DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

March 30, 2022

Marie Matthews
Medicaid Director
Montana Department of Public Health and Human Services
111 North Sanders
Room 301
Helena, MT 59620

Dear Ms. Matthews:

The Centers for Medicare & Medicaid Services (CMS) is approving Montana's Waiver for Additional Services and Populations section 1115 demonstration amendment (Project Number 11-W-00181/8), in accordance with section 1115(a) of the Social Security Act ("the Act"). Approval of this amendment sunsets expenditure authority for the twelve-month continuous eligibility for parents and caretaker relatives (PCR) initially determined eligible under the state plan in the eligibility groups described in either section 1931 of the Act or section 1925 of the Act. This authority will end at the earlier of: the end of the continuous enrollment requirement under section 6008(b)(3) of the Families First Coronavirus Response Act (FFCRA) or the date that the state no longer claims the increased Federal medical assistance percentage (FMAP) under section 6008(a) of the FFCRA. This amendment also removes cost sharing and copayments for demonstration enrollees, to align with the removal of cost sharing from the Montana Medicaid state plan effective January 1, 2020. With this amendment, the demonstration continues to provide expenditure authority for twelve-month continuous eligibility and coverage of health care services for lower-income individuals age 18 or older who not otherwise eligible for Medicaid who have been diagnosed with a severe disabling mental illness of schizophrenia, bipolar disorder, major depression, or another severe disabling mental illness. The demonstration also continues to authorize expenditures for Montana to provide dental treatment services above the state plan dental treatment services annual limit of $1,125 for certain categorically eligible beneficiaries. This approval is effective through December 31, 2022, upon which date, unless extended or otherwise amended, all authorities granted to operate this demonstration will expire.

CMS's approval of this section 1115(a) demonstration amendment is subject to the limitations specified in the attached expenditure authorities, special terms and conditions (STCs), and any supplemental attachments defining the nature, character, and extent of federal involvement in this project. The state may deviate from Medicaid state plan requirements only to the extent those requirements have been specifically listed as not applicable under the demonstration.

Consistent with CMS's requirements for monitoring and evaluation of section 1115 demonstrations, the state will continue conducting systematic monitoring and a comprehensive evaluation of its section 1115 demonstration per the STCs, and will accommodate this amendment into the demonstration's monitoring and evaluation deliverables, as applicable.

Consideration of Public Comments

The state provided public notice for this amendment in accordance with the processes described in the September 27, 1994 Federal Register notice (59 FR 49249) as generally acceptable methods of state public notice for demonstration amendments.

The state held a public comment period from July 3, 2021 through August 31, 2021. The State received 262 comments. The majority of comments were in opposition of the amendment The commenters listed limited access to care as a result of lost coverage; potential churn of eligible individuals due to seasonal work cycles; administrative burden on health care providers to track patient insurance status as well as on Department of Public Health and Human Services (DPHHS) to process additional renewals; impact to the Purchase and Referred Care (PRC) program; and the negative revenue impacts Tribal, IHS and Urban clinics will face due to patients losing Medicaid coverage as their reasons for opposition.

The federal public comment period opened on September 15, 2021 and closed on October 15, 2021. There were 109 comments received, all comments opposed the amendment. Some of the commenters cited loss of continuous coverage, reporting burden for beneficiaries, vulnerable populations would be adversely affected, administrative burden on state, American Indian and Alaska Native populations adversely impacted and negative impact on community health centers as reasons for opposition to the amendment.

There is no federal Medicaid State Plan authority for twelve-months continuous coverage for adults, and therefore, CMS does not ordinarily have the authority to match state expenditures for these costs. Any state that wishes to provide twelve-months continuous coverage for adults must apply for and receive CMS approval for expenditure authority under section 1115(a)(2) of the Act to authorize federal expenditures for the costs of this continuous coverage. CMS's approval of demonstration authority under section 1115 of the Act is discretionary and requires that CMS find that the demonstration as a whole is likely to assist in promoting the objectives of the Medicaid program. Montana was only one of two states that had voluntarily elected to provide twelve-month continuous eligibility for adults through an 1115 demonstration. CMS does not have the authority to require Montana to continue this voluntary election, particularly as we have determined that the demonstration as a whole, with this amendment, is likely to assist in promoting the objectives of the Medicaid program because the demonstration continues to provide coverage beyond what is required under the state plan. With this approval, Montana's revised policy will now be aligned with the vast majority of other states' Medicaid programs.

With the sunset of the expenditure authority for continuous eligibility for parents and caretaker relatives initially determined eligible under the state plan in the eligibility groups described in either section 1931 of the Act or section 1925 of the Act, Montana will align the processes for parents and caretaker relatives with its state plan Medicaid eligibility and enrollment processes.

When information is received that indicates PCRs no longer meet eligibility requirements, the state will conduct a renewal beginning with an ex parte review (using existing data or data matches) to identify whether the individual continues to be eligible including under another eligibility category for which the PCR qualifies, including transitional medical assistance. If yes, the PCR will receive a notice indicating the change in eligibility category or they may stay in the parent caretaker relative group. If the state does not have sufficient information available to make an eligibility determination, the PCR will receive a notice of action (NOA) requesting additional information in compliance with 42 CFR § 435.916. The NOA will specify what information is needed, the date when that information is due, the date by which the beneficiary will no longer be enrolled absent response, and details of appeal rights and steps to pursue an appeal. Many individuals who lose Medicaid eligibility will have access to other coverage such as through an employer or the subsidized plans on the Federally-Facilitated Marketplace (FFM). For any individual who is found ineligible for Medicaid coverage, the state will continue to connect these individuals to the FFM in order to have their eligibility determined for other Insurance Affordability Programs.

Other Information

The award is subject to CMS receiving written acceptance of this award within 30 days of the date of this approval letter. Your project officer is Ms. Wanda Boone-Massey who is available to answer any questions concerning implementation of the state's section 1115(a) demonstration and her contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop S2-25-26
7500 Security Boulevard
Baltimore, Maryland 21244-1850
Email: wanda.boone-massey@cms.hhs.gov

We appreciate your state's commitment to improving the health of people in Montana, and we look forward to our continued partnership on the Montana Additional Services and Populations section 1115(a) demonstration. If you have any questions regarding this approval, please contact Ms. Judith Cash, Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at (410) 786-9686.

Sincerely,

[redacted]

Daniel Tsai
Deputy Administrator and Director

Enclosure

cc: Barbara Prehmus, State Monitoring Lead, Medicaid and CHIP Operations Group

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: **11-W-00181/8**

TITLE: **Section 1115 Waiver for Additional Services and Populations**

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, 2018, through December 31, 2022.

The state shall claim expenditures for federal matching at the regular matching rate. The expenditure authorities listed below promote the objectives of title XIX of the Social Security Act by providing flexibility for Montana to extend coverage to certain low-income individuals, and provide twelve-month continuous eligibility period to individuals in the demonstration.

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

1. Expenditures for the Waiver Mental Health Services Plan Program (WMHSP) Population

Expenditures for coverage of health care services for no more than 3,000 individuals age 18 or older, not otherwise eligible for Medicaid who have been diagnosed with a severe disabling mental illness of schizophrenia, bipolar disorder, major depression, or another severe disabling mental illness, and at the time of their initial enrollment were receiving (or meet the qualifications to receive) a limited mental health services benefit package through enrollment in the state-financed Mental Health Service Plan Program, and either: 1) have income above 133 up to and including 150 percent of the FPL, or 2) are eligible for or enrolled in Medicare and have income at or below 133 percent of the FPL.

2. Expenditures for the Twelve-Month Continuous Eligibility Period Population

a. Expenditures for health care related costs for parents and caretaker relatives initially determined eligible under the state plan in the eligibility groups described in either section 1931 of the Act or section 1925 of the Act, but who no longer meet those standards during some portion of a twelve-month continuous enrollment period. This authority remains effective only until the earlier of: the last day of the quarter during which the COVID-19 Public Health Emergency ends, or until the date that the state no longer claims the increased Federal medical assistance percentage (FMAP) under section 6008(a) of the Families First Coronavirus Response

Act (FFCRA).

b. Expenditures for health care related costs for individuals initially determined eligible under the demonstration as WMHSP population, but who no longer meet the standards during some portion of a twelve-month continuous enrollment period.

3. Expenditures for Dental Services above the Dental Treatment Services Limit for the Aged, Blind, and Disabled (ABD) Population

Expenditures for Montana to provide dental treatment services above the state plan dental treatment services annual limit of $1,125 for beneficiaries determined categorically eligible as ABD.

