MONTANA DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

Section 1115 Waiver for Additional Services and Populations (formerly Basic Medicaid)

Evaluation Report
February 2014 – January 2016

July 15, 2016

Executive Summary

The Basic Medicaid Program 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.

Basic Medicaid Demonstration History

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 comprised of 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, offered 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, DPHHS submitted an 1115 Waiver application to Centers for Medicare and Medicaid Services (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 has remained constant throughout the life of the Basic Program. The State submits quarterly and annual Basic Medicaid reports as one of the Operational Protocol conditions.

A Health Insurance Flexibility and Accountability (HIFA) proposal was submitted on June 27, 2006. Amendments to the 1115 Basic Medicaid Waiver 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. On July 30, 2009 and August 6, 2010, submittals requested only one population, Waiver Mental Health Services Plan (WMHSP) individuals, in addition to Able-Bodied Adults. CMS approved the Waiver extension and the request to insure the additional WMHSP population, effective December 1, 2010. The WMHSP population included those individuals age 18 through 64, with incomes at or below 150 percent of the Federal Poverty Level (FPL), who have been diagnosed with severe disabling mental illness (SDMI) of schizophrenia or bipolar disorder. Priority enrollment was based on a current diagnosis of schizophrenia and a secondary population of individuals with bipolar disorder.

The Basic Medicaid Waiver renewal was submitted in June, 2013, and approved by CMS effective January 1, 2014. The renewal included raising the enrollment cap from "up to 800" to "up to 2,000"; added a random drawing to include the SDMI diagnosis of Major Depressive disorder as the third priority population; and home infusion as a covered service.

In June 2014, Montana submitted an amendment to the Section 1115 Basic Medicaid Waiver, 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 Mental Health Service Plan (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; updated the diagnosis codes for Schizophrenia spectrum, Bipolar Related disorders, Major Depressive disorders, and then all remaining SDMI 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 WMSHP 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.

On November 16, 2015, effective January 1, 2016, Montana submitted an amendment, to remove the Able-Bodied Adult population, remove Medicaid Expansion SDMI population eligible for State Plan, which gives MHSP Waiver population Standard Medicaid benefits, and close the Basic Medicaid 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 provides a 12-month continuous eligibility period for all non-expansion Medicaid-covered individuals whose eligibility is based on modified adjusted gross income (MAGI). Overall, this amendment will re-finance state funds by utilizing federal funds.

On March 7, 2016, effective March 1, 2016, an Amendment was submitted 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.

Department of Public Health and Human Services
Richard Opper is the Director of DPHHS and Mary E. Dalton is the State Medicaid Director. The Montana Medicaid Program consists of the following Divisions: Health Resources Division, Disability Services Division, Addictive and Mental Disorders Division, Child and Family Services Division, Senior and Long Term Care Division, Quality Assurance Division, Human and Community Services Division, and the Public Health and Safety Division. Medicaid eligibility is determined in the Human and Community Services Division.

Montana Medicaid Program Goal
To assure that medically necessary medical care is available to all eligible Montanans within available funding resources.

Section 1115 Basic Medicaid Waiver Goal
Montana's goal is to provide Basic Medicaid coverage, originally designed to replicate a basic health plan benefit as a Welfare Reform Waiver, for Able-Bodied Adults while using the generated Federal Waiver savings to provide Basic coverage for the previously uninsured WMHSP.

Basic Medicaid Policies
All requirements of the Medicaid Program expressed in law not expressly waived or identified as not applicable in the award letter of which the terms and conditions are part, shall apply to Montana's demonstration. Montana Medicaid Program administrative rules, policies, processes, eligibility, cost sharing, and reimbursement apply to individuals on Basic Medicaid unless specified in the Waiver.

Basic Medicaid Benefit Excluded Services (February 1, 1996 - January 1, 2016)
The Basic package was the Full Medicaid benefit, with the following medical services generally excluded under Basic Medicaid: audiology, dental and denturist, durable medical equipment, eyeglasses, optometry and ophthalmology for routine eye exams, personal care services, home infusion and hearing aids. Under the FAIM Waiver, these services were excluded to align with the basic medical coverage of a work-related insurance program. That is, an employed individual who is insured under a work-related insurance policy would not have coverage for the list of excluded services.

