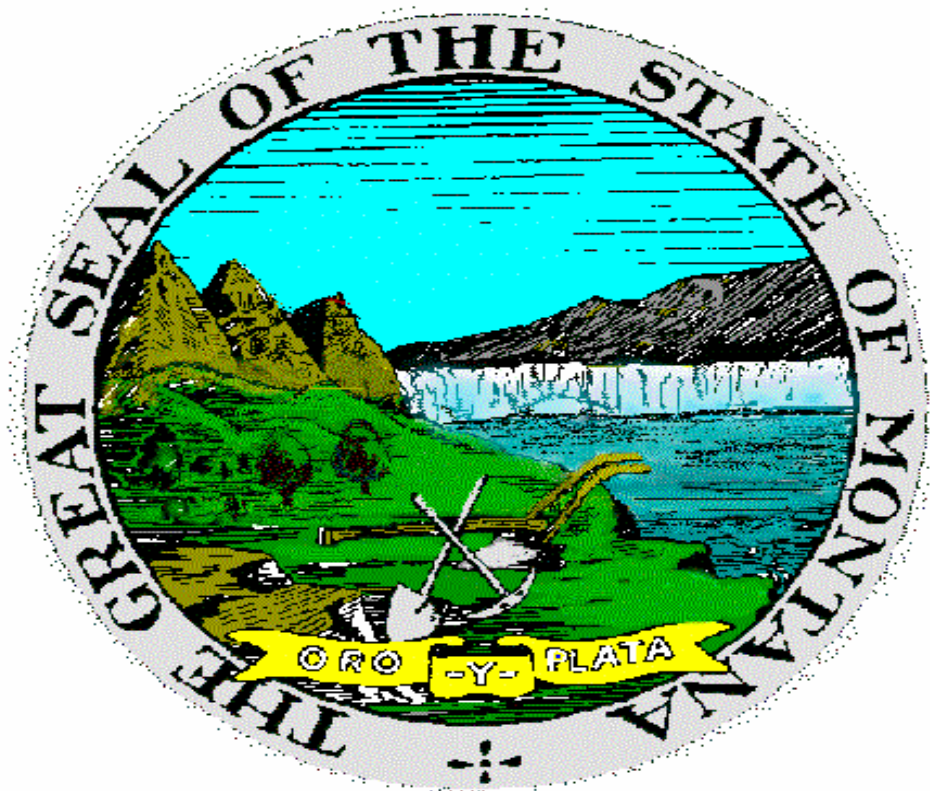


**A PROPOSAL TO PROVIDE
HEALTH CARE SERVICES TO
UNINSURED LOW-INCOME MONTANANS
THROUGH AN 1115 MEDICAID WAIVER**



Prepared by

The Montana Department of Public Health and Human Services

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ACRONYMS

AMDD: Addictive and Mental Disorders Division

CHIP: Children's Health Insurance Plan

CMHSBG: Community Mental Health Service Block Grant

CMS: Centers for Medicare and Medicaid Services

DPHHS/Department: Montana Department of Public Health and Human Services

DSH: Disproportionate Share Hospital

FPL: Federal Poverty Level

GF: State General Fund

HB 667: House Bill 667, Montana 2005 Legislature - small business health insurance pool

HIFA: Health Insurance Flexibility and Accountability

ICHIP: Illinois Comprehensive Health Insurance Program

MCHA: Montana Comprehensive Health Association

MEG: Medicaid Eligible Group

MHSP: Mental Health Services Plan

MMIS: Medicaid Management Information System

MOE: Maintenance of Effort

PMPM: Per Member Per Month

SAA: Service Area Authority

SDMI: Severe and Disabling Mental Illness

SED: Serious Emotional Disturbance

SSR: State Special Revenue

TANF: Temporary Assistance for Needy Families

TMA: Transitional Medicaid

MONTANA 1115 WAIVER PROPOSAL: EXECUTIVE SUMMARY

The Public Health Advisory Council in 2004 made 18 recommendations to “Re-Design Montana’s Medicaid Program,” which included an 1115 Health Insurance Flexibility and Accountability (HIFA) waiver. At the request of the Department of Public Health and Human Services (DPHHS), the 2005 Montana Legislature requested Senate Bill 110 entitled “*An act implementing certain recommendations of the Montana Public Health Care Redesign Project to provide for improved coverage of the health care and related needs of particular groups of persons: providing authority for the establishment of Health Insurance Flexibility and Accountability Demonstration initiatives and other demonstration projects upon approval of waiver of federal law.*” Governor Brian Schweitzer signed into law Senate Bill 110, with the provision that DPHHS would conduct a 60-day comment period and carefully consider public comments before making a final decision to submit a proposed HIFA waiver. Montana’s application for a HIFA waiver is detailed in this concept paper.

Estimates from the State Planning Grant study completed in August 2004 identified that Montana has historically had one of the highest rates of uninsurance in the nation. Estimates identify approximately 19% of Montanans as uninsured. This information indicates a great need for health-coverage for the most in need, the least and the last of our citizens. The proposed 1115 waiver is an alternative for Montana to expand Medicaid eligibility to uninsured Montanans in creative ways to provide cost effective Medicaid funded health care.

Background on Medicaid and 1115 Demonstration Waivers: The Montana Medicaid program is a joint federal-state program administered by DPHHS in a partnership with the federal Centers for Medicare and Medicaid Services (CMS). DPHHS is responsible for determining eligibility for low-income populations including pregnant women, children, individuals with disabilities and the elderly. Medicaid benefits are a defining element of Medicaid’s individual entitlement benefit. The Montana Medicaid program pays for a broad range of medically necessary health care services and the Medicaid benefits package is broad and flexible ranging from preventive services to long-term care. Under federal law, if a state chooses to participate in Medicaid, then every resident of the state who meets the State’s Medicaid eligibility requirements is entitled to have payment made on his or her behalf for covered services. These services are often referred to as “State Plan” Medicaid services, and State Plan services are the fundamental basis of the Montana Medicaid program that provides the health care safety net for low-income Montanans.

For a number of years the federal government has employed the Medicaid 1115 Demonstration Waiver (1115 Waiver) as a vehicle that enables states to experiment with new ways of delivering healthcare services under Medicaid. The 1115 Waiver allows States to waive requirements of the Social Security Act in areas such as comparability of services, state-wideness, freedom of choice, early and periodic screening, diagnostic and treatment services (EPSDT), and cost sharing. Waiving provisions of the Social Security Act allows States to be creative in designing new health care programs to meet the needs of their citizens. The waiver authority also has the ability to change the basic concept of entitled Medicaid services for individuals determined eligible under the waiver program. This change in the concept of entitled benefits only applies to individuals eligible under the waiver program and does not change the entitlement benefit under “State Plan” Medicaid Services. Other states’ waivers have been controversial because they have reduced services to existing Medicaid eligibility groups. However, that is not the case in Montana. This waiver proposal does nothing to reduce the quality or quantity of the Medicaid benefits or services currently available to any existing Medicaid eligibility group, nor does it increase the cost sharing required under State Plan Medicaid services.

The HIFA Waiver is a version of the existing 1115 Demonstration Waiver authority that gives states greater flexibility in designing Medicaid funded healthcare coverage for their low-income citizens who are uninsured and not eligible for full Medicaid health care benefits. Unlike the federal entitlement required under the Medicaid program, HIFA does not create an entitlement to services for eligible individuals. An upper limit on the number people served and the total dollars spent on services under the waiver can be defined by the State. In addition to providing greater coverage flexibility, HIFA requires that each waiver outline a strategy for exploring ways to better coordinate publicly funded coverage with private insurance. States can meet the coordination requirement by offering individuals who enroll in the waiver the option to receive assistance with paying monthly premiums for health insurance available through their employer rather than receiving direct public benefits. States are also permitted to use HIFA to restructure existing state-funded health care benefits as long as any savings are reinvested in expanded health care coverage for low-income citizens who are uninsured. All 1115 Demonstration Waivers, including HIFA waivers, are subject to a “cost neutrality test” requiring that federal expenditures for services provided through the waiver are less than or equal to the projected cost of services to the federal government without the waiver. In addition to the requirement to be cost-neutral, states must also negotiate an upper limit cap on the annual rate of growth of the average per person Medicaid expenditure for individuals enrolled in the waiver only. The federal government will not participate in the costs for services provided to the waiver groups above the limits set by the caps.

Highlights of Montana’s 1115 HIFA Waiver Proposal: The proposal will utilize the 1115 Demonstration waiver authority granted by CMS to provide an innovative plan to address the health care needs of the uninsured in Montana. DPHHS proposes to amend the existing 1115 Basic Medicaid Waiver for Able-Bodied Adults and utilize the HIFA waiver concepts and guidelines to provide limited health care benefits for over 5,000 uninsured Montanans. At the heart of this proposal is a plan to free up existing state money by using the Medicaid waiver to finance mental health services that are currently state-funded. The plan then reallocates the state’s savings to provide Medicaid-funded limited health care benefits to several thousand low-income Montanans who are currently uninsured. The plan also proposes to utilize the Medicaid waiver authority to refinance services under the Montana Comprehensive Health Association (MCHA). In addition, the plan proposes to utilize new funding authorized by the 2005 legislature under House Bill (HB) 667 to provide health insurance coverage for employers and their employees. HB 667, “An Act creating a Small Business Health Insurance Pool, providing for employer premium incentive payments, employee premium assistance payments, and tax credits,” was supported by Governor Brian Schweitzer as another example of the creative thinking in Montana to provide affordable access to health care to Montana citizens and encourage economic development. This bill contains a provision for DPHHS to apply for an 1115 waiver and consider the option of funding a portion of the premium incentive payment and premium assistance payments under Medicaid. Therefore, this waiver proposal has evolved to include the concepts passed under HB 667.

Montana’s proposed waiver has eight key components:

1. Funding the Mental Health Services Plan (MHSP) with Medicaid: This proposal will request approval from CMS to obtain Medicaid financing for a portion of the state-funded MHSP. MHSP currently provides mental health services and pharmacy benefits to approximately 2,200 people per month who have a Severe Disabling Mental Illness (SDMI) but are not eligible for Medicaid. The number of people enrolled in MHSP is limited by current legislative appropriations and not by a cap on the number of slots created by DPHHS. Clients in MHSP are not currently eligible for Medicaid services because they do not meet the income and resource eligibility requirements. In addition to the existing MHSP mental health services and drug benefit,

the waiver will provide MHSP participants who do not have health insurance with the opportunity to choose among three limited physical health care benefit options, including:

- a. Assistance with the cost of the monthly premium of employer based insurance;
- b. Payment of the monthly premium for private individual insurance policies; or
- c. Medicaid fee-for-service benefits that average \$2,000 per person per year.

MHSP clients determined eligible for waiver services will receive education and assistance in choosing the most appropriate coverage option for their needs. DPHHS estimates that up to 1,500 MHSP clients will be eligible to participate in this waiver proposal. Approximately one third of the MHSP clients will not be able to participate in the proposed waiver program because they currently have private health insurance or they have health coverage under Medicare. Under the Federal waiver guidelines the state cannot obtain federal matching dollars for the health care services they receive. Therefore, the State will continue to provide their existing MHSP mental health services using state dollars.

2. Using the Savings Created by Restructuring MHSP with Medicaid to Cover the Uninsured: DPHHS proposes to use the savings realized from securing Medicaid funding of MHSP outlined in 1 above, as state match to provide a variety of Medicaid funded health care benefit packages. The packages are designed to address the health care needs of several thousand low-income uninsured Montanans, from three different populations in need of health care coverage. The actual healthcare benefit packages, eligibility groups, and the number of people served under the waiver may change as a result of public comments received and negotiations with the federal government. Currently, the proposed uninsured groups and their individual coverage include:

- a. **Proposed Eligibility Group:** Up to 1,500 uninsured children from families whose incomes are equal to or less than 150% of the Federal Poverty Level (FPL). This target group will be children who apply for or lose Medicaid eligibility because they do not meet the income and resource requirements for Medicaid. These children however may be eligible for the Children's Health Insurance Plan (CHIP) but cannot access services because CHIP is full and has a cap on the number of the children served. DPHHS sees this waiver proposal as an opportunity to fill a gap in the system for those uninsured children who would be put on a CHIP waiting list. This waiver proposal would provide the ability for those children to access healthcare services sooner while they wait for a slot to open under CHIP. (Note: After further analysis of the appropriations and anticipated expenditures, we project covering up to 1,500 children. An earlier projection identified during the legislature was 1,800 children.) **Proposed Coverage:** A Medicaid funded health care benefit that is identical to the one provided by CHIP.
- b. **Proposed Eligibility Group:** Up to 300 Seriously Emotionally Disturbed (SED) youths, ages 18 through 20, who have incomes equal to or less than 150% of FPL, are in transition from children's mental health services and are no longer eligible for Medicaid due to their age. **Proposed Coverage:** Up to three years of a Medicaid funded health care benefit identical to the one provided by CHIP and a set of specialized transitional behavioral health services designed to meet the needs of this group.
- c. **Proposed Eligibility Group:** Up to 600 working parents with incomes less than or equal to 200% FPL who are no longer eligible for Medicaid, but whose children continue to be enrolled in Medicaid. Most of these parents are at the end of 12 months transitional Medicaid. **Proposed Coverage:** The choice of

one of the same three Medicaid funded physical healthcare options available to MHSP recipients, as described earlier in the key component 1 above.

3. Developing and Implementing a Medicaid Premium Assistance Pilot Program: To meet the HIFA requirement that states pursue ways to better coordinate publicly funded health care with private insurance, DPHHS proposes a provision to develop and implement a Medicaid Premium Assistance pilot program. The pilot will measure the impact of providing members of one or more of the HIFA waiver groups with the option to receive assistance with paying the cost of the monthly premium for health insurance that is offered through employers rather than enrolling in the direct coverage available to eligibility groups under the waiver.
4. Funding Montana Comprehensive Health Authority Premium Assistance (MCHA) with Medicaid: DPHHS collaborated with the State Auditor's Office and the MCHA Board of Directors to include a provision in the waiver that will provide Medicaid funding for a portion of the existing state-funded MCHA Premium Assistance Program. MCHA Premium Assistance is a source of health insurance for people who have serious medical conditions that cause them to be denied coverage by private health insurers and whose incomes are less than or equal to 150% FPL. The savings realized from the Medicaid financing of MCHA would be reinvested in the MCHA premium assistance program to maintain the long-term viability of the program, maintain or increase program participation and maintain or increase the level of premium assistance to individual MCHA participants. DPHHS estimates that up to 260 MCHA clients will be eligible to participate in this waiver proposal. Approximately ten percent of the MCHA clients will not be able to participate in the proposed waiver program because they currently have health care coverage under Medicare. Therefore, the State will continue to provide their existing MCHA benefits using state dollars.
5. Health insurance premium assistance/incentive payments provided under the small business insurance pool: The 2005 Montana legislature passed HB 667 that created a small business health insurance purchasing pool to provide affordable health insurance coverage for employers and their employees. This bill provides legislative intent for DPHHS to apply for an 1115 waiver and consider the option of funding a portion of the premium incentive payment on behalf of eligible small employers or premium assistance payments on behalf of eligible employees under Medicaid. Therefore, this waiver includes the concept to utilize some of the new funding under HB 667 to provide a system of monthly employer premium incentive, and employee premium assistance payments for small businesses that do not currently offer employee health insurance, but begin to do so, through the new small business purchasing pool. It is estimated that approximately 1,200 Montanans will be eligible for Medicaid funded assistance through the premium assistance and incentive program. It is important to note this figure represents the DPHHS estimate of the population we can fund with Medicaid. The premium assistance and incentive program administered under the State Auditor's Office will cover additional Montanans using state funding authorized under HB 667.
6. Amend the existing 1115 Medicaid Waiver: DPHHS proposes to amend the existing 1115 Basic Medicaid Waiver for Able-Bodied Adults. Since 1996 Montana has provided a different and limited package of Medicaid services to able-bodied adults who are eligible for Medicaid under Sections 1925 or 1931 of the Social Security Act. This policy was implemented initially in 1996 through a federally approved Medicaid 1115 Demonstration Waiver and was recently reauthorized by CMS with an effective date of February 2004. In order to meet the requirement that 1115 waivers be cost neutral to the federal government, DPHHS proposes that Montana's existing 1115 Basic Medicaid Waiver for Able-Bodied Adults and its cost saving provisions be amended to incorporate the HIFA concepts under the waiver. Such a change will enable

Montana to use the cost savings currently realized through the existing waiver to offset the increases in cost to the federal government that will result from the expanded services that are called for in this waiver proposal. The amended waiver will provide access to additional federal funding with which to provide healthcare to uninsured low-income Montanans, and do so without the need to resort to additional benefit reductions or other unpopular cost savings measures in order to meet the federal cost neutrality test. The new waiver created after combining the existing 1115 Basic Medicaid Waiver for Able Bodied Adults and the HIFA concept waiver will, for CMS purposes, become a HIFA waiver.

7. Adopting Mechanisms to Maintain Control of Waiver Spending: Spending under the proposed waiver will be managed and controlled by limiting the number of people served in the waiver and the maximum amount of money the state is obligated to spend on benefits for the eligibility groups covered under this waiver. Therefore, the waiver eligibility groups and the services provided are not like the regular Medicaid program where *every person* determined to meet the eligibility criteria is *entitled to receive all of the Medicaid services* offered by the state for which they have a medical necessity, regardless of the availability of state funding. Spending on the waiver eligibility groups will be limited and capped to a specific benefit regardless of the medical necessity of the services. If it appears there is a risk of exceeding the spending or enrollment limits the Department will limit enrollment in the program and/or reduce the number of eligible clients by attrition. If necessary those identified most in need at a lower percentage of poverty will maintain eligibility and those at a higher percentage of poverty will have eligibility discontinued or suspended for a period of time. Clients will be put on a waiting list and given priority for the next available slot in the eligibility group. In addition, DPHHS will manage benefits under the waiver program, and if necessary, reduce the coverage of services available under the eligibility waiver groups. This would include reducing the maximum dollar limit of a benefit, limiting the amount, scope and duration of a service, or eliminating the benefit entirely. DPHHS will control spending within and among the waiver groups covered under this waiver proposal. Limits and controls on spending for this waiver will not impact the existing Medicaid program eligibility, benefits, and reimbursement rates provided under State Plan services.
8. Negotiating Reasonable Expenditure Caps: The critical final step in the federal waiver approval process is the negotiation of an average annual per person limit on the growth of expenditures for the eligibility groups covered under the waiver. DPHHS will ensure that any budget growth caps required by the federal government are set at reasonable levels that do not expose the state to an unacceptable risk of overspending and the potential loss of federal funding for expenditures above the budget caps. While the potential to provide a significant number of uninsured Montanans with health care benefits is very appealing, if in the end the federal government seeks to impose limits on average growth in expenditures or other requirements that expose Montana to an undue financial risk, DPHHS will withdraw its waiver proposal and maintain the existing MHSP services as currently funded.

