, or are enrolled in, the Section 1115 WASP by providing coverage to receive Standard Medicaid benefits for mental health services.

The following chart helps depict our connections between our goal, intended outcomes, and how those are translated into quantifiable targets for improvement.

Goal	Hypotheses	Measure	Intended Outcome
Improve access to mental health care	Access to care will improve	Member report per the annual satisfaction survey	Receiving the Standard Medicaid benefit will allow members to be able to access more providers which will improve overall care.
Improve utilization of mental health care	Utilization of mental health services and medications will increase	Pulled claims data	Receiving the Standard Medicaid benefit will allow members to attend appointments and receive medications.
Improve mental health outcomes	Utilization of emergency services and hospitals will decrease	Pulled claims data	With improved access and utilization of outpatient services and medications, hospitals and emergency services will be needed and less relied on as a primary source of treatment.

PCR Population

The goal of including the PCR population into the WASP coverage is to provide a 12-month continuous eligibility period for all non-expansion Medicaid covered individuals whose eligibility is based on MAGI. The PCR population receives the Standard Medicaid benefit already, without the aid of the WASP waiver. Including this population into the WASP coverage, eliminates the redetermination burden on the member and the state while aligning these members with an annual redetermination schedule that mirrors most other Montana Healthcare Program members.

The PCR population began receiving this singular benefit under WASP on January 1, 2016. There are no similar groups for which to compare the PCR population, or any additional services covered for them under WASP, only the absence of an extra eligibility requirement. Likely, most PCR members do not realize they are participants in the WASP waiver as its action is virtually invisible to them. Therefore, member satisfaction surveys and outside comparisons for this population are purposely excluded.

PCR Goal

Provide 12-month continuous eligibility period for all non-expansion Medicaid covered individuals whose eligibility is based on MAGI.

The following chart depicts the alignment of our goals, hypothesis, and how they relate to intended outcomes for the PCR population.

Goal	Hypothesis	Measure	Intended Outcome
Provide 12-month continuous eligibility	Enrollees will continue to utilize services during this period	Pulled claims data	Continuing to receive the Standard Medicaid benefit without the redetermination burden should allow members to have uninterrupted access to care and they will continue to utilize services.

ABD Population

The ABD population began receiving this singular benefit under WASP on March 1, 2016. The baseline year determined in the evaluation design was CY 2017. For the purposes of this report and ease to the reader, the data will be displayed on a 5-year reporting period as the rest of the data is shown for the other populations beginning with 2018 and ending with 2022. There are no similar groups to compare with this ABD population or any additional services covered for them under WASP, only the absence of the dental treatment cap. Likely, most ABD WASP members do not realize they are participants in the WASP as its action is invisible to them.

The ABD population is aged, blind, and disabled. When they apply for Standard Medicaid benefits, if they are eligible for Medicaid under the determination of ABD, they are automatically also enrolled in WASP. This is why most of the ABD population under WASP may not be aware they are covered under WASP. They are offered this additional annual coverage because of the hardship inherent in providing dental services incrementally. This population is especially difficult to service with dental care, sometimes needs to be anesthetized, often prone to behavioral combativeness and emotional trauma.

The service itself is offered at the request of providers who find this population especially in need of dental care that is not limited by timeframe or dollar amount. Providers are able to look up the members coverage and see they are covered under the ABD population even if the member is unaware. With the WASP coverage for the ABD population, the providers are able to provide all the necessary services for the patient to receive the care they need to be healthy. This is a population who, if offered a survey, would likely have it completed by a proxy if able to complete one at all. Therefore, member satisfaction surveys and outside comparisons for this population are purposely excluded.

ABD Goal

The goal of including the ABD dental population into the WASP coverage is to provide individuals determined categorically eligible for ABD with dental treatment services above the State Plan dental treatment cap.

The following chart depicts the alignment of our goals, hypothesis, and how they relate to intended outcomes for the ABD population.

Goal	Hypothesis	Measure	Intended Outcome
Provide dental coverage above the State Plan cap	Enrollees will continue to utilize dental services above the treatment cap	Pulled claims data	Receiving dental care services above the State Plan cap should lead to continued use of dental services above the treatment cap.

