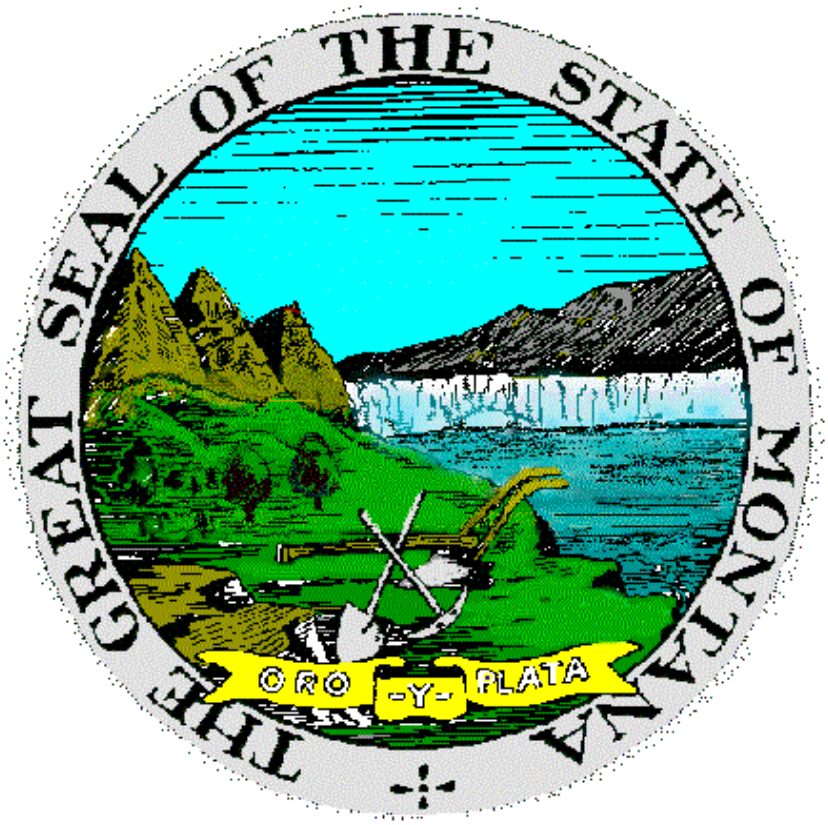

MONTANA DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

Mary E. Dalton, State Medicaid Director

Section 1115 Basic Medicaid Waiver Renewal

June 28, 2013 Submittal

Effective February 1, 2014

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

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

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

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

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

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

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

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

Basic Medicaid Allowances/Special Circumstances:
DPHHS recognizes there may be situations where the excluded services are necessary as in an emergency or when essential for employment. Coverage for the excluded services may be provided at the State's discretion in cases of emergency or when essential to obtain or maintain employment. Examples of emergency circumstances include, but are not limited to, coverage for emergency dental situations, medical conditions of the eye, which include but are not limited to annual dilated eye exams for individuals with diabetes or other medical conditions, and certain medical supplies such as diabetic supplies, prosthetic devices and oxygen. In these situations, the State will provide approval to the provider, and make associated records available upon CMS request.

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

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

Figure I. Montana's Amendment Population Summary

Able Bodied Adults = Mandatory MHSP Waiver = Expansion			***Funding Source***		***Benefit Package***		***Cost Sharing***	
Demonstration Population	***Number of Clients***	***Financial Eligibility***	***Current***	***Proposed***	***Current***	***Proposed***	***Current***	***Proposed***
1) Able Bodied Adults *Act Sections 1925 and 1931 Mandatory 8,800 33% FPL*	*8,800 Not Capped*	*Section 1925 or 1931(b)*	*Title XIX and State match*	*No change*	*Basic Medicaid Services*	*No change*	*Same as State Plan Medicaid*	*No change*
2) MHSP Waiver *Expansion 800 150% FPL*	*2,000 Capped*	*Less than or equal to 150% FPL*	*State Only Funds*	***State Spending:*** *State Maintenance of Effort. Funding from the current State only MHSP Program will be used to fund MEG 2) MHSP Waiver.* ***Federal Spending:*** *Budget Neutrality Surplus from the existing 1115 Basic Medicaid Waiver will be used to cover MEG 2) MHSP Waiver.*	*Limited Mental Health Benefits, up to $425 Mental Health Prescription Drugs, PACT, and 72 Hour Services.*	*Basic Medicaid Services or pay premium for Employer Sponsored Plan or Private Health Insurance.*	*MHSP State Only Program: $3 DBT services, $12 generic and $17 non generic, up to $425 mental health pres-cription drug.*	*Basic Medicaid is minimal, the same as State Plan Full Medicaid. Employer Sponsored or Private Health Insurance would vary depending on the plan.*

