



MONTANA DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

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***Montana Medicaid Part D Prescription Drug Program
Section 1115 Waiver
For Health Care Reform
DRAFT***

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SECTION 1115 WAIVER
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MEDICAID PART D PRESCRIPTION DRUG PROGRAM WAIVER FLOWCHART

**Montana Medicaid Part D Prescription Drug Program
Section 1115 Waiver
For Health Care Reform
EXECUTIVE SUMMARY**

The State of Montana, Department of Public Health and Human Services (DPHHS), informally submits this Montana Medicaid Part D Prescription Drug Program Section 1115 Waiver demonstration initiative designed, “To provide citizens of Montana access to Medicaid drug pricing to increase affordable prescription drug coverage.”

Insured In Montana

The Kaiser Family Foundation report estimated there were over nine million (9,073,366) prescriptions filled in 2005 by retail pharmacies in Montana (this estimate did not include mail order pharmacies).⁽³⁾ An annual 2009 estimate of the Montana population of 974,989 shows 15.9% are without health insurance. This means almost one in six residents do not have private or public health insurance. Health insurance is highly correlated with pharmacy benefits, so a lack of health insurance indicates a lack of pharmacy benefits.

A study by the Kaiser Family Foundation shows that about 98% of health insurance plans offered by employers have some form of pharmacy benefit. This implies that residents with health insurance will most likely have some coverage to reduce the out-of-pocket expenses for medications. Another source indicates that 20% of families with at least one person working fulltime were uninsured.⁽³⁾

In Montana, 45% of private employers offer health insurance benefits.⁽³⁾ Availability of benefits varies by size of the business with 36.3% of employers with fewer than 50 employees providing health insurance compared to 94.7% of employers with 50 or more employees.⁽³⁾

To contain costs related to pharmaceuticals, many health insurance plans and pharmacy benefit managers have excluded coverage for some high-cost medications through multiple tier systems and/or increased patient cost-sharing fees for any given tier.⁽²⁾ Since 2000, the percent of individuals with employer-based health insurance whose pharmacy benefits have added third and fourth copayment tiers has almost tripled (27% to 74%). The additional tiers represent added financial burden on the patient.

In 2003, approximately 14.2% of Montanans were living below the Federal poverty level.⁽⁵⁾ The percent of the population below poverty ranged from 9.2% in Jefferson County up to 26.2% in Roosevelt.⁽⁶⁾ The number of residents living below Federal poverty rates has implications for inability to afford health insurance or out-of-pocket health care costs such as prescriptions.

Although prescription medications comprise only one-tenth of the all healthcare spending, they are one of the most apparent expenses to the patient. Prescription services involve an out-of-pocket expense for virtually everyone. It is one of the most immediate felt costs associated with healthcare. Just over half (54%) of all out-of-pocket healthcare expenses are related to prescriptions.⁽⁴⁾ Even insured patients will likely have expenses in the form of co-payments and deductibles for their prescription medications. In 2004, prescriptions accounted for 9.1% of personal health expenditures.⁽³⁾

Waiver Purpose

The purpose of this waiver is to remove barriers to pharmacy coverage for Montanans by extending Medicaid eligibility for a Medicaid prescription drug benefit through a Section 1115 Waiver. The prescription drug benefit is to offer prescription drugs at a lower price, which is the Medicaid best price, to all Montana residents regardless of insurance status. Best price will be achieved in a two step process, first by offering Medicaid drug pricing at the pharmacy counter and passing on associated Medicaid drug rebates, net of administrative costs.

Waiver Population

Montana residents regardless of insurance status and up to 200 percent of Federal Poverty Level (FPL) (income above this level will be disregarded) will be eligible to enroll. Individuals must be U.S. citizens and must apply. Enrollment will be voluntary. The waiver population does not include otherwise enrolled Medicaid individuals, those already enrolled in Medicaid through the State Plan or other Medicaid waivers. The population will not be capped.

Pharmacy Benefit Administrator (PBA)

Montana negotiates the best Medicaid drug price with pharmaceutical drug manufactures. The best price may be achieved through a drug rebate program. This benefit will be extended to all U.S. citizens who are residents of Montana that apply for the Montana Medicaid Part D Prescription Drug Program Section 1115 Waiver.

Drug Program Benefit

The waiver will offer Medicaid prescription drug pricing for Montana Medicaid covered prescription drugs to waiver enrollees. Waiver enrollees will be issued a Medicaid Part D Prescription Drug Program Waiver card. Uninsured waiver individuals will pay the Medicaid price. Waiver individuals with Third Party Liability (TPL) will pay the TPL cost share up to the Medicaid drug price. TPL pays the pharmacy the TPL price. TPL benefits for otherwise insured individuals will not change. The Medicaid waiver will only apply to drugs covered by the State Plan Medicaid Pharmacy Program. We will not provide wrap around pharmacy services.

Prescription Drug Card

The Medicaid Part D Prescription Drug Program Waiver card will identify the waiver individual and include the phone number for the program. Participating providers, including out of state providers, will be reimbursed at the Medicaid rate.

Cost Share

The Medicaid Part D Prescription Drug Program Waiver does not require cost share. Individuals will continue to be responsible for the amount of TPL cost share up to the Montana Medicaid drug allowed amount.

