DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

Center for Medicaid, CHIP and Survey & Certification

Children and Adults Health Programs Group

MAY 13 2011

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DPHHS DIRECTOR'S OFFICE

Mary E. Dalton
State Medicaid Director
Montana Department of Public Health and Human Services
PO Box 4210
Helena, MT 59604-4210

Dear Ms. Dalton:

The Centers for Medicare & Medicaid Services (CMS) is issuing technical corrections to the Montana section 1115 Medicaid Demonstration, entitled "Basic Medicaid for Able-Bodied Adults (project number 11-W-00181/8)." The technical corrections are being made under the authority of section 1115(a) of the Social Security Act (the Act) to ensure that the waivers granted reflect the authority approved to carry out the Demonstration.

In particular, we are removing the "Medicare, or Veterans benefits" clause in the last sentence of the Expenditure Authorities related to the Waiver Mental Health Services Program (WMHSP) population. This agreed upon change was correctly made to the Special Terms and Conditions (STCs), and this technical correction will ensure that concurrence of both documents.

The second technical change is a clarification that the Montana Nurse First Advice Line is not a managed care program and was incorrectly referred to in the Demonstration documents as a prepaid ambulatory health program (PAHP). With the concurrence of the CMS Denver Regional Office, the requested technical corrections will be made to the waiver list and STCs.

If you have additional questions, please contact Terri Fraser, Project Officer, Children and Adults Health Program Group, Center for Medicaid, CHIP and Survey & Certification at 410-786-5573.

We look forward to continuing to work with you and your staff.

Sincerely,

Richard Jensen

Richard Jensen,
Director
Division of State Demonstrations and Waivers

Enclosure: Revised section 1115 Basic Medicaid Documents

cc: Lou Armstrong, Administrator, DPHHS AMDD
Marcia Armstrong, Medicaid Mental Health Program Manager, DPHHS AMDD
Jo Thompson, Medicaid Analyst, DPHHS Director's Office
Richard Allen, Associate Regional Administrator, CMS Regional Office
Terri Fraser, Project Officer, CMS Division of State Demonstrations and Waivers

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: **11-W-00181/8** **Title XIX**

TITLE: **Montana Basic Medicaid for Able-Bodied Adults**

AWARDEE: **Montana Department of Public Health and Human Services**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the State for the items identified below, which are not otherwise included as expenditures under section 1903, shall, for the period of this Demonstration extension, be regarded as expenditures under the State's Medicaid title XIX State plan.

The following expenditure authorities shall enable Montana to implement this section 1115 Demonstration.

1. Expenditures Related to WMHSP Expansion Population

Expenditures for coverage of health care services for no more than 800 individuals aged 18 through 64, with incomes at or below 150 percent of the Federal poverty level (FPL), who have been diagnosed with a severe disabling mental illness (SDMI) of schizophrenia, bipolar disorder, or major depression, and who, at the time of their initial enrollment were receiving a limited mental health services benefit package through enrollment in the State-financed Mental Health Service Plan (SMHSP), but are otherwise ineligible for Medicaid.

MEDICAID REQUIREMENTS NOT APPLICABLE TO THE DEMONSTRATION ELIGIBLE POPULATION

Requirements of the Medicaid statute will be applicable to those individuals who are made eligible for services solely by virtue of the demonstration project, for whom, under the expenditure authority listed above, the State will receive Federal financial participation in its expenditures, except those requirements specified below:

1. Reasonable Promptness (enrollment limit) **Section 1902(a)(8)**
To enable the State to enroll WMHSP-eligible individuals using a lottery system to phase in and maintain enrollment up to the designated enrollment limit.

2. Retroactive Eligibility **Section 1902(a)(34)**
To permit the State not to offer retroactive eligibility to WMHSP individuals.

CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER LIST

NUMBER: **11-W-00181/8** **Title XIX**

TITLE: **Montana Basic Medicaid for Able-Bodied Adults**

AWARDEE: **Montana Department of Public Health and Human Services**

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived in the following list or specified as *not applicable* to the expenditure authorities, shall apply to the demonstration project under title XIX of the Social Security Act (the Act) beginning December 1, 2010 through December 31, 2013. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs).

MEDICAID TITLE XIX REQUIREMENTS WAIVED FOR MEDICAID STATE PLAN GROUPS

1. Amount, Duration, and Scope of Services and Comparability **Section 1902(a)(10)(B)**

To the extent necessary to enable the State to offer a reduced benefit package, a different benefit package, or cost-effective alternative benefit packages to populations affected by the Demonstration.

2. Home Health Services **Section 1902(a)(10)(D)**

To the extent necessary to enable the State not to offer the medical equipment and home infusion component of the home health benefit to populations affected by the Demonstration.

3. Freedom of Choice **Section 1902(a)(23)**

To enable the State to restrict freedom of choice of provider for populations affected by the Demonstration, through the use of mandatory enrollment in managed care entities (Primary Care Case Management orNurse First Advice Line) for the receipt of applicable Demonstration covered services. And to enable the States to mandate managed care enrollment for any individual in the populations affected by the Demonstration who is an Indian as defined in section 4(c) of the Indian Health Care Improvement Act of 1976 (25 U.S.C. 1603(c)).