The driver diagram below helps depict our theory of change and the connections between the demonstration and our goals or aim of the entire Waiver including all three populations.

Aim	Primary Driver	Secondary Driver	Change Ideas
To assure medically necessary care is available to all eligible Montanans within available funding	Access	Eligibility	Increase eligibility for population members.
		Coverage	Increase coverage options by providing the Standard Medicaid benefits and remove the dental cap for ABD.
	Utilization	Medical and Mental Health	Allow access to both medical and mental health to treat the whole person.
		Treatment Options	Improve treatment options and increase provider types to meet the needs of the population members.
	Cost	Improved Functioning	Improve overall member functioning, including better health outcomes, ultimately leading to lower costs long term.
		Decrease Hospital Utilization	With covered access to medical and mental health care needs, population members will be less likely to use the hospital as primary source of treatment.

Methodology

As stated before, the populations covered under the WASP waiver are very different and so are the services or benefits they receive from the waiver. The evaluation focuses on specific measures for each population. For instance, the MHSP population measures will be specific to mental and behavioral health. This population's eligibility for WASP is dependent on their mental health diagnosis criteria. It is assumed this population will mainly utilize the mental and behavioral health services with medical services being a secondary need.

The PCR population measures will include those for overall utilization. The data will also include a measure for the top 10 utilized services for this population. The ABP population is similar with measures for overall utilization and top 10 utilized services.

This evaluation will be an assessment of pre and post evidence. This report will mainly focus on the 5-year reporting period for the ease of the reader and to develop a clear picture and understanding of the data. The exception to this is the ABD population data as that is based on a different data pulling schedule (3/1/YY – 2/28/YY). Because of this the ABD population data will include a small portion of pre-evidence from 2017.

To add to the purposes of ease when reading and understanding this report, the baseline data will be the initial year of measure (DY 15, CY 2018). The data will be discussed with an overview of changes that occurred during this reporting period specifically. This report will not examine the data against comparison groups other than the MHSP population satisfaction survey. The MHSP satisfaction survey is compared against non-WASP respondents. The other data will not include comparison groups due to the limited benefit received by the ABD and PCR populations and the small sample size for MHSP population.

Data for this report was collected through Montana's claims processing system, Medicaid Management Information System (MMIS). The State of Montana maintains and continually monitors the measures within our MMIS system and analytics department. Providers are given a 365-day period for claims submission from time of services, making complete data obtained from processed claims subject to a one-year lag time. For this summative evaluation, all claims' data have been received for this reporting period.

The efforts to validate and clean the data include re-running the queries each time a report is being completed. This ensures all data is up to date. The newly pulled data is then compared against the previously pulled data to check for inconsistencies. If inconsistencies are found, there is an examination of why this was. If any inconsistencies are found, it will also be discussed in the reports.

Methodological Limitations

The WASP waiver evaluation and reporting requirements for this reporting period were completed all in-house by Montana State staff. The Evaluation Design, Annual Reports, Budget

Neutrality, Interim Evaluation, Summative Evaluation, and all data pulling have been completed internally. This has some advantages as well as some disadvantages. Some of the strengths of this design include being able to utilize the MMIS system to pull large amounts of claims data. Our staff are familiar with our systems and creating queries within the systems to pull the data needed for the reporting. This can also be more cost effective as it eliminates the burden of finding, procuring, and paying an outside contractor. One of the weaknesses of having the state staff complete all of these requirements includes staff turnover. It becomes difficult when there is staff turnover as it can lead to a lack of knowledge and more mistakes made.

The WASP STCs for this reporting period did not require an outside entity to complete the evaluation or reporting requirements and therefore another disadvantage is that we are subject to more potential biases when reporting that an outside entity might be. Another weakness unrelated to the issues discussed above would include the nature of the populations and number of members covered under WASP. This creates difficulty in studying the waiver or getting robust data for other states to use if they are considering adding similar populations or benefits to their programs.