Total Impact of Montana's 1115 Waiver Proposal: If approved by CMS, this proposed waiver would produce approximately \$15 million dollars per year in additional federal revenue with which to provide Medicaid funded health care benefits to several thousand low-income uninsured Montanans. It would do so without creating an open-ended entitlement to services and without the need for the additional state funding beyond the levels that are currently appropriated to the MHSP, MCHA programs and the small business insurance pool.

Additional Changes to the Waiver Proposal are Likely to Occur: This waiver proposal reflects the evolution of the Department's thinking over the past year regarding the potential for developing and submitting

a Medicaid 1115 Demonstration Waiver for Montana. The proposal changed substantially during that time. While some of the changes reflect a better understanding of the federal waiver requirements, the majority of the modifications are the product of an effort by DPHHS to meld the many values and interests of the groups with a potential stake in this project into a coherent waiver proposal that is both creative and fiscally accountable. It is likely the waiver will continue to evolve. Our goal is to utilize existing resources effectively in an effort to provide assistance to the uninsured citizens of this state, yet ensure that the services funded through an 1115 Waiver, and any existing resources or new resources for health care expenditures, complement each other. After a period of public comment and review this waiver proposal will be sent to the Centers for Medicare and Medicaid Services (CMS) with an estimated implementation date of July 1, 2007.

I. STATE OF MONTANA WAIVER PROPOSAL

Challenge of Providing Healthcare Coverage to the Uninsured

The large number of citizens without access to public or private health care coverage is a vexing problem in states across the country, including ours. A survey of Montana households conducted in 2003 as part of the activities of the Montana State Planning Grant found that 173,000 Montanans, 19% of the state's total population, had no public or private health insurance. At the time of the survey 17% of Montana children were uninsured, one of the highest rates in the United States. One of the most disturbing findings was the large number of Montanans who were working but were uninsured either because their employers did not offer health insurance, or the available group or individual coverage was too expensive. For example, forty-three percent of surveyed households with incomes between 125% and 150% of the Federal Poverty Level (FPL)—between \$22,625 and \$27,150 per year for a family of four-- did not have health insurance. People seeking ways to provide affordable health care to low-income citizens often look to government for the answer. Past efforts to address the issue of the large number of uninsured Montanans have included proposals to extend the reach of existing state and federally funded health care programs such as Medicaid and the Children's Health Insurance Plan (CHIP).

Covering the Uninsured through Traditional Medicaid

Medicaid, a jointly funded state and federal program administered by the states, is the primary source of publicly funded health care for low-income families with children, people with disabilities and the elderly. Each state participating in the Medicaid program is required to fund a percentage of Medicaid expenditures with state matching dollars. The matching percentage varies by state, based on a federal formula related to changes in average per capita income. Montana's Medicaid matching requirement is relatively low compared to other states, with the federal government paying approximately \$.70 of every dollar spent on Medicaid services. While Medicaid specifies a set of mandatory services that must be provided, and eligibility groups that must be served, states have the discretion to add other services, and the option to make more groups of low-income people eligible for the program. However, once a state elects to add an optional eligibility category to its Medicaid program *every person* determined to meet the eligibility criteria for the new group is *entitled to receive all of the Medicaid services* offered by the state for which they have a medical necessity, regardless of the availability of state funding.

The option to extend Medicaid eligibility to additional groups of low-income people, coupled with our state's attractive matching rate, have made expanding Medicaid coverage the subject of many discussions concerning strategies to reduce the number of Montanans without health insurance. Attempts to increase the availability of health care coverage by expanding access to the traditional Medicaid program have met with limited success. Most states, including Montana, have been reluctant to add additional Medicaid eligibility groups due, in part, to recent experiences with rapidly increasing Medicaid expenditures, coupled with what seem to be perpetually tight state budgets and persistent revenue shortfalls. Even in better fiscal times, the all or nothing entitlement nature of Medicaid has proven to be a barrier that inhibits the use of the program as a vehicle to provide expanded health care. Intentionally increasing the number of people eligible for Medicaid has a high probability of producing expenditures that far exceed the estimates on which the original policy initiative and budgets are based. It is also important to know that should Medicaid budget deficits loom the Medicaid program will face the choice of spending additional money that the state may not have, or making painful and unpopular reductions in the quality and quantity of services offered to those in need of essential health care.

Covering the Uninsured through CHIP

Recent efforts to bring affordable healthcare within the reach of uninsured people with low incomes have focused on the expansion of SCHIP, the jointly funded state and federal program that provides health insurance to low-income uninsured children. CHIP provides comprehensive health care coverage, including services such as physician, lab and x-ray, hospitalization, pharmacy, and dental services. Unlike the Medicaid entitlement, the federal funding for CHIP comes through an annual capped grant award. In addition to the annual grant award, states that fully utilize their annual grant award may also be eligible to receive a periodic redistribution of a portion of unexpended funds from the CHIP grants made to other states. Currently, there are over 10,900 children from families with incomes less than or equal to 150% of the Federal Poverty Level (FPL) enrolled in Montana CHIP.¹ The total annual cost is \$17.6 million dollars (FY2004) and state matching funds are 19 percent of this total.

In addition to the obvious value as a source of funding for badly needed health care services, unlike Medicaid, states are permitted to cap enrollment and limit the amount of money they are obligated to spend on SCHIP. While there continues to be a good deal of interest in, and support for, increasing the number of children covered under CHIP in Montana, the limited amount of state match, coupled with uncertainty regarding the level of additional federal grant funds available in the future, have restrained efforts to cover more children by expanding CHIP. While the primary mission of CHIP is clearly to provide a source for health care for children from families with low-incomes, federal regulations give states the option to cover parents of children who are enrolled in CHIP as well. If states choose to cover parents in CHIP, federal regulations require that they must enroll all eligible children who apply. Given the funding limitations and estimated number of uninsured children in Montana, this does not appear to be an option under CHIP.

It is estimated that there are approximately 15,000 Montana children currently uninsured, not covered by Indian Health Services (IHS) and who could be eligible for CHIP². Recognizing this, the 2005 Montana Legislature provided additional state funding for CHIP to increase the enrollment by 3,000 additional children beginning July 1, 2005. The legislature added funds to expand CHIP enrollment from 10,900 to 13,900 children. In addition, the legislature passed House Bill 552 (effective date July 1, 2006) that changed the Medicaid asset test for children. This change will ultimately result in moving approximately 2,975 children from CHIP to Medicaid, thus freeing up slots for coverage under CHIP for children with assets greater than \$15,000.

¹ CHIP enrollment as of April 2005.

² Source: 2003 Montana KIDS COUNT Data Book and Household Survey and Employer Survey Findings about Health Insurance Coverage in Montana, February 2004

II. HEALTH INSURANCE FLEXIBILITY & ACCOUNTABILITY (HIFA) WAIVERS

Coverage Options Available For the Uninsured Through HIFA Waivers

A HIFA waiver is a type of Medicaid 1115 Demonstration waiver that enables the state to provide Medicaid funded health care to additional groups of low-income people without the concerns regarding the Medicaid program requirements that have restricted such expansion in the past. The HIFA waiver program is not the product of a new piece of legislation, but rather a policy initiative by the federal Centers for Medicare and Medicaid Services (CMS), the purpose of which is to encourage states to explore creative ways to expand private and/or public health care coverage through proposals that go beyond the all or nothing approach that inhibits the use of traditional Medicaid as a vehicle to address unmet health care needs. HIFA places special emphasis on expanding health care coverage to currently uninsured individuals with incomes equal to or less than 200% FPL.

While much of what HIFA does is theoretically available under the existing federal 1115 Demonstration Waiver authority, the promotion of this policy option, with its submission guidelines and expedited review process, sends a clear signal to states that CMS is open to, and encouraging, proposals that increase the availability of health care through the development of unique benefit packages for optional and non-traditional Medicaid eligibility groups. This means CMS is open to unique demonstration ideas that are different than traditional Medicaid. Under traditional Medicaid, if a state chooses to participate in the Medicaid program, then every resident of the state who meets the State's Medicaid eligibility requirements is entitled to have payment made on his or her behalf for covered services. These services are often referred to as "State Plan" Medicaid Services. What HIFA does is allow states to expand Medicaid eligibility to cover new optional and non-traditional eligibility groups beyond the State Plan services, and waive provisions of the federal law and the entitlement benefit for these new eligibility groups. The purpose is to allow states the flexibility to be creative with new proposals that increase the availability of health care for uninsured citizens.

Detailed Overview of Medicaid HIFA Waiver Option:

Flexibility Under HIFA—Among the noteworthy features of the new policy option is the flexibility it gives states to:

1. Design alternative Medicaid benefit packages to meet the unique health care needs of some existing and new eligibility groups;
2. Require increased cost sharing for some eligibility groups (e.g. premiums, deductibles, and co-payments);
3. Limit or cap the state's financial obligation for services to new eligibility groups; and
4. Provide waiver participants with the option to receive financial assistance to help with the purchase of private insurance offered through employers rather than receiving direct public benefits.

Mandatory Benefits and Eligibility Groups: HIFA *does not allow* states to adjust the benefits or eligibility of the mandatory eligibility groups (low-income aged, disabled, children, etc.) that states are *required* to serve under the traditional State Plan Medicaid. HIFA does, however, identify two groups whose benefit packages may be adjusted with a waiver from CMS. They are:

1. **Optional Populations:** These are waiver eligibility groups that states have the option to cover under Medicaid or CHIP, *regardless of whether or not they are currently covered*. Examples of potential Optional Populations under a waiver include parents and children with incomes above the federal minimums for Medicaid eligibility. Children with CHIP and their parents are also considered optional populations.
2. **Expansion Populations:** Expansion Populations are those low-income individuals who are members of groups that are never eligible for coverage under the existing Medicaid or CHIP programs. Low-income childless adults are an example of a potential waiver Expansion Population that could never be eligible for Medicaid without a waiver.

Flexible Benefit Packages: States can alter the benefit package offered to the optional and expansion eligibility groups included in a waiver. HIFA specifies that benefits for optional populations must minimally include hospital, physician, laboratory and x-ray, and well-baby and well-child services. It does not mandate a specific level for these services. Benefits for expansion populations must only include basic primary care services from physicians. HIFA allows for increased cost sharing for both the Optional and Expansion Populations in the form of larger co-payments, deductibles and/or premiums. Furthermore, under a HIFA waiver, states are not required to provide “wrap-around” coverage regardless of cost sharing, benefit limits and/or medical necessity.

Budget Neutrality: As is the case with all Medicaid waivers, states must demonstrate that federal expenditures under the proposed waiver will be less than or equal to federal expenditures without the waiver. The state must also demonstrate that the additional cost of serving any proposed expansion population will be offset in one of the following three ways:

1. **Offsetting Savings:** Savings achieved from providing reduced benefits package(s) to existing *or future* optional eligibility groups may be used to offset additional spending for new services provided under the waiver;
2. **Unused Federal Disproportionate Share Hospital (DSH) Spending Authority:** Excess federal DSH spending authority may be used to cover the federal share of the additional spending for new services provided under the waiver; and
3. **Unused federal SCHIP Allocation:** States may choose to apply any unused portion of their federal SCHIP allocation to offset the federal share of spending for new services provided under the waiver, even if the expenditures are for services to eligibility groups that are not ordinarily eligible for Montana CHIP.

Optional Populations meet the waiver cost neutrality test as long as the average cost to Medicaid for all of their services while enrolled in the waiver is less than the amount Medicaid would have spent had the state exercised its option to adjust its eligibility standards in order to make all of the members of that Optional Population eligible for Medicaid, and therefore entitled to all of the services provided by the traditional Medicaid program.

Maintenance of Effort (MOE) Requirement: The waiver may not be used to simply refinance existing state health care programs. States wishing to use HIFA to fund services they already provide under state financed health care programs will be subject to the MOE requirement. The MOE requires that states maintain their

current level of spending on any existing state program that is included in a HIFA waiver. While states are required to maintain the level of state spending that existed prior to a program's inclusion in the waiver, HIFA does not require that all of the money continue to be spent in the same state program. States have the flexibility to redistribute those dollars as long as they are used to purchase health care benefits for low-income people who are uninsured. The MOE precludes states from employing schemes that seek to use HIFA waivers as a vehicle through which to secure Medicaid refinancing for state health care programs and then using the savings for purposes other than to increase the number of low-income people with health care benefits.

Montana's waiver frees up state general fund dollars previously used to fund the Mental Health Services Plan. Under the waiver, MSHP will become a Medicaid eligibility group for those who qualify, that is, those who are currently uninsured. The same state general fund dollars will be used to expand health care coverage to additional groups of uninsured Montanans. As CMS requires, Montana will not use the waiver to secure Medicaid funding for MHSP and then fund other non-health care programs. Montana will increase the number of low-income people with health care benefits. The overall dollar amounts for the new populations will be maintained at current levels.

Limits on the Growth of Average Per Person Expenditures for Waiver Groups: One of the federal requirements for securing approval of 1115 Waivers, including HIFA waivers, is the negotiation of expenditure limits, or growth caps, for each of the Medicaid populations covered by the waiver. Each mandatory or optional eligibility group included in the waiver is a separate Medicaid Eligible Group or "MEG." The expenditure limits are expressed as an average cost of Medicaid services Per Member Per Month (PMPM) for each waiver MEG. The use of an average cost per month rather than average cost per year is intended to control for the impact of people who are enrolled in the waiver for less than a full 12 months in a single year. The PMPM amount for a waiver MEG for any given year is computed by dividing the total Medicaid expenditures for services to that group during that year by the total number of months in which the members of that MEG were eligible for services. It is not necessary that a person receive services in a month, just that the person be eligible to receive services. The following is a formula for computing the average PMPM cost for a waiver MEG:

The Average PMPM for MEG #1 for a waiver year is equal to A divided by B where:

A = Total Medicaid expenditures for services to all members of MEG #1 for a given year of the waiver, and

B = Total Member Months of enrollment of all the individuals in MEG #1 for the same waiver year.

As part of the negotiations of the terms and conditions of the waiver, the state and federal governments agree on a base year for the purpose of establishing the average PMPM budget caps. DPHHS computes, and the federal government agrees, to a PMPM base year cost for each MEG included in the waiver. Finally, the state and federal governments agree to annual percentage increases to the average PMPM base year cost for each MEG included in the waiver. These inflated figures become the average PMPM expenditures caps for each MEG for each year of the waiver.

Function of the Waiver Expenditure Caps: The expenditure caps limit the average rate of increase in the annual PMPM cost of Medicaid services for only those MEGs included in each waiver. The growth caps do not apply to Medicaid expenditures for services provided to people from eligibility groups other than the groups included in a waiver. While the budget caps do limit the rate of increase in the average expenditure per person for members of the various waiver MEGs, they do not limit Medicaid spending for the caseload growth related to

serving additional people who are determined to be Medicaid eligible from each MEG. Although the caps are stated as an average PMPM expenditure amount for each MEG for each of the five years of the waiver, they are applied as an aggregate growth limit over the life of the waiver that is equal to the sum of each year's allowable percentage increase. In other words, average PMPM expenditures may exceed the annual cap in one waiver year as long as there is reduced spending of an equal or greater amount in other waiver years. The growth caps serve as upper limits on the costs in which the federal government will participate during the life of the waiver. If the average PMPM Medicaid expenditure for a waiver MEG exceeds the cumulative growth cap at the end of the waiver, the state is responsible for 100% of all of the Medicaid expenditures above the cap. This risk is mitigated by a CMS requirement for the state to implement a plan specifying the actions intended to reduce expenditures to the levels required by the waiver agreement. CMS does not wait until the expiration of the waiver to recover any federal payments in excess of the expenditure limits if a state appears to be at risk of exceeding budget caps.

Administrative Requirements: As is the case with all 1115 waivers, HIFA waivers are awarded for five-year periods. States are required to collect ongoing evaluation and outcome data. As part of the evaluation, HIFA requires that states document and track the percentage of the population that is uninsured. CMS has the authority to contract for an independent evaluation of the waiver, but it is not a requirement.

III. OUTLINE OF MONTANA’S PROPOSAL FOR A HIFA WAIVER

The Public Health Advisory Council in 2004 made 18 recommendations to “Re-Design Montana’s Medicaid Program,” which included an 1115 Health Insurance Flexibility and Accountability (HIFA) waiver. At the request of the Department of Public Health and Human Services (DPHHS), the 2005 Montana Legislature requested Senate Bill 110 entitled “*An act implementing certain recommendations of the Montana Public Health Care Redesign Project to provide for improved coverage of the health care and related needs of particular groups of person's: providing authority for the establishment of Health Insurance Flexibility and Accountability Demonstrations initiatives and other demonstration projects upon approval of waiver of federal law.*” Governor Brian Schweitzer signed into law Senate Bill 110, with the provision that DPHHS would conduct a 60-day comment period and carefully consider public comments before making a final decision to submit a proposed HIFA waiver. Montana’s application for a HIFA waiver is detailed in this concept paper.

This 1115 Medicaid Demonstration waiver proposes to strengthen community mental health services for adults and provide increased healthcare coverage to uninsured low-income children and adults in Montana. DPHHS’ proposal is a product of over a year’s work in cooperation with staff from the Medicaid program, state and federal elected officials, consumer advocacy groups and service providers.