Federal and State Basic Medicaid Waiver Benefit Cost and Sustainability:
CMS confirmed that states have previously been allowed to carry waiver savings from an extension year to a new waiver period. We have projected State and Federal expenditures for DY11 (2/14 – 1/15) – DY13 (2/16 – 1/17) and can sustain these populations through January 2017.

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

Figure V. State and Federal Waiver Benefit Costs:

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

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

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

I. BASIC MEDICAID WAIVER HISTORY

Basic Medicaid Wavier History:
In 1996 under the authority of an 1115 welfare reform waiver referred to as Families Achieving Independence in Montana (FAIM), Montana implemented a limited Medicaid benefit package of optional services to the same group of adults eligible for Medicaid under Sections 1925 or 1931 of the Social Security Act. The limited Medicaid benefit package was referred to as "Basic Medicaid." The FAIM welfare reform waiver expired on January 31, 2004 (confirmed by correspondence dated October 7, 2003

from Mr. Mike Fiore, Director, Family and Children's Health Program Group, Centers for Medicare and Medicaid Services).

Basic Medicaid Wavier 2004:
On October 23, 2003, the State of Montana, Department of Public Health and Human Services (Department) submitted a request for an 1115 Basic Medicaid Waiver of amount, duration and scope of services, Section 1902(a)(10)(B) of the Social Security Act, to provide a limited Medicaid benefit package of optional services for those adults age 21 to 64 who are not pregnant or disabled. The waiver was approved to operate beginning February 1, 2004, and end January 31, 2009 for those Able Bodied Adults who are eligible for Medicaid under Sections 1925 or 1931 of the Social Security Act. The Basic Medicaid Waiver is a type of health care reform; it resembles a basic health plan benefit. Optional excluded (to the defined eligibility group) services will be preserved for elderly, disabled or pregnant Medicaid beneficiaries. The 1115 Basic Medicaid Waiver is a replica of the welfare reform in the area of limited optional services under Medicaid. The Department updated the list of standards, and criteria and continued using the term Basic Medicaid as the providers and the consumers are familiar with it.

1115 Amendments:
A HIFA proposal was submitted on June 27, 2006. 1115 Basic Medicaid Waiver amendments were submitted on March 23, 2007 and January 28, 2008 requesting seven new optional and expansion populations. Tribal Consultation was completed on December 14, 2007. As a result of discussions with CMS, Montana submitted a revised 1115 Basic Medicaid Waiver amendment on June 6, 2008 requesting four new populations. Further discussion resulted in a July 30, 2009 submittal requesting only one population, MHSP Waiver individuals, in addition to Able Bodied Adults. Small changes were made to the July 30, 2009 application as a result of continuing conversations with CMS and the Basic Medicaid Waiver was approved December 2010. This waiver renewal will be submitted prior to June 30, 2013, effective February 2014.

II. GENERAL DESCRIPTION OF PROGRAM

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

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

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

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

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

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

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

Able Bodied Adults:

State Funds:	*State legislature appropriated funding at the current FMAP rate.*
Federal Funds:	*New Federal matching Medicaid funds for the mandatory population at the current FMAP rate.*

MHSP Waiver:

State Funds:	*The State's Maintenance of Effort of current State funding levels for a portion of the Mental Health Services Plan State only program.*
Federal Funds:	*Federal matching Medicaid funds for the expanded population will be from Montana's existing 1115 Basic Medicaid Waiver surplus budget neutrality savings.*

III. DEFINITIONS

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

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

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

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

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

IV. HIFA DEMONSTRATION STANDARD FEATURES

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

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

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

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

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

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

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

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

V. STATE SPECIFIC ELEMENTS

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

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

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

- *MEG 1) Able Bodied Adults*

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

- *MEG 2) MHSP Waiver*

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

B. Eligibility:

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

Mandatory Populations *(as specified in Title XIX)*

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

MEG) 1 Able Bodied Adults

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

❑ Blind and Disabled
❑ Aged
❑ Poverty-related Children and Pregnant Women

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

Categorical

❑ Children and pregnant women covered in Medicaid above the mandatory level
❑ Parents or caretaker relatives covered under Medicaid
❑ Children covered under SCHIP
❑ Parents or caretaker relatives covered under SCHIP
❑ Other (please specify)