Results

The following data and results are from the WASP MHSP population satisfaction surveys. The MHSP population receives a satisfaction survey administered by the BHDD. The ABD and PCR populations do not receive WASP specific satisfaction surveys due to their limited benefits received under the WASP as previously discussed.

In the CMS approved evaluation design for the period of December 2010 through December 2017, there was a member satisfaction survey included for the WASP MHSP population. The first survey was completed in 2012 with a follow up survey being completed in 2015 and 2017. The next survey was not scheduled until 2019, which is the second year of this current reporting period (2018-2022). The baseline data for the WASP MHSP population will be starting at 2019 because of this.

A new, though less extensive survey of the WASP MHSP population was completed in 2019 and continued yearly throughout this reporting period. The survey was condensed to provide participants the opportunity to take the questionnaire in a shorter period while still gathering answers necessary to determine a participant's level of satisfaction. Despite this effort to increase the response rate of surveys by increasing the ease or the survey, there was a decrease in surveys returned by WASP recipients yearly.

Annual satisfaction surveys are performed for the MHSP population of the WASP waiver as they receive the most benefits from the waiver. They are based on the State Fiscal Year (SFY) which runs from October 2022 – June 2023. The non-wasp comparison group consists of members also receiving the Standard Medicaid benefit but are not eligible for WASP based on the MHSP criteria or SDMI diagnosis. The comparison group for the survey (non-WASP) includes any Medicaid members that had a mental health claim in 2023 (this also includes grant-funded programs).

In the SFY2019, there were 177 WASP respondents and in SFY2020, there were 77 WASP respondents. In the SFY2021 survey, there were 89 WASP respondents and in SFY 2022, there were 59 WASP respondents. It is difficult to say why the number of respondents has dropped so low other than the overall number of members has decreased. There will be discussion about whether the survey is providing adequate feedback for the MHSP population and whether new evaluation criteria need to be implemented in the future. If the survey were to be altered, it would include questions more specific to its members and allow members to provide greater feedback. In addition, the current survey for MHSP members is provided by the Behavioral Health and Developmental Disabilities Division (BHDD). It could be more helpful if the survey was a collaboration between the Health Resources Division (HRD) and BHDD as different parts of WASP are managed in both divisions. Below are the WASP MHSP population survey responses broken down by category and compared to non-WASP respondents.

Domain	SFY19 WASP	SFY19 NON-WASP
General Satisfaction	90%	85%
Access to Services	87%	83%
Quality & Appropriateness of Services	86%	87%
Participation in Treatment	86%	86%
Outcomes	68%	64%
Improved Functioning	66%	65%
Improved Social Connectedness	69%	66%
Average of all 7 Domains	**79%**	**77%**

Domain	SFY20 WASP	SFY20 NON-WASP
General Satisfaction	85%	87%
Access to Services	82%	85%
Quality & Appropriateness of Services	89%	86%
Participation in Treatment	80%	84%
Outcomes	58%	68%
Improved Functioning	64%	66%
Improved Social Connectedness	64%	71%
Average of all 7 Domains	**75%**	**78%**

Domain	SFY21 WASP	SFY21 NON-WASP
General Satisfaction	85%	88%
Access to Services	87%	84%
Quality & Appropriateness of Services	84%	85%
Participation in Treatment	93%	91%
Outcomes	57%	66%
Improved Functioning	63%	68%
Improved Social Connectedness	50%	71%
Average of all 7 Domains	**74%**	**79%**

Domain	SFY22 WASP	SFY22 NON-WASP
General Satisfaction	90%	90%
Access to Services	91%	83%
Quality & Appropriateness of Services	83%	85%
Participation in Treatment	83%	85%
Outcomes	53%	67%
Improved Functioning	64%	68%
Improved Social Connectedness	56%	70%
Average of all 7 Domains	**74%**	**78%**

The WASP MHSP survey responses have not significantly changed overall for this reporting period. It has slightly decreased from 2019 to 2022 going from an overall satisfaction of 79 percent to 74 percent. This is slightly different from the non-WASP respondents as their overall satisfaction slightly increased from 2019 to 2022 from 77 percent to 78 percent. The primary categories that have lower scores are outcomes, improved functioning, and improved social connectedness. These three categories are consistently lower in both WASP and non-WASP respondents. In order to locate the root cause of the lower ratings for these categories, we would need to ask more in-depth questions on future surveys or have an open response area for members to complete.