MEDICAID REQUIREMENTS NOT APPLICABLE TO THE DEMONSTRATION ELIGIBLE POPULATION

All requirements of the Medicaid program expressed in statute, regulation and policy statement, not expressly waived in this list, shall apply to the demonstration project beginning as of January 1, 2018, through December 31, 2022. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs)

The following requirements of the demonstration will be applicable to those beneficiaries who are made eligible for services solely by virtue of the demonstration project, 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. No waiver of reasonable promptness is authorized for the ABD population receiving dental services through this demonstration.

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

To permit the state not to offer retroactive eligibility to WMHSP individuals. No waiver of retroactive eligibility is authorized for the ABD population receiving dental services through this demonstration.

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

NUMBER: **11-W-00181/8**

TITLE: **Montana Section 1115 Waiver for Additional Services and Populations**
AWARDEE: **Montana Department of Public Health and Human Services**

DEMONSTRATION PERIOD: January 1, 2018, through December 31, 2022

I. PREFACE

The following are the special terms and conditions (STCs) for Montana's Section 1115 Waiver for Additional Services and Populations (hereinafter referred to as "demonstration") to enable Montana to operate this demonstration for the period of January 1, 2018, through December 31, 2022. The parties to this agreement are the Montana Department of Public Health and Human Services ("state") and the Centers for Medicare & Medicaid Services ("CMS"). CMS has granted a waiver of specific requirements under section 1902(a) of the Social Security Act (the Act). 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, 2022.

The STCs have been arranged into the following subject areas:

II. I. PROGRAM DESCRIPTION AND OBJECTIVE

The Montana Section 1115 Waiver for Additional Services and Populations is a statewide section 1115 demonstration administered by the state. The demonstration began in 1996, under the authority of an 1115 welfare reform demonstration 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 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 demonstration expired on January 31, 2004, and was replaced (without change) by a section 1115 Medicaid demonstration titled "Montana Basic Medicaid for Able-Bodied Adults," 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 relative 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 basic Medicaid 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 of the Waiver Mental Health Services Plan (WMHSP) population in the section 1115 demonstration, these individuals received a very limited mental health benefit through enrollment in a state-financed Mental Health Services 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 was renewed for 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 included increasing enrollment in the WMHSP from 800 to 2000 individuals and covering home infusion services, which are services that were previously excluded under the benefits package in the demonstration. On November 8, 2013, the demonstration renewal was approved for three years, January 1, 2014, through December 31, 2016.

On June 30, 2014, Montana submitted a formal amendment to increase enrollment in the WMHSP from 2,000 to 6,000 individuals. The amendment updated eligible diagnostic codes and add severe disabling mental illness (SDMI) diagnoses to the enrollment process, updated the per member per month cost, and updated the money for maintenance of effort amount. This amendment request was approved on December 16, 2014.

On July 19, 2016, CMS approved Montana's amendment request to reduce the enrollment cap from 6,000 to 3,000 and change the populations eligible for benefits only under the demonstration. The demonstration provides for coverage of health care services for no more than 3,000 individuals age 18 or older, not otherwise eligible for Medicaid who have been diagnosed with a SDMI of schizophrenia, bipolar disorder, major depression, or another SDMI, and at the time of their initial enrollment were receiving (or meet the qualifications to receive) a limited mental health services benefit package through enrollment in the state-financed MHSPP, and either: 1) have income above 133 up to and including 150 percent of the FPL, or 2) are eligible for or enrolled in Medicare and have income at or below 133 percent of the FPL. The demonstration offers a benefit package that aligns with the Medicaid state plan. In addition, the demonstration provides twelve months of continuous eligibility for parents and caretaker relative adults initially determined eligible under the state plan based on modified adjusted gross income (MAGI). CMS approval of this amendment reflects Montana's recent approval of Medicaid expansion, which began January 1, 2016.

On December 5, 2016, CMS approved Montana's third amendment request to change the name of the demonstration, from "Montana Basic Medicaid for Able-Bodied Adults" to the "Section 1115 Waiver for Additional Services and Populations," and provides dental treatment services above the state plan dental services annual limit of $1,125 for beneficiaries determined categorically eligible as aged, blind, and disabled (ABD).

On December 15, 2017 CMS approved Montana extension request to continue the demonstration for five years with no changes.

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act) as amended (42 U.S.C. 1320b-5). This authority took effect as of 6:00 PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1,

2020. On March 18, 2020, the FFCRA was enacted. Section 6008 of the FFCRA offers a temporary Federal Medical Assistance Percentage (FMAP) point increase through the last day of the calendar quarter in which the COVID-19 public health emergency ends as long as the state adheres to the requirements of section 6008(b) of the FFCRA. Section 6008(b)(3) includes the requirement that states maintain the enrollment of beneficiaries who were enrolled in Medicaid as of or after March 18, 2020, through the end of the month in which the COVID-19 PHE ends.[1]

On September 3, 2021, Montana submitted an amendment for the section 1115 demonstration titled, Montana Waiver for Additional Services and Populations (WASP) to remove expenditure authority for the 12-month continuous eligibility for all non-expansion Medicaid-covered individuals whose eligibility is based on MAGI. This amendment sunsets the parents and caretaker relatives (PCR) group from any coverage under WASP, as this was the only benefit they received under the waiver. The state requested a retroactive approval effective July 1, 2021, as directed by Montana's 2021 Legislature. The state understands that it is required to maintain continuous enrollment of Medicaid beneficiaries during the COVID-19 PHE as a condition of receiving a temporary 6.2 percentage point FMAP increase under the FFCRA.

This amendment also seeks to remove cost sharing and copayments for demonstration enrollees, to align with the removal of cost sharing from the Montana Medicaid plan effective January 1, 2020. This will apply to Waiver Mental Health Service Plan (WMHSP) individuals (individuals previously covered under a State-funded program who had schizophrenia, severe depression, or bipolar disease) as well as the categorically eligible aged, blind, and disabled (ABD) individuals who receive expanded dental treatment services through the WASP waiver.

While the state requested approval on July 1, 2021, in order to comply with section 6008(b)(3) of the FFCRA and section 1902(a)(4) and (a)(19) of the Social Security Act, the approval for the authority to discontinue continuous eligibility for parents and caretaker relatives may not be implemented until the end of the continuous enrollment requirements, on the first day of the first calendar quarter after the end of the COIVD-19 PHE or until the state is no longer claiming enhanced FMAP under 6008(a) of the FFCRA.

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 of1964, 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,**

[1] https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-433/subpart-G/section-433.400
https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf

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, withinthe 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.

    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 day such legislation was required to be in effect under federal law.

5. **State Plan Amendments.** The state will not be required to submit title XIX or title XXIstate 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 thediscretion of the Secretary in accordance with section 1115 of 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 otherdeliverables 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 14, 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 timethe 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 careprovided 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 detailedand 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 beingtested 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 objectiveof 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.

   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 commentswhen 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 thephase-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 fair hearing 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 redetermine eligibility for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to making a determination of ineligibility and terminating coverage as required under 42 CFR 435.916. For individuals determined ineligible for Medicaid, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e)The state must comply with all fair hearing and notice requirements found in 42 CFR part 431 subpart E. 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, ...

e. Exemption from Public Notice Procedures 42.CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements under circumstancesdescribed 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. **Post Award Forum.** Within six months of the demonstration's implementation, and annually thereafter, the state shall afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state can either use its Medical Care Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of this STC. The state must include a summary of the comments in the quarterly report associated with the quarter in which the forum was held. The state must also include the summary in its annual report.

11. **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.

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

13. **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's 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.

14. **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.

15. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the state notice procedures as required in 42 Code of Federal Regulations (CFR) section 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also comply with the public notice procedures set forth in 42 CFR section 447.205 for changes in statewide methods and standards for setting payment rates.

    If the state has federally recognized tribes, the state must also comply with the tribal consultation requirements set forth in section 1902(a)(73) of the Act and implemented in regulation at 42 CFR section 431.408(b), and the tribal consultation requirements contained in the state's approved Medicaid State Plan, when any program changes to thedemonstration, either through amendment as set out in STC 7 or extension, are proposedby the state.

16. **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.

17. **Common Rule Exemption.** The state shall ensure that the only involvement of human subjects in research activities which may be authorized and/or required by this demonstration for projects which are conducted by or subject to the approval of CMS, and which are designed to study, evaluate, or otherwise examine the Medicaid program – including procedures for obtaining Medicaid benefits or services; possible changes in or alternatives to those programs or procedures; or possible changes in methods or level of payment for benefits or services under those programs. CMS has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.101(b)(5).