Reimbursement Process

- *Waiver individuals, regardless of insurance status, will present the Medicaid Part D Prescription Drug Program Waiver card at the pharmacy.*
- *Uninsured individuals will pay the Medicaid price for the Medicaid covered drug at the counter. The waiver will not cover prescription drug wrap around services. The pharmacy will submit the claim to DPHHS Medicaid. DPHHS Medicaid will process claims for the sole purpose of*

collecting drug rebates for all Medicaid covered drugs. Drug rebates will be distributed periodically, net of administrative costs.

- *Individuals with TPL will continue to pay the plan required cost share at the pharmacy not to exceed the Medicaid drug allowed amount. The waiver will only apply to drugs covered by the State Plan Medicaid Pharmacy Program. We will not cover prescription drug wrap around services.*

TPL will pay the TPL amount to the pharmacy for the prescription as primary payer. The pharmacy will submit the claim to DPHHS Medicaid. DPHHS Medicaid will process claims for the sole purpose to collect drug rebate for all Medicaid covered drugs. Drug rebates will be distributed periodically, net of administrative costs.

State Plan Prescription Drug Program

Medicaid will continue to process prescription drug claims in the same manner for non-waiver Medicaid State Plan Pharmacy Program services. The Medicaid State Plan Pharmacy Program will receive the negotiated best price as does the waiver.

Medicaid covers legend drugs; some prescribed over-the-counter products manufactured by companies who have a signed Federal rebate agreement; some vaccines; compound prescriptions; and contraceptive supplies and devices.

State Plan Pricing Methodology

Medicaid reimbursement for drugs shall not exceed the lowest of: 1) The Estimated Acquisition Cost (EAC) of the drug plus a dispensing fee; or 2) The Federal Upper Limit (FUL), Maximum Allowable Cost (MAC) of the drug, plus a dispensing fee; or, 3) The State Maximum Allowable Cost (SMAC) of the drug, plus a dispensing fee; or, 4) The provider's usual and customary charge of the drug to the general public. See IV. State Specific Elements, E. Benefit Package for the Medicaid pricing methodology.

Individuals otherwise enrolled in Medicaid have the State Plan prescription drug benefit, which remains unchanged.

Federal and State Waiver Cost

The uninsured individual pays the best Medicaid price for Medicaid covered prescription drugs. The TPL will continue to pay the pharmacy the TPL reimbursement. The Medicaid waiver will only apply to drugs covered by the State Plan Medicaid Pharmacy Program. We will not provide wrap around pharmacy services.

Federal and State governments will share in administrative costs for system changes, eligibility staff, and rebate staff.

I. GENERAL DESCRIPTION

This demonstration will extend pharmacy coverage to all Montana residents in a fashion that furthers public, private, and individual fiscal responsibility. The demonstration is designed to assist Montanans by offering access to afford prescription drug coverage by enrolling them in the Medicaid Part D Prescription Drug Program Waiver. The prescription drug benefit is to offer prescription drugs at a lower price, which is the Medicaid best price, to all Montana residents regardless of insurance status. Best price will be achieved in a two step process, first by offering Medicaid drug pricing at the pharmacy counter and passing on associated Medicaid drug rebates, net of administrative costs.

DPHHS will negotiate the best price for Medicaid covered prescription drugs with pharmaceutical drug manufactures. The best price may be achieved through a drug rebate program. The waiver will offer Medicaid prescription drug pricing for Montana Medicaid covered prescription drugs to waiver enrollees.

Medicaid Prescription Drug Program Waiver enrollment is voluntary and is not capped. Montana residents regardless of insurance status and up to 200 percent of FPL (income above this level will be disregarded) will be eligible to enroll. Individuals must apply and must not be otherwise enrolled in Medicaid. Waiver enrollment will be entered into the CHIMES eligibility system unless it is determined that another DPHHS eligibility system will be less expensive and time consuming to modify for waiver enrollment. DPHHS will issue Medicaid Part D Prescription Drug Program Waiver cards to waiver enrollees.

The waiver will offer Medicaid prescription drug pricing for Montana Medicaid covered prescription drugs to waiver enrollees. Waiver enrollees will be issued a Medicaid Part D Prescription Drug Program Waiver card. Uninsured waiver individuals will pay the Medicaid price. Waiver individuals with Third Party Liability (TPL) will pay the TPL cost share up to the Medicaid drug price. TPL pays the pharmacy the TPL price. TPL benefits for otherwise insured individuals will not change. The Medicaid waiver will only apply to drugs covered by the State Plan Medicaid Pharmacy Program. We will not provide wrap around pharmacy services. Pharmacies will send, via any acceptable claims format, all waiver enrollee prescription drug claims to the DPHHS MMIS claim system.

DPHHS Medicaid will process the claim for the sole purpose of collecting drug rebate for all Medicaid covered drugs. Medicaid will pass on associated drug rebates, net of administrative costs.

Medicaid will continue to process prescription drug claims in the same manner for non-waiver Medicaid State Plan Pharmacy Program services. Medicaid State Plan Pharmacy Program will receive the negotiated best price as does the waiver.