Montana’s proposal for a HIFA waiver has three major concepts to address health care for the uninsured.

1. Secure Medicaid Funding to Strengthen the State Mental Health Services Plan (MHSP): The core concept underlying Montana’s waiver proposal is to secure federal Medicaid financing for the state-funded MHSP. Because the federal government pays approximately \$.70 cents of each dollar spent on Medicaid services in Montana, funding MHSP under Medicaid will free up a significant amount of the existing state appropriation for MHSP services. The plan calls for using a portion of the state funds that become available to enhance MHSP mental health services and provide a physical healthcare benefit for MHSP recipients.
2. Provide Medicaid Funded Health Care Coverage for Low-Income Uninsured Montanans: The second concept of Montana’s waiver proposal allocates the remaining state money that is no longer required to provide current MHSP services as a result of securing Medicaid funding, for use as the state match necessary to provide Medicaid health care coverage for several thousand uninsured low-income children and adults. In essence, the proposal uses Medicaid to maintain and enhance services to MHSP recipients, then reallocates the remaining savings to fund increased health care benefits for other uninsured Montanans with low incomes. In addition, the proposal includes new funding under the small business insurance pool (HB667) to provide assistance for low-income Montanans and their access to healthcare benefits.
3. Secure Medicaid Funding to Strengthen the MCHA Premium Assistance Program: The final concept of Montana’s proposed waiver is a plan to secure Medicaid funding for a portion of the state program that provides premium assistance to low-income people enrolled in the Montana Comprehensive Health Association (MHCA) program. MCHA is a last resort insurance program for people who are denied insurance because of serious health conditions. The savings generated by securing Medicaid participation in the cost of MCHA Premium Assistance will be used to ensure the continued viability of the program, reduce the out-of-pocket cost to consumers, and/or maintain or increase participation in the program.

IV. PLAN TO FUND THE MENTAL HEALTH SERVICES PLAN (MHSP) WITH MEDICAID

Rationale for Funding MHSP under HIFA

There are a number of reasons why securing Medicaid funding for a portion of the existing state-funded MHSP program through a Medicaid HIFA waiver appears to be a realistic option worth pursuing.

1. MHSP serves people with low income: HIFA focuses on providing health care benefits to people whose incomes are equal to or less than 200% of FPL. Eligibility for MHSP requires that people have incomes equal to or less than 150% of FPL.
2. HIFA does not require an asset test: MHSP eligibility criteria do not include an asset test. HIFA eligibility does not require an asset test.
3. The majority of MHSP participants are uninsured: HIFA is aimed at providing health care benefits to low-income people who do not have public or private health insurance. Two-thirds of MHSP recipients are uninsured. Of the one-third of MHSP recipients who are publicly or privately insured, Medicare is primarily the coverage.
4. MHSP provides health care services: The existing MHSP pharmacy and mental health therapy benefits are medical services that are usually included in health care benefit packages. The intent behind HIFA is to provide healthcare benefits.
5. HIFA gives states the ability to limit total expenditures: Currently, every person who meets the MHSP eligibility criteria is not automatically entitled to receive every service offered by the program. Total annual MHSP expenditures are limited to the amount appropriated by the legislature, without a legal requirement to meet all of the needs for services for individuals eligible for MHSP. Unlike the case with the majority of the Medicaid program, services provided under a HIFA waiver are not an entitlement. Waiver expenditures may be capped at a predetermined level established by the state.
6. MHSP is Largely State Funded: Approximately \$7 million of the MHSP program's \$8.3 million FY2007 appropriation is made up of state General Fund and State Special Revenue. Securing Medicaid funding for a portion of the MHSP program through HIFA significantly reduces the amount of state dollars required to provide current level MHSP services. HIFA permits states to leverage federal Medicaid dollars for state health care programs as long as the savings are used to provide health care benefits to additional low-income people who are uninsured.

Description of the Existing Mental Health Services Plan

Overview of MHSP: MHSP provides state-funded mental health services for low-income adults who have a Severe Disabling Mental Illness (SDMI) but are not eligible for Medicaid. MHSP services include a limited pharmacy benefit and an array of basic mental health therapy and support services delivered through one of four contracted Community Mental Health Centers. On average, 2,200 adults receive MHSP services each month. Approximately one-third of these MHSP recipients are enrolled in the Medicare program or have some form of health insurance, and the remaining two-thirds are uninsured. MHSP is a discretionary program that is not required by state or federal law. As a result, each person determined to be eligible for the MHSP program does

not automatically have a legal entitlement to receive services. The Addictive and Mental Disorders Division (AMDD) of DPHHS is responsible for the administration of the MHSP program within the funding level appropriated by the legislature.

For a detailed description of MHSP services and eligibility criteria see Attachment A.

Current MHSP Funding: The total FY2007 appropriation for MHSP services was approximately \$8.3 million dollars. Based on historical spending patterns, AMDD allocates \$3.5 million to purchase drugs used in the treatment of severe mental illnesses, while the remaining \$4.8 million is allocated to purchase the therapeutic and support services provided by the four Community Mental Health Centers. MHSP is funded with a combination of State General Fund (GF), State Special Revenue (SSR) and federal Community Mental Health Services Block Grant (CMHSBG). In FY2007, the SSR is funded by the State's tobacco tax.

MHSP FY2007 Appropriation

GF:	\$3,762,471
SSR:	\$3,250,000
CMHBSG:	<u>\$1,250,525</u>
Total:	\$8,262,996

Description of Proposed MHSP Services Under a Medicaid HIFA Waiver

1. Maintains MHSP Services and Eligibility Criteria while Increasing Funding through Medicaid: Under the proposed waiver there would be no change to the eligibility criteria for MHSP. No one currently eligible for MHSP and actively utilizing services will lose eligibility because of this waiver. The pharmacy benefit, therapies, and other mental health services currently available under MHSP will continue to be provided under HIFA. MHSP funding is currently provided under contracts with four community mental health centers. Allocation of funding is based on the percentage of the eligible population in each geographic region and is distributed monthly. Adjustments are not made for demographic changes during the contract period. Under HIFA, reimbursement will be provided using a capitated formula based upon individuals enrolled and receiving services. DPHHS is considering providing a state-funded pharmacy benefit for people on the MHSP waiting list.

DPHHS will review options to expand the provider network, although the waiver will restrict *total* freedom of choice under Medicaid. The proposal allocates almost \$1.3 million per year in additional Medicaid funding with which to provide existing MHSP services to individuals enrolled in the HIFA waiver. DPHHS will consider additional crisis services, such as an increase to the prescription drug benefit, crisis stabilization, or PACT.

DPHHS will establish a maximum number of individuals to be enrolled in MHSP and anticipates the possibility of a waiting list for services. The number of people enrolled in MHSP is limited by current legislative appropriations and not by a cap on the number of slots created by DPHHS. To improve access to services, DPHHS may disenroll eligible MHSP beneficiaries who have not accessed treatment for a period of 90 days in order to reduce the waiting list for those needing services. The Department will review the financial and eligibility determination processes and will develop a quality assurance process to ensure that only people eligible for MHSP are enrolled.

2. Reserves a Portion of Existing MHSP Resources to Serve Non-Waiver MHSP Participants: Approximately one-third of current MHSP participants already have some form of healthcare coverage, either through Medicare or some other health insurance. Because they are insured, they are ineligible for Medicaid funded healthcare services provided through HIFA. In order to ensure they continue to receive MHSP drug and therapy services they require, DPHHS plans to reserve approximately one-third of the current MHSP annual appropriation to continue services for MHSP recipients who already have health insurance. The remainder of the appropriation will be used as matching funds in the HIFA waiver. None of the CMHBG will be use for matching funds in the HIFA waiver.
3. Provides a New Physical Healthcare Benefit for Uninsured MHSP Recipients: One of the requirements of HIFA is to increase the number of low-income people who have health insurance. Approximately 1,500 people, or two-thirds of MHSP participants, are uninsured and as a result, are eligible for Medicaid funded health care through HIFA. In addition to continuing existing MHSP drug and mental health therapy benefits, Montana's waiver proposal provides uninsured MHSP participants with a physical health care benefit. HIFA does not require that the state provide the full Medicaid benefit package available to eligibility groups in its existing Medicaid program. States have the flexibility to provide health care benefits designed specifically for groups such as MHSP, as long as they meet a minimum set of federal requirements. Because many MHSP recipients are childless adults under the age of 65 and have not been determined disabled by Social Security, they are not eligible for traditional Medicaid. Non-traditional eligibility groups such as MHSP are considered to be "Expansion Populations" under HIFA. At a minimum, states are required to provide members of Expansion Populations with basic primary care, including physician services.

Important Note: Before considering the proposed MHSP physical health care benefit, it is important to understand the process that led to the coverage described herein. Since the planning began in December 2003, there has been a good deal of discussion of what should be included in the MHSP physical health care coverage under the waiver. During that time some people have expressed the opinion that in order to be minimally acceptable DPHHS' proposal must provide a full range of benefits including hospitalization, regardless of what the minimum requirements for a HIFA waiver might be. While DPHHS shares the goal of providing MHSP clients with the best and most comprehensive health care possible, the agency must also deal with the reality that the waiver cost neutrality requirements impose a limit on the amount of Medicaid money the state is able to spend on providing services to this group. DPHHS has tried to balance the desire to provide a broad physical health care benefit with the reality of an upper limit on the resources available for that purpose in the waiver proposal. The evolution of the MHSP health care benefit reflects this balancing act. The initial waiver concept presented to the Public Health Advisory Council provided up to \$500.00 per year in Medicaid funded physician and other basic primary care services to each MHSP adult. In response to criticism that the benefit was insufficient and did not include services such as hospitalization, the plan for coverage was revised and the annual cost of the health care benefit was increased to almost double the original amount. The revised plan called for identifying one or more private insurance policies or products that the state would purchase for each MHSP recipient who was uninsured. The cost of the insurance would vary based on the age of the individual to be insured, but the average annual cost would be no more than \$900 per person. While many people considered the enhanced coverage to be a step in the right direction, others remained unconvinced. In addition to continued concerns about the scope of the benefit, the use of private insurance products rather than a state administered fee-for-service program drew additional criticism. To address this concern, DPHHS worked to identify an actuarially sound Medicaid fee-for-service healthcare benefit package for the MHSP population. After developing and analyzing a

variety of fee-for-service plans, DPHHS concluded that the projected cost of a broad-based Medicaid fee-for-service option was well above the level necessary for the waiver to be cost neutral. The proposed MHSP physical health care benefit is the product of the compromises and adjustments described here. While the benefit may be less than some might like, it would be a valuable source of paid health care for a group of people who will otherwise be uninsured.

MHSP Physical Health Care Benefit: The waiver proposal includes a flexible strategy for providing the best physical health care benefits possible to uninsured MHSP recipients with the money available. The plan, a blend of the various proposed benefit packages DPHHS explored over the past year, provides MHSP recipients with the ability to choose one of three physical health care benefit options. It also provides each person with education and assistance in selecting the coverage that best meets his or her needs. While the three proposed MHSP physical health care benefit options provide individuals the choice of different methods and approaches to procuring health care, the average per person cost to Medicaid for each option is the same.

The three MHSP benefit options are:

- a. **Employer Premium Assistance:** Uninsured MHSP recipients who work at jobs where their employer offers group health insurance will be given the choice to receive assistance with the cost of the monthly premiums for the employer based group insurance. The level of premium assistance available may vary by the age of the individual, but the average amount will not exceed \$166.00 per month (\$2,000 per year).

The rate chart below has been calculated based on current age distribution (Average Age 40) and premium ratio for the largest health insurer in Montana.

RATE CHART

	Monthly Premium Equivalent
Under 20	\$ 101.00
Age 20-24	\$ 116.00
Age 25-29	\$ 130.00
Age 30-34	\$ 138.00
Age 35-39	\$ 151.00
Age 40-44	\$ 170.00
Age 45-49	\$ 198.00
Age 50-54	\$ 225.00
Age 55-59	\$ 263.00
Age 60-64	\$ 313.00
Average	\$ 166.00

While DPHHS wants to encourage individual choice for health insurance options, minimum benefits will be required equal to those outlined in Attachment F.

- b. Individual Private Health Insurance Plans: If employer-based insurance is unavailable, or the individual chooses not to participate, he or she will have the option to apply for, and enroll in, existing individual private health insurance policies. The cost of monthly premiums for the individual health care policies selected by MHSP recipients will be paid by Medicaid as long as the cost is no more than a maximum upper limit established by DPHHS. The monthly premium upper limit will vary based on the age of the insured individual, but the average of all payments will be no greater than \$166.00 per month (\$2,000 per year), see rate chart above. In addition to paying the premiums of existing insurance benefit plans, DPHHS will encourage private insurance carriers to develop new physical health care insurance options designed specifically to provide coverage to MHSP recipients. While DPHHS wants to encourage individual choice for health insurance options, minimum benefits will be required equal to those outlined in Attachment F.
- c. Medicaid Individual Health Care Benefit: If an MHSP recipient cannot secure private insurance, or he or she chooses not to do so, the proposal provides the option to receive a Medicaid waiver physical health care benefit of up to \$2,000 per person per year. A Medicaid waiver Individual Health Care Benefit will be established for each eligible person selecting this option. The benefit may be used to reimburse up to \$166.00 per month in Medicaid waiver funded health care services at the Medicaid fee-for-service rate as long as the individual continues to meet the Medicaid waiver program eligibility criteria. If an individual receives less than \$166.00 in Medicaid waiver reimbursed services in any month, the difference between the \$166.00 maximum and the actual reimbursement will be added to the following month's benefit. The benefit balance can accumulate as long as the individual continues to be enrolled in MHSP, unless the waiver is modified or terminated. The Individual Health Care Benefit provides access to a range of medical care and services, while reinforcing people who are judicious consumers of health care. There is, however, one important difference: should the individual withdraw from the program, or lose eligibility, any remaining balance of the benefit will revert to DPHHS. DPHHS is exploring the technological and administrative options and issues associated with operating a system of individual health care benefits such as the one described here, including the potential to provide the benefit through some form of debit card. While DPHHS would prefer to implement the health care benefit as part of the existing Medicaid fee-for-service system, if for some reason that is not feasible due to cost, administrative complexities, or unforeseen problems, other administrative options that do not employ Medicaid fee-for-service processes and rates will be explored.

In order to facilitate the most appropriate choices possible, DPHHS, in cooperation with the four Community Mental Health Centers, will provide education and assistance to MHSP recipients in selecting their health care benefit. While the current plan calls for providing every uninsured MHSP participant with a physical health care benefit, the proposed waiver includes a provision that allows DPHHS to limit enrollment in the physical health care benefit if such a step is necessary in order to ensure the continued cost neutrality or fiscal viability of the waiver. The implementation of a cap on enrollment in the Medicaid physical health care benefit program would in no way impact the ability of eligible individuals to receive the existing state-funded MHSP pharmacy and therapy benefits. The total cost of the new physical health care benefit for MHSP recipients is projected to be approximately \$3.0 million per year.

4. Provides Funding for New MHSP Short Term In-Patient Acute Psychiatric Services: Although some MHSP enrollees experience acute psychiatric episodes requiring short term in-patient treatment, MHSP does not currently offer such a benefit. To address this deficiency in the community-based continuum of care, this HIFA proposal provides a total of \$200,000 per year in total Medicaid funding for the purchase of short-

term, acute in-patient psychiatric care. Clinical review and management of this benefit will be included in the DPHHS utilization review contract, currently held by First Health Services. DPHHS anticipates that community hospitals with psychiatric in-patient units in Glendive, Billings, Missoula, Great Falls, and Kalispell will comprise the provider network for this benefit. Reimbursement will be calculated using the Medicaid fee schedule for DRGs. Because the budgetary allocation for the in-patient benefit is limited, DPHHS may determine that it is necessary to restrict individual access to not more than one admission per person per year, or to a limited number of days. Because it has not been included in the plan of benefits since 1999, it is difficult to anticipate the demand for in-patient care.

5. Reallocates a Portion of the Community Mental Health Service Block Grant to Fund SAAs: An additional benefit of securing Medicaid funding for MHSP is the ability to reallocate a portion of the federal Community Mental Health Service Block Grant (CMHSBG), currently used to fund MHSP services, to address other unmet needs in Montana's community mental health service system. Montana's waiver proposal reallocates \$226,675 per year of the CMHSBG funds to the state's Service Area Authorities (SAAs) to address other system of care issues. The state's three SAAs are stakeholder-based entities that are statutorily mandated to collaborate with DPHHS in the planning and oversight of mental health services. The additional funding will be made available for community-based services for adults that have been identified by the SAAs with SDMI and not available in the existing mental health system.

Summary of Positive Impact of the Waiver on Services for People with a Mental Illness

The proposed Medicaid HIFA waiver would enhance the quantity, quality and range of services available to Montanans who have SDMI. Significant service improvements include:

1. Additional Funding for MHSP: The waiver proposal provides almost \$1.3 million per year in additional funding for the existing Mental Health Services Plan;
2. A New Physical Healthcare Benefit for MHSP Participants: The waiver creates a physical health care benefit for approximately 1,500 of the existing MHSP recipients per month who currently do not have health insurance, at an estimated total cost of \$3 million per year;
3. A New Short Term In-Patient Acute Psychiatric Benefit for MHSP Participants: The waiver proposal adds \$200,000 per year in Medicaid funding for a new short term in-patient acute psychiatric benefit for MHSP recipients; and
4. Community Mental Health Service Block Grant Funds for Development of SAAs: The waiver reallocates \$226,675 in federal Community Mental Health Service Block Grant funds to address other system of care issues. The additional funding will be made available for community-based services that have been identified by the SAAs for adults with SDMI.
5. Beneficiary Choice: DPHHS adopted a strength-based recovery model for services for people with serious mental illness. This is an orientation toward service provision that suggests positive clinical outcomes are best achieved when the client directs the goals and priorities for care. The strengths model focuses on individual resources, skills, personal qualities, and interests, rather than on symptoms and disabilities. To the extent possible, decisions are made in collaboration with the client and, when appropriate, family

members. The strengths model was developed through clinical trials and research at the University of Kansas in the late 1980s and early 1990s.