MHSP Data

The population data below depicts a gradual decrease in MHSP members under WASP over the reporting period with an overall decrease of 281 member from 2018 to 2022. It is important to note the potential impact on the MHSP population due to the PHE. Members were not removed from Medicaid during this time period so they may have not needed to qualify for WASP if they were already covered under the Standard Medicaid plan. This could account for a decrease in the population numbers during this reporting period.

MHSP Base Population by Demonstration/Calendar Year				
DY 15 (2018)	**DY 16 (2019)**	**DY 17 (2020)**	**DY 18 (2021)**	**DY 19 (2022)**
1325	1143	1014	1099	1044

The following chart analyzes the evaluation question: How does the provision of Standard Medicaid benefits coverage for WASP enrollees impact utilization of services? The hypothesis for this question was that utilization of community-based mental health services and psychotropic prescription drugs services will increase. This was measured by analyzing the number of enrollees receiving community-based mental health services, specifically outpatient therapy services, targeted case management services, behavioral health day treatment services, rehabilitation and support services, illness management and recovery services, behavioral health group home services, program of assertive community treatment services, peer support services, and adult foster care services. This data was tracked by calendar year with claims based on date of service.

Utilization of Community-Based Mental Health Services				
CY2018	**CY2019**	**CY2020**	**CY2021**	**CY2022**
1037 out of 1325 MHSP members	774 out of 1143 MHSP members	653 out of 1014 MHSP members	732 out of 1099 MHSP members	676 out of 1044 MHSP members
78%	68%	64%	67%	65%

The second measure of utilization of services using the same evaluation question and hypothesis listed above measures the number of enrollees receiving psychotropic prescription drug services by pulling psychotropic prescription drug claims data.

Utilization of Psychotropic Prescription Drugs				
CY2018	**CY2019**	**CY2020**	**CY2021**	**CY2022**
150 out of 1325 MHSP members	106 out of 1143 MHSP members	100 out of 1014 MHSP members	95 out of 1099 MHSP members	83 out of 1044 MHSP members
11.3%	9.3%	9.9%	8.6%	8%

The utilization of psychotropic medication has decreased steadily over the 5 years with a small increase in CY2020. It is difficult to say why this decrease is occurring. The hope would be that more outpatient services are being used, which has decreased the need for psychotropic medication, but that is not shown in the data. The data also shows a decrease in the utilization of community-based services, so it appears there is in an overall decrease in utilization of services by the MHSP population which is in direct conflict with our hypotheses for these measures. Another thing to consider is that the overall population has decreased which correlated with a decrease in service utilization at least for the community based mental health services in CY 2020.

The next four charts will analyze the evaluation question: How does the provision of Standard Medicaid benefits coverage impact health care outcomes in the WASP population? The hypotheses are utilization of emergency department services, stabilization services, inpatient mental health services, and admission to the Montana State Hospital for mental health will all decrease. These again were all tracked on a calendar year for claims. These measures are broken down by distinct member count to track the total number of members rather than the total number of hospitalizations to rule out those members with higher utilization than others. The emergency department claims only include those claims where the primary diagnosis code is a mental health related code. The chart measuring the admission to the Montana State Hospital has become an unhelpful measure during this tracking period. This is because the Montana State Hospital lost is ability to accept payment for Medicaid claims. After investigations and warnings to the Montana State Hospital following safety concerns, they were informed they would no longer receive federal Medicaid and Medicare reimbursement effective April 12, 2022. There is no data available for when the Montana State Hospital no longer was able to accept Medicaid payment.

