



MONTANA DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

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***Basic Medicaid Waiver
Section 1115 Revised Extension Amendment
For Health Care Reform***

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MONTANA
1115 REVISED DEMONSTRATION EXTENSION AMENDMENT
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**SECTION 1115 BASIC MEDICAID WAIVER
REVISED DEMONSTRATION EXTENSION AMENDMENT
EXECUTIVE SUMMARY**

The State of Montana, Department of Public Health and Human Services (DPHHS), requests to amend and extend the existing section 1115 Basic Medicaid Waiver for Able Bodied Adults with, “An Amendment to Provide Health Care Services to Low-Income Montanans Through an 1115 Medicaid Waiver,” which will increase the number of individuals in Montana with health insurance coverage.

Waiver Populations:

This revised Section 1115 Basic Medicaid Waiver extension amendment request replaces the January 25, 2008 Section 1115 request for extension. This amendment includes 8,755 Able Bodied Adults under Section 1931 and 1925 of the Act, with incomes at or below 33% of the Federal Poverty Level (FPL), as described in the current Basic Medicaid Waiver, without change. This amendment request includes one additional population, up to 800 individuals referred to as “MHSP Waiver.” These are individuals qualified for the State only Mental Health Services Plan Program, who have schizophrenia or bipolar disorder, who are at least 18 years of age, and who are a resident of Montana with incomes at or below 150% FPL. MHSP Waiver individuals with schizophrenia will be enrolled first, up to 50 per month, to reach the estimated 300 total individuals with schizophrenia. The remaining waiver openings will be filled through a computer based random drawing, first with individuals who have schizophrenia, then individuals with bipolar disorder up to 800 total individuals. Montana will continually analyze waiver sustainability.

This extension of the Basic Medicaid Waiver will allow Montana to continue Basic Medicaid benefits for 8,755 Able Bodied Adults and furnish Basic Medicaid benefits, which includes both physical and mental benefits, to (up to) an additional 800 Montanans who currently have a very limited mental health only benefit through the State only Mental Health Services Plan. Montana intends to begin implementation of the new waiver population in October 2010.

Basic Medicaid:

The Basic Medicaid benefit will continue for the Able Bodied Adults age 21 through 64, neither pregnant nor disabled. MHSP Waiver individuals will also be covered with the Basic Medicaid benefit.

Basic Medicaid 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, home infusion and hearing aids. Under the FAIM waiver, these services were excluded to align with the basic medical coverage of a work-related insurance program. That is, an employed individual who is insured under a work-related insurance policy would not have coverage for the list of excluded services.

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, including an individual on Basic Medicaid, 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 will be available to the MHSP 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 benefits.

Figure I. Montana’s Amendment Population Summary

Able Bodied Adults = Mandatory			Funding Source		Benefit Package		Cost Sharing	
MHSP Waiver = Expansion								
Demonstration Population	Number of Clients	Financial Eligibility	Current	Proposed	Current	Proposed	Current	Proposed
1) Able Bodied Adults Act Sections 1925 and 1931 Mandatory 8,755 33% FPL	8,755 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	800 Capped	Less than or equal to 150% FPL	State Only Funds	State Spending: State Maintenance of Effort. Funding from the current State only MHSP Program will be used to fund MEG 2) MHSP Waiver. Federal Spending: Budget Neutrality Surplus from the existing 1115 Basic Medicaid Waiver will be used to cover MEG 2) MHSP Waiver.	Limited Mental Health Benefits, up to \$425 Mental Health Prescription Drugs, PACT, and 72 Hour Services.	Basic Medicaid Services or pay premium for Employer Sponsored Plan or Private Health Insurance.	MHSP State Only Program: \$3 DBT services, \$12 generic and \$17 non generic, up to \$425 mental health prescription drug.	Basic Medicaid is minimal, the same as State Plan 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 DY7 – DY10 and can sustain these populations through January 2014.

The accumulated Federal Basic Medicaid Waiver savings from DY1 – DY6, February 1, 2004 through January 31, 2010 is estimated at \$39,412,837. Total State and Federal costs for the extension through January 2014, for continuing Able Bodied Adults and adding one new MHSP Waiver expansion population, 800 individuals, is estimated at \$149,666,823. The estimated total extension Federal benefit cost is \$110,979,680 and the estimated total year extension State cost is \$38,687,144.