Medically Needy

❑ TANF Related
❑ Blind and Disabled
❑ Aged
❑ Title XXI children (Separate SCHIP Program)
❑ Title XXI parents or caretaker relatives (Separate SCHIP Program)

Additional Optional Populations

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

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

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

Existing Expansion Populations

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

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

New Expansion Populations

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

- ❑ Pregnant Women in SCHIP (This category will include individuals from ___ percent FPL through ___ percent FPL.)
- ☑ Other. Please specify:
  MEG 2) MHSP Waiver
  - *Qualified State Only Mental Health Services Plan (MHSP) Individuals*
  - *Not otherwise Medicaid eligible*
  - *Age 18-64*
  - *150% FPL*
  - *2,000 Individuals (Capped)*

C. <u>Enrollment/Expenditure Cap:</u>

- ❑ No ☑ Yes If Yes, Number of participants or dollar limit of demonstration (express dollar limit in terms of total computable program costs).
- ***Enrollment Cap:***
  - *MEG 2) MHSP Waiver will be capped at 2,000 individuals served.*

D. <u>Phase-In:</u>

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

- ☑ The HIFA demonstration will be implemented at once. *Montana will enroll Waiver individuals each month until we reach the goal of 2,000. Since our PMPM for the MHSP Waiver group is estimated, we will study the sustainability of 2,000 individuals.*
- ❑ The HIFA demonstration will be phased-in.
  If applicable, please provide a brief description of the State's phase-in approach (including a timeline): *N/A*

E. <u>Benefit Package:</u>

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

1. Mandatory Populations

- ❑ The benefit package specified in the Medicaid State Plan as of the date of the HIFA application.
- ☑ Other:
  - ***MEG 1) Able Bodied Adults – Basic Medicaid Benefit:***

Basic Medicaid services are a reduced benefit of optional services as described in the existing Basic Medicaid 1115 Waiver for Able Bodied Adults. Under the FAIM waiver, these services were excluded to align with the basic medical coverage of a work-related insurance program. That is, an employed individual who is insured under a work-related insurance would generally not have coverage for the list of excluded services.

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

Allowances/Special Circumstances:

The Department recognizes there may be situations where the excluded services are necessary as in an emergency or when essential for employment. Coverage for the excluded services may be provided at the State's discretion in cases of emergency or when essential to obtain or maintain employment. Examples of emergency circumstances include, but are not limited to, coverage for emergency dental situations, medical conditions of the eye, which include but are not limited to annual dilated eye exams for individuals with diabetes or other medical conditions, and certain medical supplies such as diabetic supplies, prosthetic devices and oxygen. In these situations, the State will provide approval to the provider, and make associated records available upon CMS request.

2. Optional populations included in the existing Medicaid State Plan

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

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

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

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

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

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

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

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

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

5. Expansion Populations

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

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

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

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

MEG 2) MHSP Waiver – Basic Medicaid Benefit

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

F. Coverage Vehicle

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

Figure II. Coverage Vehicle

Eligibility Category	Fee-For-Service	Medicaid or SCHIP Managed Care	Private Health Insurance Coverage	Group Health Plan Coverage	Other (specify)	*Comments*
Mandatory Population ***MEG 1) Able Bodied Adults***	√	***Basic Medicaid Benefit***	√*	√*		√****Individuals have the Basic Medicaid benefit unless the individual is able to obtain Employer Sponsored Health Care or Private Health Insurance through the Montana Medicaid HIPP Program.***
New HIFA Expansion ***MEG 2) MHSP Waiver***	√	***Basic Medicaid Benefit***	√*	√*		

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

G. Private Health Insurance Coverage Options

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

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

- *If individuals from MEG 2) MHSP Waiver have the opportunity to obtain employer sponsored insurance or private insurance, if cost effective, the waiver will pay the full premium payment. See Attachment D Private and Public Health Insurance Coverage Options Including Premium Assistance.*

The State elects to provide the following coverage in its premium assistance program: (Check all applicable and describe benefits and wraparound arrangements, if applicable, in Attachment D to the

proposal if necessary. If the State is offering different arrangements to different populations, please explain in Attachment D.)