IV. POPULATIONS AFFECTED BY AND ELIGIBLE FOR THE DEMONSTRATION

18. **Use of Modified Adjusted Gross Income (MAGI) Based Methodologies for Demonstration Groups.** For individuals eligible for continuous eligibility or the Waiver Mental Health Services Plan (WMHSP) only under the demonstration, financial eligibility is determined using modified adjusted gross income

(MAGI), and otherwise applicable non-financial standards that would be applicable for state plan populations apply, except as expressly inconsistent with the demonstration eligibility criteria. Eligibility for the demonstration is outlined below in Table 1.

Table 1: Demonstration Eligible Populations

Demonstration Populations	Source of Initial Eligibility	Receives Continuous Eligibility	Eligible for Benefits Described in Section VI
Parents and caretaker relatives enrolled in coverage under sections 1931 or 1925 of the Act, who would be ineligible if subject to redetermination prior to the end of 12 months of continuous enrollment.	§1931 and §1925 of the Act	Yes - until the earlier of: the end of the continuous enrollment requirement under section 6008(b)(3) of the Families First Coronavirus Response Act (FFCRA) or until the date that the state no longer claims the increased Federal medical assistance percentage (FMAP) under section 6008(a) of FFCRA.	No
Waiver Mental Health Services Plan (WMHSP) Enrollees	Section IV, paragraph 2 of these STCs	Yes	Yes. (section VI., 1)

19. **Demonstration Eligible Population – Waiver Mental Health Services Plan Populations.** WMHSP enrollees are individuals who, at the beginning of a twelve-month period of enrollment (subject to paragraph V), have been diagnosed with a SDMI, are age18 and older, who at the time of their enrollment meet the financial and clinical eligibility criteria for the MHSP, but are otherwise ineligible for Medicaid benefits by either:

    i. Having income above 133 up to and including 150 percent of the FPL; or

    ii. Having an income up to and including 133 percent of the FPL, while being eligible for or enrolled in Medicare.

V. CONTINUOUS ELIGIBILITY

20. **Duration.** The state is authorized to provide a twelve-month continuous eligibility period for Medicaid covered parents and caretaker relative adults whose eligibility is based on section 1931 or 1925 of the Social Security Act. This authority remains effective only until the earlier of: the end of the continuous enrollment requirement under section 6008(b)(3) of the Families First Coronavirus Response Act (FFCRA) or until the date that the state no longer claims the increased Federal medical assistance percentage (FMAP) under section 6008(a) of the FFCRA.

    The state is also authorized to provide a twelve-month continuous eligibility period for

individuals who qualify for or are enrolled in WMHSP, under the demonstration. Once the state begins exercising this authority, each individual's 12-month period shall begin at the initial determination of eligibility; for those individuals who are re-determined eligible consistent with Medicaid state plan rules, the 12-month period begins at that point. At each annual eligibility redetermination thereafter, if an individual is re-determined eligible under the Medicaid state plan the individual is guaranteed a subsequent twelve-month continuous eligibility period.

21. **Continuous Eligibility Exceptions.** If any of the following circumstances occur during an individual's twelve-month continuous eligibility period, the individual's Medicaid eligibility shall, after appropriate process, be terminated:

    i. The individual is no longer a Montana resident.
    ii. The beneficiary ages out of eligibility.
    iii. The individual requests termination of eligibility voluntarily.
    iv. The individual dies.
    v. The agency determines that eligibility was erroneously granted at the most recent determination, redetermination or renewal of eligibility because of agency error or fraud, abuse, or perjury attributed to the beneficiary or the beneficiary's representative.

22. **Continuous Eligibility Funding.** Continuous eligibility population funding will be matched at the regular Federal Medical Assistance Percentage (FMAP) rate, and expenditures within the agreed upon per member per month limit for parents and caretaker relatives receiving continuous eligibility in the demonstration will not count against the state's accumulated savings for budget neutrality.

VI. BENEFITS

23. **Benefits for WMHSP Enrollees.** All individuals enrolled in the demonstration will receive all Medicaid state plan services. This coverage is considered Minimal Essential Coverage (MEC).

24. **Dental Benefit for Aged, Blind, and Disabled Enrollees.** All individuals enrolled in the state plan aged, blind, and disabled population will receive dental treatment services without limitation above the state plan dental services cap of $1,125.

25. **Cost-Effective Insurance.** When a demonstration 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.

VII. ENROLLMENT

26. **General Requirements**

    a. Unless otherwise specified in these STCs, all processes for eligibility, enrollment, redeterminations, terminations, fair hearings, 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 a fair hearing, consistent with the requirements at 42 CFR part 431 subpart E and 42 CFR 435.917.

    c. There is no separate enrollment process required for individuals enrolled in the state plan aged, blind, and disabled population to receive dental services through this demonstration.

27. **Imposing WMHSP Waiver Enrollment Limit and Lifting Enrollment Limit.** The state will facilitate enrollment of up to 3,000 eligible individuals into the WMHSP demonstration population. With 30 days prior notice, the state may impose an enrollment limit upon the WMHSP demonstration population of less than 3,000 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 3,000 slots.

28. **Prioritization for WMHSP 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 forthe WMHSP program.

    b. Priority of WMHSP enrolled individuals being moved into the WMHSP demonstration population will be based upon a current SDMI primary diagnosis of schizophrenia spectrum disorder. At the state's discretion, available slots in thedemonstration will then be open to eligible individuals with a SDMI bipolar disorder type. The state may then open enrollment of any remaining slots to individuals with a diagnosis of a SDMI major depression type. The state may then open enrollment of any remaining slots to individuals with a SDMI diagnosisoutside of these three groups.

c. The state uses a computer based random drawing to select the individuals (basedon priority of diagnosis established in subparagraph b) to fill the available statewide slots.

29. **Enrollment into Primary Care Case Management (PCCM), Enhanced Primary Care Case Management (EPCCM), Patient Centered Medical Home 1932a (PCMH 1932a.** The state may enroll demonstration-eligibles into PCCMs, EPCCMs, and PCMHs. By cross-reference, the enrollment, benefits, and cost sharing in the associated CMS-approved state plan in place in these STCs will apply to this demonstration.

VIII. COST-SHARING

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

IX. DELIVERY SYSTEMS FOR WMHSP ENROLLEES

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

    a. May also be enrolled in the PCCM, EPCCM, or PCMH 1932a, which are Montana Medicaid's primary care case management programs. Under the PCCM programs, Medicaid members 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, EPCCM, or PCMH 1932a program enrollees must be provided or approved by the individual's primary care provider.

    b. Those who are not enrolled in the Montana PCCM, EPCCM, or PCMH 1932a programs may receive a covered benefit from any provider participating with the Montana Medicaid program.

    c. Those who are enrolled in the Nurse First Nurse First Advice Line may receive covered benefits from the one Disease Management Organization.

32. **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 behavioral health provider participating with the Montana Medicaid program.

33. **Dental Services.** This demonstration does not impact the delivery system of dental services for individuals enrolled in the state plan aged, blind, and disabled population who receive dental services through this demonstration.

X. GENERAL REPORTING REQUIREMENTS

34. **Deferral for Failure to Submit Timely Demonstration Deliverables.** CMS will issue deferrals in the amount of $5,000,000 per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs) (hereafter singly or collectively referred to as "deliverable(s)") are not submitted timely to CMS or found to not be consistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the current demonstration period. The state does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

    The following process will be used: 1) thirty (30) calendar days after the deliverable was due, if the state has not submitted a written request to CMS for an approval of an extension as described in subsection (b) below; or 2) thirty (30) calendar days after CMS has notified the state in writing that the deliverable was not accepted for being inconsistent with the requirement of this agreement and the information needed to bring the deliverable into alignment with CMS requirements:

    a. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverable(s).

    b. For each deliverable, the state may submit to CMS a written request for an extension to submit the required deliverable that includes a supporting rationale for the cause(s) of the delay and the state's anticipated date of submission. Should CMS agree to the state's request, a corresponding extension of the deferral process can be provided. CMS may agree to a corrective action as an interim step before applying the deferral, if a corrective action is proposed in the state's written extension request.

    c. If CMS agrees to an interim corrective process in accordance with subsection (b), and the state fails to comply with the corrective action steps or still fails to submit the overdue deliverable(s) that meets the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the state.

    d. If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement for submitting deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the standards outlined in these STCs, the deferral(s) will be released.

    As the purpose of a section 1115 demonstration is to test methods of operation orservices, a state's failure to submit all required deliverables may preclude a state from renewing a demonstration or obtaining a new demonstration.

35. **Submission of Post-approval Deliverables.** The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs.

36. **Compliance with Federal Systems Updates.** As federal systems continue to evolve and incorporate 1115 demonstration reporting and analytics, the state will work with CMS to:

    a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;

    b. Ensure all 1115, T-MSIS, and other data elements that have been agreed to for reporting and analytics are provided by the state; and

    c. Submit deliverables to the appropriate system as directed by CMS.