Utilization of Emergency Department Services for Mental Health				
CY2018	**CY2019**	**CY2020**	**CY2021**	**CY2022**
113 out of 1325 MHSP members	301 out of 1143 MHSP members	247 out of 1014 MHSP members	63 out of 1099 MHSP members	51 out of 1044 MHSP members
8.5%	26.3%	24.4%	5.7%	4.9%

Utilization of Stabilization Services for Mental Health				
CY2018	**CY2019**	**CY2020**	**CY2021**	**CY2022**
53 out of 1325 MHSP members	58 out of 1143 MHSP members	37 out of 1014 MHSP members	35 out of 1099 MHSP members	29 out of 1044 MHSP members
4%	5.1%	3.6%	3.2%	2.8%

Utilization of Inpatient Mental Health Services				
CY2018	**CY2019**	**CY2020**	**CY2021**	**CY2022**
39 out of 1325 MHSP members	36 out of 1143 MHSP members	33 out of 1014 MHSP members	24 out of 1099 MHSP members	29 out of 1044 MHSP members
3%	3.1%	3.3%	2.2%	2.8%

Montana State Hospital Admissions				
CY2018	**CY2019**	**CY2020**	**CY2021**	**CY2022**
6 out of 1325 MHSP members	2 out of 1143 MHSP members	3 out of 1014 MHSP members	1 out of 1099 MHSP members	N/A

As the data shows, there were some unexpected results for the MHSP population. There were small fluctuations from the expectations but still there was a decrease in overall utilization in the categories of psychotropic prescription medication use and community-based mental health services. The data that does align with our hypotheses is a decrease in the need or utilization of inpatient mental health services, stabilization services, and Emergency department services for mental health. The measures of utilization of inpatient mental health services, stabilization services, and Emergency department services for mental health all have cost effective outcomes as these services have high reimbursement values.

PCR Data

PCR Base Population by Demonstration/Calendar Year				
DY 15 (2018)	**DY 16 (2019)**	**DY 17 (2020)**	**DY 18 (2021)**	**DY 19 (2022)**
381	5,269	6,206	4,684	531

The PCR data is somewhat skewed due to the quick changes needed around the time of the PHE. At the start of the PHE, Montana only had one member deprivation code for "transitional

eligibility". When Montana was no longer disenrolling due to the PHE, the decision was made to move all the enrollees that needed redetermination to the transitional eligibility deprivation code. The Health Resources Division (HRD) noticed the rapid incline of member counts and claims and at that point were informed of the decision. HRD requested a new deprivation code be assigned for all the non-PCR enrollees. This change was made, but unfortunately, because all claims were tagged and the member records were not updated retroactively, we are unable to correct the time frame when transitional PCR counts increased. The PCR enrollment change was an unintended consequence of the quick changes needed during the PHE.

The following measures will examine the evaluation question: How did beneficiaries utilize covered health services? The state's hypotheses are enrollees will continue to utilize PCR services during the transitional period. The measures will be based on a calendar year with claims data for overall percentage of beneficiaries using services and average number of services used.

Percentage of beneficiaries with at least one claim				
CY2018	**CY2019**	**CY2020**	**CY2021**	**CY2022**
63.3%	68.6%	80.4%	82.4%	79.8%

Average number of services utilized by beneficiaries				
CY2018	**CY2019**	**CY2020**	**CY2021**	**CY2022**
15.5	9.6	19.1	19.0	31.6