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS (STCs)

NUMBER: **11-W-00181/8**

TITLE: **Montana Basic Medicaid for Able-Bodied Adults**

AWARDEE: **Montana Department of Public Health and Human Services**

DEMONSTRATION PERIOD: February 1, 2009 through December 31, 2013
**Note: Temporary Extensions were granted under the same terms and conditions as the previous STCs for the period of February 1, 2009 through November 30, 2010.*

I. PREFACE

The following are the Special Terms and Conditions (STCs) for Montana's Basic Medicaid for Able Bodied Adults section 1115 Demonstration program (hereinafter referred to as "Demonstration") for the Demonstration under section 1115(a) of the Social security Act (the Act) for the period of December 1, 2010 through December 31, 2013. The parties to this agreement are the Montana Department of Public Health and Human Services ("State") and the Centers for Medicare & Medicaid Services ("CMS"). All requirements of the Medicaid and CHIP programs expressed in law, regulation and policy statement, not expressly waived or made not applicable in the list of Waivers and Expenditure authorities, shall apply to the Demonstration project.

The STCs set forth in detail the nature, character, and extent of Federal involvement in the Demonstration and the State's obligations to CMS during the life of the Demonstration. The STCs are effective as of the approval letter's date, unless otherwise specified. Amendment requests, correspondence, documents, reports, and other materials that are submitted for review or approval shall be directed to the CMS Central Office Project Officer and the Regional Office State Representative at the addresses shown on the award letter. All previously approved STCs, Waivers, and Expenditure Authorities are superseded by the STCs set forth below. This Demonstration extension is approved through December 31, 2013. The STCs have been arranged into the following subject areas:

I. PREFACE
II. PROGRAM DESCRIPTION AND OBJECTIVES
III. GENERAL PROGRAM REQUIREMENTS
IV. ELIGIBILITY
V. BENEFITS
VI. ENROLLMENT
VII. COST SHARING
VIII. DELIVERY SYSTEMS
IX. GENERAL REPORTING REQUIREMENTS
X. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX
XI. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION
XII. EVALUATION OF THE DEMONSTRATION
XIII. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION EXTENSION

ATTACHMENT A
ATTACHMENT B

II. PROGRAM DESCRIPTION AND OBJECTIVES

The Montana Basic Medicaid for Able-Bodied Adults (Basic Medicaid) is a statewide section 1115 Demonstration administered by the Montana Department of Public Health and Human Services (the State). The Basic Medicaid program began in 1996, under the authority of an 1115 welfare reform waiver referred to as Families Achieving Independence in Montana (FAIM). Under FAIM, Montana provided all mandatory Medicaid benefits and a limited collection of optional services to approximately 8,500 able-bodied adults (aged 21through 64 and neither pregnant nor disabled), who are parents and/or caretaker relatives of dependent children at or below the State Standard of Need (i.e., otherwise eligible for Medicaid under Sections 1925 or 1931 of the Social Security Act). The FAIM welfare reform waiver expired on January 31, 2004, and was replaced (without change) by a section 1115 Medicaid Demonstration, which was approved for the period of February 1, 2004 through January 31, 2009. The Demonstration was continued through a series of Temporary Extensions through November 30, 2010.

On January 25, 2008, Montana proposed to renew the Basic Medicaid for Able-Bodied Adults Demonstration for eligible parents and caretaker adults and in subsequent communications proposed to expand eligibility using demonstration savings. On July 30, 2009 and August 13, 2010, the State submitted revised proposals to CMS. Under the revised proposals, Demonstration savings are used to provide Medicaid-like coverage to up to 800 individuals, aged 18 through 64, with incomes at or below 150 percent of the Federal poverty level (FPL), who have been diagnosed with a severe disabling mental illness (SDMI) of schizophrenia, bipolar disorder, or major depression, and who would not otherwise be eligible for Medicaid benefits. Prior to enrollment in the section 1115 Demonstration, these individuals received a very limited mental health benefit through enrollment in a State-financed Mental Health Service Plan (MHSP).

On the basis of the State's July 30, 2009 and August 13, 2010 proposals, CMS approved the extension of the Basic Medicaid Demonstration under authority of section 1115(a) of the Social Security Act (the Act). The Demonstration will continue for the period of December 1, 2010 through December 31, 2013, and the following Special Terms and Conditions, waivers, and costs not otherwise matchable will apply.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The State must comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), must apply to the Demonstration.

3. **Changes in Medicaid Law, Regulation, and Policy.** The State must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in Federal law, regulation, or policy affecting the Medicaid program that occur during this Demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

    a. To the extent that a change in Federal law, regulation, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this Demonstration, the State must adopt, subject to CMS approval, a modified budget neutrality agreement for the Demonstration as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.

    b. If mandated changes in the Federal law require State legislation, the changes must take effect on the day such State legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **State Plan Amendments.** The State will not be required to submit title XIX or title XXI State plan amendments for changes affecting any populations made eligible solely through the Demonstration. If a population eligible through the Medicaid State Plan is affected by a change to the Demonstration, a conforming amendment to the appropriate State Plan may be required, except as otherwise noted in these STCs.

6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, cost sharing, sources of non-Federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the Demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Social Security Act (the Act). The State must not implement changes to these elements without prior approval by CMS. Amendments to the Demonstration are not retroactive and FFP will

not be available for changes to the Demonstration that have not been approved through the amendment process set forth in paragraph 7 below.