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

H. Cost Sharing

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

Figure III. MEG Cost Sharing

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

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

VI. ACCOUNTABILITY AND MONITORING

Please provide information on the following areas:

1. Insurance Coverage

The rate of uninsurance in Montana as of 2011 for all individuals of the total population was 24 percent.

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

Note: Respondents can have more than one type of health insurance.
IHS is not considered insurance and Medicaid pays prior to IHS.

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

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

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

❑ Yes ☑ No

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

A State Survey was used.

❑Yes ☑ No

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

2. State Coverage Goals and State Progress Reports

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

The U.S. Census Bureau data indicates Montana's overall uninsured rate is 24 percent. The Basic Medicaid Waiver would allow Montana to continue benefits for 8,800 Able Bodied Adults, 800 MHSP Waiver individuals and furnish health care benefits up to 1,200 Montanans who are currently uninsured.

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

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

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

VII. PROGRAM COSTS

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

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

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

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

VIII. WAIVERS AND EXPENDITURE AUTHORITY REQUESTED

A. Waivers

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

Title XIX:

❑ Statewideness 1902(a)(1)

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

The waiver will be available to qualified participants statewide from the date of implementation.

☑ Amount, Duration, and Scope (1902(a)(10)(B)

To permit the provision of different benefit packages to different populations in the demonstration. Benefits (i.e. amount, duration, and scope) may vary by individual based on eligibility category.

❑ Freedom of Choice 1902(1)(23)

To enable the State to restrict the choice of provider.

Title XXI:

❑ Benefit Package Requirements 2103

To permit the State to offer a benefit package that does not meet the requirements of section 2103.

❑ Cost Sharing Requirements 2103(e)

To permit the State to impose cost sharing in excess of statutory limits.

B. Expenditure Authority

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

Note: Checking the appropriate box(es) will allow the State to claim Federal Financial Participation for expenditures that otherwise would not be eligible for Federal match.

☑ Expenditures to provide services to populations not otherwise eligible to be covered under the Medicaid State Plan. ***MEG 2) MHSP Waiver.***

❑ Expenditures related to providing ___ months of guaranteed eligibility to demonstration participants.

❑ Expenditures related to coverage of individuals for whom cost-sharing rules not otherwise allowable in the Medicaid program apply.

Title XXI:

❑ Expenditures to provide services to populations not otherwise eligible under a State child health plan.

❑ Expenditures that would not be payable because of the operation of the limitations at 2105(c)(2) because they are not for targeted low-income children.

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

Figure IV. Waivers and Expenditure Authority Requested

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

IX. ATTACHMENTS

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

❑ Attachment A: Discussion of how the State will ensure that covering individuals above 200 percent of poverty under the waiver will not induce individuals with private health insurance coverage to drop their current coverage. ***No individuals above 150 percent FPL will be covered by the waiver.***

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

☑ Attachment C: Benefit package description.

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

☑ Attachment E: Detailed discussion of cost sharing limits.

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

☑ Attachment G: Budget worksheets.

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

X. SIGNATURE

_____
Date

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

_____
Signature of Authorizing State Official

ATTACHMENT B - DETAILED DESCRIPTION OF EXPANSION POPULATIONS

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

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

The Basic Medicaid Waiver was approved for a five-year period of February 1, 2004 through January 31, 2009. A HIFA proposal was submitted on June 27, 2006. 1115 Basic Medicaid Waiver amendments were submitted on March 23, 2007 and January 28, 2008 requesting seven new optional and expansion populations. Tribal Consultation was completed on December 14, 2007. As a result of discussions with CMS, Montana submitted a revised 1115 Basic Medicaid Waiver amendment on June 6, 2008 requesting four new populations. A July 30, 2009 submittal requested only one population, MHSP Waiver, in addition to Able Bodied Adults. This amendment extension requested one additional expansion population, up to 800 MHSP Waiver individuals, and represented small changes from the July 30, 2009 application as a result of continuing conversations with CMS regarding the Basic Medicaid Waiver and was approved by CMS effective December 2010.