Figure V. State and Federal Waiver Benefit Costs:

	10/2010- 1/2011	2/2011-1/2012	2/2012-1/2013	2/2013-1/2014	Extension Total
	Remainder - DY 7	DY 8	DY 9	DY 10	
Cumulative Federal Variance	\$51,612,341	\$56,591,01	\$61,592,761	\$66,597,532	\$66,597,532
Federal Variance	\$5,930,073	\$4,978,673	\$5,001,747	\$5,004,770	\$20,915,263
Total Federal and State Waiver Benefit Costs	\$7,514,281	\$42,094,302	\$48,244,089	\$51,814,151	\$149,666,823
Total Federal Waiver Benefit Costs	\$5,413,038	\$31,405,808	\$35,757,393	\$38,403,440	\$110,979,680
Total State Waiver Benefit Costs	\$2,101,243	\$10,688,494	\$12,486,696	\$13,410,711	\$38,687,144

Reporting:

The Basic Medicaid Waiver’s goal is to “Reduce the uninsurance rate for low-income individuals by providing coverage through the demonstration.” 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 it is emergent care or 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 give them access to significant health care benefits. Without granting approval of the Section 1115 Basic Medicaid Waiver extension amendment request, Montana will not have the Federal fund portion to finance the MHSP Waiver expansion population.

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 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. A July 30, 2009 submittal requested only one population, MHSP Waiver individuals, in addition to Able Bodied Adults. This amendment extension requests one additional expansion population, MHSP Waiver individuals, and represents small changes from the July 30, 2009 application as a result of continuing conversations with CMS regarding the Basic Medicaid Waiver.

II. GENERAL DESCRIPTION OF PROGRAM

This revised Section 1115 Basic Medicaid Waiver extension request, scheduled to begin on October 1, 2010, will continue to provide health care coverage to approximately 8,755 (current average) Able Bodied Adults. It will provide coverage for an additional 800 MHSP Waiver individuals, residents of the State of Montana, with Basic Medicaid health care benefit for a total of 9,555 lives covered annually by January 2012.

Montana will phase-in about 50 MHSP Waiver individuals each month until we reach 800 individuals. We will enroll all of the individuals with schizophrenia, and as many individuals with bipolar disorder until we reach 800 enrolled individuals. We estimate the PMPM is about double for those with schizophrenia than bipolar disorder and will analyze the data monthly to maintain budget neutrality. 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.

As this demonstration matures, and we have baseline information, Montana intends to consider enrolling Basic Medicaid Waiver individuals in a case management program to further assist them with the complexities of their health condition. Montana recently implemented the new Health Improvement Program and we will continue to discuss the merits of enrolling all Basic Medicaid Waiver individuals. 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
8,755 (current average) Individuals (Not Capped)
Mandatory Population*

MEG 2) MHSP Waiver

*Mental Health Services Plan (MHSP) Individuals
Age 18-64
150% FPL
800 Individuals (Capped)
Expansion Population*

Funding:

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

Able Bodied Adults:

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

MHSP Waiver:

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

III. DEFINITIONS

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

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

Optional Populations: Refers to eligibility groups that can be covered under a Medicaid or SCHIP State Plan, i.e., those that do not require a section 1115 demonstration to receive coverage and who have incomes above the mandatory population poverty levels.

Groups are considered optional if they can be included in the State Plan, regardless of whether they are included. The Medicaid optional groups are described at 42 CFR Part 435, Subpart C. Examples include children covered in Medicaid above the mandatory levels, children covered under SCHIP, and parents covered under Medicaid. For purposes of the HIFA demonstrations, Section 1902(r)(2) and Section 1931 expansions constitute optional populations.