This prescription drug benefit will not cost the Federal or State government in benefits. The uninsured individual pays the best Medicaid price for Medicaid covered prescription drugs. The TPL will continue to pay the pharmacy the TPL reimbursement. Medicaid will not provide wrap around pharmacy services for Medicaid Part D Prescription Drug Program Waiver enrolled individuals. Federal and State governments will share in administrative costs for system changes, eligibility staff, and rebate staff. These costs will be funded by rebate collections.

See Figure VI. Draft Timeline for Medicaid Part D Prescription Drug Program Waiver for waiver activity proposed completion dates.

II. DEFINITIONS

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

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

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

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

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

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

TPL: Is defined as Medicare, IHS, private insurance or VA.

III. HIFA DEMONSTRATION STANDARD FEATURES

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

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

IV. STATE SPECIFIC ELEMENTS

A. Upper Income Limit:

Montana residents regardless of insurance status and up to 200 percent of FPL (income above this level will be disregarded) will be eligible to enroll. Individuals must be U.S. citizens and must apply. Enrollment will be voluntary. The waiver population does not include otherwise enrolled Medicaid individuals, those already enrolled in Medicaid through the State Plan or other Medicaid waivers. The population will not be capped.

B. Eligibility:

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

Mandatory Populations (as specified in Title XIX)

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

Optional Populations (included in the existing Medicaid State Plan)

Categorical

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

Medically Needy

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

Additional Optional Populations

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

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

Existing Expansion Populations

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

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

New Expansion Populations

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

- Pregnant Women in SCHIP (This category will include individuals from ___ percent FPL through ___ percent FPL.)

Other. Please specify:

Medicaid Eligibility Group (MEG) 1) Medicaid Part D Prescription Drug Program Waiver Individuals – Eligibility Criteria

Medicaid Part D Prescription Drug Program Waiver enrollment is voluntary and is not capped. Montana residents regardless of insurance status and up to 200 percent of FPL (income above this level will be disregarded) will be eligible to enroll. Individuals must be U.S. citizens. Individuals must apply and must not be otherwise enrolled in Medicaid. The waiver does not induce individuals with private health insurance coverage to drop their current coverage as this is a Medicaid best prescription drug price pharmacy benefit only.

Eligibility determinations for Medicaid Part D Prescription Drug Program Waiver individuals will be processed by eligibility staff at DPHHS. Eligibility will be accomplished through the CHIMES or other cost effective DPHHS eligibility system.

C. Enrollment/Expenditure Cap:

- No Yes If Yes, Number of participants or dollar limit of demonstration (express dollar limit in terms of total computable program costs).

D. Phase-In:

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

The HIFA demonstration will be implemented at once.

The HIFA demonstration will be phased-in.

If applicable, please provide a brief description of the State's phase-in approach (including a timeline): *N/A*

E. Benefit Package:

Montana will negotiate the best Medicaid drug price with pharmaceutical drug manufactures. The best price may be achieved through a drug rebate program. The waiver prescription drug benefit is to offer Medicaid prescription drug pricing for Montana Medicaid covered prescription drugs to all Montana residents regardless of insurance status. The prescription drug price is the Medicaid best price. Best price will be achieved in a two step process, first by offering Medicaid drug pricing at the pharmacy counter and by passing on associated Medicaid drug rebates, net of administrative costs.

Waiver enrollees will be issued a Medicaid Part D Prescription Drug Program Waiver card. Uninsured waiver individuals will pay the best Medicaid price. Waiver individuals with TPL will pay the TPL cost share up to the Medicaid drug price. TPL pays the pharmacy the TPL price. TPL benefits for otherwise insured individuals will not change. The Medicaid waiver will only apply to drugs covered by the State Plan Medicaid Pharmacy Program. We will not provide wrap around pharmacy services.

The Medicaid State Plan Pharmacy Program covers legend drugs; some prescribed over-the-counter products manufactured by companies who have a signed Federal rebate agreement; some vaccines; compound prescriptions; and contraceptive supplies and devices.

Services or prescription drugs not covered under the State Plan Pharmacy Program will not be reimbursed by the waiver. The following is the State Plan Pharmacy Program pricing methodology:

Prescription Drug Reimbursement:

Reimbursement for drugs shall not exceed the lowest of:

1. The Estimated Acquisition Cost (EAC) of the drug plus a dispensing fee, or;
2. The Federal Upper Limit (FUL), if applicable, plus a dispensing fee, or;
3. The State Maximum Allowable Cost (SMAC) of the drug, in the case of multi-source (generic), plus a dispensing fee, or;
4. The provider's usual and customary charge of the drug to the general public.

Exception: The FUL or SMAC limitation shall not apply in a case where a physician certifies in his/her own handwriting the specific brand is medically necessary for a particular recipient. An example of an acceptable certification is the handwritten notation "Brand Necessary" or "Brand Required." A check off box on a form or rubber stamp is not acceptable.

Exception: For outpatient drugs provided to Medicaid recipients in state institutions, reimbursement will conform to the state contract for pharmacy services; or for institutions not participating in the state contract for pharmacy services, reimbursement will be the actual cost of the drug and dispensing fee. In either case, reimbursement will not exceed, in the aggregate, the EAC or the SMAC plus the dispensing fee.

The EAC is established by the state agency using the Federal definition of EAC as a guideline: that is, "Estimated Acquisition Cost" means the state agency's best estimate of what price providers generally pay for a particular drug.