37. **Cooperation with Federal Evaluators.** As required under 42 CFR 431.420(f), the state shall cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents; providing data and analytic files to CMS; entering into a data use agreement that explains how the data and data files will be exchanged; and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state shall include in its contracts with entities that collect, produce or maintain data and files for the demonstration, that they shall make such data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 34.

38. **Corrective Action Plan Related to Monitoring.** If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. A state corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where monitoring data indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 11. CMS will withdraw an authority, as described in STC 11, when metrics indicate substantial and sustained directional change inconsistent with the state's demonstration goals, and the state has not implemented corrective action. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

39. **Monitoring Reports.** The state must submit one (1) compiled Annual Monitoring Report each DY. The Annual Monitoring Report is due no later than ninety (90 days) following the end of the DY. The reports will include all required elements as per 42 CFR 431.428. and should not direct readers to links outside the report. Additional links not referenced in the document may

be listed in a Reference/Bibliography section. The Monitoring Reports must follow the framework provided by CMS, which is subject to change as monitoring systems are developed/evolve, and be provided in a structured manner that supports federal tracking and analysis.

a. Operational Updates – Per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports shall provide sufficient information to document key challenges, underlying causes of challenges, and how challenges are being addressed. The discussion should also include any lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. Monitoring Reports should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration. In addition, Monitoring Reports should describe key achievements, as well as the conditions and efforts to which these successes can be attributed.

b. Performance Metrics – Any required monitoring and performance metricsmust be included in writing in the Annual Reports. Information in the reports will follow the framework provided by CMS and be provided in astructured manner that supports federal tracking and analysis.

c. Budget Neutrality and Financial Reporting Requirements – The state mustprovide an updated budget neutrality workbook with every Annual Reportthat meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request.In addition, the state must report annual expenditures associated with the populations affected by this demonstration on the Form CMS-64.

d. Evaluation Activities and Interim Findings. The state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how theywere addressed. The state shall specify for CMS approval a set of performance and outcome metrics and network adequacy, including their specifications, reporting cycles, level of reporting (e.g., the state, health plan and provider level, and segmentation by population) to support rapidcycle assessment in trends for monitoring and evaluation of the demonstration.

e. Increasing the Frequency of the Required Annual Reports. CMS reserves the right to increase the frequency of the required reports, as determined necessaryby CMS officials.

f. Yearly enrollment reports for demonstration enrollees for each DY (enrollees include all individuals enrolled in the demonstration) that include the member months, as required to evaluate compliance with the budget neutrality agreement.

XI. MONITORING CALLS AND DISCUSSIONS

40. **Monitoring Calls. CMS will convene periodic conference calls with the state.**

    a. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration.

    b. CMS will provide updates on any amendments or concept papers under review, as well as federal policies and issues that may affect any aspect of the demonstration.

    c. The state and CMS will jointly develop the agenda for the calls.

    d. Areas to be addressed during the monitoring call include, but are not limited to:
        i. Transition and implementation activities;
        ii. Stakeholder concerns;
        iii. Operations and performance;
        iv. Enrollment;
        v. Cost sharing;
        vi. Quality of care;
        vii. Beneficiary access;
        viii. Benefit package and wrap around benefits;
        ix. Audits;
        x. Lawsuits;
        xi. Financial reporting and budget neutrality issues;
        xii. Progress on evaluation activities and contracts;
        xiii. Related legislative developments in the state; and
        xiv. Any demonstration changes or amendments the state is considering.

XII. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

41. **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.

42. **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.

43. **Accounting for Enrollment and Expenditures of Demonstration Populations.** All enrollment and expenditures of WMHSP individuals enrolled in the PCCM, EPCCM, or the PCMH 1932a Programs will be attributable to this demonstration and reported in accord with section IX, X, and XI. The enrollment and expenditures of WMHSP individuals enrolled in these programs will not be included in the state's section 1915(b) Passport to Health Waiver reports.

44. **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: Parents and caretaker relatives** — 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. Expenditures up to the PMPM limit established in STC paragraph XII, 3. Table 2, for this demonstration population will not count against the state's accumulated savings for

budget neutrality.

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.

iii. **Demonstration Population 3: Dental—**EG consists of the cost of dental services above the state plan annual dental treatment services limit of $1,125 for beneficiaries who are aged, blind, and disabled whose Medicaid eligibility derives from their status as a mandatory Medicaid population under section 1602 of the Act- counted in the "with" and "without" waiver calculations. Expenditures up to the PMPM limit established in STC paragraph XII, 3.

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 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.** While the state collects prescription drug rebates on 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 the population included in the Basic demonstration. The amendment would need to include a rebasing of 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 report 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 WMHSP eligibles.

iv. Because IHS expenditures were excluded from the original calculation of the without-waiver PMPM costs estimates for Parents and caretaker relatives, the state must report IHS expenditures for Parents and other caretaker relatives 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 Parents and caretaker relatives' expenditures in subparagraphs (b) through (d) above.

iv. 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 underwaiver name "WMHSP Adults," following the instructions in subparagraphs (b) through (d).

45. **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 Section 1115 Waiver for Additional Services and Populations."

46. **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.

47. **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.

48. **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

49. **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.

50. **Maintenance of Effort for the WMHSP Population.** In order for the demonstration to include up to 3,000 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. The state must determine the total reported health benefit expenditures for WMHSP waiver enrolled individuals for each DY, and in each annual report provide assurance to CMS that state expenditures for WMHSP and SMHSP will be maintained at the projected level.

ii. The state is not eligible to claim the increased FFP established under the American Recovery and Reinvestment Act of 2009 for the WMHSP population.

iii. The state is not eligible to claim the increased FFP established under the Affordable Care Act for this WMHSP population.

51. **Monitoring the Demonstration.** The state will provide CMS with information to

effectively monitor the demonstration, upon request, in a reasonable timeframe.

XIII. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

52. **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 3.

53. **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) above the state's projected PMPM cost for Medicaid eligibles in the following eligibility group(s): "Parents and other Caretaker Relatives," and "Dental" 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.

54. **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 PMPM cost for Parents and caretaker relatives times the actual number of member months (reported by the state in accordance with **Table 2**.

    b. For each DY of the budget neutrality agreement, an annual target is calculated as the projected PMPM cost for the Aged, Blind, and Disabled population times the actual number of member months (reported by the state in accordance with section X).

    c. Member months for WMHSP eligibles are not used for calculation of the budget neutrality expenditure limit.

    d. The following table gives the projected PMPM costs for the calculation described in paragraph 3(a) by DY.

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

	DY 15 PMPM (2018)	DY 16 PMPM (2019)	DY 17 PMPM (2020)	DY 18 PMPM (2021)	DY 19 PMPM (2022)
Parents and caretaker relatives (formerly known as Able-Bodied Adults)	$408.55 1.63%	$415.21 1.63%	$421.98 1.63%	$428.86 1.63%	$435.85 1.63%
Aged Blind or Disabled	$8.24 4.1%	$8.58 4.1%	$8.93 4.1%	$9.30 4.1%	$9.68 4.1%

e. 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).

f. 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.

55. **Calculating the Federal Medical Assistance Percentage (FMAP) for Continuous Eligibility.** Adults receiving continuous eligibility in the demonstration will be matched at the regular FMAP rate.

56. **State Reporting for FMAP.** Individuals in the demonstration shall be claimed at the regular FMAP rate. For the purposes of budget neutrality, expenditures within the agreed upon PMPM limit for individuals in the Parents and other Caretaker Relatives population and the Dental population will be treated as a hypothetical population, and will not count against the state's accumulated savings, nor will they accumulate savings.

57. **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.

58. **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 15	DYs 1 through 15 combined budget neutrality limit	0 percent
DY 16	DYs 1 through 16 combined budget neutrality limit	0 percent
DY 17	DYs 1 through 17 combined budget neutrality limit	0 percent
DY 18	DYs 1 through 18 combined budget neutrality limit	0 percent
DY 19	DYs 1 through 19 combined budget neutrality limit	0 percent

59. **Budget Neutrality Savings Phase-Down.** Beginning with the demonstration period that begins on January 1 2018, the net variance between the without-waiver and actual with- waiver costs will be reduced. The reduced variance is used in place of the total variance to determine overall budget neutrality of the demonstration. The reduced variance is comprised of the last five years of demonstration accumulated savings, January 1, 2013 through December 31, 2017. As of January 1, 2018, the state will not accumulate future budget neutrality savings.

60. **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.

XIV. EVALUATION OF THE DEMONSTRATION

61. **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 one hundred twenty (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.