Emergencies and Essentials for Employment Program
DPHHS recognized there may be situations where the excluded services were necessary as in an emergency or when essential for employment. Coverage for the excluded services was provided at the State's discretion in cases of emergency or when essential to obtain or maintain employment. Examples of emergency circumstances included, but were not limited to, coverage for emergency dental situations, medical conditions of the eye, which included but were not limited to annual dilated eye exams for individuals with diabetes or other medical conditions, and certain medical supplies such as diabetic supplies, prosthetic devices and oxygen. In these situations, the State provided approval to the provider, and made associated records available upon CMS request. Medicaid manuals contained Basic information, which could be found on the DPHHS site at http://medicaidprovider.mt.gov/providertype.

The *General Information for Providers, Medicaid and Other Medical Assistance Programs,* is found at http://medicaidprovider.mt.gov.

Medicaid provider training was offered several times a year and Basic Medicaid billing, policies, and procedures were included. Providers, when inquiring about members eligibility, receive eligibility information including whether a person was receiving Full or Basic Medicaid regardless of the various eligibility methods of Faxback, Voice Response, Web Portal or when contacting the Office of Public Assistance, DPHHS, or Montana Medicaid's Provider Relations.

Medicaid members received a post card informing them the Montana Medicaid and Healthy Montana Kids Plus Member Guide was available online or they could request a hard copy by contacting the member Help Line; the Montana Medicaid and Healthy Montana Kids Plus Member Guide can be found at: http://dphhs.mt.gov/MontanaHealthcarePrograms/Welcome/MembersServices. A chart of Medicaid covered benefits was published with additional service details. Members received education and information regarding Full and Basic Medicaid services through the Montana Medicaid Help Line. The provider community and individuals who were affected by the 1115 Waiver were accustom to the provisions of the Waiver.

Standard Medicaid Benefit (January 1, 2016 – present)
All Medicaid members are eligible for Standard Medicaid services if medically necessary. Covered services include, but are not limited to, audiology services, clinic services, community health centers

services, dental services, doctor visits, hospital services, immunizations, Indian Health Services, laboratory services, mental health services, Nurse First services, nursing facility, occupational therapy, pharmacy, public health clinic services, substance dependency services, tobacco cessation, transportation, vision services, well-child checkups, and x-rays.

Basic Medicaid Population

Individuals on Basic Medicaid included Able Bodied Adults who were not pregnant, not blind, under age 65, and not disabled or receiving SSI. These were individuals eligible for Basic Medicaid under the designation of Family Medicaid and Transitional Medicaid.

Basic Medicaid Population
DY11 Average - DY12 Average

N/A	**February 2014 – January 2015 DY11 Average**	**February 2015 - January 2016 DY12 Average**
Family Medicaid	78%	64%
Transitional Medicaid	11%	14%
WMHSP Schizophrenia	3%	3%
WMHSP Bipolar Disorder	5%	5%
WHMSP Major Depressive Disorder	4%	6%
WMHSP Post-Traumatic Stress Disorder	N/A	0%
WHMSP Anxiety Disorder	N/A	1%
WMHSP Borderline Personality Disorder	N/A	0%
***WHMSP Other**	0%	0%

*The WMHSP Other category covers diagnoses for personality disorders, mood disorders, and other psychotic disorders that do not fall under Schizophrenia spectrum, Bipolar spectrum, Major Depressive disorders, Anxiety disorders, Post-Traumatic Stress disorder, and Borderline Personality disorder.

Basic and Full Medicaid Enrollment DY11 Average – DY12 Average

In DY11, a quarterly average of 13,751 members were enrolled in Basic Medicaid; compared to 37,264 members were enrolled in Full Medicaid. In DY12, Basic Medicaid members increased 11% and Full Medicaid enrollment increased 13%.

Basic and Full Medicaid Enrollment
DY11 Average – DY12 Average

N/A	February 2014 – January 2015 DY11 Average	February 2015 – January 2016 DY12 Average
Basic Medicaid Enrollment	13,751	15,406
Full Medicaid Enrollment (Age 21-64)	37,264	43,000

Full (Age 21-64) and Basic Medicaid Gender, Ethnic and Race DY11 Average – DY12 Average
In DY11, Basic Medicaid was 68% predominately female; compared to 67% females for Full Medicaid in the 21-64 age group. In DY12, Basic Medicaid was 69% predominately female; compared to 67% females for Full Medicaid in the 21-64 age group. In DY11, Basic Medicaid was 31% males; compared to 33% males in Full Medicaid. In DY12, Basic Medicaid was 31% males; compared to 33% males in Full Medicaid. In DY11, the American Indian average for Basic Medicaid was 24% and 21% for DY12, which is averaged at 5% more than the Full Medicaid for both demonstration years.