The EAC, which includes single source, brand necessary and drugs other than multi-source, is established using the following methodology:

Drugs paid by their Average Wholesale Price (AWP) will be paid at AWP less 15 percent. If the state agency determines that acquisition cost is lower than AWP less 15 percent then the state agency may set an allowable acquisition cost based on data provided by the drug pricing file contractor.

The SMAC for multiple-source drugs shall be based on actual acquisition cost (AAC) data as determined by wholesaler/manufacturer data, direct pharmacy survey and other relevant cost information as reported in published national compendia (e.g., First DataBank, Medi-Span or the Red Book).

A variable dispensing fee will be established by the state agency. The dispensing fee is based on the pharmacy's average cost of filling a prescription. The average cost of filling a prescription will be based on the direct and indirect costs that can be allocated to the cost of the prescription department and that of filling a prescription, as determined from the Montana dispensing fee questionnaire.

A provider's failure to submit, upon request, the dispensing fee questionnaire properly completed will result in the assignment of the minimum dispensing fee offered. A copy of the Montana dispensing fee questionnaire is available upon request from the department.

Dispensing fees shall be established as follows:

- 1. The dispensing fees assigned shall range between a minimum of \$2.00 and a maximum of \$5.04.*
- 2. Out-of-state providers will be assigned a \$3.50 dispensing fee.*
- 3. If the individual provider's usual and customary average dispensing fee for filling prescription is less than the foregoing method of determining the dispensing fee, then the lesser dispensing fee shall be applied in the computation of the payment to the pharmacy provider.*

In-state pharmacy providers that are new to the Montana Medicaid program will be assigned an interim \$5.04 dispensing fee until a dispensing fee questionnaire can be completed for six months of operation. At that time, a new dispensing fee will be assigned which will be the lower of the dispensing fee calculated for the pharmacy or the \$5.04 dispensing fee. Failure to comply with the six months dispensing fee questionnaire requirement will result in assignment of dispensing fee of \$2.00.

An additional dispensing fee of \$0.75 will be paid for "unit dose" prescriptions. This "unit dose" dispensing fee will offset the additional cost of packaging supplies and materials which are directly related to filling "unit dose" prescriptions by the individual pharmacy and is in addition to the regular dispensing fee allowed. Only one unit dose dispensing fee will be allowed each month for each prescribed medication. A dispensing fee will not be paid for a unit dose prescription packaged by the drug manufacturer.

An additional compounding fee based on level of effort will be paid for compounded prescriptions. Montana Medicaid shall reimburse pharmacies for compounding drugs only if the client's drug therapy needs cannot be met by commercially available dosage strengths and/or forms of the therapy. Reimbursement for each drug component shall be determined in accordance with "lower of" pricing methodology. The compounding fee for each compounded drug shall be based on the level of effort required by the pharmacist. The levels of effort compounding fees payable are level 1: \$12.50, level 2: \$17.50, and level 3: \$22.50.

Benefit Delivery System:

Waiver individuals, regardless of insurance status, will present the Medicaid Part D Prescription Drug Program Waiver card at the pharmacy. Uninsured individuals will pay the Medicaid price for the Medicaid covered drug at the counter. The waiver will not cover prescription drug wrap around services. Individuals with TPL will continue to pay the plan required cost share at the pharmacy not to exceed the Medicaid drug allowed amount. The pharmacy will submit the claim to DPHHS Medicaid as well as any TPL. TPL will pay the TPL amount to the pharmacy for the prescription as primary payer.

DPHHS Medicaid will process claims for the sole purpose to collect drug rebates for all Medicaid covered drugs. Medicaid will pass on associated drug rebate, net of administrative costs.

Medicaid will continue to process prescription drug claims in the same manner for non-waiver Medicaid State Plan Pharmacy Program services. Medicaid State Plan Pharmacy Program will receive the negotiated best price as does the waiver.

Cost Share:

The Medicaid Part D Prescription Drug Program Waiver does not require cost share. Individuals will continue to be responsible for the amount of TPL cost share up to the Medicaid drug allowed amount.

1. Mandatory Populations

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

2. Optional populations included in the existing Medicaid State Plan

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

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

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

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

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

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

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

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

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

5. Expansion Populations

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

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

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

MEG 1) Medicaid Part D Prescription Drug Program Waiver Individuals - Benefits

Medicaid Part D Prescription Drug Program Waiver individuals will be eligible to receive Medicaid prescription drug pricing for Montana Medicaid covered prescription drugs. Waiver enrollees will be issued a Medicaid Part D Prescription Drug Program Waiver card. Uninsured waiver individuals will pay the best Medicaid price. Waiver individuals with TPL will pay the TPL cost share up to the Medicaid drug price. TPL pays the pharmacy the TPL price. TPL benefits for otherwise insured individuals will not change. The Medicaid waiver will only apply to drugs covered by the State Plan Medicaid Pharmacy Program. We will not provide wrap around pharmacy services.