62. **Inclusion of the ABD Population into the Evaluation Design.** The state will submit an addendum to the Draft Evaluation Design previously submitted for the demonstration. The revised Draft Evaluation Design that incorporates the Waiver for Additional Services and Populations Section 1115 demonstration addendum will be submitted to CMS for approval no later than 60 days after CMS's approval of the state's Amendment 3.

63. **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 extension.

64. **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's comments. The state must implement the evaluation design and submit its progress in each of the annual 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's comments.

65. **Summative Evaluation Report.** The state must submit to CMS a draft of the Summative Evaluation Report within 120 days after the end of this approval period represented by these STCs. Unless otherwise agreed upon in writing by CMS, the state must submit a revised Summative Evaluation Report within 60 days after receipt of CMS's comments on the draft. The state must post the final Summative Evaluation Report to the state's Medicaid website within 30 days of approval by CMS.

66. **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.

67. **Corrective Action Plan Related to Evaluation.** If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of an extension process when associated with the state's Interim Evaluation Report, or as part of the review of the summative evaluation report. A corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where evaluation findings indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an

interim step to withdrawing waivers or expenditure authorities, as outlined in STC 11 of Section I. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

XV. HEALTH INFORMATION TECHNOLOGY

68. **Health Information Technology (HIT).** 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. HIT: Montana 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 (HIE). 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 Montana State Medicaid HIT Plan and other planning efforts such as the Office of National Coordinator HIE Operational Plan.

XVI. T-MSIS REQUIREMENTS

69. 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.

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 MedicaidManual 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.

XVII. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION EXTENSION

STC	Deliverable
Within 30 days of the date of award	State acceptance of demonstration Waivers, STCs, and Expenditure Authorities (approval letter)
Monthly Deliverables	**Deliverable**
In compliance with section XI paragraph 1.	Monitoring Call
Annual Due 90 days after the end of the 4th quarter	**Deliverable**
In compliance with section X, paragraph 6.	Draft and Final Annual Reports
Other	**Deliverable**
120 days after expiration of the demonstration per section XIV, paragraph 5.	Submit Draft Final Evaluation Report
Within 60 days after receipt of CMS comments per section XIV, paragraph 5.	Submit Final Evaluation Report

ATTACHMENT A

ANNUAL REPORT FORMAT AND CONTENT

Under Section X, paragraph 6, the state is required to submit annual reports to CMS. The purpose of the annual 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 90 days after the end of each calendar year.

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

NARRATIVE REPORT FORMAT:

Title Line One – Montana Section 1115 Waiver for Additional Services and Populations Demonstration
Title Line Two - Section 1115 Annual Report
Demonstration Reporting Period:

Example:
Demonstration Year: 1 (January 1, 2010 – December 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)	Enrollment (last day of quarter)				Enrollment Annual Total	Newly Enrolled (annual count)	Disenrolled (annual count)
	Q1	Q2	Q3	Q4			
Parent and caretaker relatives							
Dental							
WMHSP Adults							
• **Schizophrenia**							

• **Bipolar Disorder**							
• **Major Depression**							
• **Other Diagnoses**							

Member Month Reporting

Enter the member months for each quarter, and the annual total.

Eligibility Group	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual Total
Parents and caretaker relatives					
Dental					
WMHSP Adults					
• **Schizophrenia**					
• **Bipolar Disorder**					
• **Major Depression**					
• **Other Diagnoses**					

Outreach/Innovative Activities:
Summarize outreach activities and/or promising practices in each quarter.

Operational/Policy Developments/Issues:
Identify all significant program developments/issues/problems that have occurred in each 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 from each 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 each 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 each quarter.

Status of Benefits and Cost Sharing:

Provide update regarding any changes to benefits or cost sharing during each 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:

Attachment B - Evaluation Design

Montana
Section 1115 Waiver for Additional Services and Populations (WASP) Demonstration (formerly Basic Medicaid)
Draft Evaluation Design

Submitted 01/13/2021

Introduction

Montana's Waiver for Additional Services and Populations (WASP), formally known as the Basic Medicaid Waiver, has remained a positive source of Medicaid coverage since the program's inception in 1996. The Basic Program was comprised of mandatory Medicaid benefits and a collection of optional services available for emergencies and when necessary, for seeking and maintaining employment. These services were available to Able-Bodied Adults (neither pregnant nor disabled) who were parents and/or caretaker relatives of dependent children. This waiver has undergone multiple changes over the years.

Changes that directly impacted this waiver's services in 2016 were precipitated by the implementation of Medicaid expansion, called the Health and Economic Livelihood Partnership (HELP) Plan. Due to Medicaid expansion, many Basic Medicaid / WASP Program members became eligible for Montana Medicaid. At the same time, significant changes were made to the Basic Program / WASP Program. An amendment effective January 1, 2016, reduced the number of persons covered, changed the nature of the population eligible and changed the plan of benefits for WASP members. Basic Medicaid previously did not cover or had very limited coverage of some services. This amendment aligned the Basic Medicaid benefit package with the Standard Medicaid benefit package.

An additional amendment, effective March 1, 2016, changed the name of the Basic Waiver to Waiver for Additional Services and Populations. It also added dental treatment coverage, above the Medicaid State Plan cap of $1,125, for categorically eligible ABD individuals, as a pass-through cost.
The benefits for this demonstration are offered though a fee for service model to individuals who qualify.

WASP Populations Covered

1. Individuals age 18 or older, with SDMI who qualify for or are enrolled in the state-financed Mental Health Services Plan (MHSP), but are otherwise ineligible for Medicaid benefits and either:
   - Have income 0-138% of the FPL and are eligible for or enrolled in Medicare; or
   - Have income 139-150% of the FPL regardless of Medicare status (they can be covered or not covered by Medicare and be eligible).
2. Provide a 12-month continuous eligibility period for all non-expansion Medicaid-covered individuals whose eligibility is based on MAGI.
3. Individuals determined categorically eligible for ABD for dental treatment services above the $1,125 State Plan dental treatment cap.

Detailed History and Key Dates of Approval/Operation

The Montana Medicaid Program is authorized under 53-6-101, Montana Codes Annotated, and Article XII, Section 3 of the Montana Constitution. The Department of Public Health and Human Services (DPHHS) administers the Medicaid Program. The Basic Medicaid Program was the medical services provided for able-bodied adults (neither pregnant nor disabled) and who were parents and/or caretaker relatives of dependent children, eligible for Medicaid under Sections 1925 or 1931 of the Social Security Act. The Basic Program was operated under a Section 1115 waiver, offering all mandatory services and a reduced package of Medicaid optional services through a fee-for-service delivery. Amount, duration, and scope of services, under Section 1902(a)(10)(B) of the Act were waived enabling Montana to carry out the 1115 demonstration.

In February 1996, Montana implemented its state-specific welfare reform program known as Families Achieving Independence in Montana (FAIM). This sweeping change involved the cash assistance, food stamp, and Medicaid programs that were administered on the federal side by several agencies under multiple statutes. As part of welfare reform, Montana obtained a Section 1115 waiver, approved in February 1996. On October 23, 2003, the DPHHS submitted an 1115 waiver application to CMS requesting approval to continue the Basic Medicaid Program. CMS approved the waiver application on January 29, 2004, for a five-year period from February 1, 2004, through January 31, 2009. Terms of the request and

the approval were consolidated into an Operational Protocol document as of February 2005. The waiver structure remained constant throughout the life of the Basic Program. The State was required to submit a quarterly Basic Medicaid report as one of the Operational Protocol conditions.

A HIFA proposal was submitted on June 27, 2006. 1115 Basic Medicaid Waiver amendments were submitted on March 23, 2007, and January 28, 2008, requesting seven new optional and expansion populations. Tribal Consultation was completed on December 14, 2007. As a result of discussions with CMS, Montana submitted a revised 1115 Basic Medicaid Waiver amendment on June 6, 2008, requesting four new populations. July 30, 2009, and August 6, 2010, submittals requested only one population, Mental Health Service Plan (MHSP) Waiver individuals (individuals with schizophrenia and individuals with bipolar), in addition to Able Bodied Adults. CMS approved the waiver extension and the request to insure the additional population, effective December 1, 2010.

The 1115 Basic Medicaid Waiver renewal was submitted in June of 2013 and approved by CMS effective January 1, 2014. The renewal includes raising the enrollment cap from "up to 800" to "up to 2000"; the primary Severe Disabling Mental Illness (SDMI) clinical diagnosis of major depressive disorder as a covered diagnosis; and home infusion as a covered service.