Procedure Code with Average Utilization per Member & Rank (R#)					
Procedure Codes	**2018**	**2019**	**2020**	**2021**	**2022**
90837 – Psychotherapy, 1hour	0.37 (R4)	0.36 (R2)	0.79 (R1)	1.07 (R1)	1.54 (R1)
99213 – Established patient outpatient/office visit, 20+ min	0.87 (R1)	0.39 (R1)	0.65 (R2)	0.68 (R2)	0.89 (R2)
99214 – Established patient outpatient/office visit, 30+ min	0.52 (R2)	0.25 (R4)	0.42 (R3)	0.54 (R4)	0.85 (R3)
S0109 – Methadone, oral, 5mg		0.26 (R3)	0.41 (R4)	0.55 (R3)	0.68 (R4)
97110 – Therapeutic exercises to develop strength	0.43 (R3)	0.08 (R9)	0.18 (R6)	0.25 (R6)	0.45 (R5)
97140 – Manual therapy, 15 min	0.30 (R5)	0.08 (R8)	0.17 (R8)	0.19 (R7)	0.39 (R6)
97530 – Therapeutic activities		0.11 (R5)	0.23 (R5)	0.3 (R5)	0.34 (R7)
97112 – Neuromuscular reeducation				0.15 (R9)	0.31 (R8)
H0016 – Alcohol and/or drug services (MAT intake)			0.13 (R10)	0.18 (R8)	0.28 (R9)
36415 – Routine venipuncture	0.12 (R9)	0.07 (R10)			0.2 (R10)
J0574 – Buprenorphine/Naloxone, oral, 6.1 to 10mg			0.18 (R7)		
92507 – Speech/Hearing therapy			0.15 (R9)	0.15 (R10)	
90471 – Administration of vaccine	0.16 (R7)	0.09 (R6)			
92015 – Determine refractive state for prescription eyewear	0.12 (R10)				
97113 – Aquatic therapy/exercises	0.17 (R6)				
99283 – Emergency department visit	0.16 (R8)				
H2019 – Therapeutic behavioral services					
H2020 – Therapeutic behavioral home support services					
J0572 – Buprenorphine/Naloxone, oral, 3mg		0.08 (R7)			

One of the major improvements seen in the chart above is the decrease in emergency department visits, procedure code 99283. In 2018, procedure code 99283 was the number 8 most utilized service and in the following four years, 2019, 2020, 2021, and 2022, it was not in the top 10 utilized services. The services with high utilization that are compelling include the usage of Buprenorphine/Naloxone, procedure codes J0574 and J0572 in years 2019 and 2020 as well as Alcohol and/or drug services, procedure code H0016 in 2020, 2021, and 2022. These treatments and medications are typically used for Opioid use disorder. This population was not added to the WASP waiver for any reasons related to substance abuse issues. This is something that would be favorable to monitor and consider for any other demonstrations that decide to include a similar population. There is also high utilization of Methadone, procedure code S0109, which can be used for opioid withdrawal and treatment as well. It may be of interest to compare this data to the non-waiver Medicaid participants to assess whether this is a standard reading throughout all Medicaid participants, or an abnormality related to this population specifically. It is important to note that this population was discontinued from the WASP waiver in 2022 so there will be no more monitoring of the PCR population under WASP. Overall, the top 10 utilized services for this PCR population have not seen much change over this reporting period.

ABD Data

ABD Base Population by Demonstration/Calendar Year				
3/1/2017 – 2/28/2018	**3/1/2018 – 2/28/2019**	**3/1/2019 – 2/28/2020**	**3/1/2020 – 2/28/2021**	**3/1/2021 – 2/28/2022**
39,599	38,574	38,420	35,233	33,297

Percentage of beneficiaries who had at least one dental service above the State Plan cap				
3/1/2017 – 2/28/2018	**3/1/2018 – 2/28/2019**	**3/1/2019 – 2/28/2020**	**3/1/2020 – 2/28/2021**	**3/1/2021 – 2/28/2022**
3.010%	2.377%	2.811%	2.994%	4.285%

Number of services utilized per beneficiary				
3/1/2017 – 2/28/2018	**3/1/2018 – 2/28/2019**	**3/1/2019 – 2/28/2020**	**3/1/2020 – 2/28/2021**	**3/1/2021 – 2/28/2022**
0.061	0.057	0.061	0.062	0.116