F. Coverage Vehicle

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

Figure I. Coverage Vehicle

<i>Eligibility Category</i>	<i>Fee-For-Service</i>	<i>Medicaid or SCHIP Managed Care</i>	<i>Private Health Insurance Coverage</i>	<i>Group Health Plan Coverage</i>	<i>Other (specify)</i>	<i>Comments</i>
<i>New HIFA Expansion</i> MEG 1) Medicaid Part D Prescription Drug Program Waiver Individuals		<i>The waiver will offer Medicaid prescription drug pricing for Montana Medicaid covered prescription drugs to waiver enrollees.</i>	√ <i>Individuals may have TPL.</i>	√ <i>Individuals may have TPL.</i>		<i>TPL will pay TPL reimbursement to the pharmacy.</i>

G. Private Health Insurance Coverage Options

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

The waiver will offer Medicaid prescription drug pricing for Montana Medicaid covered prescription drugs to waiver enrollees, regardless of insurance status. Waiver individuals with TPL will pay the TPL cost share up to the Medicaid drug allowed amount. TPL pays the pharmacy the TPL. TPL benefits for otherwise insured individuals will not change, Medicaid will not provide wrap around pharmacy services. The waiver does not induce individuals with private health insurance coverage to drop their current coverage as this is a Medicaid best prescription drug price pharmacy benefit only.

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

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

- The same coverage provided under the State’s approved Medicaid plan.
- The same coverage provided under the State’s approved SCHIP plan.
- The benefit package for the health insurance plan that is offered by an HMO, and has the largest commercial, non-Medicaid enrollment in the State.

- The standard Blue Cross Blue Shield preferred provider option service benefit plan that is described in, and offered to Federal employees under 5 U.S.C. 8903(1). (Federal Employees Health Benefit Plan (FEHBP)).
- A health benefits coverage plan that is offered and generally available to State employees.
- A benefit package that is actuarially equivalent to one of those listed above (please specify).
- Secretary-Approved coverage.
- Other coverage defined by the State. (A copy of the benefits description must be included in Attachment D.)
- The State assures that it will monitor aggregate costs for enrollees in the premium assistance program for private health insurance coverage to ensure that costs are not significantly higher than costs would be for coverage in the direct coverage program. (A description of the Monitoring Plan will be included in Attachment D.)
- The State assures that it will monitor changes in employer contribution levels or the degree of substitution of coverage and be prepared to make modifications in its premium assistance program. (Description will be included as part of the Monitoring Plan.)

H. Cost Sharing

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

Figure II. MEG Cost Sharing

Eligibility Category	Nominal Amounts Per Regulation	Up to 5 Percent of Family Income	Comments
New HIFA Expansion <i>MEG 1) Medicaid Part D Prescription Drug Program Waiver Individuals</i>			<i>Uninsured individuals do not pay cost share. TPL individuals pay TPL required cost share up to the Medicaid drug allowed amount.</i>

V. ACCOUNTABILITY AND MONITORING

Please provide information on the following areas:

1. Insurance Coverage

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

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

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

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

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

- Yes No

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

A State Survey was used.

- Yes No

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

2. State Coverage Goals and State Progress Reports

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

An annual 2009 estimate of the Montana population of 974,989 shows 15.9% are without health insurance. This means almost one in six residents do not have either private or public health insurance. Health insurance is highly correlated with pharmacy benefits, so a lack of health insurance indicates a lack of pharmacy benefits.

The goal of this demonstration is to remove barriers to pharmacy coverage for Montanans by extending Medicaid eligibility for a Medicaid prescription drug benefit through a Section 1115 Waiver. The prescription drug benefit is to offer prescription drugs at a lower price, which is the Medicaid best price, to all Montana residents regardless of insurance status. Best price will be achieved in a two step process, first by offering Medicaid drug pricing at the pharmacy counter and passing on associated Medicaid drug rebates, net of administrative costs.

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

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

See Attachment F Additional Detail Regarding Measuring Progress Toward Removing Barriers to Pharmacy Coverage and Figure IV. Waiver Reporting Deliverables – Performance Plan.

VI. PROGRAM COSTS

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

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

- Medical Care Consumer Price Index, published by the Bureau of Labor Statistics. (Available at <http://stats.bls.gov>.) The Medical Care Consumer Price Index will only be offered to States proposing statewide demonstrations under the HIFA initiative. If the State chooses this option, it will not be used to submit detailed historical data.
- Medicaid-specific growth rate. States choosing this option should submit five years of historical data for the eligibility groups included in the demonstration proposal for assessment by CMS staff, with quantified explanations of trend anomalies. A sample worksheet for submission of this information is included with this application package. The policy for trend rates in HIFA demonstrations is that trend rates are the lower of State specific history or the President's Budget Medicaid baseline for the eligibility groups covered by a State's proposal. This option will lengthen the review time for a State's HIFA proposal because of the data generation and assessment required to establish a State specific trend factor.

This prescription drug benefit will not cost the Federal or State government any money in benefits. The uninsured individual pays the best Medicaid price for Medicaid covered prescription drugs. The TPL will continue to pay the pharmacy the TPL reimbursement. Medicaid will not provide wrap around pharmacy services for Medicaid Part D Prescription Drug Program Waiver enrolled individuals.

Federal and State governments will share in administrative costs for system changes, eligibility staff, and rebate staff.

VII. WAIVERS AND EXPENDITURE AUTHORITY REQUESTED

A. Waivers

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

Title XIX:

- Statewide 1902(a)(1)

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

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

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

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

Freedom of Choice 1902(1)(23)

To enable the State to restrict the choice of provider.