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

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

IV. HIFA DEMONSTRATION STANDARD FEATURES

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

- The HIFA demonstration will be subject to Special Terms and Conditions (STCs). The core set of STCs is *not* included in the application package. Depending upon the design of its demonstration, additional STCs may apply.
- Federal financial participation (FFP) will not be claimed for any existing State-funded program. If the State is seeking to expand participation or benefits in a State-funded program, a maintenance of effort will apply.
- Any eligibility expansion will be statewide, even if other features of the demonstration are being phased-in.
- HIFA demonstrations will not result in changes to the rate for Federal matching payments for program expenditures. If individuals are enrolled in both Medicaid and SCHIP programs under a HIFA demonstration, the Medicaid match rate will apply to FFP for Medicaid eligibles, and the SCHIP enhanced match rate will apply to SCHIP eligibles.
- HIFA demonstrations covering childless adults can only receive the Medicaid match rate. As a result of the passage of the Deficit Reduction Act (DRA), states can no longer receive the SCHIP enhanced match rate for childless adults for HIFA applications submitted on, or after, October 1, 2005.
- Premium collections and other offsets will be used to reduce overall program expenditures before the State claims Federal match. Federal financial payments will not be provided for expenditures financed by collections in the form of pharmacy rebates, third party liability, or premium and cost sharing contributions made by or on behalf of program participants.

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

V. STATE SPECIFIC ELEMENTS

A. Upper Income Limit:

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

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

- *MEG 1) Able Bodied Adults*

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

- *MEG 2) MHSP Waiver*

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

B. Eligibility:

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

Mandatory Populations (as specified in Title XIX)

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

MEG) 1 Able Bodied Adults

- *Age 21-64, Not Disabled or Pregnant*
- *33% FPL*
- *8,755 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*
 - Age 18-64*
 - 150% FPL*
 - 800 Individuals (Capped)*

C. Enrollment/Expenditure Cap:

- No Yes If Yes, Number of participants or dollar limit of demonstration (express dollar limit in terms of total computable program costs).
- ***Enrollment Cap:***
 - MEG 2) MHSP Waiver will be capped at 800 individuals served annually.*

D. Phase-In:

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

- The HIFA demonstration will be implemented at once. *Montana will enroll 50 MHSP Waiver individuals each month to reach the goal of 800 by January 2012. Since our PMPM for the MHSP Waiver group is estimated, we will study the sustainability of 800 individuals. If we encounter system issues, our phase-in plan will need to be modified.*
- The HIFA demonstration will be phased-in.
If applicable, please provide a brief description of the State's phase-in approach (including a timeline): *N/A*

E. Benefit Package:

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

1. Mandatory Populations

- The benefit package specified in the Medicaid State Plan as of the date of the HIFA application.
- Other:

- o ***MEG 1) Able Bodied Adults – Basic Medicaid Benefit:***
Basic Medicaid services are a reduced benefit of optional services as described in the existing Basic Medicaid 1115 Waiver for Able Bodied Adults. Under the FAIM waiver, these services were excluded to align with the basic medical coverage of a work-related insurance program. That is, an employed individual who is insured under a work-related insurance would generally not have coverage for the list of excluded services.

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

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 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 package is described in Attachment D.)

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

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

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

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

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

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

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

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

5. Expansion Populations

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

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

- Inpatient
- Outpatient
- Physician’s surgical and medical services
- Laboratory and x-ray services
- Pharmacy
- A benefit package that is actuarially equivalent to one of those listed above—
- Other (please specify). Please include a description of any Secretary approved coverage or flexible expansion benefit package as Attachment C to your proposal. Please include a discussion of whether different benefit packages will be available to different expansion populations.

MEG 2) MHSP Waiver – Basic Medicaid Benefit

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

F. Coverage Vehicle

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

Figure II. Coverage Vehicle

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

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

G. Private Health Insurance Coverage Options

Coordination with private health insurance coverage is an important feature of a HIFA demonstration. One way to achieve this goal is by providing premium assistance or “buying into” employer-sponsored insurance policies. Description of additional activities may be provided in Attachment D to the State’s

application for a HIFA demonstration. If the State is employing premium assistance, please use the section below to provide details.

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

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

The State elects to provide the following coverage in its premium assistance program: (Check all applicable and describe benefits and wraparound arrangements, if applicable, in Attachment D to the proposal if necessary. If the State is offering different arrangements to different populations, please explain in Attachment D.)

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

H. Cost Sharing

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

Figure III. MEG Cost Sharing

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

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

VI. ACCOUNTABILITY AND MONITORING

Please provide information on the following areas:

1. Insurance Coverage

The rate of uninsurance in Montana as of 2007-2008 for all individuals of the total population was 15.9 percent.