Under the HIFA waiver, MHSP beneficiaries will have the ability to choose the physical health care benefit that best meets their needs. Support staff employed by the community mental health centers will provide coordination of benefits as well as linkage and referral services as appropriate.

V. PLAN FOR HEALTH CARE FOR UNINSURED MONTANANS

Because seventy cents of every dollar spent on Medicaid services in Montana comes from the federal government, securing Medicaid funding for MHSP through a HIFA waiver will free up almost \$2.5 million dollars in state funds. The previous section describes a plan to reinvest some of these newly available state dollars in expanded mental and physical health services for MHSP recipients. Because HIFA imposes a Maintenance of Effort (MOE) requirement whenever a waiver provides reimbursement for previously state-funded programs, any state dollars not used to expand or enhance MHSP must be used to provide health care benefits to other groups of uninsured Montanans with low incomes. The DPHHS HIFA waiver proposal reinvests the remaining state dollars no longer required to maintain MHSP to fund health care benefits for members of the following three groups of uninsured Montanans:

Group#1: Low-income children who apply for or lose Medicaid eligibility because they no longer meet the income and resource requirements for Medicaid. These children, however, are eligible for CHIP but cannot access services because the program has a waiting list and cap on the number of the children served.

Group#2: Seriously Emotionally Disturbed (SED) youths who are in transition from Medicaid funded children's mental health services to adulthood.

Group#3: Working parents of young children who are attempting to make the transition from Medicaid and Temporary Assistance for Needy Families (TANF) to employment, whose children remain eligible for Medicaid.

In addition, to provide additional assistance to address the health care needs of uninsured working Montanans, the Montana 2005 Legislature passed HB667, which provides \$11.5 million new funding in SFY2007 for access to health care. Under this new small business purchasing pool, the Department proposes to leverage Medicaid funding to provide coverage for working, uninsured parents of children who are also uninsured who may be eligible for funded insurance premium incentive/assistance payments.

DPHHS understands the importance of ensuring that people comprising these groups be aware of the availability of new health care coverage. The Department will consider options to expand the outreach and enrollment network to uninsured Montanans who will be eligible for health care coverage under the waiver.

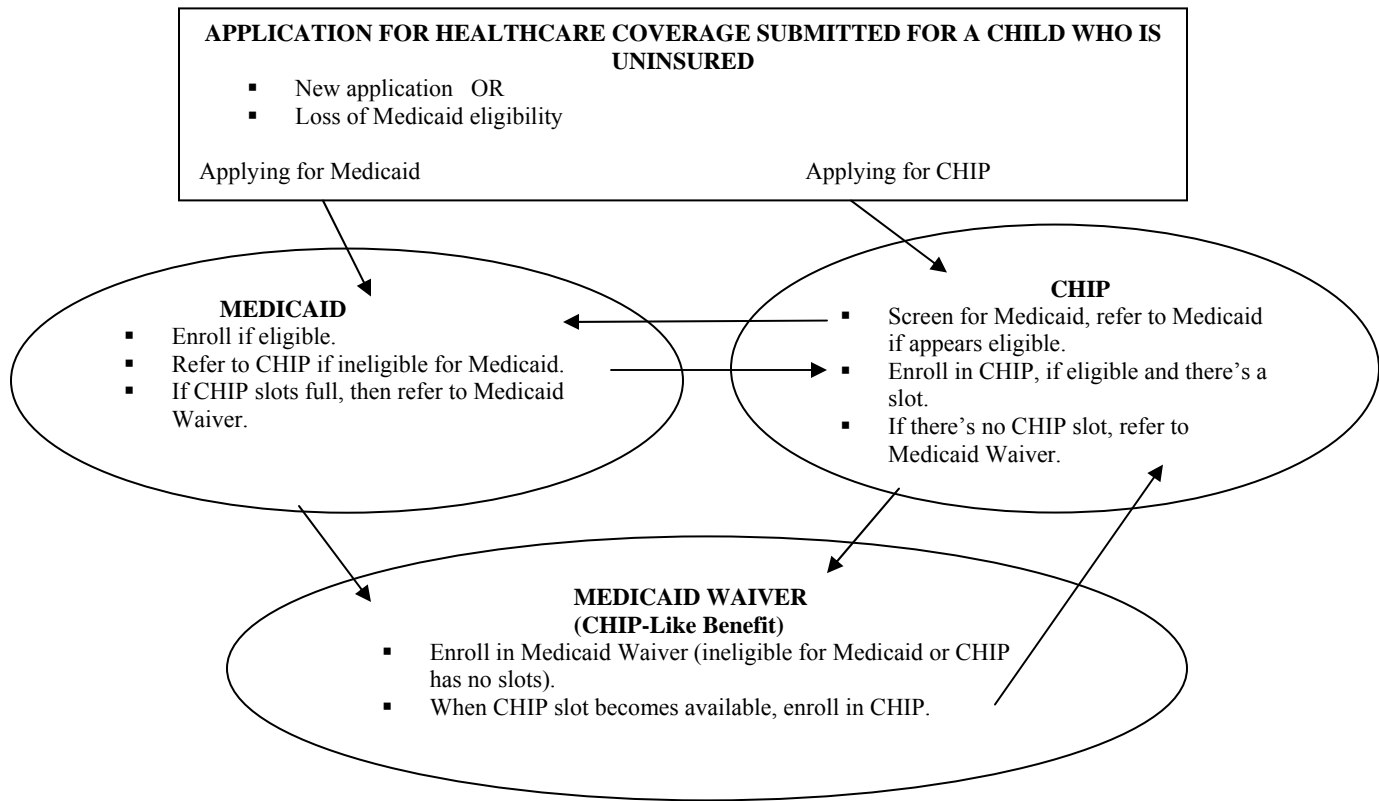
Uninsured Group#1: Provide Medicaid Funded Healthcare to Low-Income Children.

The Need for Additional Funding to Serve Uninsured Low-Income Children: Montana's CHIP program is currently the main source of critically needed health care services for approximately 10,900 otherwise uninsured Montana children who are ineligible for Medicaid (as of April 2005), but have family incomes equal to or less than 150% of FPL. Because the enrollment in CHIP is capped, and the program is currently at capacity, eligible children are required to wait until there are openings or additional resources are allocated to the program. The Montana State Planning Grant indicates there may be up to 22,000 uninsured Montana children who are eligible for CHIP or Medicaid, but are not enrolled in either program. From this figure it is estimated that there are approximately 15,000 Montana children who are currently uninsured and could be eligible for CHIP. While there appears to be a great deal of interest in increasing the number of children enrolled in CHIP, there are two issues that must be addressed in order to expand the program.

1. **State Match:** In order to increase the number of children enrolled in CHIP the state must pay approximately 19% of the total cost. Finding a source for state matching funds necessary to expand any state program, even one as popular as CHIP, is always difficult. Governor Brian Schweitzer identified additional funding for CHIP as a priority during the 2005 Montana Legislature. Using new revenue resources generated under the tobacco tax initiative (I-149), the legislature added funds to expand CHIP enrollment from 10,900 to 13,900 children. In addition, the legislature passed House Bill 552, effective July 1, 2006, that will change the Medicaid asset test for children. This legislation change will ultimately result in moving approximately 2,975 children from CHIP to Medicaid, thus freeing up slots for coverage under CHIP for children with assets greater than \$15,000.
2. **Uncertainty Regarding the Availability of Additional Federal Grant Funds:** In addition to state matching funds, any expansion of CHIP requires that there be sufficient federal CHIP grant authority to support the additional services. Although Montana currently has a balance of over \$20 million in federal CHIP grant funding, it is important to note that the federal share of projected CHIP expenditures in FY2005 exceeds the amount of that year's annual federal grant award by about a million dollars. A surplus in carry-over funds from the grants for previous years will be sufficient to support the current level of CHIP spending for the foreseeable future. However, without an increase in the annual grant award, or the reallocation of a significant amount of unused federal CHIP funding from other states, the potential for a large expansion of the CHIP program may be limited. While a future increase in the size of the federal grant, and/or a reallocation of funding from other states is likely, the magnitude and timing of any additional funding is less than certain. With the increases in state matching funds authorized by the 2005 legislature, Montana has increased the demand on the CHIP grant authority and the demand on the reallocation funding of unused federal CHIP authority from other states. Montana is expecting Congress to grant additional CHIP authority or reallocation funding for the CHIP program to cover the expansion of the program as authorized by the legislature. Therefore, based upon this analysis Montana does not foresee the availability of "unused federal CHIP authority" as a mechanism to meet the cost neutrality requirements of the waiver as mentioned earlier in this document. In addition, the budget neutrality requirements do not allow the use of unused reallocation funding under CHIP to meet these requirements of the waiver.

Description of Proposed Medicaid Health Care Benefit for Low-Income Children: Montana's proposed HIFA waiver includes a provision that uses a portion of the state's savings that result from securing Medicaid funding for MHSP as matching funds to increase the number of low-income children with a health care benefit. This waiver proposal includes a plan to provide a Medicaid funded health care benefit package for uninsured low-income children identical to the one provided by CHIP. The target eligibility group will be low-income children who apply for or lose Medicaid eligibility because they no longer meet the income and resource requirements for Medicaid. These children historically have gone into the ranks of the uninsured because while they are typically eligible for CHIP, they cannot access services because the program is full and has a waiting list. This waiver proposes a stopgap measure to provide health care coverage for these children who are waiting for slots to open under the CHIP program. DPHHS proposes to provide the CHIP benefit for these uninsured children but the funding for this will come from Medicaid and not the CHIP program. The underlying concept for this proposal is that the client will be able to obtain health care coverage immediately when transitioning from state plan Medicaid services to CHIP. As far as the client and the family are concerned they are receiving CHIP benefits, as there will be no difference in the health care coverage under the Medicaid waiver and the CHIP program. The funding for this coverage will be transparent to the client as DPHHS will provide this benefit and fund the coverage with Medicaid dollars. When a CHIP slot becomes available, DPHHS will shift the funding under the Medicaid waiver slot to the CHIP slot. This will provide uninterrupted coverage for needy low-

income children. The following diagram explains the relationship between Medicaid, CHIP, and the Medicaid Waiver as outlined above.



Note: This waiver proposes a stopgap measure to provide healthcare coverage for uninsured children. DPHHS will assure access to Medicaid first and all applicants will be screened for Medicaid eligibility before enrollment in CHIP or the Medicaid Waiver (HIFA). Children whose households exceed income or asset limits for Medicaid, CHIP and the Medicaid Waiver are referred to other programs for which they may qualify.

This alternative approach to serving low-income children under a waiver is possible because the state already has the *option* to raise the income eligibility standards for its traditional Medicaid program in order to serve children from families with higher incomes, although for reasons related to the fiscal concerns described earlier in this document it has not done so. The children in the new higher income group are considered an “Optional Population” under HIFA; as such the state is required to provide them with a minimum set of benefits that is more extensive than one required for Expansion Populations such as MHSP. The coverage provided through Montana’s CHIP program is the actuarial equivalent of the health insurance benefit available to state employees, as a result it meets the minimum benefit requirements for Optional Populations served under a HIFA waiver. Therefore, the Department proposes to provide an additional health care benefit for low-income children funded under a Medicaid waiver.

While using the Medicaid 70/30 matching rate would reduce the number of children served through the waiver when compared to a direct expansion of the CHIP program, current projections indicate that such a funding switch would still have sufficient resources to provide a high quality health care benefit for up to 1,500 low-income children per year. (Originally, we anticipated covering up to 1,800 children but after further analysis of the appropriations and anticipated expenditures, we now believe we will be able to cover up to 1,500 children.)

Regardless of whether the additional services for low-income children are funded through CHIP or through a Medicaid funded alternative, the waiver will initially retain and use the existing CHIP upper income limit of 150% of FPL when determining eligibility. DPHHS wants to ensure it has done everything possible to make families who are already eligible at the existing income standard aware of the health care benefits that are available for low-income Montana children. Under this waiver proposal, the Department reserves the right to increase the income eligibility standard in small increments to coincide with the eligibility requirements of the Montana CHIP program.

For a complete description of the CHIP health care benefit, see Attachment B.

Uninsured Group#2: Provide Medicaid Funded Health Care to SED Youths.

The Need for Physical Health and Transitional Mental Health Services for Older SED Children:

Montana currently provides Medicaid funded mental and physical health care to 6,000 children who have a Serious Emotional Disturbance (SED) and are under the age of 18. The Department's Child and Family Services Division (CFSD) acts as legal guardian for some Medicaid eligible SED children, many of which reside in licensed foster care homes. A much smaller group of low-income SED children remain with their natural families, receiving Medicaid funded treatment and therapeutic family services. Finally, a small percentage of children with the most serious emotional and behavioral problems are served in higher cost 24-hour residential treatment facilities or psychiatric hospitals, with funding from Medicaid. One of the significant challenges associated with serving SED children in general, and children who reside in 24-hour treatment programs in particular, is assisting them in making a reasonably smooth transition to adulthood. While the road from being a child to being an adult may be rough for some children, it is especially so for children also dealing with serious emotional problems. Facing the demands and challenges of becoming an adult is made more difficult by the fact that when they turn eighteen and no longer qualify for Medicaid as children, many may find that they are also ineligible for Medicaid as adults because they do not meet the Social Security Administration's definition of disabled. Some are ineligible for state-funded adult mental health services under MHSP as well because their condition does not meet the state's definition of Severe Disabling Mental Illness (SDMI), which has greater clinical acuity criteria than SED. Increasing awareness of the gap between the mental health systems for children and adults has resulted in a greater emphasis on preparing SED children at an earlier age for the inevitable movement out of children's services. While many SED kids do make a relatively smooth transition to adulthood, some do not. For these young people the expectation that they cope with their existing emotional problems without the benefit of the services and supports they counted on as children, and at the same time deal successfully with the additional emotional and practical challenges and expectations that come with being a young adult, is too much to ask. The outlook for these children is not good. Surveys of former foster care youth indicate that 22% become homeless after foster care; 33% earn below the federal poverty limit; 50% have used illegal drugs; 48% have not graduated high school at the time of discharge from services; and 25% are involved in the legal system (Child Trends 2003). Their failure to successfully adapt often results in chronic unemployment, substance abuse, frequent contact with law enforcement agencies and, all too often, eventual incarceration. For some, the loss of mental health services exacerbates their emotional problems to the point where they meet the federal and/or state adult mental disability criteria and are again eligible for publicly funded mental health services. Unfortunately, by the time they are determined to be Medicaid eligible as adults, the nature and degree of their emotional problems are often more serious. In addition to the obvious negative impact on their mental health, losing Medicaid eligibility at age eighteen typically means that these young men and women no longer have access to public or private physical health

care benefits and they join the ranks of the uninsured.

Proposed Medicaid Funded Physical and Mental Health Benefit for SED Youths: The Department's HIFA waiver proposal includes a plan to use a portion of the state's savings that result from securing Medicaid funding for MHSP as match to provide a group of high risk uninsured SED youths with a Medicaid funded physical health care benefit, and a set of therapeutic and support services designed to assist them in making a successful transition to adulthood. The plan calls for serving up to 300 SED youths at a projected annual total cost of \$2.3 million. There is no asset or resource test.

In order to be eligible for services under the proposed waiver SED children must:

1. Be age 18 through 20 years old;
2. Receive children's mental health services with SED diagnosis immediately prior to enrollment in the waiver and no longer eligible for those services due to age;
3. Be ineligible for the state's MHSP adult mental health services program;
4. Have incomes equal to or less than 150% of FPL;
5. Have been recipients of the child welfare foster care system and been discharged from the child welfare foster care system; and
6. Be uninsured and ineligible for Medicare or Medicaid.

In addition to the general eligibility criteria described above, the program will specifically target SED children who:

1. Are turning age 18;
2. Receive Residential Treatment, Therapeutic Group Care, Therapeutic Family Care, or Foster Care services; and
3. Have no family or other informal support systems on which to rely.

Prior to discharge from the child welfare foster care system, the Child and Family Service social worker and the Children's Mental Health case manager will meet with the individual to develop a transition plan and timeline. Part of that transition plan will include an assessment of eligibility for this waiver. If the individual is deemed clinically eligible and desires to be enrolled in the waiver, the individual will complete an application and the application will be sent to the Office of Public Assistance for final determination. Eligibility will be for a one-year period of time and annually the individual's eligibility will be re-determined based on diagnosis and other eligibility criteria. In the event the individual opts not to participate in the waiver at the time of discharge from the child welfare foster care system and they subsequently would like to participate in the waiver, he or she will be allowed to enroll as long as the eligibility requirements are met and the program is open for new enrollees.

Note: Under the Foster Care Independence Act the state has the option of providing Medicaid coverage to all young people who were in the foster care system up to age 21. Furthermore, the state has the flexibility to provide Medicaid to "reasonable categories" of recipients. Therefore, this population is deemed an Optional Population (information provided in a December 1, 2000 letter from CMS to State Child Welfare and State Medicaid Directors).

Description of Proposed Physical Health Care Benefit for SED Youths: The DPHHS proposal provides each SED child served under the waiver with a comprehensive Medicaid funded physical health care benefit identical

to the one available through the state's CHIP program. The projected cost of providing the CHIP health care benefit to 300 SED children is approximately \$600,000 per year.

The CHIP health care benefit includes mental health services, which are defined below:

- (1) Mental health benefits include:
 - (a) inpatient services furnished by public or private licensed and qualified practitioners in a hospital, including a state-operated mental hospital, a residential service or a partial hospitalization program; and
 - (b) outpatient services furnished by public or private licensed and qualified practitioners in a community based setting or in a mental hospital.

- (2) Mental health benefits are limited to:
 - (a) 21 days of inpatient mental health care per benefit year;
 - (b) partial hospitalization benefits exchanged for inpatient days at a rate of two partial treatment days for one inpatient day; and
 - (c) 20 outpatient visits per year, which can be furnished in community-based settings or in a mental hospital.