Title XXI:

Benefit Package Requirements 2103

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

Cost Sharing Requirements 2103(e)

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

B. Expenditure Authority

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

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

Expenditures to provide services to populations not otherwise eligible to be covered under the Medicaid State Plan. *MEG 1) Medicaid Part D Prescription Drug Program Waiver Individuals*

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

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

Title XXI:

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

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

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

Figure III. Waivers and Expenditure Authority Requested

	<i>MEG 1) Medicaid Part D Prescription Drug Program Waiver Individuals</i>
<i>XIX. Amount, Duration, and Scope (1902(a)(10)(B) – Applied to Services</i>	√
<i>XIX. Expenditures to provide services to populations not otherwise eligible to be covered under the Medicaid State Plan.</i>	√

VIII. ATTACHMENTS

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

Attachment A: Discussion of how the State will ensure that covering individuals above 200 percent of poverty under the waiver will not induce individuals with private health insurance coverage to drop their current coverage.

Individuals will be covered up to 200% FPL and income above this level will be disregarded. The waiver does not induce individuals with private health insurance coverage to drop their current coverage as this is a Medicaid best prescription drug price pharmacy benefit only. The waiver does not provide wrap around coverage.

- Attachment B: Detailed description of expansion populations included in the demonstration.
- Attachment C: Benefit package description.
- Attachment D: Detailed description of private health insurance coverage options, including premium assistance if applicable.
- Attachment E: Detailed discussion of cost sharing limits.
- Attachment F: Additional detail regarding measuring progress toward reducing the rate of insurance.
Figure IV. Waiver Reporting Deliverables – Performance Plan
- Attachment G: Budget worksheets.
Federal and State Benefit Cost
This prescription drug benefit will not cost the Federal or State government any money in benefits. The uninsured individual pays the best Medicaid price for Medicaid covered prescription drugs. The TPL will continue to pay the pharmacy the TPL reimbursement. Medicaid will not provide wrap around pharmacy services for Medicaid Part D Prescription Drug Program Waiver enrolled individuals.

Federal and State governments will share in administrative costs for system changes, eligibility staff, and rebate staff.
- Attachment H: Additional waivers or expenditure authority request and justification.

IX. SIGNATURE

11-16-2010
Date

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

informal submission of waiver
Mary E. Dalton
Signature of Authorizing State Official

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

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

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

An annual 2009 estimate of the Montana population of 974,989 shows 15.9% are without health insurance. This means almost one in six residents do not have either private or public health insurance. Health insurance is highly correlated with pharmacy benefits, so a lack of health insurance indicates a lack of pharmacy benefits.

Medicaid Part D Prescription Drug Program Waiver Goal:

The goal of this demonstration is “To provide citizens of Montana access to Medicaid drug pricing to increase affordable prescription drug coverage” through a Section 1115 Waiver. The prescription drug benefit is to offer prescription drugs at a lower price, which is the Medicaid best price, to all Montana residents regardless of insurance status. Best price will be achieved in a two step process, first by offering Medicaid drug pricing at the pharmacy counter and passing on associated Medicaid drug rebate.

Waiver Objectives:

- *One: Analyze individuals who have gained access to pharmacy coverage through the waiver.*
- *Two: Define and analyze the waiver benefit package for the waiver population.*
- *Three: Determine number of and analyze waiver individuals covered by employer sponsored and private insurance plans.*
- *Four: Observe participant’s view of quality of care and identify quality of care issues.*

Waiver Impact On Waiver Individuals:

- **Objective One: Analyze individuals who have gained access to pharmacy coverage through the waiver.**
 - **Measures:**
 - *Measure One: Describe the waiver enrollment policies and procedures.*
 - *Measure Two: Quantify the number of individuals in the waiver.*
 - *Measure Three: Compare and contrast the number of waiver participants with Medicaid recipients.*
 - *Measure Four: Assess insurance coverage levels in the State categorized by coverage sources, including Medicaid and CHIP direct coverage, Medicaid and CHIP premium assistance programs, those covered through employer sponsored insurance, other group health plans including COBRA coverage, and individual market coverage. (The availability of data appears to be limited.)*
 - *Measure Five: Compare and contrast the waiver population, Medicaid recipients, and the Montana population as a whole using demographic indicators such as age, sex, income, race-ethnicity, etc.*
 - *Measure Six: Determine if the waiver increased the number and rate of Montana residents who had access to pharmacy coverage.*
 - *Measure Seven: Identify any available projections of future uninsured rates.*