Basic Medicaid Gender, Ethnic and Race
DY11 Average – DY12 Average

N/A	February 2014 – January 2015 DY11 Average	February 2015 – January 2016 DY12 Average
Female	68%	69%
Male	32%	31%
Hispanic of Any Race	3%	3%
White	72%	75%
American Indian/AK	24%	21%
Other: African American, Asian, Pacific Islander	1%	1%

Full Medicaid Gender, Ethnic and Race (Age 21-64)
DY11 Average – DY12 Average

N/A	February 2014 – January 2015 DY11 Average	February 2015 – January 2016 DY12 Average
Female	67%	67%
Male	38%	33%
Hispanic of Any Race	3%	3%
White	78%	79%
American Indian/AK	17%	18%
Other: African American, Asian, Pacific Islander	1%	1%

DY11 and DY12 Expenditures by Provider Type for the Top Ten Providers

PROV PAY TO TYPE	DY11 2/1/2014 to 1/31/2015 Total	DY11 Percent of Total	DY12 2/2/2015 to 1/31/2016 Total	DY12 Percent of Total
PHARMACY	$15,577,346	22.97%	$18,200,068	21.45%
HOSPITAL - OUTPATIENT	$8,781,209	12.95%	$10,938,572	12.89%
HOSPITAL - INPATIENT	$8,395,117	12.38%	$10,652,854	12.56%
CRITICAL ACCESS HOSPITAL	$7,621,233	11.24%	$9,894,454	11.66%
GROUP/CLINIC	$6,133,363	9.04%	$8,920,625	10.51%
INDIAN HEALTH SERVICES	$3,397,037	5.01%	$3,832,689	4.52%
CASE MANAGEMENT - MENTAL HEALTH	$2,749,773	4.05%	$3,367,153	3.97%
MENTAL HEALTH CENTER	$2,732,549	4.03%	$3,324,322	3.92%
PHYSICIAN	$2,194,593	3.24%	$2,375,586	2.80%
FEDERALLY QUALIFIED HEALTH CENTER	$1,568,458	2.31%	$1,938,614	2.29%
Grand Total	**$67,824,110**	**88.77%**	**$84,839,915**	**86.57%**

Top ten provider types averages 87.67% of total costs.

Section 1115 Montana Basic Medicaid Waiver
Primary Survey Findings

In October, 2015, DPHHS mailed 2,760 surveys to all currently enrolled WMHSP individuals. As in the previous survey, completed in 2012, a drawing for $50 gift certificate to a grocery store of their choice was provided as an incentive to complete and return the survey in the pre-paid envelope by November 15. In all, 26% of the surveys were returned (705), which was comparable to the 2012 return rate (26.5%).

The survey addressed six different components, which are: General Coverage, Demographics, Health Status, Access to Health Care, Quality of Health Care, and Travel to Healthcare. The 2012 survey data was intended as a baseline. Five percent of the 2015 surveys were second-time respondents; the remaining 672 surveys (95% of the returned 2015 surveys) were first-time respondents. Comparison of results showed; members reported a greater understanding of their benefits, reported a greater percentage had seen their physician for their physical health in the past month, reported a smaller percentage where there were zero days in which poor physical or mental health kept them from doing their usual activities, and reported a greater percentage of members receiving Medicaid travel reimbursement to see specialists outside of their community. Additionally, all the 2015 responses are compared with the 2012 responses, which are included in the findings under the Baseline Comparison heading.

Primary findings from the 2015 survey data are below. Additional details are provided in the attached Detailed Analysis Report.

General Coverage:

- More than half (55%) said they understood their Basic Medicaid benefits well or very well; 45% said they did not understand their benefits well at all (Q1).
- Two-thirds (66%) did not have additional coverage; 28% had Medicare in addition to Medicaid (Q2).
- 84% currently indicated having a primary physician for physical health while only 58% had a primary physician prior to receiving Basic Medicaid (a 31% increase) (Q3+Q4).
- Half (50%) had seen a physician for physical healthcare within the past month, while an additional 40% (280) last saw their physician within the past 2-12 months. Ten percent had last seen a physician two or more years ago (Q5).