In June 2014, Montana submitted an amendment to the Section 1115 Basic Medicaid Waiver (Amendment #1) which was approved by CMS with an August 1, 2014, effective date. This amendment increased the enrollment cap for individuals who qualify for the State only MHSP Program from "up to 2,000" to "up to 6,000" It also updated the eligible diagnosis codes to allow all MHSP Program individuals with SDMI; added a random drawing with the diagnosis code hierarchy selection of schizophrenia first, bipolar second, major depressive disorder third, and then all remaining diagnosis codes. It also updated the per member per month costs of all waiver populations; updated the amount of money (Maintenance of Effort) the State needed to continue to spend on benefits for the mental health waiver population; updated the budget neutrality; revised the CMS approved evaluation design; updated the Federal Poverty Level from 33% FPL to approximately 47% FPL for Able Bodied Adults; and lastly, updated general waiver language.

Effective January 1, 2016, Montana submitted an amendment (Amendment #2), to remove the Able-Bodied Adult population, remove the SDMI population eligible for State Plan expansion, give the MHSP Waiver population the Standard Medicaid benefit, and close the Basic benefit. This amendment proposed to cover individuals age 18 or older, with SDMI who qualify for or are enrolled in the state-financed MHSP

but are otherwise ineligible for Medicaid benefits and either: 1) have income 0-138% of the federal poverty level (FPL) and are eligible for or enrolled in Medicare; or 2) have income 139-150% of the FPL regardless of Medicare status. The MHSP Waiver enrollment cap was reduced from 6,000 to 3,000. The amendment provided for 12-month continuous eligibility period for all non-expansion Medicaid-covered individuals whose eligibility is based on modified adjusted gross income (MAGI).

On March 7, 2016, an amendment was submitted (Amendment #3) that proposed to: change the name of the Waiver to Section 1115 Montana Waiver for Additional Services and Populations and cover individuals determined categorically eligible for ABD for dental treatment services above the Medicaid State Plan cap of $1,125, as a pass-through cost. This amendment was approved with an effective date of March 1, 2016.

Following the third quarter report for DY13, the decision was made to change the reporting for this demonstration to a January through December calendar year as opposed to the prior February through January schedule. Therefore, the DY13 Annual Report covered an abbreviated year, 02/01/2016 through 12/31/2016. The DY14 Annual Report was applicable to the entire calendar year of 2017.

The Montana WASP Medicaid Demonstration was granted an extension on December 15, 2017. This extension, including new Special Terms and Conditions, was accepted by Montana DPHHS, January 12, 2018, and is effective January 1, 2018 through December 31, 2022.

Enrollment Count from DY14 through DY16

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

Demonstration Populations (as hard coded in the CMS 64)	Newly Enrolled (annual count) DY14	Disenrolled (annual count) DY14	Enrollment Annual Total* DY14	% Change in Total Enrollment from Prior DY	Newly Enrolled (annual count) DY15	Disenrolled (annual count) DY15	Enrollment Annual Total* DY15	% Change in Total Enrollment from Prior DY	Newly Enrolled (annual count) DY16	Disenrolled (annual count) DY16	Enrollment Annual Total* DY16	% Change in Total Enrollment from Prior DY
Parent and caretaker relatives	5,757	17,778	27,846	n/a	6,078	10,482	23,578	-15.3%	10,880	7,127	27,486	+16.6%
Dental	4,239	4,891	31,555	n/a	3,932	4,736	30,856	-2.2%	4,136	4,401	30,724	-0.4%
MHSP Adults	221	454	1,335	n/a	132	144	1,325	-0.8%	116	158	1,283	-3.2%
• Schizophrenia	56	91	404	n/a	39	45	398	-1.5%	52	39	411	+3.3%
• Bipolar Disorder	52	158	370	n/a	30	42	358	-3.2%	22	44	336	-6.2%
• Major Depression	72	168	432	n/a	40	49	423	-2.1%	24	54	393	-7.1%
• Other Diagnoses	41	37	129	n/a	23	8	146	+13.2%	19	21	144	-1.4%

*The annual enrollment totals are more than any single quarterly total because the quarterly totals are based on enrollment on the last day of the quarter while the annual total counts members enrolled at any point during the year.

Demonstration Objectives/Goals

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

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 principal focus of this evaluation design.

MHSP Population Goal

The goal of WASP for the MHSP population is threefold. The goals include improving (1) access to mental health care, (2) utilization of mental health care, and (3) mental health outcomes for individuals age 18 or older, with Severe Disabling Mental Illnesses (SDMI) who qualify for, or are enrolled in, the Section 1115 Waiver for Additional Services and Populations (WASP) by providing coverage to receive Standard

Medicaid benefits for mental health services. The evaluation plan utilizes three research questions that seek to understand how the provision of Standard Medicaid benefits coverage for the MHSP population of WASP impacts their (1) access to mental health care, (2) utilization of mental health care, and their (3) mental health outcomes. 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 improves 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.

The State will conduct the evaluation for the MHSP population using survey responses and claims data specific to the MHSP population over a defined time period. The distinct measurements evaluate access to and utilization of services covered by Standard Medicaid benefits, which would be unavailable to the MHSP population without WASP. The defined data sources ensure that the evaluation design utilizes measurements primarily effected by the provision of Standard Medicaid benefits to ensure the evaluation is isolated from other initiatives within the State.

Evaluation Questions and Hypotheses

Research 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?

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.

Summary of Key Evaluation Questions, Hypotheses, Data Sources, and Analytic Approaches

Mental Health Services Plan (MHSP) Population

Demonstration Goal 1: Improve access to mental health care, improve utilization of mental health care and improve mental health outcomes for individuals age 18 or older, with Severe Disabling Mental Illness (SDMI) who qualify for, or are enrolled in, the Section 1115 Waiver for Additional Services and Populations (WASP) by providing coverage to receive Standard Medicaid benefits for mental health services.

Table 1. Illustrative Demonstration Goal with Examples of Related Research Questions, Hypotheses, and Measures

Demonstration Goal	Improve access to mental health care, improve utilization of mental health care and improve mental health outcomes for individuals age 18 or older, with Severe Disabling Mental Illnesses (SDMI) who qualify for, or are enrolled in, the Section 1115 Waiver for Additional Services and Populations (WASP) by providing coverage to receive Standard Medicaid benefits for mental health services.
Research 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?
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.
Measures	1a. Enrollee perception of difficulty getting care. 2a. Number of enrollees receiving community-based mental health services, specifically Outpatient Therapy services, Targeted Case Management services, Behavioral Health Day Treatment services, Rehabilitation & 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. 2b. Number of enrollees receiving psychotropic prescription drug services. 3a. Number of enrollees utilizing emergency department services for mental health services. 3b. Number of enrollees admitted to a crisis stabilization facility. 3c. Number of enrollees admitted to an inpatient psychiatric facility. 3d. Number of enrollees admitted to the Montana State Hospital.

Table 2. Design Measure Structure

Evaluation Component	Evaluation Question	Evaluation Hypotheses	Measure (to be reported for each Demonstration Year)	Recommended Data Source	Analytic Approach
Process	How does the provision of Standard Medicaid benefits coverage for WASP enrollees impact their access to covered services?	Access to care will improve for members of the WASP population who receive Standard Medicaid benefits for mental health services.	Enrollee perception of difficulty accessing care.	Mental Health Statistical Improvement Survey (MHSIP); Domain: Access.	Baseline data will be MHSIP survey responses from 1/1/2019-7/30/2019 in the Access Domain of the survey. Will track annual trends to monitor if beneficiaries perceive their ability to access care has improved.
Process	How does the provision of Standard Medicaid benefits coverage for WASP enrollees impact utilization of covered services?	Utilization of community-based mental health services and psychotropic prescription drug services will increase.	Number of enrollees receiving community-based mental health services, specifically Outpatient Therapy services, Targeted Case Management services, Behavioral Health Day Treatment services, Rehabilitation & Support services, Illness Management and Recovery services, Behavioral Health Group Home services,	Community-based mental health services claim data from the MT claims reporting system.	Baseline data will be claims with Dates of Service between 1/01/2019-12/31/2019. Will track annual trends to monitor if beneficiaries are accessing increased number of community-based mental health services.

