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

Submitted 01/13/2021

Introduction

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

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

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

WASP Populations Covered

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

Detailed History and Key Dates of Approval/Operation

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

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

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

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

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

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

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

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

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

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

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

Enrollment Count from DY14 through DY16

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

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

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

Demonstration Objectives/Goals

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

The three populations covered under WASP differ significantly from each other and the benefit each population derives from inclusion in WASP also differ. The MHSP population receives the broadest service package and is therefore the principal focus of this evaluation design.

MHSP Population Goal

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

Medicaid benefits for mental health services. The evaluation plan utilizes three research questions that seek to understand how the provision of Standard Medicaid benefits coverage for the MHSP population of WASP impacts their (1) access to mental health care, (2) utilization of mental health care, and their (3) mental health outcomes. The evaluation design and research questions enable an understanding of the impact of WASP on the MHSP population by hypothesizing that the provision of Standard Medicaid benefits will enable the MHSP population to receive timely and appropriate mental health care, including community-based mental health care services and psychotropic prescription drug services, that improves their mental health outcomes by reducing the MHSP population's utilization of emergency rooms, crisis facilities, inpatient behavioral health units and the Montana State Hospital for mental health care.

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

Evaluation Questions and Hypotheses

Research Questions:

1. How does the provision of Standard Medicaid benefits coverage for WASP enrollees impact their access to covered services?
2. How does the provision of Standard Medicaid benefits coverage for WASP enrollees impact utilization of covered services?
3. How does the provision of Standard Medicaid benefits coverage impact health care outcomes in the WASP population?

Hypotheses:

1. Access to care will improve for members of the WASP population who receive Standard Medicaid benefits for mental health services.
2. Utilization of community-based mental health services and psychotropic prescription drug services will increase.
3. Utilization of emergency department services for mental health services and admission to crisis stabilization facilities, inpatient psychiatric facilities, and the Montana State Hospital will decrease for

members of the WASP population who receive Standard Medicaid benefits for mental health services.

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

Mental Health Services Plan (MHSP) Population

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

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

Demonstration Goal	Improve access to mental health care, improve utilization of mental health care and improve mental health outcomes for individuals age 18 or older, with Severe Disabling Mental Illnesses (SDMI) who qualify for, or are enrolled in, the Section 1115 Waiver for Additional Services and Populations (WASP) by providing coverage to receive Standard Medicaid benefits for mental health services.
Research Questions	1. How does the provision of Standard Medicaid benefits coverage for WASP enrollees impact their access to covered services? 2. How does the provision of Standard Medicaid benefits coverage for WASP enrollees impact utilization of covered services? 3. How does the provision of Standard Medicaid benefits coverage impact health care outcomes in the WASP population?
Hypotheses	1. Access to care will improve for members of the WASP population who receive Standard Medicaid benefits for mental health services. 2. Utilization of community-based mental health services and psychotropic prescription drug services will increase. 3. Utilization of emergency department services for mental health services and admission to crisis stabilization facilities, inpatient psychiatric facilities, and the Montana State Hospital will decrease for members of the WASP population who receive Standard Medicaid benefits for mental health services.
Measures	1a. Enrollee perception of difficulty getting care. 2a. Number of enrollees receiving community-based mental health services, specifically Outpatient Therapy services, Targeted Case Management services, Behavioral Health Day Treatment services, Rehabilitation & Support services, Illness Management and Recovery services, Behavioral Health Group Home services, Program of Assertive Community

	Treatment services, Peer Support services, and Adult Foster Care services. 2b. Number of enrollees receiving psychotropic prescription drug services. 3a. Number of enrollees utilizing emergency department services for mental health services. 3b. Number of enrollees admitted to a crisis stabilization facility. 3c. Number of enrollees admitted to an inpatient psychiatric facility. 3d. Number of enrollees admitted to the Montana State Hospital.

Table 2. Design Measure Structure

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

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

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

Table 3. Quantitative Methods

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

Table 4. Data Collection Process

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

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

MHSP Evaluation Budget

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

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

PCR Population Goal

The goal of including the PCR population into the WASP coverage is to provide a 12-month continuous eligibility period for all non-expansion Medicaid-covered individuals whose eligibility is based on MAGI. The PCR population receives the standard Medicaid benefit already, without the aid of WASP eligibility. Including this population into the WASP coverage eliminates the redetermination burden on the member and the state while aligning these members with an annual redetermination schedule that mirrors most other Montana Healthcare Program members.

The PCR population began receiving this singular benefit under WASP on January 1, 2016. There are no similar groups for which to compare the PCR population or any additional services covered for them under WASP, only the absence of an extra eligibility requirement. Likely, most PCR WASP members do not realize they are participants in the WASP as its action is invisible to them. Therefore, member satisfaction surveys and outside comparisons for this population are purposely excluded.

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

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

PCR Goal: Data Collection Process

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

PCR Quantitative Methods

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

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

PCR Evaluation Budget

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

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

ABD Dental Population Goal

The goal of including the ABD Dental population into the WASP coverage is to provide individuals determined categorically eligible for ABD with dental treatment services above the $1,125 State Plan dental treatment cap.

The ABD population began receiving this singular benefit under WASP on March 1, 2016. There are no similar groups to compare with this ABD population or any additional services covered for them under WASP, only the absence of the dental treatment cap. Likely, most ABD WASP members do not realize they are participants in the WASP as its action is invisible to them. The ABD population is aged, blind and disabled. They are offered this additional annual coverage because of the hardship inherent in providing dental services incrementally. This population is especially difficult to serve with dental care, sometimes needs to be anesthetized, often prone to behavioral combativeness and emotional trauma. The service itself is offered at the request of providers who find this population especially in need of dental care that is not limited by timeframe or dollar amount. This is a population who, if offered a survey, would likely have it completed by a proxy if able to complete one at all. Therefore, member satisfaction surveys and outside comparisons for this population are purposely excluded.

ABD Dental Goal: provide individuals determined categorically eligible for ABD with dental treatment services above the $1,125 State Plan dental treatment cap.

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

ABD Dental Goal: Data Collection Process

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

ABD Quantitative Methods

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

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

ABD Evaluation Budget

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

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

1. Simplified Evaluation Budget (Full Evaluation):

Full Evaluation Budget

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

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

Deliverable Schedule

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

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

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

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

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

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