7. **Amendment Process.** Requests to amend the Demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a Demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the State to submit required reports and other deliverables in a timely fashion according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:

    a. An explanation of the public process used by the State, consistent with the requirements of paragraph 12, to reach a decision regarding the requested amendment;

    b. A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current Federal share "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

    c. An up-to-date CHIP allotment neutrality worksheet, if necessary;

    d. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and

    e. If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

8. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the Demonstration (in whole or in part) at any time before the date of expiration, whenever it determines following a hearing that the State has materially failed to comply with the terms of the project. CMS will promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date.

9. **Finding of Non-Compliance.** The State does not relinquish its rights to challenge the CMS finding that the State materially failed to comply.

10. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS will promptly notify the State in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the State an opportunity to request a hearing to challenge CMS' determination

prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

11. **Adequacy of Infrastructure.** The State must ensure the availability of adequate resources for implementation and monitoring of the Demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other Demonstration components.

12. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The State must continue to comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) and the tribal consultation requirements pursuant to section 1902(a)(73) of the Act as amended by section 5006(e) of the Recovery and Reinvestment Act of 2009. In States with Federally recognized Indian tribes, Indian health programs, and / or Urban Indian organizations, the State is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any waiver proposal, amendment, and / or renewal of this Demonstration. In the event that the State conducts additional consultation activities consistent with these requirements prior to the implementation, documentation of these activities will be provided to CMS.

13. **FFP.** No Federal matching funds for expenditures for this Demonstration will take effect until the effective date identified in the Demonstration approval letter.

IV. ELIGIBILITY

1. **Eligibility Criteria.** Mandatory and optional Medicaid State Plan populations derive their eligibility through the Medicaid State Plan, and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid State Plan, except as expressly waived and as described in these STCs. Able Bodied Adults, as defined below, are included in the Demonstration to generate savings for covering the expansion populations and to waive other specific programmatic requirements.

2. The section 1115 Demonstration affects the following Eligibility Groups:

   a) **Able Bodied Adults.** Individuals who are eligible as Family Medicaid or Transitional Medicaid under sections 1925 and 1931 of the Social Security Act, are age 21 through 64, and who are not pregnant or disabled.

   Waiver Montana Mental Health Services Plan (WMHSP) Enrollees. Individuals aged 18 through 64, with incomes at or below 150 percent of the Federal poverty level (FPL), who have been diagnosed with a severe disabling mental illness (SDMI) of schizophrenia, bipolar disorder, or major depression, who at the time of their enrollment were receiving a limited mental health services benefit package through enrollment in the State-financed Mental Health Service Plan (SMHSP), but are otherwise ineligible for Medicaid benefits.

V. BENEFITS

1. **Benefits for Able Bodied Adults and WMHSP Enrollees.** All individuals enrolled in the Demonstration will receive all Medicaid State plan services excluding: audiology, dental and denturist, medical equipment, eyeglasses, optometry and ophthalmology for routine eye exams, personal care services, home infusion and hearing aids.

2. **Allowances / Special Circumstances.** Coverage for the excluded services may be provided:

    a. At the State's discretion in cases of emergency or when essential to obtain or maintain employment. Examples of emergency circumstances include, but are not limited to coverage for emergency dental situations, medical conditions of the eye (e.g., annual dilated eye exams for individuals with diabetes or other medical conditions), and certain medical supplies (e.g., diabetic supplies, prosthetic supplies, oxygen). In these situations, the State will provide approval to the provider, and make associated records available upon CMS request; or

    b. Are age-appropriate EPSDT services.

3. **Changes to the State Plan Benefits or to Other Demonstrations Integrated with the Able-Bodied Demonstration.**

    a. During each Monthly Monitoring Call, the State will discuss with CMS (Central and Regional Offices) proposed State plan amendments (SPAs) or changes to other waivers/demonstrations (e.g., PASSPORT To Health), which are integrated with the Able-Bodied Demonstration and would impact the Demonstration enrollees. The discussion would include the intent of the amendment; anticipated programmatic and fiscal impacts; and intended submission and implementation dates.

    b. CMS reserves the right to require the State to submit an amendment if it is determined that it is warranted.

4. **Cost-Effective Insurance.** When a WMHSP-eligible individual has access to cost-effective health coverage through a cost-effective group health plan, the State may obtain benefits for the individual by providing premium assistance to the individual for this purpose in accord with the State plan for the provision of alternative cost effective coverage authorized for State plan eligible populations under section 1906 of the Act.

VI. ENROLLMENT

1. General Requirements

a. Unless otherwise specified in these STCs, all processes for eligibility, enrollment, redeterminations, terminations, appeals, etc. must comply with Federal law and regulations governing Medicaid and CHIP.

b. Any individual who is denied eligibility in any health coverage program authorized under this Demonstration must receive a notice from the State that gives the reason for denial, and includes information about the individual's right to appeal.

c. The State will adhere to the Demonstration population enrollment limits presented in Section IV *Eligibility*.

2. **Enrollment of Able Bodied Adults.** Upon determination of Medicaid eligibility, Able-Bodied Adults (as defined in section IV.3(a)) will be enrolled in the Demonstration. Enrollment for this population will not be capped.