Demographics:

- Race, ethnicity, gender and age of the respondents reflected that of publically funded adult mental health members in Montana, but with an underrepresentation of American Indians (3% of survey respondents vs. 6.6%); however, five percent of the respondents categorized as having more than one race most often were of American Indian/Alaska Native descent (Q6-Q8).
- 38% had completed high school and an additional 49% of the sample had attended college (Q9); the percent who had attended college was not representative of publically funded adult mental health clients in Montana (which was reported to be 22% in 2015).
- One-fourth (26%) were employed (Q10), 66% owned or rented a home (Q11), and four percent considered themselves homeless (Q11) (including some who lived with others in their home).

Health Status:

- 44% considered their general health to be good, very good, or excellent; 36% fair; and 19% poor (Q12).
- 38% believed their general health had *improved* since receiving the Basic Medicaid benefits; 30% believed it had stayed the same; 10% felt their health had gotten worse; and 22% were not sure (Q13).
- Members presented themselves as being healthier physically than mentally:
    - 34% said their *physical* health was not good for 14 or more days out of the past 30 days (Q14), while 51% said their *mental* health was not good for 14 or more days out of the past 30 days (Q15).
    - Similarly, 51% said their *physical* health was *not* good for just 0-7 days out of the past 30 days (Q14), while only 29% said their *mental* health was *not* good for just 0-7 days out of the past 30 days (Q15).
- When asked the number of days, in the past 30 days, that poor physical *or* mental health kept them from doing their usual activities, 16% said zero days; 17% said 1-7 days; nine percent said 8-13 days; 20% said 14-20 days; and 20% said 21-30 days (Q16).
- Most (91%) said they had received mental or physical health care in the last three months, and 88% had received care from their physician (Q17-Q18).
- In the last three months, 23% received physical or mental health care at the Emergency Room, and 11% were hospitalized (Q19-Q20).

Access to Health Care:

- For *physical* care in the last three months, 19% could get an appointment with their physician within one day, 43% within a week, 22% within two weeks, and 16% greater than two weeks. For physical care in general, 83% found their wait-time to be satisfactory. (Q21)
- Members had to wait longer for mental health care than physical care for wait-times that exceeded one day: 19% could get an appointment with their mental health physician within one day, 34% within a week, 24% within two weeks, and 23% greater than two weeks. For mental care in general, 71% found their wait-time to be satisfactory, which was a 12% lower satisfaction rate than that for physical appointment wait-times. (Q21). (Satisfaction rates and comments suggest that some members may have felt they needed to be seen for mental health care more often than the once-a-week appointments they were given.)
- For those who had to wait *over* two weeks for an appointment, 53% found the wait-time to be unsatisfactory for physical care, and 54% found the wait-time to be unsatisfactory for mental care (Q21).
- For those who were able to get an appointment *within* two weeks, 24% found the wait-time unsatisfactory for physical care and 23% found the wait-time unsatisfactory for mental care (Q21).
- When asked if they were unable to see a physician for physical or mental health care in the past three months because of *cost*, 72% said no, and 28% said yes or sometimes (Q22). One member said, “No, I have Medicaid.” Some members commented that $4-$5 co-pays for appointments and

medications are not always affordable; others said that medication is cheaper, and that without Medicaid they would not be able to afford physicians, specialists, and needed procedures.

Quality of Health Care:

- The majority (81%) felt their physician always or usually spent enough time listening to their concerns, answering their physical and mental health questions, and explaining their medical conditions, treatment options and medications; 16% felt their physician sometimes spent enough time; and three percent said their physician never spent enough time with them (Q23-Q24). Comments suggested that the amount of time spent listening varied from provider to provider, and that specialists tended to spend less time than Primary Care Providers (PCPs), therapists, or case managers.
- The majority (70%) said that in the past three months they were able to get all the physical and mental health care services they thought they needed (Q25). One member said, "Medicaid has helped me a lot. I have been very sick and out of work and seeing a lot of physicians."
- In the comments, three percent of respondents expressed a desire for dental coverage, some of them with dire needs; and two percent expressed a need for vision care. (Fortunately, both dental and vision will be covered for nearly all these members when they move from Basic Medicaid to Standard Medicaid in January, 2016.)
- 88% were prescribed medication, and 94% of respondents said they take their medication as prescribed every day (Q26).