- (3) Mental health benefits will not be limited for enrollees with the following disorders:
 - (a) schizophrenia
 - (b) schizo-affective disorder
 - (c) bipolar disorder
 - (d) major depression
 - (e) panic disorder
 - (f) obsessive-compulsive disorder
 - (g) autism.

- (4) Mental health benefits shall be provided at least to the extent required by state law.

The State of Montana pays a health insurance premium for CHIP health care services, except eyeglasses and dental, which are paid fee for service. Participants in the CHIP health care benefit utilize the network of providers contracted with the CHIP vendor.

For a more detailed description of the CHIP health care benefit, see Attachment B.

Description of Proposed Transitional Mental Health Services Benefit for SED Youth: In addition to the CHIP health care benefit, the waiver proposal creates a new transitional mental health services benefit specifically designed for SED children leaving the children's mental health system to adjust to life in the community and make a successful transition to adulthood. Many SED youth are eligible for services under the Chafee Foster Care Independence Act (1999), which requires that states provide all foster care youth who are likely to "age out" of care with appropriate services to give them the skills and knowledge they need to make a successful transition to self-sufficiency. In Montana, foster care youth 16 to 18 years old must be referred to the Montana Foster Care Independence Program to prepare them for adult community living. The program provides tangible life skills instruction such as money management, apartment hunting, employment skills, and prevention resources. The program provides the education and services necessary to obtain and retain employment and housing, and to enter post secondary education and training institutions. Once they "age out" of care, youth ages

18 to 21 are eligible to continue to receive services, including financial assistance and other assistance necessary to complement their own efforts to achieve self-sufficiency.

Unfortunately research shows that 38% of foster care children are emotionally disturbed and these young people have difficulty acquiring the intangible life skills that most children learn throughout their childhood. Intangible life skills include decision-making, problem solving, impulse control, and basic interactive social skills. Without these skills, they have difficulty learning the tangible life skills taught in an independent living program. As a result, foster care alumni have a greater likelihood than other children to experience unstable living conditions.

Health and medical care represent a big challenge for youth aging out of care. Transition from state care generally means that eligibility for Medicaid is lost. The Northwest Foster Care Alumni Study (2005) found that 54.4 % of foster care alumni had clinical levels of at least one mental health problem such as depression, social phobia, panic syndrome, or drug dependence. One in five had three or more mental health problems. Emotionally disturbed youth cannot benefit from independent living programs without extra mental and physical health supports. Health services to give youth greater access to mental health services and to prepare them to manage their own medical and mental health needs are critical to ensuring positive outcomes for foster care alumni.

The proposed additional mental health services are designed to 1) supplement the CHIP health care benefits, and 2) provide new services not currently available. The goal of providing these services is to assist the SED youth in making a successful transition to adulthood.

To receive supplemental mental health services, the recipient must have exhausted outpatient benefits under the CHIP benefit and have received prior authorization before they can receive these additional benefits:

- Medication management and consultation
- Individual psychotherapy
- Group psychotherapy

Under the waiver, participants will receive supplemental mental health services from the same providers they use in the CHIP network. These providers will be reimbursed on a fee for service basis, using the Medicaid fee schedule.

New mental health services not currently provided:

- Develop community based mentor relationship.
- Wraparound facilitation, which includes:
 - Community based plan to assess the patient needs and skill development plan, goals, objectives, responsibilities, timelines, outcomes and performance measures.
 - Training and instruction to develop intangible life skills, defined as problem solving, decision-making, impulse control and critical thinking. These skills are needed before the individual can fully comprehend and learn tangible life skills.
 - Monitoring waiver services (physical health and mental health) and budgets or service limits.
 - Collaboration and coordination with other services; such as Montana Foster Care Independence Program, affordable housing, and other poverty related programs.
 - Training and instruction to develop social interaction skills.

One or two vendors who will contract with the State will provide the new mental health services. These vendors will be selected based on their skills and abilities to serve SED youth. Reimbursement of services may include per member per month capitation, fee for service arrangements, bonus payments for achieving outcomes, or any combination of methods.

SED youth will not incur any cost sharing for Transitional Mental Health Services and expenditures for Transitional Mental Health Services will be limited to \$4,500 per year per individual recipient.

The Department's waiver proposal allocates over \$1.5 million per year to provide up to 300 SED youths per year with transitional mental health services.

The State of Montana recognizes there may be a concern related to coordinating Medicaid and other federal programs. DPHHS will coordinate and ensure that Medicaid is not paying for services typically payable under the Foster Care System and/or Montana Foster Care Independence Program (MFCIP). MFCIP is designed to assist individuals to develop tangible life skills. Tangible life skills include: health promotion and preventative health services, budgeting and financial management, shopping, work skills to remain in the community, sex offender treatment, and knowledge of community support. In addition to these services, the individuals are eligible for certain stipends and financial assistance to help with secondary education, housing and household goods, travel assistance, and job readiness. This program is funded by the Chaffee grant and is not subject to this waiver, however, the program does provide necessary services to assist the individuals to successfully transition to adulthood. Please refer to Attachment G for a summary of all the transitional mental health services available to SED youth to assist in their successful transition to adulthood.

Uninsured Group #3: Provide Medicaid Funded Health Care to Uninsured Working Parents of Medicaid Eligible Children.

The Need for an Extension of Health Care Benefits for Working Parents of Medicaid Children: Parents of children who are enrolled in Medicaid risk losing their own eligibility when they become employed and their incomes exceed the eligibility standard for adults in the Family Medicaid eligibility category. In many cases the ineligible parents are working in low-wage jobs where they make too much money to be eligible for Medicaid themselves, but their incomes are low enough to allow their children to remain Medicaid eligible due to the higher family income standards for children (please refer to Attachment H regarding Medicaid eligibility criteria). In order to address the obvious disincentive to continued employment that comes with the loss of Medicaid funded health care, the federal government permits states to maintain the Medicaid eligibility of adults who are making the transition from Family Medicaid to employment. Montana currently provides two six month periods of Transitional Medicaid to families whose incomes exceed the Section 1931 Medicaid eligibility standard.

The rationale for providing a period of Transitional Medicaid eligibility is that by extending their Medicaid coverage for up to one year, the clients will have the time to be able to afford and enroll in, group health insurance offered through employers, or some other form of private insurance coverage. Unfortunately, the experience has been that when the year of Transitional Medicaid expires many working parents find themselves uninsured because their employer does not offer group insurance or the group insurance is too expensive, as are most of the available private health insurance policies for individuals. If a need for medical care arises for the working parent, the need tends to go unmet. Lack of timely and appropriate medical care often leads to more

serious health problems, which in turn lead to voluntary or involuntary loss of employment, and the parent's eventual return to Medicaid.

In addition to the obvious benefit of public health care coverage on the health and emotional status of a low-income parent who would otherwise be uninsured, there is some evidence that when parents have health insurance, there is a positive impact on the health of their children. Based on the analysis of data gathered from a study that examined medical service utilization patterns, researchers concluded that if a child is raised in a family where parent(s) and children both have some form of public or private health insurance, children will receive more frequent and better medical care than children raised in families where only the children have health care benefits³.

Some people question how realistic it is to expect that people who lose their Medicaid eligibility because they are now working in lower wage jobs will secure private health care coverage, even with a year of Transitional Medicaid. These same people argue that if states took advantage of the available option to raise the income eligibility standard for adults in the 1931 Family Medicaid eligibility group, thereby providing these low-income working people with a stable source of health care for more than one year, it would increase the likelihood that they would remain healthy and have the opportunity to secure both a better paying job and private health insurance. Higher incomes and private health insurance also make it more likely that people will be self-reliant and able to leave Medicaid and remain off Medicaid. If it is true that children of insured parents receive more frequent health care services, another reason for providing health care benefits to working parents of Medicaid children is the potential for a positive impact on the health and welfare of the children themselves, especially younger children. For some children, providing appropriate and timely medical services will prevent a host of health problems that not only diminish the child's quality of life, but inevitably result in higher Medicaid expenditures as well.

There appears to be a subjective case to be made that extending some form of publicly funded health care coverage to low-income working parents of Medicaid children may increase the likelihood that they remain in their new jobs, secure private health insurance, avoid a return to Medicaid, and raise healthier children. At this time, there is not enough data on this subject to base a policy decision to create a new entitlement to Medicaid services in the traditional Medicaid program.

For a complete listing of the criteria used to determine eligibility for Transitional Medicaid see Attachment C.

Description of Proposed Medicaid Funded Health Care Benefit for Working Parents: The DPHHS waiver proposal includes a provision to provide Medicaid funded physical health care for up to 600 working parents of Medicaid eligible children per year, at a projected annual cost of about \$1.3 million. This population is considered an Optional Population. Medicaid parents will be able to choose one of the same three physical health care options available to the adult MHSP participants, as described earlier in this document. In order to qualify for the Medicaid funded benefits, the individual must remain employed, have an income equal to or less than 200% FPL, remain a Montana resident, and continue to have at least one child in their care under the age of 21 who qualifies for Medicaid. DPHHS is interested in assessing the impact that extending publicly funded healthcare would have on the ability of working Medicaid parents to get and keep jobs, secure private health insurance for themselves and their families, and ensure their children are as healthy as possible. The Department intends to measure the impact of the policy change by gathering evaluative data such as the percent of people

³ Source: Hanson, Karla. 1998 "Is Insurance for Children Enough? The Link Between Parents and Children: Health Care Use Revisited". Inquiry 35 (3).

who stay employed, the length of their employment, the number that enroll in private health insurance, as well as the impact of the utilization of preventive health care services by, and the health status of, their children. Because people in this waiver eligibility group must be working in order to qualify, and because one of the primary goals of the extended coverage is to assist them to access private insurance, the parents of Medicaid children are a logical group to give the option to choose between either employer insurance premium assistance, private insurance, or direct public benefits from the Department.

Uninsured Group #4: Provide Medicaid Funded Insurance Premium Incentive or Assistance Payments for Uninsured Parents with Children and Uninsured Youths.

The Need for Premium Incentive or Assistance Payments for Uninsured Parents with Children and Uninsured Youths: Many working parents with children and youth working for small business employers do not qualify for Medicaid because their incomes or resources exceed the eligibility standard for adults in the Family Medicaid eligibility category. In many cases the ineligible parents are working in low-wage jobs where they make too much money to be eligible for Medicaid. In addition, many working parents are employed with small businesses that often do not provide health insurance coverage for their employees. Many working Montanans find themselves uninsured because their employer does not offer group insurance or the group insurance is too expensive, as are most of the available private health insurance policies for individuals. If a need for medical care arises for the employee or their children, it tends to go unmet. Lack of timely and appropriate medical care often leads to more serious health problems, which in turn lead to voluntary or involuntary loss of employment and the possibility of the parent's eventual eligibility for Medicaid.

Recognizing this dilemma in the provision of affordable health care, the 2005 Montana Legislature passed HB 667, the small business insurance pool. Under the provisions and intent of HB 667, small business employers will have the opportunity to join a small business purchasing pool and receive assistance from the State of Montana to pay a portion of monthly insurance premiums. The assistance will be available in two forms, premium assistance payments for the employee, and premium incentive payments for the employer. This program will benefit those small businesses that begin to provide insurance coverage for their employees. HB 667 also includes a program to provide tax credits for small businesses that provide health insurance coverage for their employees. Employers that meet program criteria established by the purchasing pool board and the State Auditor's Office are eligible for this benefit. The obvious benefit of health care coverage for Montanans is to improve the health and emotional status of individuals who are attempting to be economically self-sufficient and would otherwise be uninsured. In addition, when parents have health insurance, there is a positive impact on the health of their children as well because children of insured parents tend to receive more frequent healthcare services⁴. Another reason for providing health care benefits to working parents is the potential for a positive impact on the health and welfare of the children themselves, especially younger children. For some children, providing appropriate and timely medical services will encourage preventive care, provide access to immunizations and prevent a host of health problems that not only diminish the child's quality of life but also inevitably could result in higher medical costs.

Description of Proposed Premium Incentive/Assistance Payments for Uninsured Parents with Children and Uninsured Youths: The Department's proposal for a waiver includes a provision to provide Medicaid funded premium assistance payments for the employee and premium incentive payments for the employer for up to

⁴ Source: Hanson, Karla. 1998 "Is Insurance for Children Enough? The Link Between Parents and Children: Health Care Use Revisited". Inquiry 35 (3).

1,200 working parents with children and youths per year with incomes less than or equal to 200% FPL, at a projected annual cost of about \$3.3 million. DPHHS will collaborate with the State Auditor's Office in the administration of this benefit. The actual amount of premium incentive and assistance payments may vary. The purchasing pool board of directors will set the level of incentive payments, which has to be the same for each participating employer. The board will also set the amount of the premium assistance payment, which, combined with the premium incentive payment, will either be consistent with the amount of the tax credits, or will vary if the board decides to adopt a payment schedule that is equitably proportional to the income or wage level for eligible employees. The board will have flexibility in setting the amounts of both the incentive payments and the assistance payments. For reference, the amounts outlined in HB 667 for tax credits are as follows:

- Not more than \$100 each month for each employee and \$100 each month for each employee's spouse, if the employer covers the employee's spouse, if the average age of the group is under 45 years of age; or
- Not more than \$125 each month for each employee and \$100 each month for each employee's spouse, if the employer covers the employee's spouse, if the average age of the group is 45 years of age or older; and
- Not more than \$40 each month for each dependent, other than the employee's spouse, if the employer is paying for coverage for the dependents, not to exceed two dependents of an employee in addition to the employee's spouse.

In order to qualify for Medicaid funded benefits the individual must be referred from the small business purchasing pool administered by the State Auditor's Office, remain employed, remain a Montana resident, and meet eligibility requirements. These include employees who are not currently eligible for Medicaid or CHIP, but meet the following criteria: Uninsured adults ages 19 through 64 who have children under the age of 21, and have incomes less than or equal to 200% of FPL; and uninsured youth ages 18 through 20 who have incomes less than or equal to 200% of FPL.

DPHHS is interested in assessing the impact that extending publicly funded health care would have on the ability of working parents to get and keep jobs, secure private health insurance for themselves and their families, and ensure that their children are as healthy as possible. The Department will measure the impact of the policy change by gathering evaluative data such as the percent of people who stay employed, the length of their employment, as well as the impact of the utilization of preventive health care services by, and the health status of the employee and children.

At least one state, Massachusetts, has secured federal approval for an 1115 Medicaid Waiver that funds portions of the Insurance Partnership of Massachusetts, a program that is very similar to the one proposed under HB 667. The Insurance Partnership provides monthly employer incentive and employee premium assistance payments to small businesses (50 or fewer employees) that employ people whose incomes are equal to or less than 200% (FPL), and who provide, or begin to provide, employee health insurance that meets a set of standards established by the state. Medicaid funding for the Insurance Partnership is only available for employer incentive, and employee premium assistance, payments in those instances where the business has not provided its employees with health insurance in the past, but begins to do so. The Massachusetts program, however, is not tied to a small business insurance pool such as the one proposed in HB 667.

Based on an analysis of the federal 1115 Waiver guidelines, a review of similar 1115 waivers, and several discussions with CMS, it appears that at least a portion of the employer premium incentive and employee premium assistance payments authorized under HB 667 could be funded through an 1115 Medicaid waiver. Significant characteristics of such a waiver include:

Services: The waiver would provide Medicaid funding for both the Employer Premium Incentive payments, and the Employee Premium Assistance payments made on behalf of employees who meet the eligibility criteria established in the waiver.

Employees eligible for Medicaid under the Waiver: Employees who are not currently eligible for Medicaid or CHIP, but meet the following criteria:

- Group One: Uninsured adults ages 19 through 64 who have children under the age of 21, and have incomes equal to or less than 200% of FPL
- Group Two: Uninsured youth ages 18 through 20 who have incomes less than or equal to 200% FPL.

This alternative approach to serving low-income parents with children under a waiver is possible because the state already has the *option* to raise the income eligibility standards for its traditional Medicaid program in order to serve this population with higher incomes, although for reasons related to fiscal concerns of creating an expanded Medicaid entitlement, the State has not done so. The individuals in this eligibility group are considered an “Optional Population” under HIFA.

The program established under HB 667 will be available to all employees eligible under the small business insurance pool. For purposes of this waiver we propose to serve only those individuals that meet the criteria as noted above. The waiver proposal will not serve childless adults as it relates to eligibility under HB 667. Premium incentive and assistance payments to childless adults will require 100% state funding through the State Auditor’s Office. The childless adult group will not be covered under the waiver because we will not be able to meet the budget neutrality requirement. In order to meet the federal budget neutrality requirement, the waiver is required to offset the cost of serving childless adults by reducing services and benefits to existing Medicaid eligibility groups, and/or increasing the required co-payments and deductibles of people who are currently eligible for Medicaid. As mentioned before in this document, the Department is not proposing to change the services and benefits to existing Medicaid eligibility groups.

DPHHS believes we will be able to meet the federal budget neutrality test under the proposal to extend Medicaid eligibility to a new group of uninsured low-income adults who have children (group 1 above), and a new group of uninsured low-income youth (group 2 above). We would meet the cost neutrality requirement as long as the average cost of the Employer Premium Incentive payments plus the Employee Premium Assistance payments for each group is less than the average of what it would have hypothetically cost to provide each of these groups with full Medicaid benefits, had the state exercised its option to do so. Serving these two groups in this way under an 1115 waiver would have no impact on Montana’s existing Medicaid eligibility groups or services.