<i>Employer</i>	<i>47.8%</i>
<i>Individual</i>	<i>7.2%</i>
<i>Medicaid</i>	<i>12.2%</i>
<i>Medicare</i>	<i>14.8%</i>
<i>Other Public</i>	<i>2.1%</i>
<i>Uninsured</i>	<i>15.9%</i>
<i>Total</i>	<i>100%</i>

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 2007-2008 U.S. Census Bureau data indicates Montana's overall uninsured rate is 15.9 percent. The Basic Medicaid Waiver would allow Montana to continue benefits for 8,755 Able Bodied Adults and furnish health care benefits up to an additional 800 Montanans who are currently uninsured. The Basic Medicaid Waiver would provide health care to a total of 9,555 individuals by January 2012. This expansion group is a very important population to insure, although it is very small.

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 Additional Detail Regarding Measuring Progress Toward Reducing The Rate Of Uninsurance, for further discussion of survey tools to measure progress toward reducing the rate of uninsurance in Montana.*

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:

- Statewide 1902(a)(1)

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

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

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

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

- Freedom of Choice 1902(1)(23)

To enable the State to restrict the choice of provider.

Title XXI:

- Benefit Package Requirements 2103

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

- Cost Sharing Requirements 2103(e)

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

B. Expenditure Authority

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

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

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

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

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

Title XXI:

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

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

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

Figure IV. Waivers and Expenditure Authority Requested

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

IX. ATTACHMENTS

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

- Attachment A: Discussion of how the State will ensure that covering individuals above 200 percent of poverty under the waiver will not induce individuals with private health insurance coverage to drop their current coverage. ***No individuals above 150 percent FPL will be covered by the waiver.***
- Attachment B: Detailed description of expansion populations included in the demonstration.
- Attachment C: Benefit package description.
- Attachment D: Detailed description of private health insurance coverage options, including premium assistance if applicable.
- Attachment E: Detailed discussion of cost sharing limits.
- Attachment F: Additional detail regarding measuring progress toward reducing the rate of insurance.
- Attachment G: Budget worksheets.
- Attachment H: Additional waivers or expenditure authority request and justification. ***No additional expenditure authority or waivers are requested at this time, other than those listed in the chart, IV. Waivers and Expenditure Authority Requested.***

X. SIGNATURE

Date

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

Signature of Authorizing State Official

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

ATTACHMENT B - DETAILED DESCRIPTION OF EXPANSION POPULATIONS

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

Mandatory Population

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

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

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

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 June 2010, 8,755 individuals were enrolled in Basic Medicaid. Enrollment will not be capped for Able Bodied Adults.

Mental Health Services Plan (MHSP) - State Only Program

The Mental Health Services Plan 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 two-thirds of the MHSP individuals only receive this limited benefit and are not eligible for Medicaid and do not receive other insurance. The number of people enrolled in the State only MHSP is limited by current legislative appropriations and not by a cap on the number of slots created by DPHHS. MHSP beneficiaries are not eligible for Medicaid services because they do not meet the income and resource Medicaid eligibility requirements. The income limit for State only MHSP is less than or equal to 150 percent FPL and there is no asset or resource test. The State only MHSP is a discretionary program that is not required by State or Federal law. As a result, people eligible for the State only MHSP do not have legal entitlement to services. The Addictive and Mental Disorders Division administers the State only MHSP within the funding levels appropriated by the legislature. There is no physical health benefit offered by the State only MHSP.

State Only Mental Health Services Plan Program Eligibility:

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

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

MEG 2) MHSP Waiver

Expansion Population

For those MHSP individuals not enrolled in the waiver, the State will continue to provide the State only MHSP benefit using State only dollars. The waiver will enroll up to 800 of those qualified MHSP Waiver individuals.

MHSP Waiver Participation Criteria:

- Be on or eligible for the Mental Health Services Plan;*
- 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 staff in the Addictive and Mental Disorders Division. Eligibility is accomplished through the CHIMES eligibility system.