Procedure Code with Average Utilization per Member & Rank (R#)					
Procedure Codes	**3/1/2017 – 2/28/2018**	**3/1/2018 – 2/28/2019**	**3/1/2019 – 2/28/2020**	**3/1/2020 – 2/28/2021**	**3/1/2021 – 2/28/2022**
D7210 – Extraction, erupted tooth	0.050 (R1)	0.046 (R1)	0.051 (R1)	0.052 (R1)	0.067 (R1)
D7140 – Extraction, erupted tooth or exposed root	0.041 (R2)	0.039 (R2)	0.045 (R2)	0.034 (R2)	0.045 (R2)
D2740 – Crown, porcelain/ceramic				0.012 (R4)	0.031 (R3)
D2950 – Core buildup, including pins	0.010 (R6)		0.009 (R7)	0.013 (R3)	0.022 (R4)
D2392 – Two surfaces posterior, resin-based composite	0.011 (R4)	0.019 (R3)	0.012 (R4)	0.012 (R5)	0.017 (R5)
D7250 – Tooth root removal	0.009 (R9)			0.009 (R8)	0.014 (R6)
D4341 – Periodontal scaling and root	0.010 (R5)	0.017 (R4)	0.010 (R6)	0.009 (R7)	0.013 (R7)
D2391 – One surface posterior, resin-based composite	0.009 (R8)	0.013 (R6)	0.009 (R8)	0.009 (R9)	0.012 (R8)
D2393 – Three surface posterior, resin-based composite	0.008 (R10)	0.014 (R5)	0.008 (R9)	0.008 (R10)	0.011 (R9)
D7310 – Alveoloplasty with extraction	0.010 (R7)		0.010 (R5)		0.010 (R10)
D2751 – Crown-porcelain fused to base metal	0.017 (R3)	0.008 (R10)	0.016 (R3)	0.011 (R6)	
D2330 – Resin one surface-anterior		0.010 (R8)	0.008 (R10)		
D2331 – Resin two surfaces-anterior		0.010 (R7)			
D2332 – Resin – three surfaces-anterior					
D2335 – Resin based composite – four or more surfaces		0.009 (R9)			

The ABD data is compiled on a different measurement cycle or timeline. It is set up this way as the ABD population was approved on March 1st, 2016, and therefore the data began collecting on that date. The data was also presented on this timeline for the Interim Evaluation and will continue to be presented on this timeline for the following report as well.

The top 10 procedure codes used and ranking of those codes for this population have not changed by much over this reporting period. The top services used include extractions. Typically, extractions are last resort treatment option for dental health. This means this population has a higher rate of severe dental issues and therefore need this benefit they receive from WASP.

Although the overall member numbers for the ABD population have gradually decreased over this reporting period, the utilization of services still steadily increased. More ABD population members are using necessary services, aligning with the goals and hypotheses of the waiver.

Conclusions

As stated at the beginning of this report, the goal of the WASP demonstration mirrors the state's Medicaid goal, that is to assure medically necessary medical care is available to all eligible Montanans within available funding resources. In general, the results show the WASP waiver met a majority of the intended goals and hypotheses for the three populations.

During this evaluation period, WASP extended unique coverage opportunities for medically necessary medical care to three unique opportunities. The MHSP population utilized needed mental health services as well as other medical care for each year evaluated even though there was a gradual decrease. During the evaluation for the ABD population, utilization of dental services above the standard benefit treatment cap grew slowly but steadily. Assessing WASPs role in assuring medically necessary medical care for the PCR population is more difficult. The PCR population's single benefit under WASP is 12-month continuous eligibility for medical care

for which they are already eligible. The 12-month continuous eligibility removed the currently unmeasurable barrier of members losing care due to more frequent eligibility determination. Note an amendment approved March 30, 2022, removed the 12-month continuous eligibility for the PCR population, and thus removes this population from WASP coverage, effective at the end of the federal PHE.

The measures and analysis of this waiver reporting period have led to various insights about the populations and procedures. There are many learning and improvement opportunities as well as a great deal of accomplishments. The State of Montana hopes to continue its work with CMS and improve the lives of Montanans.