Evaluation Component	Evaluation Question	Evaluation Hypotheses	Measure (to be reported for each Demonstration Year)	Recommended Data Source	Analytic Approach
			Program of Assertive Community Treatment services, Peer Support services, and Adult Foster Care services.		
Process	How does the provision of Standard Medicaid benefits coverage for WASP enrollees impact utilization of covered services?	Utilization of community-based mental health services and psychotropic prescription drug services will increase.	Number of enrollees receiving psychotropic prescription drug services.	Psychotropic prescription drug claims data from the MT claims reporting system.	Baseline data will be claims with Dates of Service between 1/01/2019-12/31/2019. Will track annual trends to monitor if beneficiaries are accessing increased number of psychotropic prescription drug services.
Process	How does the provision of Standard Medicaid benefits coverage impact health care outcomes in the WASP population?	Utilization of emergency department services for mental health services will decrease.	Number of enrollees utilizing emergency department services for mental health services.	Emergency department claims data from the MT claims reporting system.	Baseline data will be claims with Dates of Service between 1/01/2019-12/31/2019. Will track annual trends to monitor if beneficiaries are accessing emergency department services for mental health services less frequently.
Process	How does the provision of Standard Medicaid benefits coverage impact health care	Admission to crisis stabilization facilities, inpatient psychiatric facilities, and the Montana State	Number of enrollees admitted to a crisis stabilization facility.	Crisis stabilization facility claims data from the MT claims reporting system.	Baseline data will be claims with Dates of Service between 1/01/2019-12/31/2019. Will

Evaluation Component	Evaluation Question	Evaluation Hypotheses	Measure (to be reported for each Demonstration Year)	Recommended Data Source	Analytic Approach
	outcomes in the WASP population?	Hospital will decrease for members of the WASP population who receive Standard Medicaid benefits for mental health services.			track annual trends to monitor if beneficiaries are being admitted to crisis stabilization facility less frequently.
Process	How does the provision of Standard Medicaid benefits coverage impact health care outcomes in the WASP population?	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.	Number of enrollees admitted to an inpatient psychiatric facility.	Inpatient psychiatric facility claims data from the MT claims reporting system.	Baseline data will be claims with Dates of Service between 1/01/2019-12/31/2019. Will track annual trends to monitor if beneficiaries are being admitted to inpatient psychiatric facilities less frequently.
Process	How does the provision of Standard Medicaid benefits coverage impact health care quality and outcomes in the WASP population?	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.	Number of enrollees admitted to the Montana State Hospital.	Admission and discharge data from the Montana State Hospital.	Baseline data will be admission and discharge data with dates between 1/01/2019-12/31/2019. Will track annual trends to monitor if beneficiaries are being admitted to the Montana State Hospital less frequently.

Table 3. Quantitative Methods

Evaluation Question	Method of Evaluation
How does the provision of Standard Medicaid benefits coverage for WASP enrollees impact their access to covered services?	Measure trend over the demonstration life cycle.
How does the provision of Standard Medicaid benefits coverage for WASP enrollees impact utilization of covered services?	Measure trend over the demonstration life cycle.
How does the provision of Standard Medicaid benefits coverage impact healthcare outcomes in the WASP population?	Measure trend over the demonstration life cycle.

Table 4. Data Collection Process

Measure	Source
Enrollee perception of difficulty getting care.	Mental Health Statistical Improvement Survey (MHSIP); Domain: Access.
Number of enrollees receiving community-based mental health services, specifically Outpatient Therapy services, Targeted Case Management services, Behavioral Health Day Treatment services, Rehabilitation & 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.	Community-based mental health services claims data from the MT claims reporting system.
Number of enrollees receiving psychotropic prescription drug services.	Psychotropic prescription drug claims data from the MT claims reporting system.
Number of enrollees utilizing emergency department services for mental health services.	Emergency department claims data from the MT claims reporting system.
Number of enrollees admitted to a crisis stabilization facility.	Crisis stabilization facility claims data from the MT claims reporting system.
Number of enrollees admitted to an inpatient psychiatric facility.	Inpatient psychiatric facility claims data from the MT claims reporting system.
Number of enrollees admitted to the Montana State Hospital.	Admission and discharge data from the Montana State Hospital.

(1a) Simplified Evaluation Budget (MHSP Portion):

MHSP Evaluation Budget

The state will conduct the MHSP evaluation utilizing state staff only. Outside evaluation contractors will not be employed for this project.

Activity	Cost
Computer programming (cost per hour x hours)	No additional programming costs will be incurred for this evaluation.
Analysis of the data (cost per hour x hours)	$30.00/hour x 40 hours = $1,200.00
Preparation of the report (cost per hour x hours)	$30.00/hour x 10 hours = $300.00
Other (specify work, cost per hour, and hours). If work is outside the requirements of the basic evaluation this should be identified in the draft evaluation design along with justification for an increased budget match.	Survey task will be completed by a non-cost-allocated employee so no additional charge will be incurred for this data collection task. The cost of including this data in the report is covered under the "Preparation of the report" category.

PCR Population Goal

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 WASP eligibility. 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 WASP members do not realize they are participants in the WASP as its action is invisible to them. Therefore, member satisfaction surveys and outside comparisons for this population are purposely excluded.

PCR Goal: provide a 12-month continuous eligibility period for all non-expansion Medicaid-covered individuals whose eligibility is based on MAGI.

Evaluation Component	Evaluation Question	Evaluation Hypotheses	Measure (to be reported for each Demonstration Year)	Recommended Data Source	Analytic Approach
Process	How did beneficiaries utilize covered health services?	Enrollees will continue to utilize PCR services during the transitional period.	Number of beneficiaries who had at least one service encounter in each year of the demonstration/total number of beneficiaries	PCR claims data from the MT claims reporting system pulled from the database and the total PCR transitional Enrollment Data pulled from the database that receives information from the eligibility system. Both the numerator and the denominator will be a distinct count of PCR transitional beneficiaries, counting the beneficiary only once regardless of the number of services covered by their PCR transitional Enrollment.	Base line data will be claims with Dates of Service between 01/01/2016-12/31/2016. Will track annual trends over time to monitor if a higher proportion of beneficiaries are using services.
Process	How did beneficiaries utilize covered health services?	Enrollees will continue to utilize PCR services during the transitional period.	Number of services utilized/total number of beneficiaries	PCR claims data from the MT claims reporting system pulled from the database and the total PCR transitional Enrollment Data pulled from the database that receives information from the eligibility system. Will pull the total count of services to get an average annual per beneficiary count of services utilized.	Base line data will be claims with Dates of Service between 01/01/2016-12/31/2016. Will track annual trends to see if service utilization per beneficiary increases, decreases, or remains flat.
Process	How did beneficiaries utilize covered health services?	Enrollees will continue to utilize PCR services during the transitional period.	Top ten utilized services in each year of the demonstration/total number of beneficiaries	PCR claims data from the MT claims reporting system pulled from the database and the total PCR transitional Enrollment Data pulled from the database that receives information from the eligibility system. Will pull the total services each year by total count of claims and report the top ten most highly utilized services/ total PCR count to get the Top 10 service per beneficiary.	Base line data will be claims with Dates of Service between 01/01/2016-12/31/2016. Will compare the top services from one year to the next to see how the services change or remain the same over time. Compare the trend of like services to see if service utilization per beneficiary increases, decreases, or remains flat.

PCR Goal: Data Collection Process

Measure	Source
Number of beneficiaries who had at least one service encounter in each year of the demonstration/total number of beneficiaries	PCR claims data from the MT claims reporting system pulled from the database and the total PCR transitional Enrollment Data pulled from the database that receives information from the eligibility system.
Number of services utilized/total number of beneficiaries	PCR claims data from the MT claims reporting system pulled from the database and the total PCR transitional Enrollment Data pulled from the database that receives information from the eligibility system.
Top ten utilized services in each year of the demonstration/total number of beneficiaries	PCR claims data from the MT claims reporting system pulled from the database and the total PCR transitional Enrollment Data pulled from the database that receives information from the eligibility system.

PCR Quantitative Methods

Evaluation Question	Method of Evaluation
How did beneficiaries utilize covered health services?	Measure trend over the demonstration life cycle.
Does the demonstration improve health outcomes?	Measure trend over the demonstration life cycle.
Are beneficiaries satisfied with services?	n/a

(1b). Simplified Evaluation Budget (PCR Portion):

PCR Evaluation Budget

The state will conduct the evaluation utilizing state staff only. Outside evaluation contractors will not be employed for this project.

Activity	Cost
Computer programming (cost per hour x hours)	No additional programming costs will be incurred for this evaluation.
Analysis of the data (cost per hour x hours)	$52.60/hour x 20 hours = $1,052.00
Preparation of the report (cost per hour x hours)	$30.00/hour x 6 = $180.00
Other (specify work, cost per hour, and hours). If work is outside the requirements of the basic evaluation this should be identified in the draft evaluation design along with justification for an increased budget match.	n/a

ABD Dental Population 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 $1,125 State Plan dental treatment cap.

The ABD population began receiving this singular benefit under WASP on March 1, 2016. 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. They are offered this additional annual coverage because of the hardship inherent in providing dental services incrementally. This population is especially difficult to serve 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. 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 Dental Goal: provide individuals determined categorically eligible for ABD with dental treatment services above the $1,125 State Plan dental treatment cap.