MHSP Waiver Enrollment:

Starting in October 2010, Montana will phase-in about 50 MHSP Waiver individuals each month until we reach 800 individuals. We will enroll all of the individuals with schizophrenia and as many individuals with bipolar disorder until we reach 800 enrolled individuals. We estimate the PMPM is about double for those with schizophrenia than bipolar disorder and will analyze the data monthly 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

We estimate up to 800 individuals annually 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, home infusion and hearing aids. Under the FAIM waiver, these services were excluded to align with the basic medical coverage of a work-related insurance program. That is, an employed individual who is insured under a work-related insurance policy would not have coverage for the list of excluded services.

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 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. Medicaid saves an average of \$1,500 per person on those who have other insurance.

HIPP reimburses for the following health plans:

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

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

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

ATTACHMENT E - COST SHARING LIMITS

Cost Sharing Limits – Basic Medicaid Benefit:

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

Waiver Individuals Subject To Cost Share:

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

Individuals Not Subject To Cost Share:

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

Medicaid Cost Share Exempt Services:

Basic Medicaid services also follow Medicaid rules regarding exemption from cost share. Affected providers or services exempt from cost sharing include: emergency services, hospice, personal assistance, home dialysis attendant, home and community based waiver services, non-emergency medical

transportation, eyeglasses purchased by the Medicaid Program under a volume purchasing arrangement, EPSDT services, independent laboratory and x-ray services, and family planning services.

Medicaid Cost Share Amount:

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

Figure VI. Medicaid Cost Sharing

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

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

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

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

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

Basic Medicaid Waiver Draft Evaluation Design:

Montana’s goal is to reduce the uninsurance rate for low-income individuals by providing coverage to Able Bodied Adults and the MHSP Waiver population through the Basic Medicaid Waiver. As such, the State is interested in evaluating the impact of the Basic Medicaid Waiver and anticipates using the information obtained from the evaluation as a means to assist in policy decisions. The State is committed to measuring progress in reducing the number of uninsured for the Department’s use, and intends to gather lessons learned on an incremental basis to shape future policy for Basic Medicaid Waiver extension years DY7 – DY10.

Basic Medicaid Waiver Goal:

Montana's goal is to reduce the uninsurance rate for low-income individuals by providing coverage through the demonstration.

Waiver Impact On The Uninsured:

- **Objective One: Analyze individuals who have gained insured through the waiver to determine the affect on the uninsurance rate.**
 - **Measures:**
 - *Measure One: Describe the waiver enrollment policies and procedures for each eligibility group.*
 - *Measure Two: Quantify the number of individuals in the waiver and in each waiver population.*
 - *Measure Three: Compare and contrast the number of waiver participants with Medicaid recipients.*
 - *Measure Four: Assess insurance coverage levels in the state categorized by coverage sources, including Medicaid and CHIP direct coverage, Medicaid and CHIP premium assistance programs, those covered through employer sponsored insurance, other group health plans including COBRA coverage, and individual market coverage. (The availability of data appears to be limited.)*
 - *Measure Five: Compare and contrast the waiver populations, Medicaid recipients, and the Montana population as a whole using demographic indicators such as age, sex, income, race-ethnicity, etc.*
 - *Measure Six: Determine if the waiver increased the number and rate of Montana residents who were covered by health insurance under 150% FPL.*
 - *Measure Seven: Identify any available projections of future uninsured rates.*
 - *Measure Eight: Identify lessons learned, identify unintended consequences, policy changes observed, and any recommendations going forward.*
 - **Data Sources:**
 - *MMIS Medicaid Claims System – Medicaid claims data*
 - *CHIMES Systems – Medicaid eligibility data*
 - *DPHHS – Uninsurance rates*
 - *US Census Bureau - Uninsurance rates, self insured, employer sponsored insurance, and private insurance plans enrollment and demographic data*
 - *State Auditor's Office – Uninsurance rates, self insured, employer sponsored insurance, and private insurance plans enrollment and demographic data*
 - *National and State Uninsured or Underinsured Data Sources - Uninsurance rates, self insured, employer sponsored insurance, and private insurance plans enrollment and demographic data*
- **Objective Two: Define the waiver benefit package for each population.**
 - **Measures:**
 - *Measure One: Describe the waiver benefit package for each population.*
 - *Measure Two: Compare and contrast the benefit package for waiver participants, Medicaid recipients, and the Montana population as a whole (from information available), in general, using selected measures of medical service utilization and service cost information.*