3. **Imposing WMHSP Waiver Enrollment Limit and Lifting Enrollment Limit.** Upon approval of these STCs, the State will facilitate enrollment of up to 800 eligible individuals into the MHSP Demonstration population. With 30 days prior notice, the State may impose an enrollment cap upon the WMHSP Demonstration population of less than 800 in order to phase in enrollment and remain under the budget neutrality limit/ceiling for expenditures established for the Demonstration. The State must submit an amendment to this Demonstration in order to increase MHSP enrollment above 800 slots.

4. **Prioritization for WMHSP Waiver Enrollment.** The State will enroll individuals into the WMHSP program using the following process:

   a. The individual meets the financial and clinical eligibility criteria established for the State MHSP program, and is enrolled in the State MHSP program.

   b. Priority of State MHSP enrolled individuals being moved into the Demonstration will be based upon a current primary diagnosis of schizophrenia. At the State's discretion, available slots in the Demonstration will then be open to eligible individuals with bipolar disorder. The State may then open enrollment of any remaining slots to individuals with a diagnosis of major depression.

   c. To initially phase in enrollment, or at such time as the number of eligible individuals exceeds the number of available slots, the State will use a computer based random drawing to select the individuals (based on priority of diagnosis established in subparagraph b) to fill the available statewide slots.

5. **Enrollment into PASSPORT to Health, Enhance Primary Care Case Management, and Nurse First.** The State may enroll Demonstration-eligibles into the PCCMs and Nurse First Advice Line. By cross-reference, the enrollment, benefits, and cost sharing in the associated CMS-approved State plan in place as of the effective date of these STCs will apply to this Demonstration.

VII. COST SHARING

1. **Cost Sharing.** All Demonstration-enrolled individuals will be subject to the Medicaid cost share requirements as set forth in the State Plan. Cost sharing for Demonstration-enrolled individuals enroll is a cost-effective insurance plan, will be in accord with Section V.4.

VIII. DELIVERY SYSTEMS

1. **Freedom of Choice of Health Care Providers.** Individuals enrolled in the Demonstration:

    a. May also be enrolled in the PASSPORT to HEALTH Managed Care Program and/or the Enhanced Primary Case Management Program, which are Montana Medicaid's primary care case management (PCCM) programs. Under the PCCM programs, Medicaid clients are required to choose one primary care provider and develop an ongoing relationship that provides a "medical home." With some exceptions, all services to PCCM program enrollees must be provided or approved by the individual's primary care provider.

    b. Who are not enrolled in the Montana PCCM programs may receive a covered benefit from any provider participating with the Montana Medicaid program.

    c. Who are enrolled in the Nurse First Nurse First Advice Line may receive covered benefits from the one Disease Management Organization.

2. **Delivery System of a Cost-Effective Insurance Plan.** Demonstration-enrolled individuals receiving services through a cost-effective insurance plan will receive plan-covered services through the delivery systems provided by their respective insurance plan and additional services as necessary to ensure access to the full benefit package otherwise available. All additional services may be obtained from any physical or mental health provider participating with the Montana Medicaid program.

IX. GENERAL REPORTING REQUIREMENTS

1. **General Financial Requirements.** The State must comply with all general financial requirements under title XIX set forth in section IX.

2. **Reporting Requirements Relating to Budget Neutrality.** The State shall comply with all reporting requirements for monitoring budget neutrality as set forth in section XI. The State must submit any corrected budget neutrality data upon request.

3. **Compliance with Managed Care Reporting Requirements.** The State will comply with all applicable managed care regulation at 42 CFR 438 *et seq* for Demonstration-eligible individuals enrolled in the PCCM program. A status update on the PCCM, including a discussion of recent developments, problems encountered and steps taken to resolve them, must be included in each Annual Report.

4. **Monitoring Calls.** CMS shall schedule monthly conference calls with the State to ascertain progress and issues related to implementation of the MHSP component of the demonstration. Once start-up issues and concerns are resolved (at approximately 6 months post-implementation), the State and CMS may resume quarterly monitoring calls. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the Demonstration. Areas to be addressed include, but are not limited to, health care delivery, enrollment, quality of care, access, benefits, audits, lawsuits, financial reporting and budget neutrality issues, progress on evaluations, State legislative developments, and any Demonstration amendments, concept papers or State plan amendments the State is considering submitting. The State and CMS shall discuss quarterly expenditure reports submitted by the State for purposes of monitoring budget neutrality. CMS shall update the State on any amendments or concept papers under review as well as Federal policies and issues that may affect any aspect of the Demonstration. The State and CMS shall jointly develop the agenda for the calls.

5. **Quarterly Progress Reports.** The State must submit progress reports in accordance with the guidelines in Attachment A no later than 60 days following the end of each quarter. The intent of these reports is to present the State's analysis and the status of the various operational areas. These quarterly reports must include, but not be limited to:

   a. An updated budget neutrality monitoring spreadsheet;

   b. A discussion of events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including, but not limited to: approval and contracting with new plans, benefits, enrollment and disenrollment, grievances, quality of care, access, health plan contract compliance and financial performance that is relevant to the Demonstration, pertinent legislative or litigation activity, and other operational issues;

   c. Action plans for addressing any policy, administrative, or budget issues identified;

d. Quarterly enrollment reports for Demonstration-eligibles, that include the member months and end of quarter, point-in-time enrollment for each Demonstration population, and other statistical reports listed in Attachment A; and

e. Evaluation activities and interim findings.