Able Bodied Waiver Participation Criteria:

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

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

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

Mental Health Services Plan (MHSP) - State Only Program

The Mental Health Services Plan (MHSP) is a State only program for low-income adults, age 18 through 64, who have a Severe Disabling Mental Illness (SDMI). The program currently provides a limited mental health benefit, a related mental health pharmacy benefit of up to $425, PACT Services, and 72 Hour Presumptive Eligibility services. Approximately one-third of the MHSP individuals receive other insurance. The number of people enrolled in the State only MHSP is limited by current legislative appropriations and not by a cap on the number of slots created by DPHHS. MHSP beneficiaries are not eligible for Medicaid services because they do not meet the income and resource Medicaid eligibility requirements. The income limit for State only MHSP is less than or equal to 150 percent FPL and there is no asset or resource test. The State only MHSP is a discretionary program that is not required by State or Federal law. As a result, people eligible for the State only MHSP do not have legal entitlement to services. The Addictive and Mental Disorders Division administers the State only MHSP within the funding levels appropriated by the legislature. There is no physical health benefit offered by the State only MHSP.

State Only Mental Health Services Plan Program Eligibility:

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

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

MEG 2) MHSP Waiver

Expansion Population

For those MHSP individuals not enrolled in the waiver, the State will continue to provide the State only MHSP benefit using State only dollars. The waiver will enroll up to 2,000 of those qualified MHSP Waiver individuals.

MHSP Waiver Participation Criteria:

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

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

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

ATTACHMENTS C - BENEFIT PACKAGE DESCRIPTIONS

MEG 1) Existing Waiver - Montana Basic Medicaid for Able Bodied Adults
Mandatory Population
Under the current Montana Basic Medicaid for Able Bodied Adults 1115 demonstration, parents and/or caretaker relatives of dependent children, as described in Sections 1925 and 1931 of the Social Security Act, who are ages 21 to 64 and neither pregnant nor disabled, receive a limited package of Medicaid services called Basic Medicaid. There is not a lifetime maximum benefit for Able Bodied Adults.

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

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

Basic Medicaid Allowances/Special Circumstances:
DPHHS recognizes there may be situations where the excluded services are necessary as in an emergency or when essential for employment. Coverage for the excluded services may be provided at the State's discretion in cases of emergency or when essential to obtain or maintain employment. Examples of emergency circumstances include, but are not limited to, coverage for emergency dental situations, medical conditions of the eye, which include but are not limited to annual dilated eye exams for individuals with diabetes or other medical conditions, and certain medical supplies such as diabetic supplies, prosthetic devices and oxygen. In these situations, the State will provide approval to the provider, and make associated records available upon CMS request.

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

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

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

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

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

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

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

Referrals for the HIPP Program are generated electronically by the case workers. Anyone who is 18 years or age or older on any Medicaid Program is required to be referred. The referred individual or the parent must answer the questions on the HIPP questionnaire (449 form). It is important to have the form filled out accurately and completely so the State can ascertain whether or not it would be cost effective to the Medicaid Program to pay for the insurance versus Medicaid claims. Completing this form and sending in all insurance information within 10 days is part of the Medicaid eligibility process.

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

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

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

HIPP reimburses for the following health plans:

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

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

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

ATTACHMENT E - COST SHARING LIMITS

Cost Sharing Limits – Basic Medicaid Benefit:
MEG 1) Able Bodied Adults and MEG 2) MHSP Waiver individuals will receive the Basic Medicaid benefit.

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

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

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

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

Figure VI. Medicaid Cost Sharing

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

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

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

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

ATTACHMENT F:
Evaluation Design

Montana will evaluate the effectiveness of the Basic Medicaid Waiver with this evaluation design from December 2010 through January 2017. We took a baseline survey of the 800 MHSP Waiver individuals in the summer of 2012 and will survey the MHSP Waiver population again in December 2013 and again in December 2017 to learn about participants' health status, access to health care, and quality of care. We will also identify lessons learned, unintended consequences, policy changes observed, and any recommendations going forward.

Basic Medicaid Waiver Goal

Montana's goal is to continue to provide Basic Medicaid coverage, originally designed to replicate a basic health plan benefit as a welfare reform waiver, for Able Bodied Adults while using the generated federal waiver savings to provide Basic coverage for the previously uninsured Mental Health and Services Plan (MHSP) group.