- *Measure Three: Identify lessons learned, identify unintended consequences, policy changes observed, and any recommendations going forward.*
- **Data Sources:**
 - *MMIS Medicaid Claims System – Medicaid claims data*
 - *CHIMES Systems – Medicaid eligibility data*
 - *DPHHS – Uninsurance rates*
 - *State Auditor’s Office – Uninsurance rates, self insured, employer sponsored insurance, and private insurance plans enrollment and demographic data*
 - *National and State Uninsured or Underinsured Data Sources - Uninsurance rates, self insured, employer sponsored insurance, and private insurance plans enrollment and demographic data*
- **Objective Three: Determine and analyze waiver individuals covered by employer sponsored and private insurance plans.**
 - **Measures:**
 - *Measure One: Quantify the number and rate of waiver individuals covered by employer sponsored, private insurance plans, other group health plans including COBRA coverage, and individual market coverage.*
 - *Measure Two: Compare and contrast the number of waiver participants, Medicaid recipients, and the Montana population as a whole, covered by employer sponsored and private insurance plans.*
 - *Measure Three: Compare and contract the waiver populations, Medicaid recipients, and the Montana population as a whole using demographic indicators such as age, sex, income, race-ethnicity, etc., covered by employer sponsored and private insurance plans.*
 - *Measure Four: For waiver participants: track changes in the uninsured rate and trends in sources of insurance as listed above; monitor employer contribution levels and whether there are unintended consequences of the demonstration, such as major decreases in employer contribution levels or high levels of substitution of private coverage.*
 - *Measure Five: Identify lessons learned, identify unintended consequences, policy changes observed, and any recommendations going forward.*
 - **Data Sources:**
 - *MMIS Medicaid Claims System – Medicaid claims data*
 - *CHIMES Systems – Medicaid eligibility data*
 - *DPHHS – Uninsurance rates, self insured, employer sponsored insurance, and private insurance plans enrollment and demographic data*
 - *US Census Bureau - Uninsurance rates, self insured, employer sponsored insurance, and private insurance plans enrollment and demographic data*
 - *State Auditor’s Office – Uninsurance rates, self insured, employer sponsored insurance, and private insurance plans enrollment and demographic data*
 - *National and State Uninsured or Underinsured Data Sources - Uninsurance rates, self insured, employer sponsored insurance, and private insurance plans enrollment and demographic data*

- **Object Four: Observe State and Federal waiver spending.**
 - **Measures:**
 - *Measure One: Quantify State and Federal waiver costs as a whole by quarter and waiver year.*
 - *Measure Two: Quantify State and Federal waiver costs for each population by quarter and waiver year.*
 - *Measure Three: Determine if Federal budget neutrality was met.*
 - *Measure Four: Quantify waiver spending by quarter and waiver year.*
 - *Measure Five: Determine if State Maintenance of Effort was achieved and quantify by quarter and waiver year.*
 - *Measure Six: Identify lessons learned, identify unintended consequences, policy changes observed, and any recommendations going forward.*
 - **Data Sources:**
 - *MMIS Medicaid Claims System – Medicaid claims data*
 - *CHIMES Systems – Medicaid eligibility data*
 - *DPHHS Division’s Fiscal Bureaus – Budgets*
 - *National and State Uninsured or Underinsured Data Sources - Uninsurance rates, self insured, employer sponsored insurance, and private insurance plans enrollment and demographic data*
- **Object Five: Observe participant’s view of quality of care and identify quality of care issues.**
 - **Measures:**
 - *Measure One: Determine access to care for waiver population.*
 - *Measure Two: Determine adequacy of provider choice for waiver population.*
 - *Measure Three: Determine quality of care for waiver population.*
 - *Measure Four: Determine levels of functioning in different waiver groups for physical, mental, activities of daily living, employment, social in regard to receiving HIFA benefits.*
 - *Measure Five: Determine beneficiary satisfaction with waiver methods.*
 - **Data Sources:**
 - *MMIS Medicaid Claims System – Medicaid claims data*
 - *CHIMES Systems – Medicaid eligibility data*
 - *DPHHS – Uninsurance rates*
 - *State Auditor’s Office – Self insured, employer sponsored insurance, and private insurance plans quality data*
 - *BRFSS, Department of Labor and Industry, and DPHHS - Client quality of care and satisfaction surveys*
 - *National and State Uninsured or Underinsured Data Sources - Uninsurance rates, self insured, employer sponsored insurance, and private insurance plans enrollment and demographic data*