VI. FUNDING MONTANA COMPREHENSIVE HEALTH ASSOCIATION (MCHA) UNDER A MEDICAID HIFA WAIVER

Description of MCHA Premium Assistance Program:

The Montana Comprehensive Health Association (MCHA) was created by the Montana Legislature to provide health insurance to people who are uninsurable in the private market due to medical conditions, and who are also ineligible for public health care programs such as Medicaid. During the 2003 Session the Montana Legislature appropriated approximately \$700,000 per year in State Special Revenue to the State Auditors Office for the implementation of an MCHA premium assistance pilot project providing assistance with the cost of MCHA monthly premiums to Montanans with incomes less than or equal to 150% FPL. The 2005 Legislature appropriated approximately \$570,000 per year for the same purpose. In addition to state dollars, MCHA also received federal grant funds, some directed to support the Premium Assistance Program. As of June 2005, the pilot project was paying 45% of the MCHA monthly premiums for 200 low-income Montanans. Unfortunately, the current appropriation of state and federal funding is not enough to serve all of the people qualified for the program, witnessed by the fact that as of June 2005 there were about 60 people on the waiting list. Because of a shortage of funding, the number of people receiving premium assistance has been decreasing while the average cost of MCHA monthly premiums has increased. Faced with the fact that the federal grants have been exhausted and because of steadily increasing costs and a fixed amount of state funding with which to operate the program, the Board of Directors of MCHA was forced to reduce the level of premium assistance provided to people enrolled in the pilot project from 55% to 45%. The reduction in the level of premium assistance is clearly increasing the rate at which people drop MCHA coverage and again become uninsured. In addition to the challenge of dealing with steadily increasing costs, the long-term viability of MCHA Premium Assistance Program is made more uncertain by the fact that the future availability of federal grant funds is uncertain.

The federal government has already approved a request from the State of Illinois for a HIFA waiver securing federal funding for low-income people served through the Illinois Comprehensive Health Insurance Program (ICHIP), a program whose mission and operation are very similar to that of MCHA. An initial comparison of MCHA and ICHIP confirms that the two programs have much in common and as a result Montana is exploring the potential for funding a portion of MCHA benefits through a federal Medicaid waiver, similar to the one already secured by Illinois.

For a detailed description of MCHA, and a comparison of MCHA to the ICHIP program that was included in the Illinois HIFA waiver, see Attachment D.

Description of Method for Funding MCHA Premium Assistance through Medicaid

For the last several months the Department has been working with the State Auditor's Office to determine if it is feasible to, and if there is interest in, including a provision of Medicaid reimbursement for a portion of the MCHA Premium Assistance Program in the HIFA waiver proposal. After meeting with members of the State's Auditor's staff and representatives from Blue Cross Blue Shield of Montana, who administers the program, and based on the results of a positive vote to move forward from the MCHA Board of Directors, the consensus was that the option to include MCHA in the waiver appeared to be worth pursuing. As part of the discussions at least three potential uses were identified for any additional resources that might be generated as a result of securing Medicaid funding for MCHA. They are:

1. Maintaining or increasing the percentage of the monthly premium that MCHA pays for eligible individuals;
2. Eliminating the current waiting list for MCHA Premium Assistance Program; and
3. Ensuring the continued financial viability of the MCHA Premium Assistance Program.

DPHHS conducted a more detailed analysis of the potential benefits of including MCHA in the waiver using data provided by the Auditor's Office and Blue Cross Blue Shield of Montana. The data indicated that about 90% of the 300 people enrolled MCHA Premium Assistance as of October of 2004 would likely qualify for Medicaid funding under HIFA. The 10% who would be ineligible are enrolled in Medicare as well as MCHA and therefore are not uninsured, a HIFA requirement. The most logical way to include MCHA in the HIFA waiver would be to adopt the existing MCHA eligibility criteria, benefit package and operational procedures as part of the waiver. Medicaid would then make the monthly premium assistance payment for all the eligible individuals enrolled in the MCHA waiver eligibility group. The waiver agreement with the federal government would include a maximum number of MCHA eligible people to be served, and maximum amount of money to be spent on MCHA premium assistance under the waiver. DPHHS believes the federal government would likely consider the MCHA waiver eligibility group an Expansion Population. Therefore, other savings in the waiver must offset the cost of waiver services for the MCHA eligibility group. A logical source for the savings offset would be the DPHHS' existing Basic Medicaid Waiver. DPHHS and the Auditor's Office would enter into an inter-agency agreement detailing the accounting procedures required to be able to use a predetermined portion of the SSR currently appropriated for MCHA as matching funds for Medicaid reimbursement of MCHA services under the HIFA waiver.

Based on its initial analysis of the data available and ongoing discussions with MCHA stakeholders, the Department developed a hypothetical example of how a MCHA Premium Assistance waiver option might be implemented. The result of that scenario revealed that including a portion of MCHA in a HIFA waiver could generate approximately \$600,000 per year in additional federal Medicaid revenue at no additional cost to the state. The additional federal money could be allocated to address the three options for strengthening MCHA that emerged during discussions with the Auditor's Office and the MCHA. For example:

1. The percentage of the monthly premium paid by the MCHA Premium Assistance Program for the 200 people enrolled in the program as of June 2005, could be restored to the previous level of 55%;
2. Up to 60 people on the MCHA Premium Assistance Program waiting list as of June 2005 could be enrolled in the program; and
3. Approximately \$200,000 of the SSR appropriation for the Premium Assistance Program could be retained to by the Auditor's Office and the MCHA Board of Directors to continue to serve the 30 MCHA enrollees who do not qualify for the waiver, while the balance could be used to ensure the long-term viability of the MCHA Premium Assistance program.

Any plan to refinance a portion of the MCHA Premium Assistance Program state funds through a waiver proposal will depend on at least four factors:

1. The exact amount of the State Special Revenue appropriation for MCHA that the Auditor's Office and MCHA Board of Directors determine is available for use as Medicaid match after the other needs of the program are met, including the need to maintain the long-term viability of MCHA premium assistance;
2. Decisions by the MCHA Board of Directors and the Auditor's Office regarding policy issues such as increasing the percentage of premium assistance provided by the program and serving people on the MCHA waiting list;
3. The amount of savings from the Basic Medicaid Waiver that would be available to offset expenditures on services to MCHA enrollees. Should there not be sufficient savings available it may not be possible to include MCHA in the waiver; and
4. Because the MCHA Board of Directors is the responsible entity to ensure financial viability of the pool, they must continue to have the authority to work with the Department and CMS regarding expansion populations under a waiver. If state funds are reduced further in the future, or if financial condition of the high-risk pool worsens, the Board must have the flexibility to work around these issues.

VII. PROJECTED BUDGET, BUDGET NEUTRALITY, AND GROWTH CAPS

Summary of Projected Expenditures and Revenue Sources under the HIFA waiver

If the proposal for an 1115 waiver is approved by the federal government, DPHHS estimates it would generate approximately \$15 million dollars in additional federal Medicaid revenue per year with which to provide badly needed health care benefits to several thousand uninsured Montanans. It would do so without the need for additional state dollars above the amount already appropriated for the Mental Health Services Plan (MHSP), Montana Comprehensive Health Association (MCHA) and the new small business incentives under HB 667.

The table below provides a general summary comparing the FY 2007 appropriation for MHSP, MCHA and small business incentives to the projected annual expenditures and revenue sources for the five-year life of the HIFA waiver proposal. The numbers are rounded and will change if eligibility groups, services, and costs in the current waiver proposal are adjusted.

FY 2007 Appropriation Without HIFA

Service/Group	Number	Total			Federal
	Served	Funds	MHBG	GF/SSR	XIX
FY2007 MHSP Appropriation:	2,200	\$ 8,239,146	\$ 1,226,675	\$ 7,012,471	\$ 0
FY2007 MCHA Appropriation:	245	\$ 570,000	\$ 0	\$ 570,000	\$ 0
FY 2007 Small Business Premium Assistance Appropriation:	2,239	\$ 1,059,495	\$ 0	\$ 1,059,495	\$ 0
Total:	4,774	\$ 9,868,641	\$ 1,226,675	\$ 8,641,966	\$ 0

Appropriations with HIFA

Service/Group	FY 2008	Total Funds	MHBG	GF/SSR	Federal
	Number Served				XIX
Physical and Mental Health Services/MHSP Recipients	2,200	\$ 13,020,623	\$ 1,226,675	\$ 4,914,927	\$ 6,879,021
CHIP Benefit and Mental Health Services/SED Youth	100	\$ 665,000	\$ 0	\$ 209,608	\$ 455,392
Chip Benefit/Low-Income Kids	1,500	\$ 3,086,993	\$ 0	\$ 973,020	\$ 2,113,973
Physical Healthcare Benefit/Medicaid Parents	658	\$ 1,316,359	\$ 0	\$ 414,916	\$ 901,443
MCHA Premium Assistance/MHCA Participants	245	\$ 949,807	\$ 0	\$ 570,000	\$ 379,807
Small business premium assistance Sub-Total	2,329	\$ 3,221,068	\$ 0	\$ 1,015,281	\$ 2,205,787
Administration and system enhancements Sub-Total	-	\$ 3,530,989	\$ 0	\$ 544,215	\$ 2,986,775
Total	7,032	\$ 25,790,838	\$ 1,226,675	\$ 8,641,966	\$ 15,922,197

Service/Group	FY 2009	Total Funds	MHBG	GF/SSR	Federal
	Number Served				XIX
Physical and Mental Health Services/MHSP Recipients	2,200	\$ 13,522,856	\$ 1,226,675	\$ 5,218,591	\$ 7,077,590
CHIP Benefit and Mental Health Services/SED Youth	200	\$ 1,383,200	\$ 0	\$ 445,252	\$ 937,948
Chip Benefit/Low-Income Kids	1,500	\$ 3,179,603	\$ 0	\$ 1,023,514	\$ 2,156,089
Physical Healthcare Benefit/Medicaid Parents	658	\$ 1,369,013	\$ 0	\$ 440,685	\$ 928,328
MCHA Premium Assistance/MHCA Participants	245	\$ 1,002,505	\$ 0	\$ 570,000	\$ 432,505
Small business premium assistance Sub-Total	2,329	\$ 3,170,551	\$ 0	\$ 1,020,601	\$ 2,149,951
Administration and system enhancements Sub-Total	-	\$ 1,477,789	\$ 0	\$ 338,895	\$ 1,138,895
Total	7,132	\$ 25,105,517	\$ 1,226,675	\$ 9,057,538	\$ 14,821,304

Service/Group	FY 2010				
	Number Served	Total Funds	MHBG	GF/SSR	Federal XIX
Physical and Mental Health Services/MHSP Recipients	2,200	\$ 14,045,121	\$ 1,226,675	5,481,701	\$ 7,336,745
CHIP Benefit and Mental Health Services/SED Youth	300	\$ 2,157,792	\$ 0	\$ 698,046	\$ 1,459,746
Chip Benefit/Low-Income Kids	1,500	\$ 3,274,991	\$ 0	\$ 1,059,459	\$ 2,215,531
Physical Healthcare Benefit/Medicaid Parents	658	\$ 1,423,774	\$ 0	\$ 460,591	\$ 963,183
MCHA Premium Assistance/MHCA Participants	245	\$ 1,066,207	\$ 0	\$ 570,000	\$ 496,207
Small business premium assistance Sub-Total	2,329	\$ 3,154,870	\$ 0	\$ 1,020,601	\$ 2,134,270
Administration and system enhancements Sub-Total	-	\$ 477,789	\$ 0	\$ 238,895	\$ 238,895
Total	7,232	\$ 25,600,543	\$ 1,226,675	\$ 9,529,292	\$ 14,844,576

Service/Group	FY 2011				
	Number Served	Total Funds	MHBG	GF/SSR	Federal XIX
Physical and Mental Health Services/MHSP Recipients	2,200	\$ 14,588,072	\$ 1,226,675	\$ 5,737,764	\$ 7,623,634
CHIP Benefit and Mental Health Services/SED Youth	300	\$ 2,244,104	\$ 0	\$ 725,968	\$ 1,518,136
Chip Benefit/Low-Income Kids	1,500	\$ 3,373,240	\$ 0	\$ 1,091,243	\$ 2,281,997
Physical Healthcare Benefit/Medicaid Parents	658	\$ 1,480,725	\$ 0	\$ 479,014	\$ 1,001,710
MCHA Premium Assistance/MHCA Participants	245	\$ 1,140,638	\$ 0	\$ 570,000	\$ 570,638
Small business premium assistance Sub-Total	2,329	\$ 3,154,870	\$ 0	\$ 1,020,601	\$ 2,134,270
Administration and system enhancements Sub-Total	-	\$ 477,789	\$ 0	\$ 238,895	\$ 238,895
Total	7,232	\$ 26,459,438	\$ 1,226,675	\$ 9,863,484	\$ 15,369,279

Service/Group	FY 2012				
	Number Served	Total Funds	MHBG	GF/SSR	Federal XIX
Physical and Mental Health Services/MHSP Recipients	2,200	\$ 15,153,120	\$ 1,226,675	\$ 6,004,447	\$ 7,921,998
CHIP Benefit and Mental Health Services/SED Youth	300	\$ 2,333,868	\$ 0	\$ 755,006	\$ 1,578,862
Chip Benefit/Low-Income Kids	1,500	\$ 3,474,438	\$ 0	\$ 1,123,9810	\$ 2,350,457
Physical Healthcare Benefit/Medicaid Parents	658	\$ 1,539,954	\$ 0	\$ 498,175	\$ 1,041,779
MCHA Premium Assistance/MHCA Participants	245	\$ 1,226,233	\$ 0	\$ 570,000	\$ 656,233
Small business premium assistance Sub-Total	2,329	\$ 3,154,870	\$ 0	\$ 1,020,601	\$ 2,134,270
Administration and system enhancements Sub-Total	-	\$ 477,789	\$ 0	\$ 238,895	\$ 238,895
Total	7,232	\$ 27,360,271	\$ 1,226,675	\$ 10,211,103	\$ 15,922,493

The following assumptions were used in developing these projections:

1. The amount of state funds (GF and SSR) expended in each year of the waiver must be equal to the amount of the state funding appropriated to MHSP and MCHA in the base year.
2. The Medicaid and CHIP projections are based on actual FMAP rates for FY 2008, FY 2009, and FY 2010. FY 2010 FMAP rates were used to project FY 2011 and FY 2012 budgets.
3. The per person cost of the adult physical health care package was inflated by 4% per year.
4. The per person cost of the CHIP package was inflated by 3% per year.

5. The existing MHSP, MCHA, and the new SED services assume a fixed appropriation and therefore are not inflated.
6. The expenditures and numbers of people served are rounded.

Details Regarding the Sources of Budget Neutrality for the Department's HIFA proposal

The following are the methods by which DPHHS believes it will be able to achieve the budget neutrality required of HIFA and all other Medicaid waivers:

Achieving Budget Neutrality for the Proposed Waiver Optional Populations: Four of the six proposed eligibility groups included in the Department's HIFA waiver proposal will likely be considered Optional Populations under HIFA. They are: Parents of Medicaid children with family incomes equal to or less than 200% FPL; Low-income children with family incomes less than or equal to 150% FPL; SED children ages 18 through 20 who have lost Medicaid eligibility due to their age; and Working parents with children and youth with incomes equal to or less than 200% of FPL. Optional Populations are groups states have the ability to include as a Medicaid eligibility group under current law, although perhaps have not included. Because Montana has the option to extend Medicaid eligibility to members of these groups, the groups meet the waiver budget neutrality test as long as the average expenditure for services under the waiver is less than or equal to the projected average expenditure if they had received full Medicaid benefits.

Achieving Budget Neutrality for the Proposed Waiver Expansion Populations: The remaining two proposed eligibility groups included in the Department's HIFA waiver proposal, MHSP participants who are uninsured, and the low-income enrollees in the MCHA Premium Assistance program, will likely be considered Expansion Populations by the federal government. Expansion Populations are groups that are not ordinarily Medicaid eligible under any circumstances. The cost of services for Expansion Populations must be offset in one of three acceptable ways identified by CMS, including: Offset the additional expenditures with unused federal DSH authority; Offset the additional expenditures with unused federal CHIP authority; or, Offset the additional expenditures by providing reduced benefits to, or requiring increased cost sharing of, other Medicaid eligibility groups. Montana's HIFA waiver proposal will include a provision to achieve cost neutrality by capturing savings that are realized through an existing 1115 Demonstration waiver already approved by the federal government and currently operating in Montana, thereby offsetting the increased cost of services to the two waiver Expansion Populations. Montana currently provides a reduced set of Medicaid benefits to adults in the Family Medicaid eligibility group as part of an approved 1115 Demonstration waiver entitled, "Basic Medicaid Waiver for Able-Bodied Adults". The Basic Medicaid Waiver, originated in 1996 as part of the state's efforts at welfare reform, includes stricter limits on optional services such as dental, eyeglasses, dentures and durable medical equipment for the 1925 and 1931 Adults enrolled in the Family Medicaid eligibility group. While the restricted services available through the Basic Medicaid Waiver result in lower state and federal Medicaid expenditures, the waiver does not include a provision for new spending on other services or new eligibility groups. As a result, the savings achieved through the Basic Medicaid Waiver are theoretically available to offset any additional spending on the Expansion Populations contemplated in the new HIFA waiver proposal. During negotiations for renewal in February 2004, the Department discussed the potential to combine the savings from the Basic Medicaid Waiver as an offset to the new spending which would be included in a yet-to-be submitted HIFA waiver. At that time, federal Medicaid officials agreed they would give consideration to some form of combination of the Basic Medicaid Waiver with expanded health care coverage under a HIFA waiver, if such a proposal was submitted in the future. While the exact mechanism for combining the two waiver proposals

remains unclear, there would appear to be two options: Amend the existing Basic Medicaid Waiver to include the additional populations and services detailed in the HIFA proposal, or terminate the Basic Medicaid Waiver and include its provisions for cost savings in a new HIFA waiver. As mentioned earlier, Montana's waiver proposal amends the existing 1115 Basic Medicaid Waiver for Able-Bodied Adults to achieve budget neutrality by capturing savings realized under the existing waiver.

Description of Medicaid Eligible Groups and PMPM Expenditure Caps

MEGs and PMPM Budget Caps in Montana's Proposed HIFA waiver: In addition to the budget neutrality requirement, HIFA waivers also include expenditure/budget caps or limits on the average Per Member Per Month Medicaid expenditure for each Medicaid Eligible Group (MEG) included in the waiver. Each mandatory and optional eligibility group included in a waiver is considered to be a separate Medicaid Eligible Group (MEG) for the purpose of establishing cost neutrality and the annual upper limits on waiver expenditures.