Travel to Health Care:

- Two-thirds (64%) traveled no more than 20 miles roundtrip for healthcare; 17% traveled 22-60 miles; 15% traveled 62-200 miles; and five percent traveled 202 or more roundtrip miles (Q27).
- The most common reason for traveling outside one's community for healthcare was to see a specialist (45%); 37% said their physician did not live in their community; and 18% traveled outside their community for health care because they did not live in a large enough community (Q28).
- Only 12% received Medicaid travel reimbursement; 88% did not. One member who asked for information on travel reimbursement wrote, "A roundtrip to the physician is over 200 miles—and in a pickup. Have missed many appointments." Three percent of respondents requested travel reimbursement information or said they were unaware of travel reimbursement coverage; another ten members asked for assistance with transportation (Q29).

Baseline Comparison

Although only 33, 2015 surveys were returned by members who had also completed the 2012 baseline survey; we can still compare the responses between the three years. Comparing the averaged responses of the 705 members in 2015 with the averaged responses of the 209 members who returned the 2012 surveys, we find:

- A greater percentage of Waiver members understood their Basic Medicaid benefits well or very well in 2015 than in 2012 (55% vs. 50%).

- A smaller percentage of members had *Medicare* in addition to Medicaid in 2015 compared to 2012 (28% vs. 38%); and a greater percent did *not* have additional coverage in 2015 compared to 2012 (66% vs. 52%).
- A greater percent of 2015 members had seen their physician for *physical* health care within the last month compared to the 2012 respondents (50% vs. 45%).
- A greater percent of 2015 members felt their general health was *poor* compared to the 2012 respondents (19% vs. 12%).
- A greater percent of 2015 members felt their general health had gotten *worse* since being on the Basic Medicaid Waiver compared to the 2012 respondents (10% vs.4%).
- A greater percent of 2015 members said their *mental* health was not good for *14 days or more days* out of the past 30 compared to the 2012 respondents (51% vs. 40%).
- A smaller percent of 2015 members said there were zero days in which poor physical *or* mental health kept them from doing their usual activities (16% vs. 24% in 2012).
- The *same* percent of 2015 members were hospitalized overnight in the last three months for physical or mental health as the 2012 respondents (11% each).
- A smaller percent of 2015 members were able to get a *physical* health care appointment within one day compared to 2012 respondents (19% vs. 27%).*
- A smaller percent of 2015 members were able to get a *mental* health care appointment within one day compared to 2012 respondents (19% vs. 25%).*
- A greater percent of 2015 members had to wait over two weeks to get a *mental* health care appointment compared to 2012 respondents (23% vs. 16%).*
- A greater percent of 2015 members were *dissatisfied with the wait-time for mental health* services compared to 2012 respondents (29% vs. 24%); likewise, fewer 2015 members were *satisfied* with the mental health wait-time (71% vs. 76% in 2012).*
- A smaller percent of 2015 members said their physician never spends enough time explaining their medical condition, treatment options and medications compared to 2012 respondents (3% vs. 6%).
- *12% fewer* 2015 members felt they were able to get all of the physical or mental health care services they needed compared to 2012 respondents (70% vs. 82%). Likewise, a greater percent of 2015 members said they were *not* able to get all the health care services they needed (30% vs. 18%).*
- A greater percent of 2015 members said the reason they needed to travel was to see a specialist outside their community (45% vs. 36% in 2012).*
- A greater percent of 2015 members received Medicaid travel reimbursement compared to 2012 respondents (12% vs. 4%).*

<u>Comments of Appreciation:</u>

- Fifty-four members (8%) took the initiative to express appreciation for their Medicaid services in the Comments section. One member summed up the comments of many others when stating,

"Since I have had Medicaid, I have finally been able to get the medical and mental help so desperately needed. Thank you."

*2012 percent adjusted to exclude those not needing an appointment in the past three months to allow for equitable comparison with 2015.

Contact Information

Holly Mook, Medicaid Program Officer	(406) 444-6868
Mary E. Dalton, State Medicaid Director	(406) 444-4084