6. **Transition Plan.** The State is required to prepare, and incrementally revise a Transition Plan consistent with the provisions of the ACA for individuals enrolled in the Demonstration, including how the State plans to coordinate the transition of these individuals to a coverage option available under the ACA without interruption in coverage to the maximum extent possible. The State must submit a draft to CMS by July 1, 2012, with progress updates included in each quarterly report. The State will revise the Transition Plan as needed.

7. **Annual Report.** In lieu of the fourth quarter report, the State must submit an annual report. The State must submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, interim evaluation findings, and policy and administrative difficulties and solutions in the operation of the Demonstration. The State must submit the draft annual report no later than 120 days after the close of the Demonstration Year (DY). Within 30 days of receipt of comments from CMS, a final annual report must be submitted.

X. GENERAL FINANCIAL REQUIREMENTS

1. **Quarterly Expenditure Reports for Title XIX.** The State must provide quarterly expenditure reports using Form CMS-64 to separately report total expenditures for services provided through this Demonstration under section 1115 authority that are subject to budget neutrality. This project is approved for expenditures applicable to services rendered during the Demonstration period. CMS shall provide FFP for allowable Demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section IX.

2. **Expenditures Subject to the Title XIX Budget Neutrality Expenditure Limit.** All expenditures for health care services for Demonstration participants (as defined in section IV above) are subject to the budget neutrality expenditure limit.

3. **Accounting for Enrollment and Expenditures of Demonstration Populations.** All enrollment and expenditures of Able-Bodied Adults and WMHSP individuals enrolled in the PCCM PASSPORT to Health and the Nurse First Disease Management programs will be attributable to this Demonstration and reported in accord with section IX, X, and XI. The enrollment and expenditures of Able-Bodied Adults and WMHSP individuals enrolled in these programs will not be included in the State's 1915(b) reports.

4. **Reporting Expenditures Subject to the Title XIX Budget Neutrality Expenditure Limit.** The following describes the reporting of expenditures subject to the budget neutrality expenditure limit:

   a. **Use of Waiver Forms.** In order to track expenditures under this Demonstration, the State must report Demonstration expenditures through the Medicaid and Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual (SMM). All Demonstration expenditures claimed under the authority of title XIX of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the Demonstration Project Number (11-W-00181/8) assigned by CMS.

   b. **Reporting By Date of Service.** In each quarter, Demonstration expenditures (including prior period adjustments) must be totaled and reported on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver by Demonstration Year (DY). The DY for which expenditures are reported is identified using the project number extension (a 2-digit number appended to the Demonstration Project Number). Expenditures are to be assigned to DYs on the basis of date of service. The date of service for premium or premium assistance payments is identified as the DY that accounts for the larger share of the coverage period for which the payment is made. DY 1 will correspond to the period of February 1, 2004 through January 31, 2005, DY 2 with the period of February 1, 2005 through January 31, 2006, and so on.

c. **Waiver Name.** For each Demonstration quarter, separate Forms CMS-64.9 Waiver and/or 64.9P Waiver must be completed to report expenditures for the following Demonstration populations. The waiver names to be used to identify these separate Forms CMS-64.9 Waiver and/or 64.9P Waiver appear in bold following the colon. Expenditures should be allocated to these forms based on the guidance provided in these STCs.

   i. **Demonstration Population 1: Able-Bodied Adults**—Eligibility Group (EG) consists of parent / caretaker relative adults whose Medicaid eligibility derives from their status as an optional Medicaid population under section 1925 or 1931 of the Act – counted in the "with" and "without" waiver calculations.

   ii. **Demonstration Population 2: WMHSP** —EG consists of enrolled WMHSP adults who are only eligible with section 1115 Demonstration authority (Title XIX Demonstration-eligible expansion population) – counted only in the "with" waiver calculations.

d. **Premiums and Cost Sharing Adjustments.** Premiums and other applicable cost-sharing contributions that are collected by the State from enrollees under the Demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet Line 9D, columns A and B. In order to assure that these collections are properly credited to the Demonstration, premium and cost-sharing collections (both total computable and Federal share) should also be reported separately by DY on the Form CMS-64 Narrative, and divided into subtotals corresponding to the eligibility groups (EGs) from which collections were made. In the calculation of expenditures subject to the budget neutrality expenditure limit, premium collections applicable to Demonstration populations shall be offset against expenditures. These section 1115 premium collections will be included as a manual adjustment (decrease) to the Demonstration's actual expenditures on a quarterly basis.

e. **Cost Settlements.** For monitoring purposes, cost settlements attributable to the Demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any cost settlements not attributable to this Demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual.

   i. **Prescription Drug Rebates.** Prescription drug rebates were not included in the original PMPM for Able-Bodied Adults. While the State collects prescription drug rebates on this population and the WMHSP population, the State does not include such rebates in the expenditure reports either as a credit or as an offset of prescription drug expenditures. This process will continue for the extension of the demonstration covered by these Special Terms and Conditions.