- *Measure Eight: Identify lessons learned, identify unintended consequences, policy changes observed, and any recommendations going forward.*
- **Objective Two: Define and analyze the waiver benefit package for the waiver population.**
 - **Measures:**
 - *Measure One: Describe the waiver benefit package for the population.*
 - *Measure Two: Compare and contrast the benefit package for waiver participants. Medicaid recipients, and the Montana population as a whole (from information available), in general, using selected measures of medical service utilization and service cost information.*
 - *Measure Three: Identify the amount of drug rebated to uninsured individuals and individuals with TPL.*
 - *Measure Four: Identify the amount of supplemental drug rebated to DPHHS for administrative costs.*
 - *Measure Five: Identify lessons learned, identify unintended consequences, policy changes observed, and any recommendations going forward.*
- **Objective Three: Determine number of and analyze waiver individuals covered by employer sponsored and private insurance plans.**
 - **Measures:**
 - *Measure One: Quantify the number and rate of waiver individuals covered by employer sponsored, private insurance plans, other group health plans including COBRA coverage, and individual market coverage.*
 - *Measure Two: Compare and contrast the number of waiver participants, Medicaid recipients, and the Montana population as a whole, covered by employer sponsored and private insurance plans.*
 - *Measure Three: Compare and contrast the waiver population, Medicaid recipients, and the Montana population as a whole using demographic indicators such as age, sex, income, race-ethnicity, etc., covered by employer sponsored and private insurance plans.*
 - *Measure Four: For waiver participants: track changes in the uninsured rate and trends in sources of insurance as listed above; if possible, monitor employer contribution levels and whether there are unintended consequences of the demonstration, such as major decreases in employer contribution levels or high levels of substitution of private coverage.*
 - *Measure Five: Identify lessons learned, identify unintended consequences, policy changes observed, and any recommendations going forward.*
- **Object Four: Observe participant's view of quality of care and identify quality of care issues.**
 - **Measures:**
 - *Measure One: Determine access to pharmacy services for waiver population.*
 - *Measure Two: Determine adequacy of provider choice for waiver population.*
 - *Measure Three: Determine quality of care for waiver population.*
 - *Measure Four: Determine beneficiary satisfaction with waiver methods.*

National and State Uninsured or Underinsured Data Sources Used For Reporting:

The following are National and State organizations that offer information regarding demographics, insured, underinsured, and uninsured information. Montana will use these sites, among other sites, to analyze the above objectives and measures.

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

Figure IV. Waiver Reporting Deliverables – Performance Plan

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

References:

- Taken from: Access to Pharmacy Services and Pharmaceuticals in Montana, September 14, 2006, Jean T. Carter, Pharm.D., PH.D. Skaggs School of Pharmacy, The University of Montana-Missoula.
- (1) Kaiser Family Foundation / Health research and Educational Trust. Employer Health Benefits: 2005 Annual Survey (Report #7315)(9/14/05). Available at: <http://www.kff.org/insurance/7315/upload/7315.pdf>. Accessed 7/14/2006.
 - (2) Kaiser Commission on Medicaid and the Uninsured. The Uninsured: A Primer, Key Facts About Americans Without Health Insurance (Report #7451)(1/06). Available at: <http://www.kff.org/uninsured/upload/7451.pdf>. Accessed 8/10/2006.
 - (3) Kaiser Family Foundation / State Health Facts Website – multiple tables for Montana. Available at <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi>. Accessed 8/2006.
 - (4) Kaiser Family Foundation / Trends and indicators in the changing health care marketplace. Available at: <http://www.kff.org/insurance/7031/print-sec1.cfm>. Accessed 8/10/2006.
 - (5) U.S. Census Bureau. Montana Quick Facts (6/8/06). Available at: <http://quickfacts.census.gov/qfd/states/30000.html>.
 - (6) U.S. Census Bureau. Small Area Income & Poverty Estimates: Montana Counties, 2003 (11/05). Available at: <http://www.census.gov/hhes/www/saipe/countyhtml>.

Figure V. Rebates for Medicaid Part D Prescription Drug Program Waiver

Individual Insured Through	Receive Medicaid Drug Pricing	Receive Federal Medicaid Rebate	Receive State Supplemental Rebate	Federal and State Benefit Contribution
Medicaid and HMK Plus (Medicaid)	<i>No change. Already receive Medicaid price.</i>	<i>No change. Medicaid sends the Federal rebate portion to the Federal Government.</i>	<i>No change. Medicaid sends the Federal rebate portion to the Federal Government.</i>	<i>No change.</i>
Uninsured	<i>Yes</i>	<i>Individual receives rebate.</i>	<i>Individual receives rebate.</i>	<i>No Federal or State contribution.</i>
IHS	<i>No, if IHS funded.</i>	<i>No</i>	<i>No</i>	<i>Existing Federal benefit.</i>
Veteran's Administration (VA) Delivered On Site	<i>No</i>	<i>No</i>	<i>No</i>	<i>Existing Federal benefit.</i>
Private Health Insurance (Federal or State Employee, BCBS, etc.)	<i>Yes</i>	<i>Individual receives rebate.</i>	<i>Individual receives rebate.</i>	<i>No Federal or State contribution.</i>
Medicare Part D	<i>Yes</i>	<i>Individual receives rebate.</i>	<i>Individual receives rebate.</i>	<i>Existing Federal benefit.</i>
Healthy Montana Kids (HMK)(CHIP)	<i>Yes</i>	<i>Individual receives rebate.</i>	<i>Individual receives rebate.</i>	<i>No change.</i>
Montana Comprehensive Health Association (MCHA)	<i>Yes</i>	<i>Individual receives rebate.</i>	<i>Individual receives rebate.</i>	<i>No</i>