Evaluation Component	Evaluation Question	Evaluation Hypotheses	Measure (to be reported for each Demonstration Year)	Recommended Data Source	Analytic Approach
Process	How did beneficiaries utilize covered health services?	Enrollees will continue to utilize ABD dental services above the dental treatment cap.	Number of beneficiaries who had at least one dental service encounter above the cap in each year of the demonstration/total number of beneficiaries above the dental cap.	ABD dental claims data from the MT claims reporting system pulled from the database and the total counts of ABD eligible above the dental limit Enrollment Data pulled from the database that receives information from the eligibility system. Both the numerator and the denominator will be a distinct count of ABD beneficiaries above the dental limit, counting the beneficiary only once regardless of the number of services covered by their ABD transitional Enrollment.	Base line data will be claims with Dates of Service between 03/01/2016-02/28/2017. Will track annual trends over time to monitor if a higher proportion of beneficiaries are using services.
Process	How did beneficiaries utilize covered health services?	Enrollees will continue to utilize ABD dental services above the dental treatment cap.	Number of services utilized/total number of beneficiaries.	ABD dental claims data from the MT claims reporting system pulled from the database and the total counts of ABD eligible above the dental limit Enrollment Data pulled from the database that receives information from the eligibility system. Will pull the total count of services to get an average annual per beneficiary count of services utilized.	Base line data will be claims with Dates of Service between 03/01/2016-02/28/2017. Will track annual trends to see if service utilization per beneficiary increases, decreases, or remains flat.
Process	How did beneficiaries utilize covered health services?	Enrollees will continue to utilize ABD dental services above the dental treatment cap.	Top ten utilized dental services in each year of the demonstration/total number of beneficiaries.	ABD dental claims data from the MT claims reporting system pulled from the database and the total counts of ABD eligible above the dental limit Enrollment Data pulled from the database that receives information from the eligibility system. Will pull the total services each year by total count of claims and report the top ten most highly utilized services/ total ABD count to get the Top 10 service per beneficiary.	Base line data will be claims with Dates of Service between 03/01/2016-02/28/2017. Will compare the top services from one year to the next to see how the services change or remain the same over time. Compare the trend of like services to see if service utilization per beneficiary increases, decreases, or remains flat.

ABD Dental Goal: Data Collection Process

Measure	Source
Number of beneficiaries who had at least one dental service encounter above the cap in each year of the demonstration/total number of beneficiaries above the dental cap.	ABD dental claims data from the MT claims reporting system pulled from the database and the total counts of ABD eligible above the dental limit Enrollment Data pulled from the database that receives information from the eligibility system.
Number of services utilized/total number of beneficiaries.	ABD dental claims data from the MT claims reporting system pulled from the database and the total counts of ABD eligible above the dental limit Enrollment Data pulled from the database that receives information from the eligibility system.
Top ten utilized dental services in each year of the demonstration/total number of beneficiaries.	ABD dental claims data from the MT claims reporting system pulled from the database and the total counts of ABD eligible above the dental limit Enrollment Data pulled from the database that receives information from the eligibility system.

ABD Quantitative Methods

Evaluation Question	Method of Evaluation
How did beneficiaries utilize covered health services?	Measure trend over the demonstration life cycle.
Does the demonstration improve health outcomes?	Measure trend over the demonstration life cycle.
Are beneficiaries satisfied with services?	n/a

(1c) Simplified Evaluation Budget (ABD Portion):

ABD Evaluation Budget

The state will conduct the evaluation utilizing state staff only. Outside evaluation contractors will not be employed for this project.

Activity	Cost
Computer programming (cost per hour x hours)	No additional programming costs will be incurred for this evaluation.
Analysis of the data (cost per hour x hours)	$52.60/hour x 20 hours = $1,052.00
Preparation of the report (cost per hour x hours)	$30.00/hour x 6 = $180.00
Other (specify work, cost per hour, and hours). If work is outside the requirements of the basic evaluation this should be identified in the draft evaluation design along with justification for an increased budget match.	n/a

1. Simplified Evaluation Budget (Full Evaluation):

Full Evaluation Budget

The state will conduct the evaluation utilizing state staff only. Outside evaluation contractors will not be employed for this project.

Activity	Cost
Computer programming (cost per hour x hours)	No additional programming costs will be incurred for this evaluation.
Analysis of the data (cost per hour x hours)	MHSP section: $30.00/hour x 40 hours = $1,200.00 PCR section: $52.60/hour x 20 hours = $1,052.00 ABD section: $52.60/hour x 20 hours = $1,052.00 **Full Evaluation: $ 3,304.00**
Preparation of the report (cost per hour x hours)	MHSP section: $30.00/hour x 10 hours = $300.00 PCR section: $30.00/hour x 6 = $180 ABD section $30.00/hour x 6 = $180 **Full Evaluation: $ 660.00**
Other (specify work, cost per hour, and hours). If work is outside the requirements of the basic evaluation this should be identified in the draft evaluation design along with justification for an increased budget match.	n/a

Deliverable Schedule

Montana Waiver for Additional Services and Populations
Demonstration Approved: December 15, 2017
Approval Period: January 1, 2018 – December 31, 2022
Demonstration Year: January through December

Proposal				
Deliverable	**Timeframe**	**Due Date**	**STC**	**Content Included in the Report**
Post Award Forum	Within six months of the demonstration's implementation, and annually thereafter, the state shall afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state can either use its Medical Care Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of this STC.	**Annually** **Held 11/17/2020**	Page 11, STC #10	n/a
Draft of the Evaluation Design	Due no later than one hundred twenty (120) calendar days after the effective date of these STCs **Renegotiated with CMS 12/10/2020 and 01/07/2021**	Originally due by 05/01/2018 Adjusted due date 01/15/2021 **submitted 01/13/2021**	Page 28- 29, STC# 1	n/a

Deliverable	Timeframe	Due Date	STC	Content Included in the Report
Annual Monitoring Report	Report is due no later than ninety (90) calendar days following the end of the DY	Due by March 31, 2021 (This report covers January 1, 2020- December 31, 2020) Due by March 31, 2022 (This report covers January 1, 2021- December 31, 2021) Due by March 31, 2023 (This report covers January 1, 2022- December 31, 2022)	Page 18-19, STC# 6	Must include Operational Updates, Performance Metrics, Budget Neutrality and Financial Reporting Requirements, and Evaluation Activities and Interim Findings. The state must also include a summary of the post award forum. (Page 11, STC #10)
Budget Neutrality Report	Due with every Annual Report	Due by March 31, 2021 (This report covers January 1, 2020- December 31, 2020) Due by March 31, 2022 (This report covers January 1, 2021- December 31, 2021) Due by March 31, 2023 (This report covers January 1, 2022- December 31, 2022)	Page 18-19, STC# 6 (b)(iii)	The state must provide an updated budget neutrality workbook with every Annual Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs.
Revised Draft of the Evaluation Design (if needed)	Due within sixty (60) calendar days after receipt of CMS' comments on the Draft Evaluation Design	**TBD**	Page 28- 29, STC# 1	n/a
Final Evaluation Design	Due within sixty (60) calendar days after receipt of CMS' comments on the Draft Evaluation Design	This date is determined by the date Draft Evaluation Design comments are received from CMS.	Page # 29 STC# 4	n/a

Deliverable	Timeframe	Due Date	STC	Content Included in the Report
Post the approved Evaluation Design for Current Approval Period to the state's website	Due within thirty (30) calendar days of CMS approval	**TBD**	STC #49	n/a
Application for Extension	Due one year before date of end of demonstration period	**(TBD) 12/31/2021 *see note below this table.**	STC page 8 #8	n/a
Interim Evaluation Report	Due when the application for extension is submitted. If the state is not requesting an extension of the demonstration, an Interim Evaluation Report is due one year prior to the end of the demonstration.	**(TBD) 12/31/2021** The state must provide an updated budget neutrality workbook with every Annual Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs	Page 8-9 STC# 8	n/a
Draft Final Evaluation Report	Due within 120 days after expiration of the demonstration. (This covers the entire demonstration period of performance.)	**Due by April 30, 2023**	Page 29 STC# 4	n/a
Final Evaluation Report	Due within sixty (60) calendar days of receiving comments from	This date is determined by the date Draft Final Evaluation Report	Page 29 STC# 4	n/a

Deliverable	Timeframe	Due Date	STC	Content Included in the Report
	CMS on the draft Summative Evaluation Report	comments are received from CMS.		

*The application for extension (due 12/31/2021) will include what is possible of an interim Evaluation Report. Given this Draft Design is not due until early January 2021 and approval date is unknown. The collection of enough data for an interim report to be submitted by December of 2021 may present a challenge.