The Department anticipates there will be at least four Optional Population MEGs included in the Montana HIFA waiver proposal that would be subject to average PMPM annual expenditure caps. The waiver proposal also includes a fifth MEG made up of the members eligible for Medicaid under Sections 1925 and 1931 of the Social Security Act and enrolled in the existing 1115 Basic Medicaid Waiver for Able-Bodied Adults. The projected MEGs in the new Montana HIFA waiver include:

Optional Population Groups:

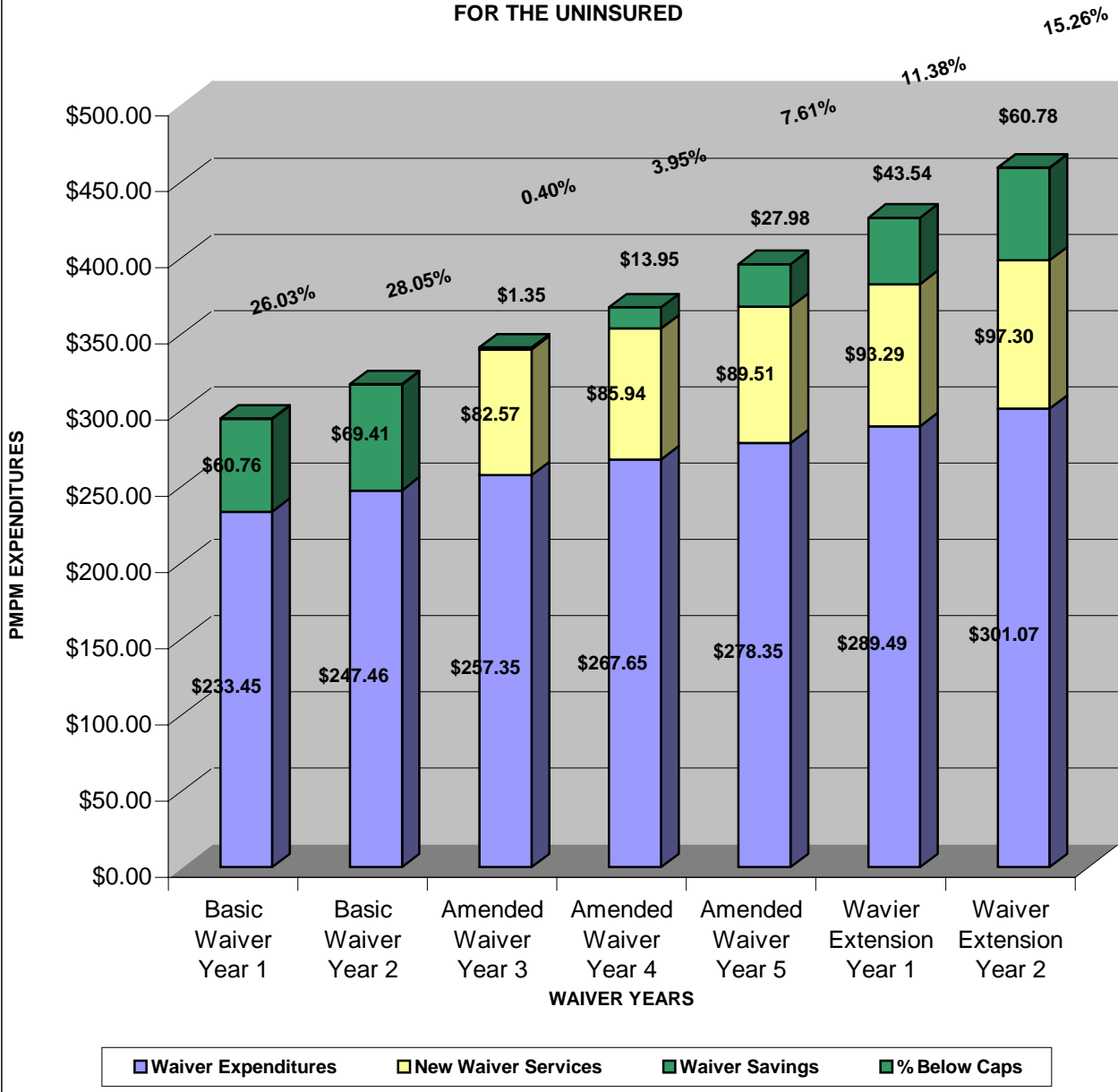
- Low-income children;
- Low-income parents of Medicaid eligible children;
- Low-income SED youth, age 18 through 20;
- Low-income parents with children and low-income youth age 18 through 20;

Expansion Population Group: Adults currently enrolled in the Basic Medicaid Waiver, including the proposed expansion groups of MHSP and MCHA individuals who are uninsured.

The annual average PMPM Medicaid expenditure on services for each of the MEGs listed here may not exceed the annual average PMPM expenditure limit for that MEG as it is specified in the waiver. While the average PMPM expenditure limits are expressed as annual limits in the waiver, they are applied as aggregate limits.

People enrolled in the MHSP and MCHA groups who are eligible to receive waiver services make up the two Expansion Populations included in the Department's HIFA waiver proposal. Consistent with the budget neutrality requirement, the total Medicaid expenditure for services to Expansion Populations such as MHSP and MCHA must be absorbed within the average PMPM expenditure cap of the Basic Medicaid MEG that is receiving a reduced set of Medicaid benefits.

AMEND MONTANA'S BASIC MEDICAID WAIVER TO FUND HEALTHCARE SERVICES FOR THE UNINSURED



VIII. Administrative Issues:

DPHHS has started the process of identifying systems enhancements, staffing and other administrative requirements necessary to implement the waiver proposal as described here.

Systems Enhancements: The nature and final cost of the modifications to existing computer systems, and the cost of any new system development, will depend on the ultimate decisions made regarding eligibility groups and benefit packages. To the extent possible, DPHHS will utilize existing systems and resources in the implementation of this waiver program. Those systems would include the Medicaid Management Information System (MMIS), eligibility determination systems, and premium payment systems. This waiver proposal will require the development of new data systems and interfaces with other agencies and vendors that have not been part of the traditional Medicaid service delivery system.

There are several components of the proposed waiver that will clearly require some system changes or system development work, including: the use of a capped Medicaid Health Care Benefit option to pay for physical health care for some members of the MHSP and Medicaid parent eligibility groups; the requirement for payment of insurance premiums for clients covered under the insurance pool and options for a physical health care benefit; the requirement to include new eligibility information and processes in the Department's Medicaid eligibility system; and, the desire to gather more detailed information about MHSP participants and their services. In addition, we anticipate the need to develop methods to exchange data with the State Auditor's Office related to client eligibility under the insurance pool and the Montana Comprehensive Health Association and with various insurance entities to verify continued coverage and eligibility for this waiver proposal.

The Department also acknowledges the lack of data on the numbers of Montanans with a Severe and Disabling Mental Illness. The Western Interstate Commission for Higher Education (WICHE) will gather sound data of mental illness in Montana. WICHE's report will be available to the Department and the public for planning and administration.

In addition, the Department will establish systems that will provide baseline data, measure outcomes, monitor the effects of the waiver on the availability of community services, and inform policy makers about changes to services and utilization. The Department will incorporate these systems to recommend improvements for the effectiveness of the project.

Administrative and Staffing Requirements: Although DPHHS believes that the majority of the administrative functions required by the waiver could be met with existing staffing levels, there may be the need for a small number of additional staff to perform the administrative work necessary to maintain the waiver and to develop and implement the new service options. DPHHS estimates up to an additional 6.0 FTE will be required for program administration. The additional staff is necessary for the Department to administer, enroll and provide support services for this waiver proposal. FTE are necessary for eligibility determination services for the new Medicaid eligibility groups. FTE will also be required to develop the new coverage options for employer premium assistance and individual private insurance under the waiver, develop administrative rules and monitor systems changes for eligibility and claims adjudication, and develop and monitor program expenditures related to the budget neutrality concepts of the waiver and the special terms and conditions as required by CMS. Under the special terms and conditions, DPHHS expects CMS to require an evaluation of the waiver proposal similar to the one required under the existing Basic Medicaid waiver. This includes waiver expenditure reporting, quality assurance activities, and analysis of the demonstration project. This administrative cost is likely to

require surveys of clients, analysis of claims data, and research of publications in relation to the waiver proposal. DPHHS intends to cover any new administrative and staffing costs within the funding allocated for the enhancement of MMIS.

In addition, HB 667 provides funding for eligibility determination and other program management functions in the administration of the waiver with the State Auditor's Office and the small business insurance pool board. DPHHS estimates it will need two FTEs to administer the program and coordinate functions: one FTE to handle new eligibility workload and one FTE to provide program management of the premium assistance and incentive payments with the State Auditor's Office and the purchasing pool. Funding is also available for systems changes that may be necessary for eligibility and payment and accounting of premiums. The Department will coordinate staffing and systems development costs authorized by the legislature to the fullest extent possible to efficiently utilize resources and coordinate staffing and benefits.

The waiver proposal presented to the 2005 Legislature included \$800,000 in state funds over the first two years of the waiver to be matched at a 90/10 federal and state matching rate in order to provide a total of \$8 million dollars for enhancements to the Medicaid Management Information Systems (MMIS). However, the amount of funding dedicated for MMIS under the enhanced match rate will be less than \$8 million depending on the resources needed for staffing and other administrative costs. Staffing and other administrative costs are claimed at a 50/50 match rate. Based on the fiscal note prepared for Senate Bill 110, additional staffing costs are estimated to be approximately \$125,000 state fund cost per year and other administrative costs are estimated to be \$75,000 state fund cost per year to administer, enroll and provide support services for this waiver proposal. Required system changes that result from the waiver will be funded with the money allocated to MMIS in the proposal.

Based on these estimates, the amount of funding set aside for MMIS is significantly more than the cost of any administrative costs and potential systems changes that relate directly to the waiver. Therefore, the Department proposes to utilize the remainder of the state funding refinanced under this waiver for a series of broader MMIS system changes that are necessary to ensure the continued viability of MMIS as a whole. The current MMIS was reprocured in 1997 and needs to be updated with current technology in the health care delivery system. The Department proposed to conduct a requirements analysis of the functionality of the system, enhancements, and design to develop and reprocure a new MMIS to ensure the continued viability of MMIS for the future. The funding under this proposal will lay the foundation to develop a financial plan and timeline in a reprocurement effort for the design and implementation of a new MMIS by state fiscal year 2009.

Nurse First Advice Line: DPHHS proposes offering a value added service to all beneficiaries under this waiver. The service is a 24 hour 7 day a week, toll free nurse advice line staffed by licensed, registered nurses. Medicaid clients are encouraged to call the nurse line anytime they are sick, hurt, or have a health concern. Nurses ask questions about callers' symptoms using clinically based algorithms, then direct them to seek the appropriate level of services at the appropriate time. Levels of care recommended range from emergency room to self-care at home. Nurses do not diagnose or provide treatment. The program is voluntary though participation is strongly encouraged.

The Nurse First Advice Line is expected to lower costs both through direction to lower levels of care where appropriate (self care instead of doctor visit) and through direction to higher levels of care where appropriate, which can prevent costly hospital stays and extended illnesses. The Department believes this value added

service will work in conjunction with other providers and will assist the beneficiaries to more efficiently utilize their benefits.

The Nurse First Advice Line began in January 2004, is available to all Medicaid beneficiaries, and is administered by an external vendor. Payment for these services is based on a PMPM basis that varies based on utilization.

Since inception the Nurse First Advice Line has been providing assistance to all Medicaid recipients. Below are several comments received from Medicaid recipients describing the positive impact the Nurse First Advice Line has had on their health care.

Comment from a mom of a 16-year-old child: "I love this hotline, it really is helpful as I don't want to go to the ER unless it is really necessary."

Comment from a mom of a 4-year-old child: "You guys are wonderful. I called one time about my other son and you guys told me to take him to the ER and he was diagnosed with pneumonia. You saved his life, thank you, thank you, please tell your supervisors what a wonderful job you do."

ATTACHMENT A: MHSP ELIGIBILITY AND SERVICES

MHSP Eligibility: In order to be eligible for MHSP an individual must meet clinical, financial and age criteria established by the Department.

1. The individual must have been determined to have a severe disabling mental illness by a licensed mental health professional. This determination includes an assessment of diagnosis, functional impairment, and duration of illness.
2. The individual must have a family income equal to or less than 150% of the Federal Poverty Level (FPL). Determination of financial eligibility will be made by the Department. Determination does not include a test of assets.
3. The individual must be currently ineligible for Medicaid as determined by the Department's Public Assistance Bureau.
4. The individual must be at least 18 years of age.

MHSP Clinical and Therapeutic Services: MHSP is currently administered by four community mental health centers under contract with AMDD. Each mental health center provides services in a multi-county area of the state. Medically necessary services include medication management by medical practitioners and related laboratory services, outpatient individual and group therapies provided by psychologists, licensed social workers or licensed professional counselors, rehabilitation services such as assertive community treatment, psychiatric rehabilitation and therapeutic support services. As appropriate, clients may receive additional support services for coordination of benefits, treatment planning, linkage and referral.

MHSP Pharmacy Services: MHSP includes a limited pharmacy benefit that covers medically necessary psychotropic medications that are prescribed for the treatment of symptoms of covered diagnoses. The pharmacy benefit is limited to \$425 per person per month. MHSP recipients who require medications that exceed the monthly limit are responsible for paying for the additional cost with their own funds. MHSP also requires that recipients make co-payments of \$17.00 per prescription for brand name drugs and \$12.00 for generic drugs. AMDD allocates \$75,000 per year to the contracted mental health centers for assistance to eligible MHSP beneficiaries who are unable to afford the costs of medications that exceed the \$425/month cap. MHSP reimburses pharmacies at the Medicaid rate for each drug.

ATTACHMENT B: CHIP HEALTH CARE BENEFIT

Eligibility:

Children until age 19

Montana residents

US citizens or qualified aliens

Not currently insured or covered by health insurance in the past 3 months

Not eligible for Medicaid

Parents not employed by the State of Montana or the Montana University System

Family income equal to or less than 150% FPL

There are no asset or resource tests. (An asset test or resource test is the determination of financial eligibility based on the investigation of the household's current and future circumstances. Any resources owned must be evaluated for accessibility, value and exclusion status when making eligibility determinations. The projection of resources is compared to the resource limitation at the time of application, for every ensuing benefit month until eligibility is redetermined or until a change in the household's circumstances occurs.)

Co-payments: The maximum co-payment for a family is \$215 per benefit year (October 1 through September 30). Some families will pay a small co-payment when services are received.

No co-payment for well-baby or well-child care, including age-appropriate immunizations

No co-payment for dental services

\$25 each inpatient hospital visit

\$5 each emergency room visit

\$5 each outpatient hospital visit

\$3 each physician visit

\$3 each generic prescription drug

\$5 each brand-name prescription drug

Services Covered:

Physician, Physician Assistants and Advance Practice Registered Nurses

Inpatient and outpatient hospital services

Routine sports or employment physicals

Clinic and ambulatory health care services

Laboratory and radiological services

Inpatient, outpatient, and residential mental health services

Inpatient, outpatient, and residential substance abuse treatment services

General anesthesia services

Eyeglasses, dental services

Prescription drugs

Vision exams

Hearing exams

Surgical services

ATTACHMENT C: TRANSITIONAL MEDICAID ADULTS ELIGIBILITY

Transitional Adults are those adults who have received Section 1931 Medicaid for at least three of the six months immediately preceding closure of Section 1931 Medicaid due to a qualifying event.

A qualifying event is when Section 1931 Medicaid coverage closes due to new or increased earned income of the assistance unit. Transitional Medicaid (TMA) is broken into two six-month periods.

For the first six months of TMA, the family must:

1. Contain at least one qualifying child,
2. Maintain Montana residency, and
3. Continue to cooperate with Child Support Enforcement Division.

For the second six months of TMA, the family must:

1. Contain at least one qualifying child,
2. Maintain Montana residency,
3. Continue to cooperate with Child Support Enforcement Division
4. Continue to be employed or have good cause for loss of employment,
5. Have countable income equal to or less than 185% FPL and
6. Meet TMA reporting requirements (complete and submit quarterly reports in the fourth, seventh and tenth months of TMA coverage).

ATTACHMENT D: OVERVIEW OF MCHA

Executive Summary: The Montana Comprehensive Health Association (MCHA) was created by the Montana Legislature to provide health insurance to people who are uninsurable in the private market due to their medical conditions, and who are also ineligible for public healthcare benefit programs such as Medicaid. The federal government recently approved a request from the state of Illinois for a waiver to federal Medicaid and S-CHIP regulations that enabled them to secure federal funding for low income people served through the Illinois Comprehensive Health Insurance Program (ICHIP), a program whose mission and operation appear to be very similar to that of MCHA. An initial comparison of MCHA and ICHIP confirms that the two programs have much in common and as a result Montana should consider exploring the potential for funding a portion of MCHA benefits through a federal Medicaid waiver, similar to the one already secured by Illinois.

Montana Comprehensive Health Association (MCHA): In 1985 the Montana Legislature created the Montana Comprehensive Health Association (MCHA) to establish a program through which health insurance could be made available to Montana residents who are otherwise considered uninsurable due to medical conditions. MCHA serves those Montanans who are not part of the traditional health insurance market because of a preexisting health condition or a significant exclusion of coverage. MCHA provides coverage of “last resort” and is not intended to duplicate coverage from any other source, public or private. MCHA is a private entity, governed by a board of directors made up of five representatives of health insurance carriers doing a high volume of business in Montana, two members-at-large and a public interest member. Coverage under MCHA is administered by Blue Cross and Blue Shield of Montana. The first MCHA policies, currently referred to as the Traditional Plan, were issued in 1987. In 1997, in response to new federal legislation, the Montana Legislature added the MCHA Portability Plan for individuals who lose employer coverage. Both plans offer consumers the choice of two options that require different deductibles, co-pays and out-of-pocket maximums.