   An amendment would be necessary should the State wish to attribute a portion of the Prescription Drug Rebate to expenditures for populations included in the Basic Demonstration. The amendment would need to include a rebasing the PMPM

costs to include prescription drug costs and a proposed methodology for assigning a portion of prescription drug rebates to the Demonstration, in a way that reasonably reflects the actual rebate-eligible utilization of the Demonstration population, and which reasonably identifies prescription drug rebate amounts with DYs. Consistent with section 1115 demonstrations, the use of the methodology is subject to the approval in advance by the CMS Regional Office, and changes to the methodology must also be approved in advance by the Regional Office. The portion of prescription drug rebates assigned to the Demonstration using the approved methodology will be reported on the appropriate Forms CMS-64.9 Waiver for the Demonstration, and not on any other CMS-64.9 form (to avoid double-counting). Each rebate amount must be distributed as State and Federal revenue consistent with the Federal matching rates under which the claim was paid.

ii. **Federally Qualified Health Center Settlement Expenses.** Within 60 days of this award, the State must propose to the CMS Regional Office a methodology for identifying the portion of any FQHC settlement expenses that should be reported as Demonstration expenditures because of a linkage between settlement payments to FQHCs and use of FQHC services by Demonstration participants. Once the methodology is approved by the Regional Office, the State will reported the amounts of FQHC settlement payments identified on the appropriate Forms CMS-64.9 and 64.9P Waiver.

iii. **Indian Health Services.** The following rules govern reporting of Indian Health Service (IHS) expenditures subject to the 100 percent Federal matching for Able-Bodied Adults and WMHSP eligibles.

1. Because IHS expenditures were excluded from the original calculation of the without-waiver PMPM costs estimates for Able-Bodied Adults, the State must report IHS expenditures for Able-Bodied Adults on forms CMS-64.9 Waiver and 64.9P Waiver, under waiver name "IHS" and with project number extension "NA." This is an exception to the instructions for reporting Able-Bodied Adults' expenditures in subparagraphs (b) through (d) above.

2. Because IHS expenditures for WMHSP eligibles are costs not otherwise matchable, they are necessarily demonstration expenditures. For this reason, the State must report these expenditures on forms CMS-64.9 Waiver and 64.9P Waiver under waiver name "WMHSP Adults," following the instructions in subparagraphs (b) through (d).

5. **Title XIX Administrative Costs.** Administrative costs will not be subject to the budget neutrality expenditure limit, but the State must separately track and report additional administrative costs that are directly attributable to the Demonstration. All such administrative costs will be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver, using waiver name "Montana Basic Medicaid for Able-Bodied Adults."

6. **Claiming Period.** All claims for expenditures subject to the budget neutrality expenditure limit (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the Demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the Demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 Demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

7. **Standard Medicaid Funding Process.** The standard Medicaid funding process shall be used during the Demonstration. The State must estimate matchable Medicaid expenditures on the quarterly form CMS-37. In addition, the estimate of matchable Demonstration expenditures (total computable and Federal share) subject to the budget neutrality agreement must be separately reported by quarter for each FFY on the form CMS-37.12 for both the medical assistance program and administrative costs. CMS shall make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

8. **Extent of Title XIX FFP for the Demonstration.** Subject to CMS approval of the source(s) of the non-Federal share of funding, CMS shall provide FFP at the applicable Federal matching rates for the Demonstration as a whole as outlined below, subject to the limits described in Section IX:

    a. Administrative costs, including those associated with the administration of the Demonstration;

    b. Net expenditures and prior period adjustments, made under approved Expenditure Authorities, with dates of service during the operation of the Demonstration

9. **Sources of Non-Federal Share.** The State certifies that the source of non-Federal share of funds for the Demonstration is State/local monies. The State further certifies that such funds shall not be used as the non-Federal share for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with title XIX of the Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.

    a. CMS shall review the sources of the non-Federal share of funding for the Demonstration at any time. The State agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

b. The State shall provide information to CMS regarding all sources of the non-Federal share of funding for any amendments that impact the financial status of the program.

c. Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the State as Demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the State and/or local government to return and/or redirect any portion of the Medicaid or Demonstration payments. This confirmation of Medicaid and Demonstration payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes (including health care provider-related taxes, fees, and business relationships with governments that are unrelated to Medicaid or the Demonstration and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid or Demonstration payment.

10. **Maintenance of Effort for the WMHSP Population.** In order to expand the Able-Bodied section 1115 demonstration to include up to 800 individuals who are not otherwise Medicaid eligible, Montana must provide the same level of State funding (referred to as Maintenance of Effort (MOE)) for the continued provision of health services to this population.

    a. **WMHSP Claiming.**

        1. During State fiscal year (SFY) 2009, the State's expenditures for health benefits provided to the over 3,400 individuals in the State-only MHSP program was $8,860,518.

        2. The State must determine the total reported health benefit expenditures for WMHSP enrolled individuals for each SFY, and in each annual report provide assurance to CMS that State expenditures for WMHSP and MHSP will be maintained at the SFY 2009 level.

        3. The State is not eligible to claim the increased FFP established under the American Recovery and Reinvestment Act of 2009 for the WMHSP population.

11. **Monitoring the Demonstration.** The State will provide CMS with information to effectively monitor the Demonstration, upon request, in a reasonable timeframe.

XI. MONITORING BUDGET NEUTRALITY

1. **Limit on Title XIX Funding.** The State shall be subject to a limit on the amount of Federal title XIX funding that the State may receive on selected Medicaid expenditures during the period of approval of the Demonstration. The limit is determined by using a per capita cost method. The budget neutrality expenditure targets are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire Demonstration. Actual expenditures subject to the budget neutrality expenditure limit shall be reported by the State using the procedures described in Section X.3.