**Prescription drugs and services must be covered by Medicaid to receive the Medicaid price.*

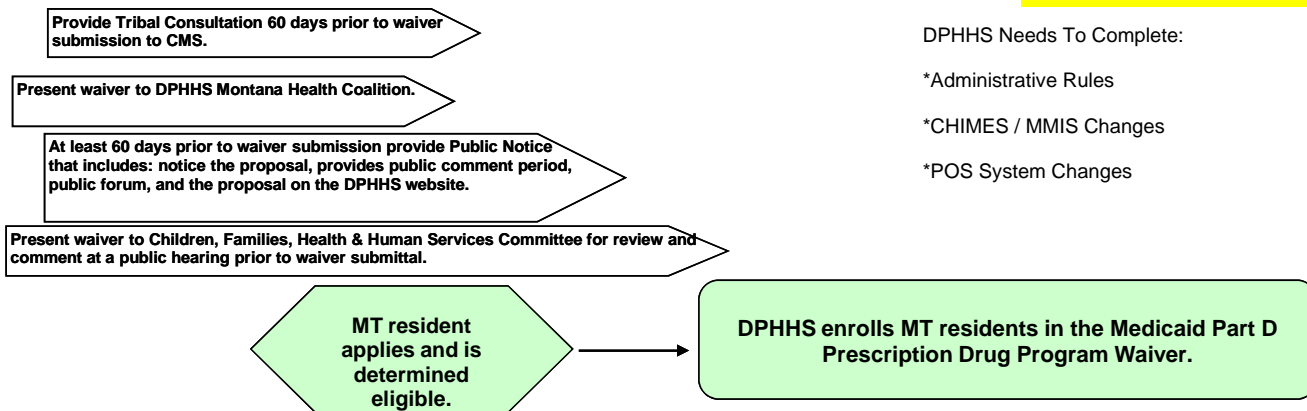
**Individuals must be Montana residents and must apply to become waiver eligible.*

**Medicaid pricing includes the pharmacy dispensing fee.*

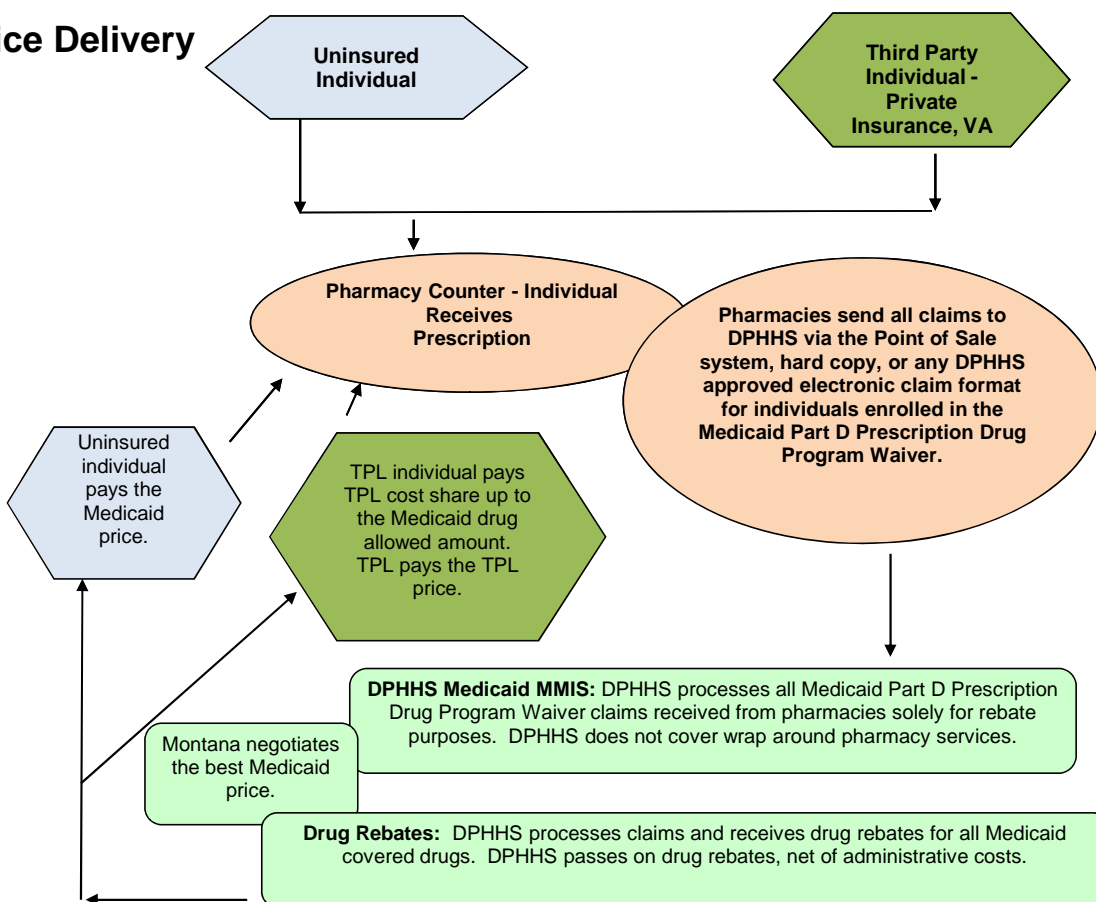
**Rebates are paid periodically, net of administrative costs.*

Montana Medicaid Part D Prescription Drug Program Section 1115 Waiver

DRAFT PROCESS



Service Delivery



*Medicaid State Plan Pharmacy program will not change for people already enrolled in Medicaid through the State Plan or other Medicaid waivers. Individuals will continue to pay Medicaid cost share. Medicaid will be included in the best price negotiation.