MCHA Premium Assistance Pilot Program: In September, 2002 MCHA implemented a “pilot program” providing subsidized premium assistance for persons who qualify for the MCHA Traditional Plan and have family incomes less than or equal to 150% FPL. The pilot program provides the same benefits as the MCHA Traditional Plan, Option A. The premium subsidy is 65% of premium during the preexisting condition waiting period and 55% after the waiting period is met. Pilot program features include: an annual deductible of \$1,000; a 20 percent co-payment; maximum deductible and co-payment expenses during a calendar year of \$5,000; and a lifetime coverage maximum of \$1,000,000. As of June 2005, 200 people are insured through the premium assistance pilot program.

MCHA Premium Assistance Benefits: The Premium Assistance Pilot Program (Traditional Plan, Option A) requires a \$1,000 deductible, 80/20 co-payment, with a \$5,000 out of pocket limit. Coverage includes:

inpatient hospital care	well child care (up to 24 months)
outpatient hospital care	lab and x-ray
home healthcare (180visits/year)	prescription drugs
professional services	ambulance
prosthetics	radiation and chemotherapies
durable medical equipment (\$5,000 max)	maternity services
immunizations	maternity screening, program
services for severe mental illness	mammography
rehabilitation therapy	diabetes education
office visits	surgery and anesthesia

newborn & adopted child care (31 days)
convalescent home care (60 days)

transplants (\$150,000)

Historical MCHA Funding: Prior to the last legislative session, MCHA had three sources of revenue from which to pay claims:

1. An annual one percent assessment on the total amount of all premiums paid to each of the health insurance carriers doing business in Montana by the people they insure - currently about \$5 million per year;
2. The monthly premiums paid to MCHA for health care coverage by insured participants, and
3. A federal grant to be used to fund premium assistance provided through the MCHA pilot program.

Appropriation of State Funds for MCHA by the 2003 Legislature: The 2003 Montana Legislature appropriated \$1,360,563 in State Special Revenue from tobacco settlement proceeds to the Montana State Auditor's Office to help fund the Montana Comprehensive Health Association for the coming biennium. The money is currently being used to pay for premium assistance and/or other health care claims paid by MCHA.

Illinois Comprehensive Health Insurance Plan (ICHIP): The Illinois Comprehensive Health Insurance Plan (ICHIP) provides access to health insurance coverage for certain eligible Illinois residents who have been denied major medical coverage because of their health by private insurers, and to serve as an acceptable alternative mechanism for complying with the individual portability requirements of the federal Health Insurance Portability and Accountability Act (HIPAA). The ICHIP program is governed by a board of directors, the membership of which is defined in Illinois state law, and administered by Blue Cross and Blue Shield of Illinois. The program is funded partly by premiums paid by its participants and, to the extent that premiums do not meet anticipated expenses, by an appropriation from the State's General Revenue Fund and an assessment of all health insurers doing business in the State of Illinois. There are several ICHIP plans available. Premiums vary by gender, age, geographic area, deductible amount (\$500, \$1,000, \$1,500 or \$2,500), and type of plan.

Illinois ICHIP Waiver: In 2002, the federal government approved a request from the state of Illinois for a Medicaid Waiver under the Health Insurance Flexibility and Accountability (HIFA) initiative from the Centers for Medicaid and Medicare Services (CMS). Among other things, the waiver secured federal funding for health care services provided to some low-income individuals served through the Illinois Comprehensive Health Insurance Program.

The descriptions of the ICHIP population and services that follow are taken directly from the "Special Terms and Conditions" that accompanied the Illinois waiver approval letter from CMS:

ICHIP Participants: "ICHIP program participants" are defined as participants in the Illinois Comprehensive Health Insurance Program with net incomes from 0 percent and up to and including 185% FPL who are uninsurable and, by definition, do not have coverage under a group health plan or health insurance coverage as defined in section 2791 of the Public Health Service Act and are not

eligible for Medicaid. No FFP is available for any members of this group who have Medicare or other insurance.

ICHIP Benefits/Cost Sharing: For those individuals included in the ICHIP program, the State will provide inpatient, outpatient, physician's surgical and medical services, laboratory and x-ray services, and pharmacy services. Coinsurance is 20% for preferred providers and 40% for other providers. (Note: A more detailed list of benefits, similar to those available under MCHA, is included in an appendix to the Illinois waiver application.)

Conclusions: After reviewing both the MCHA and ICHIP programs several things are clear:

1. The Montana Comprehensive Health Authority program and the Illinois Comprehensive Health Insurance Program were created for the same purpose, to provide last resort health care coverage to citizens who are uninsurable in the regular health insurance market due to their medical conditions, many of whom have low incomes;
2. While there are some differences in the way the monies are distributed, both programs receive some direct support through an appropriation of state funds;
3. Illinois has already secured approval for a HIFA Waiver, one component of which enables them to access federal funding for health care benefits provided to some low income ICHIP participants; and then used the general fund savings from ICHIP to fund additional health care benefits to other low income uninsured citizens of Illinois.

DPHHS and the State Auditor's Office jointly explored the potential of expanding the scope of the Montana HIFA Waiver proposal to secure federal funding for health care benefits provided to low income MCHA participants and reinvesting any savings to expand or enhance MHSP and/or provide some form of health care coverage for a group of currently uninsured low income Montanans.

ATTACHMENT E: PROPOSED GROUPS AT A GLANCE

Proposed Groups	Financial Eligibility	Service Package	Being Waived
Basic Medicaid Existing 1115 waiver <i>Mandatory group</i>	Section 1925 or 1931 of the Social Security Act	Reduced package of optional services, Nurse First	Comparability
Mental Health Services Plan <i>Expansion Group</i>	Equal to or less than 150% FPL	Mental health services, prescription drugs, physical health*, acute care (short term), Nurse First	Comparability, statewideness, freedom of choice, cost-sharing, EPSDT
Uninsured Working Parents of Children with Medicaid <i>Optional Group</i>	Equal to or less than 200% FPL	Physical health*, Nurse First	Comparability, freedom of choice, cost-sharing
Uninsured Children <i>Optional Group</i>	Equal to or less than 150% FPL	Benefit package that mirrors CHIP benefit, Nurse First	Comparability, freedom of choice, cost-sharing, EPSDT
Uninsured former SED foster youth ages 18 through 20 <i>Optional Group</i>	Equal to or less than 150% FPL	Benefit package that mirrors CHIP benefit, enhanced mental health, transition life skills, Nurse First	Comparability, statewideness, freedom of choice, cost-sharing, EPSDT
MCHA <i>Expansion Group</i>	Equal to or less than 150% FPL	Insurance premium assistance, Nurse First	Comparability, freedom of choice, cost-sharing
1) Uninsured working adults 19 to 65 who have children under age 21 2) Uninsured working youth ages 18 to 21 <i>Optional Group</i>	Equal to or less than 200% FPL	Insurance premium assistance, insurance pool, premium incentives for employers, Nurse First	Comparability, freedom of choice, cost-sharing, EPSDT

*Physical Health = average of \$166 per month

- For insurance from employer
- For private insurance
- For a health care account

Nurse First Benefit: See description on pages 46 and 47

Sections being waived from 1902 of the Social Security Act:

Comparability–Section 1902(a)(10)(A): Services, eligibility methods and standards will apply to all individuals receiving medical assistance under any approved State Plan.

State-wideness–Section 1902(a)(1): Services, eligibility methods and standards will be in effect in all political subdivisions of the State.

Freedom of Choice–Section 1902(a)(23): Individuals eligible for medical assistance may obtain assistance from any qualified provider that is enrolled as a Medicaid provider.

EPSDT–Section 1902(a)(43): Individuals eligible for medical assistance and under the age of 21 are provided Early and Periodic Screening, Diagnostic and Treatment services whereby medically necessary screening and treatment services must be provided.

Cost-Sharing–Section 1902(a)(14)/Section 1916: Any deduction, cost sharing, or similar charge imposed under the plan on other individuals or other care and services will be nominal in amount.

ATTACHMENT F: MINIMUM BENEFITS FOR PRIVATE INSURANCE

Under the waiver proposal the recipients will be able to purchase group health insurance from their employer or private individual insurance. While the Department of Public Health and Human Services (DPHHS) to allow the recipients to purchase the health insurance that best meets their needs, DPHHS recognizes they need to establish a minimum level of benefits that recipients can purchase. Below is a summary of benefits that outlines the minimum benefits. It is important to note that health insurance purchased by a recipient may vary from these benefits, but the overall benefits may exceed or be the equivalent of these benefits.

Covered Services	Copayment	Limitations and Additional Information: All services except pharmacy are subject to the \$10,000 maximum per benefit period
Physician Visits	\$20 per visit	Six (6) per benefit period
Walk-in Clinics/Urgent Care	\$40 per visit	Applies to the 6 office visit limit
Well Child Care	\$20 per visit	Not included in the 6 office visit limit
Inpatient Hospital	\$500 per yr	
Outpatient Hospital	None	\$1,000 maximum per benefit period
Professional provider visits while in the hospital	None	Through age 24 months
Emergency Room	\$75 per visit	Does not accumulate to the \$1,000 Outpatient Hospital maximum
Hospice Care	None	
Mammograms	None	Pays the lesser of \$70 or the actual charge
Medical Supplies and devices	None	
Deductible	None	No deductible, but copayments do apply
Maximum benefits	\$10,000 per year	All expenditures count toward this maximum Except prescription drugs.
Prescription Drugs	Generic \$20 Formulary: Brand name \$30 Non-formulary \$45	Annual maximum limit of \$200

To illustrate how these minimum benefits will be used see examples below:

Example 1: If a health insurer covers physician services with a \$10 copayment, this plan has met the minimum benefits under this waiver.

Example 2: If a health insurer has a \$500 deductible, the plan does not meet the minimum benefits, but if they also have a \$1,000,000 maximum lifetime benefit, they have met the minimum benefits and the overall benefits exceed the minimum benefits.

ATTACHMENT G - Summary of Transitional Mental Health Services available to SED youth to assist in their successful transition to adulthood

CHIP Mental Health	Additional Mental Health	Wraparound Facilitator	MFCIP
<ul style="list-style-type: none"> • Mental health benefits include: • inpatient services furnished by public or private licensed and qualified practitioners in a hospital, including a state-operated mental hospital, a residential service or a partial hospitalization program. • outpatient services furnished by public or private licensed and qualified practitioners in a community based setting or in a mental hospital. • Mental health benefits are limited to: • 21 days of inpatient mental health care per benefit year; • partial hospitalization benefits which are exchanged for inpatient days at a rate of two partial treatment days for one inpatient day; or • 20 outpatient visits per year, which can be furnished in community-based settings or in a mental hospital. 	<ul style="list-style-type: none"> • Medication management and consultation * • Individual psychotherapy * • Group psychotherapy *, and • Develop of community based mentor relationship. <p>* The recipient will first use their CHIP mental health benefits before becoming eligible for these additional services. These additional services will require prior authorization by the department or their designee before treatment can begin.</p>	<ul style="list-style-type: none"> • Community based plan to assess the patient needs and skill development plan, goals, objectives, responsibilities, timelines, outcomes and performance measures. • Training and instruction to develop “intangible” life skills, defined as problem solving, decision-making, impulse control and critical thinking. These skills are needed before the individual can fully comprehend and learn “tangible” life skills. • Monitoring waiver services (physical health and mental health) and budgets or service limits. • Collaboration and coordination with other services; such as MFCIP, affordable housing, and other poverty related programs. • Training and instruction to develop social interaction skills 	<ul style="list-style-type: none"> • Tangible life skills are defined to include; • Health promotion and preventative health services, • budgeting and financial management, • healthy nutrition habits, • work skills to remain in the community, • sex offender treatment; and • knowledge of community support. <p>In addition to these services the individuals are eligible for certain stipends and financial assistance to help with secondary education, housing and household goods, travel assistance and job readiness.</p>

ATTACHMENT H-MEDICAID ELIGIBILITY GROUPS

Program	Living Arrangement	Age Limit	Income Limit	Resource Limit	Target Population
Family Medicaid (FM)	Child must live with a specified relative; adult must have eligible child in home	Children 0 to 19 years; adults	Benefit Standard/ Medically Needy	\$3000	Families with children age 0 to month of 19 th birthday. Adult may be covered if not medically needy
Poverty Pregnant Women (PW)	NA	NA	133% FPL	\$3000	Pregnant women of any age
Qualified Pregnant Women (QP)	NA	NA	Medically Needy	\$3000	Pregnant women of any age who are over income for PW
Automatic Newborn (AN)	Child must continue to live with mother	Birth through month of first birthday	NA	\$3000	Children birth through month of 1 st birthday whose mother was eligible for and receiving Medicaid at time of child's birth
Poverty Child (PC)	Child may be living independently or with adult who is not a specified relative	Birth to 6 years	133% FPL	\$3000	Children birth through month of 6 th birthday
Poverty Six Child (PS)	Child may be living independently or with adult who is not a specified relative	6 to 19 years	100% FPL	\$3000	Children age 6 through month of 19 th birthday
Ribicoff Child (RK)	Child may be living independently	0 to 19 years	Benefit Standard/ Medically Needy	\$3000	Children birth through month of 19 th birthday
Subsidized Adoption (AD)	Child is living with adoptive parents	0 to 21 years	NA	NA	Adopted children with special needs. Medicaid coverage guaranteed with adoptions. If IV-E, may be eligible through month of 18 th birthday or High School graduation. If CWS, may be eligible through month of 21 st birthday
Foster Care IV-E (FF)	Child in paid foster care placement	0 to 18 years; or High School graduation	1996 AFDC standards	\$10000-initial IV-E determination \$2000/\$3000 Medicaid	Foster children who are IV-E eligible

Program	Living Arrangement	Age Limit	Income Limit	Resource Limit	Target Population
Foster Care – CWS (FW)	Child in paid foster care placement	0 to 21 years	Benefit Standard/ Medically Needy	\$3000	Foster children who do not meet IV-E eligibility requirements (excess income, etc)
Cont. Elig – Pregnant Woman (CP)	NA	NA	NA	\$3000	Pregnant women who lost Medicaid due to increased income. Coverage continues throughout pregnancy.
Extended Pregnant Woman (EP)	NA	NA	NA	None	Pregnant woman who were receiving Medicaid at time of the child’s birth
Extended Medicaid (TR)	Child must live with specified relative	Children birth through month of 19 th birthday; adults	1 st 6 months: none 2 nd 6 months: 185% FPL	None	Families whose non-medically needy FM closes due to increased earned income. Eligible for maximum of 12 consecutive months.
Extended Child/Spousal Support (EC)	Child must live with specified relative	Children birth through month of 19 th birthday; adults	NA	None	Families whose non-medically need FM closes due to new or increased child/spousal support. Eligible for up to 4 consecutive months.
Breast & Cervical Cancer Treatment (BC)	N/A	Under 65	200% FPL	None	Women screened through MBCHP who are subsequently diagnoses with breast and/or cervical cancer or precancer. Cannot have ‘creditable coverage’ or be eligible for any other non-medically needy Medicaid program.
Institutionalized - Aged (IA)	Living in a nursing home	Age 65 or older	Must not exceed cost of care	\$2000*	Institutionalized (nursing home) residents age 65 or older
Institutionalized-Disabled (ID)	Disabled individual under age 65 in nursing home or residential treatment facilities	Up to age 65	Must not exceed cost of care	\$2000*	Institutionalized individuals who meet SSA disability definition

Program	Living Arrangement	Age Limit	Income Limit	Resource Limit	Target Population
MA-Aged (MA)	Non-institutional community living	Age 65 or older	None Over SSI payment rate = must meet incurment	\$2000 or an individual \$3000 for a couple	Non-institutionalized individuals/couples over age 65
MA-Blind (MB)	Non-institutional community living	NA	None Over SSI payment rate must meet incurment	\$2000 for an individual \$3000 for a couple	Blind individuals/couples who meet SSA blind definition
MA-Disabled (MD)	Non-institutional community living	Up to age 65	None Over SSI payment rate = must meet incurment	\$2000 for an individual \$3000 for a couple	Non-institutionalized individuals/couples under age 65 who meet SSA disability definition
SSI-SSP Aged (SA)	Non-institutional community living	Age 65 or older	NA	\$2000 for an individual \$3000 for a couple	Recipients of SSI cash benefits who are age 65 or older
SSI-SSP Blind (SB)	Non-institutional community living	NA	NA	\$2000 for an individual \$3000 for a couple	Blind SSI cash recipients
SSI-SSP Disabled (SD)	Non-institutional community living	NA	NA	\$2000 for an individual \$3000 for a couple	Disabled SSI cash recipients
Waiver Aged (WA)	Individual over age 65 in the community or in a personal care home	Age 65 or older	NA	\$2000 for an individual	Those who would be eligible for nursing home care but choose to remain in the community
Waiver Disabled (WD)	Disabled individual under the age of 65 in the community or in a personal care home	Up to age 65	NA	\$2000 for an individual	Those who would be eligible for nursing home care but choose to remain in the community
Waiver Other (WO)	Group home for Developmentally Disabled individuals	NA	NA	\$2000 for an individual \$30-00 for a couple	Those who would be eligible for intermediate care facility for the mentally retarded
QMB-Aged (QA)	NA	65 and older	<\$798– one <\$1070– two	\$4000 – one \$6000 – two	Medicare beneficiaries under age 65

Program	Living Arrangement	Age Limit	Income Limit	Resource Limit	Target Population
QMB – Disabled (QD)	NA	Under age 65	<\$798– one <\$1070– two	\$4000 – one \$6000 – two	Medicare beneficiaries under age 65
SLMB	NA	NA	<\$957– one <\$1283- two	\$4000 – one \$6000 – two	Medicare beneficiaries over QMB income limit but under QI-1 limit
QI-1	NA	NA	<\$1077– one <\$1444- two	\$4000 – one \$6000 – two	Medicare beneficiaries over SLMB income limit

- If applicant has a spouse, spouse is entitled to a minimum of \$19,020 or a maximum of ½ of all resources up to \$95,100.

QMB: Medicaid pays: Medicare Part A Premium (if applicable)
 Medicare Part B Premium
 Medicare Deductibles
 Medicare Co-Insurance

QI & SLMB: Medicaid pays: Medicare Part B Premium only