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

ATTACHMENT G - BUDGET WORKSHEETS

Budget Summary:

The accumulated Federal Basic Medicaid Waiver savings from February 1, 2004 through January 31, 2009 is \$33,218,178. Total State and Federal benefit costs for the extension through January 2014 to continue Able Bodied Adults and to add the MHSP Waiver population is \$149,666,823. For both populations the total extension Federal cost is \$110,979,680 and the total extension State cost is \$38,687,144.

The total State and Federal benefit cost for the new MHSP Waiver expansion population for the extension is \$31,069,705. The total extension expansion population Federal cost is \$20,757,670. The total extension expansion population State cost is \$10,312,035.

Figure XI. State and Federal Waiver Benefit Costs:

	<i>10/2010- 1/2011</i>	<i>2/2011- 1/2012</i>	<i>2/2012- 1/2013</i>	<i>2/2013- 1/2014</i>	<i>Extension Total</i>
	<i>Remainder - DY 7</i>	<i>DY 8</i>	<i>DY 9</i>	<i>DY 10</i>	
MEG 1) Able Bodied Adults Benefit Expenditures					
<i>Federal</i>	\$4,962,879	\$26,416,658	\$28,371,491	\$30,470,981	\$90,222,010
<i>State</i>	\$1,877,612	\$8,209,975	\$8,817,513	\$9,470,009	\$28,375,108
Total State & Federal	\$6,840,491	\$34,626,633	\$37,189,004	\$39,940,990	\$118,597,118
MEG 2) MHSP Benefit Expenditures					
<i>Federal</i>	\$450,159	\$4,989,150	\$7,385,902	\$7,932,459	\$20,757,670
<i>State</i>	\$223,631	\$2,478,519	\$3,669,183	\$3,940,702	\$10,312,035
Total State & Federal	\$673,790	\$7,467,669	\$11,055,085	\$11,873,161	\$31,069,705
Waiver Total Benefits MEGS 1) Able Bodied Adults and 2) MHSP Waiver					
<i>Federal</i>	\$5,431,038	\$31,405,808	\$35,757,393	\$38,403,440	\$110,979,680
<i>State</i>	\$2,101,243	\$10,688,494	\$12,486,696	\$13,410,711	\$38,687,144
Total State & Federal	\$7,514,281	\$42,094,302	\$48,244,089	\$51,814,151	\$149,666,823

Budget Worksheet Directory for Figure VIII. Budget Worksheets:

See attached Figure VIII. Budget Worksheets:

Page 1. Calculation of BN Limit Without Waiver Ceiling

Presents the Federal funds, budget neutrality limit calculation for demonstration years 1 through 7 (DY1-DY7) and extension years (DY7-WY10).

Page 2. Waiver Costs & Variance from BN Limit Federal Funds 8 Years

Presents the budget neutrality limit and the actual and projected Federal benefit expenditures side by side and the resulting budget neutrality variance for each of the 10 years.

Page 3. Federal & State Benefit Spending DY1 – DY5

Presents the Federal and State benefits spending (actual and projected) for the 1115 Basic Medicaid Waiver for DY1 – DY7.

Pages 4. – 5. MEG Eligible Member Months, BN CAP, Expense PMPM by Fund Source

Presents total Federal and State, Federal only and State only MEG activity for MEG 1) Able Bodied Adults, current Basic Medicaid Waiver and MEG 2) MHSP Waiver.

Page 6. Total Benefits Spending and Federal Funds Budget Neutrality Summary

Presents Federal and State benefit expenditures for the 10 year period. Presents the Federal only BN limit, spending, and budget neutrality variance per year. Variance tolerance is presented per the 1115 Basic Medicaid Waiver Special Terms and Conditions.