2. **Risk.** The State assures that the demonstration expenditures do not exceed the level of expenditures had there been no demonstration.

   a. The State will be at risk for the per capita cost (as determined by the method described in this Section) for Medicaid eligibles in the following eligibility group(s): "Able-Bodied Adults," but not for the number of individuals enrolled in the group(s). By providing FFP for enrollees in the specified group(s), the State will not be at risk for changing economic conditions that impact enrollment levels.

   b. The State will be at risk, under this budget neutrality agreement, for both the number of enrollees as well as the per capita cost for the following expansion populations enrolled in the demonstration: enrolled WMHSP individuals.

3. **Budget Neutrality Expenditure Limit.** The following describes how the annual budget neutrality expenditure limits are determined:

   a. For each DY of the budget neutrality agreement, an annual target is calculated as the projected per member per month (PMPM) cost for Able-Bodied Adults times the actual number of member months (reported by the State in accordance with paragraph IX.4)

   b. Member months for WMHSP eligibles are not used for calculation of the budget neutrality expenditure limit.

   c. The following table gives the projected PMPM costs for the calculation described in paragraph XI.3(a) by DY.

Table 1: Historical PMPM Costs for Determining the Budget Neutrality Ceiling

	DY 1 PMPM	DY 2 PMPM	DY 3 PMPM	DY 4 PMPM	DY 5 PMPM
Able-Bodied Adults	$294.21	$316.87	$341.27	$367.54	$395.84

Table 2: Projected PMPM Costs for Determining the Budget Neutrality Ceiling

	DY 6 PMPM (2/1/09 – 1/31/10)	DY 7 PMPM* (2/1/10 – 1/31/11)	DY 8 PMPM (2/1/11 – 1/31/12)	DY 9 PMPM (2/1/12 – 1/31/13)	DY 10 PMPM (2/1/13 – 12/31/13)
Able-Bodied Adults	$426.32 7.7%	$459.15 7.7% $453.18 6.3%	$481.73 6.3%	$512.08 6.3%	$544.34 6.3%

** NOTE: The Demonstration was continued between February 1, 2009 and November 30, 2010 under "the same terms and conditions" meaning a 7.7% PMPM trend rate.*

d. The budget neutrality expenditure limit is the Federal share of the annual PMPM limits for the Demonstration period, and represents the maximum amount of FFP that the State may receive for title XIX expenditures during the Demonstration period, as described in paragraph X.3. The budget neutrality expenditure limit is equal to the sum of all of the subcomponents described in (a)(1) above for all DYs, times the Composite Federal Share (defined in (e) below).

e. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the State on actual demonstration expenditures during the approval period, as reported through the MBES/CBES and summarized on Schedule C by total computable Demonstration expenditures for the same period as reported on the same forms. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed upon method.

4. **Future Adjustments to the Budget Neutrality Expenditure Limit.** CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new Federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under this demonstration. CMS reserves the right to make adjustments to the budget neutrality expenditure limit if any health care-related tax that was in effect during the base year with respect to the provision of services

covered under this Demonstration, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care-related tax provisions of section 1903(w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

5. **Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality over the life of the Demonstration rather than on an annual basis. However, if the State exceeds the calculated cumulative target limit by the percentage identified below for any of the DYs, the State shall submit a corrective action plan to CMS for approval.

Year	Cumulative target definition	Percentage
DY 1	DY 1 budget neutrality cap	+8.0 percent
DY 2	DYs 1 and 2 combined budget neutrality limit	+3.0 percent
DY 3	DYs 1 through 3 combined budget neutrality limit	+1.0 percent
DY 4	DYs 1 through 4 combined budget neutrality limit	+0.5 percent
DY 5	DYs 1 through 5 combined budget neutrality limit	0 percent
DY 6	DYs 1 through 6 combined budget neutrality limit	+2.5 percent
DY 7	DYs 1 through 7 combined budget neutrality limit	+0.75 percent
DY 8	DYs 1 through 8 combined budget neutrality limit	0 percent
DY 9	DYs 1 through 9 combined budget neutrality limit	+2.5 percent
DY 10	DYs 1 through 10 combined budget neutrality limit	+.75 percent
DY 11	DYs 1 through 11 combined budget neutrality limit	0 percent
DY 12	DYs 1 through 12 combined budget neutrality limit	0 percent

6. **Exceeding Budget Neutrality.** If the budget neutrality expenditure limit has been exceeded at the end of this Demonstration period, the excess Federal funds shall be returned to CMS. If the Demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.

XII. EVALUATION OF THE DEMONSTRATION

1. **Submission of Draft Evaluation Design.** The State must submit to CMS for approval a draft evaluation design for an overall evaluation of the Demonstration no later than 120 days after the effective date of the Demonstration. At a minimum, the draft design must include a discussion of the goals and objectives set forth in Section II of these STCs, as well as the specific hypotheses that are being tested. The draft design must discuss the outcome measures that will be used in evaluating the impact of the Demonstration during the period of approval. It shall discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the Demonstration must be isolated from other initiatives occurring in the State. The draft design must identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation.

2. **Inclusion of the WMHSP Population into the Evaluation Design.** The State will submit an addendum to the Draft Evaluation Design previously submitted for the Montana Basic Medicaid for Able-Bodied Adults Demonstration. The revised Draft Evaluation Design that incorporates the WMHSP addendum will be submitted to CMS for approval no later than 60 days after CMS's approval of the WMHSP program.