Interpretations, Policy Implications and Interactions with Other State Initiatives

Interpretations and Judgements

Including the PCR population under WASP for the extended continuous eligibility as related to intended outcomes involves aligning with the goal. The intended outcomes include the thought that if this population were able to have extended eligibility and coverage, they would be more likely to utilize services as this would allow them to do so. With increased service utilization, it is thought that those members would get their healthcare needs met which would ultimately lead to better health outcomes. These members would also be able to access preventative services which can catch and treat medical issues or conditions before they become a crisis and lead to exponential treatment costs. By being able to treat or manage these medical issues or conditions early on, it should lead to reduce medical costs long-term. These intended outcomes for this population are more theoretical than measurable as the PCR population already receives the standard Medicaid coverage and it becomes difficult to develop accurate conclusions based off of data from the limited benefit the PCR population receives under this waiver. Another issue with trying to measure this population includes the issues Montana had with changing the deprivation code, which created some measuring hardships for this reporting period.

Part of the intended outcomes of including the ABD population under WASP for the increased dental limit benefit includes reducing costs long-term. The idea of being able to treat these members with more available dental procedures would in turn reduce the need to visit the urgent care or emergency room for dental related issues. The dental services should treat the issues and help prevent these major complications including broken or damaged teeth, uncontrolled dental pain, abscess or infection, etc., leading to urgent care or emergency room visits. Along with the benefit of reduced costs in the long term, it is also thought increasing the dental cap for this population will lead to increased utilization of services which would also lead to better health outcomes.

The intended outcomes for both the PCR population and the ABD population are more theoretical rather than measurable at this time. The difficulty in measuring these intended outcomes for the ABD and PCR populations includes the limited benefit they receive from the

WASP waiver and the limited timeframe for this reporting period. Because of these difficulties discussed, we have made judgements and interpretations based on a broader knowledge of healthcare systems.

Lessons Learned and Recommendations

One major lesson learned during this reporting period is the importance of changes in deprivation codes. As stated before, when the PHE began, there was one deprivation code used specifically for the PCR population covered under WASP. When Montana was no longer disenrolling due to the PHE, the decision was made to move all the enrollees that needed redetermination to the transitional eligibility deprivation code. By the time this was discovered and edited, the data contamination had already been done. Unfortunately, because all claims were tagged and the member records were not updated retroactively, we are unable to correct the time frame when transitional PCR counts increased.

If other states expect any employee turnover in the demonstration approval and reporting periods, they may want to consider contracting with an outside agency to complete the evaluation and reporting requirements. CMS expects rigorous monitoring and evaluation of these 1115 demonstrations, and it may be in the state's best interest to hire an outside party to complete these meticulous requirements. It appears CMS has also considered this for other 1115 demonstrations as some of the updated Special Terms and Conditions (STCs) require the outside contractors to report for the Interim and Summative Evaluations on 1115 waivers.

If any other states were considering implementing a similar waiver or evaluation design, Montana would recommend preparing the data queries when planning the waiver including the evaluation design. This can assist in faster and more reliable data pulling when reporting to CMS. It is much more difficult to develop the measures wanted with imputing them into the waiver and evaluation design, then later having to develop queries to match based on an idea or concept.

Some input we have received regarding the MHSP population that other states may want to consider is the income threshold and how it relates to the targeted services for this population. The current MHSP income for the WASP waiver includes "income 0-138% of the FPL and are eligible for or enrolled in Medicare; or income 139-150% of the FPL regardless of Medicare status". The services targeted and measured for this group are specific to mental health as that is what they are eligible for WASP under (SMDI diagnosis).

With this population, there tends to be a higher unemployment rate due to the nature of the conditions that make them eligible for these services. As the members receive services and become more mentally stable, they also have an increase in overall functioning. As these members receive these services and stabilize their conditions, they are better able to get and hold employment. If the members are able to get and maintain employment, they may then not qualify for the waiver benefits as they have exceeded the income limits with their new employment status. This has been identified as one of the unintended outcomes of this demonstration. If these members make too much money to qualify for the waiver services anymore, they are less likely to get their medications filled and receive the same services that helped to get and maintain their

stabilization. This tends to lead to de-stabilization again, leading to job loss, and needing to re-qualify for WASP services. There has not been any further study on this specific topic but may be considered in the future.

Attachment(s) (as applicable)

Attachment A: Evaluation Design