See attached Figure X. MOE

Pages 7. – 8. Montana State Maintenance of Effort (MOE)

See attached Figure X. Montana State Maintenance of Effort, which presents the State only MHSP budget before (without waiver) and with waiver.

Trending Rates Used in the BN Calculation Schedules:

Expenditures:

- *The Basic Medicaid Waiver BN PMPM Cap is trended at 6.3% for DY7 – DY10.*
- *Benefits for Able Bodied Adults and MHSP Waiver populations are trended at 7.4%, average DY1 – DY6 expenditure increase.*

FMAP:

- *Able Bodied Adults – ARRA enhanced FMAP of .7629 was used.*
- *MHSP Waiver – .6681 regular FMAP was used for DY7 – DY10.*

Member Months:

- *June 2010 flat enrollment of 8,755 was used for DY7 – DY10.*
- *MHSP Waiver enrollment is phase-in to reach 800 individuals in January 2012.*

Figure IX. MHSP Waiver PMPM Cost Basis Explanation:

Montana Mental Health Services Plan (MHSP) Waiver Criteria:

The expanded population will be individuals who are determined eligible, by DPHHS or designee, for the State only Mental Health Services Plan Program (MHSP), at least 18 years of age, and who are a Montana resident with incomes at or below 150% FPL with no resource test. These individuals will have been determined to have a Severe Disabling Mental Illness (SDMI) by DPHHS, or designee, including assessment of diagnosis, functional impairment, and duration of illness. The PMPM cost basis of this group are the SFY 2008 (July 1, 2007 – June 30, 2008) claim expenses for all Medicaid recipients age 18 or older with a primary diagnosis of SDMI.

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), home infusion therapy (46), 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 \$1,254.73.

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

Schizophrenia

Average PMPM cost for individuals with schizophrenia:	\$1,254.73
Average yearly costs of existing adult Medicaid recipient with schizophrenia: 299 Individuals x \$1,254.73 x 12 = \$375,164.27 x 12 =	\$4,501,971.24
Average monthly costs of existing adult Medicaid recipient with schizophrenia: 299 Individuals x \$1,254.73 x 12 =	\$375,164.27

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 \$734.46. The primary diagnoses for bipolar disorder are:

- 296.40 Bipolar I Disorder, Most Recent Episode Manic, Unspecified
- 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
- 296.80 Bipolar Disorder NOS
- 296.89 Bipolar II Disorder

Bipolar Disorder

<i>Average PMPM cost for individuals with bipolar disorder:</i>	\$734.46
<i>Average yearly costs of existing adult Medicaid recipient with bipolar disorder: 101 Individuals x \$734.46 = \$74,804.60 x 12 =</i>	\$890,154.52
<i>Average monthly costs of existing adult Medicaid recipient with bipolar disorder: 101 Individuals x \$734.46 x 12 =</i>	\$74,180.46

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 not calculated. We have more individuals qualifying with a diagnosis of schizophrenia or bipolar disorder than we have available slots. At such time that we have served all the individuals with schizophrenia or bipolar disorder, we would analyze the cost of major depression. The primary diagnoses for major depression are:

- 296.22 Major Depressive Disorder, Single Episode, Moderate
- 296.22 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

<i>Average PMPM cost for individuals with major depressive disorder:</i>	
<i>Average yearly costs of existing adult Medicaid recipient with major depressive disorder:</i>	
<i>Average monthly costs of existing adult Medicaid recipient with major depressive disorder:</i>	

* 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 \$820.07.

Figure X. Montana State Maintenance of Effort:

See Figure X. Montana State Maintenance of Effort, which presents the Mental Health Services Plan State only program budget prior (without waiver) to the before waiver and after waiver implementation. The worksheet shows that funding for the State only MHSP Program continues.

MHSP State Only Budget:

State only MHSP has three sources of revenue, general fund, tobacco tax, and federal grant funds, from which to pay claims and administer the program. The Basic Medicaid Waiver will only use general fund and tobacco tax. The Basic Medicaid Waiver will not use federal grant funds.

MHSP Waiver MOE:

Montana is requesting approval from CMS to obtain Medicaid financing for a portion of the State funded Mental Health Services Plan (MHSP).

State Administrative Costs:

The MOE reflects the type of benefits, number of enrollees, and expenditures before and after waiver.