Basic Medicaid Waiver Hypotheses for the MHSP Group:

1. *The waiver will provide basic coverage.*
2. *The waiver will improve access to care, utilization of services, and quality of care.*
3. *The waiver will improve the health status.*

Objectives:

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

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

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

1. ***BRFSS*** *- The Behavioral Risk Factor Surveillance System (BRFSS) is the primary source of State-based information on the health risk behaviors among primarily adult populations. BRFSS is administered by the DPHHS Public Health and Safety Division. Phone surveys are conducted annually with an intended sample size of 6,000 (with a typical response rate of 50%). The 2007. 2008, and 2009 BRFSS survey's included State-added questions related to health care coverage for adults and children. The 2007 BRFSS results (including responses to the 10 State-added health care coverage questions) should be available in June 2008. (http://www.brfss.mt.gov/)*
2. ***KIDS COUNT*** *– Montana KIDS COUNT data is located at the Bureau of Business and Economic Research (BBER) at the University of Montana. Montana KIDS COUNT is a statewide effort to identify the status and well-being of Montana children by collecting data about them and publishing an annual data book. (bber.umt.edu)*
3. ***Kaiser Foundation*** *- The Kaiser Family Foundation is a non-profit, private operating foundation focusing on major health care issues. The Foundation serves as non-partisan source of health facts, information and analysis. State health facts include demographics, health status, health coverage and uninsured, health costs and budgets, managed care, providers and service use, Medicaid, SCHIP and Medicare. (statehealthfacts.org)*
4. ***US Census Bureau and Current Population Survey*** *– US Census Report on income, poverty and health insurance coverage in the United States. This site includes the Current Population Survey (CPS) Report, released annually in August of each year. This is the official source of national health insurance statistics, with state-by-state annual estimates of health insurance coverage. (http://www.census.gov/)*
5. ***Medical Expenditure Panel Survey -*** *US Census Bureau and Medical Expenditure Panel Survey. Is a national data source on employer based health insurance conducted via a survey of private business establishments and government employers. This survey is released annually in the summer. (meps.ahrq.gov)*
6. ***Montana Area Health Education Center*** *- The Montana Area Health Education Center (AHEC) and Office of Rural Health are located at Montana State University. The mission of AHEC is to improve the supply and distribution of health care professionals, with an emphasis on primary care, through community/academic educational partnership, to increase access to quality health care. The Office of Rural Health has as it's mission: collecting and disseminating information within the State; improving recruitment and retention of health professionals into rural health areas; providing technical assistance to attract more Federal, State and foundation funding health and coordinating rural health interests and activities across the State. (healthinfo.montana.edu)*
7. ***USDA Economic Research Services*** *- The USDA Economic Research Services prepares State fact sheets on population, income, education, employment reported separately by rural and urban areas. (http://www.usda.gov/wps/portal/usda/usdahome?contentid=ERS_Agency_Splash.xml)*
8. ***Labor Statistics*** *– Montana Department of Labor and Industry, Research and Analysis Bureau provides information regarding employment, unemployment, wages, prevailing wages, injuries and illnesses, and other labor information. (http://wsd.dli.mt.gov/service/rad.asp)*

Figure VII. Waiver Reporting Deliverables:

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

ATTACHMENT G - BUDGET WORKSHEETS

Budget Summary:

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

Figure XI. State and Federal Waiver Benefit Costs:

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

Attached Budget Worksheets:

1) ***Quarterly Budget Neutrality Worksheets:***

   I. Calculation of Budget Neutrality Limit (Without Waiver Ceiling)
   Presents the Federal funds, budget neutrality limit calculation for DY1 - DY9.

   II. Waiver Costs & Variance from Budget Neutrality Limit (Federal Funds)
   Presents the budget neutrality limit and the actual and projected Federal benefit expenditures side by side and the resulting budget neutrality variance.

   III. Summary By Demonstration Year and Cumulatively (Federal Funds)
   Presents actual Federal benefits spending DY1 – DY9.

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

3) ***State Maintenance of Effort***
Presents the State only Mental Health Services Plan Program budget and services for individuals remaining on the State only program and MHSP Waiver individuals for DY11 – DY13.

Trending Rates Used in the BN Calculation Schedules:

Expenditures:

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

FMAP:

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

Member Months:

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

PMPM Cost Basis Explanation:

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

Excluded Basic Medicaid Services:

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

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

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

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

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

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

Schizophrenia

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

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

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

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

Bipolar Disorder

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

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

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

Major Depressive Disorder

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

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