3. **Interim Evaluation Reports.** In the event the State requests to extend the Demonstration beyond the current approval period under the authority of section 1115(a), (e), or (f) of the Act, the State must submit an interim evaluation report as part of the State's request for each subsequent renewal.

4. **Final Evaluation Design and Implementation.** CMS will provide comments on the draft evaluation design within 60 days of receipt, and the State shall submit a final design within 60 days after receipt of CMS comments. The State must implement the evaluation design and submit its progress in each of the quarterly and annual progress reports. The State must submit to CMS a draft of the evaluation report within 120 days after expiration of the Demonstration. CMS must provide comments within 60 days after receipt of the report. The State must submit the final evaluation report within 60 days after receipt of CMS comments.

5. **Final Evaluation Report**. The State must submit to CMS a draft of the evaluation report within 120 days after expiration of the Demonstration. CMS must provide comments within 60 days after receipt of the report. The State must submit the final evaluation report within 60 days after receipt of CMS' comments.

6. **Cooperation with Federal Evaluators.** Should CMS undertake an independent evaluation of any component of the Demonstration, The State shall cooperate fully with CMS or the independent evaluator selected by CMS. The State shall submit the required data to CMS or the contractor.

XIII. SCHEDULE OF DELIVERABLES FOR THE DEMONSTRATION EXTENSION PERIOD

STC	Deliverable
Within 30 days of the date of award	State acceptance of Demonstration Waivers, STCs, and Expenditure Authorities (approval letter)
In compliance with paragraph XII.1.	Submit Draft Design for Final Evaluation Report
Within 60 days of the date of award (paragraph XII.2).	Submit the WMHSP addendum to the Draft Evaluation Design
Monthly Deliverables	**Deliverable**
In compliance with paragraph IX.4.	Monitoring Call
In compliance with paragraph X.11.	Monthly Enrollment Report
Quarterly Due 60 days after the end of each quarter, except the 4th quarter	**Deliverable**
In compliance with paragraph IX.5.	Quarterly Progress Reports
In compliance with paragraph IX.5(d).	Quarterly Enrollment Reports
In compliance with section X.1.	Quarterly Expenditure Reports
Annual Due 60 days after the end of the 4th quarter	**Deliverable**
In compliance with paragraph IX.7.	Draft and Final Annual Reports (Annual Progress Reports and Annual Expenditure Reports)
Other	**Deliverable**
In compliance with paragraph IX.6, by July 1, 2012	Submit a Transition Plan
120 days after expiration of the demonstration per paragraph XII.5.	Submit Draft Final Evaluation Report
Within 60 days after receipt of CMS comments per paragraph XII.5.	Submit Final Evaluation Report

ATTACHMENT A

QUARTERLY REPORT FORMAT AND CONTENT

Under Section VII, paragraph XX, the State is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant Demonstration activity from the time of approval through completion of the Demonstration. The reports are due to CMS 60 days after the end of each quarter.
The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the State. A complete quarterly progress report must include an updated budget neutrality monitoring workbook.

NARRATIVE REPORT FORMAT:

Title Line One – Montana Basic Section 1115 Medicaid Demonstration
Title Line Two - Section 1115 Quarterly Report
Demonstration/Quarter Reporting Period:

Example:
Demonstration Year: 1 (January 1, 2010 – December 31, 2010)
Federal Fiscal Quarter: 01/01/2010 – 03/31/2010

Introduction
Information describing the goal of the Demonstration, what it does, and key dates of approval/operation. (This should be the same for each report.)

Enrollment Information
Please complete the following table that outlines all enrollment activity under the Demonstration. The State should indicate "N/A" where appropriate. If there was no activity under a particular enrollment category, The State should indicate that by "0".

Enrollment Count
Note: Enrollment counts should be person counts, not member months.

Demonstration Populations (as hard coded in the CMS 64)	Current Enrollment (last day of quarter)	Newly Enrolled in Current Quarter	Disenrolled in Current Quarter
Able-Bodied Adults			
WMHSP Adults			
• **Schizophrenia**			
• **Bipolor Disorder**			
• **Major Depression**			

Member Month Reporting

Enter the member months for the quarter.

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
Able-Bodied Adults				
WMHSP Adults				
• **Schizophrenia**				
• **Bipolor Disorder**				
• **Major Depression**				

Outreach/Innovative Activities:

Summarize outreach activities and/or promising practices for the current quarter.

Operational/Policy Developments/Issues:

Identify all significant program developments/issues/problems that have occurred in the current quarter, including, but not limited to, approval and contracting with new plans, benefit changes, and legislative activity.

Financial/Budget Neutrality Developments/Issues:

Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS-64 reporting for the current quarter. Identify the State's actions to address these issues. Specifically, provide an update on the progress of implementing the corrective action plan.

Consumer Issues:

A summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences.

Quality Assurance/Monitoring Activity:

Identify any quality assurance/monitoring activity in current quarter.

Status of Benefits and Cost Sharing:

Provide update regarding any changes to benefits or cost sharing during the quarter.

Demonstration Evaluation:

Discuss progress of evaluation design and planning.

Enclosures/Attachments:

Identify by title any attachments along with a brief description of what information the document contains.

State Contact(s):

Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise.

Date Submitted to CMS: