



NOV - 2 2015

Administrator
Washington, DC 20201

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

Dear Ms. Dalton:

The Centers for Medicare & Medicaid Services (CMS) is approving Montana's application for a five-year Medicaid demonstration project entitled, "Montana Health Economic Livelihood Partnership (HELP) Demonstration" (Project Number 11-W-00300/8). The demonstration is approved in accordance with section 1115(a) of the Social Security Act (the Act) and effective on the date of this letter. Through this demonstration, associated state plan amendments, and a section 1915(b)(4) of the Act waiver authorizing a defined provider network, the state will expand access to coverage to adults aged 19-64 in Montana who have incomes up to 133 percent of the federal poverty level (FPL). Enrollment for the expansion will begin on November 1, 2015, with eligibility effective on January 1, 2016. The demonstration is approved through December 31, 2020, assuming the state fulfills the requirements outlined within the special terms and conditions (STCs) to continue the demonstration.

The demonstration authorizes twelve months of continuous eligibility for all individuals who are eligible under the state plan in the new adult coverage group. It also authorizes demonstration provisions specific to individuals in the new adult group with incomes between 50 and 133 percent of the FPL who are not medically frail or exempt under federal or state law. This includes the authority to charge premiums of 2 percent of income to such individuals. The state will credit such individuals' premium obligations toward copayments due. In addition, non-payment of premiums for individuals at or below 100 percent of the FPL will not result in disenrollment. Individuals with incomes above 100 percent of the FPL who stop paying premiums may be disenrolled after notice and a grace period. Individuals in this group may re-enroll upon payment of arrears or when the state assesses the debt by sending notice of the debt to the individual (no later than the end of each calendar quarter).

Cost sharing for all individuals under the demonstration will be consistent with Medicaid regulations, and cost sharing and premiums will be subject to an aggregate cap of 5 percent of household income. To encourage beneficiaries to seek medical care that promotes health and well-being, certain services will be exempt from cost sharing, such as medically necessary health screenings and preventive health care services, including primary, secondary, and tertiary preventive care and medications and services to help beneficiaries manage chronic conditions.

Demonstration enrollees with incomes between 50 and 133 percent of the FPL who are not medically frail or exempt under federal or state law will be provided services through an alternative benefit plan (ABP) that will use a defined provider network managed by a third party

administrator (TPA); authority for the defined provider network is through a waiver under section 1915(b)(4) of the Act, which we are separately approving today. Other individuals in the new adult group will receive an ABP that includes the standard Medicaid benefit package, and these individuals will not be limited to a defined provider network. The ABPs offered to the new adult group will be set forth in the state plan.

The authority to deviate from Medicaid requirements is limited to the specific waiver and expenditure authorities described in the enclosed lists, and to the purposes indicated for the waiver and expenditure authorities. The enclosed STCs further define the nature, character, and extent of anticipated federal involvement in the project, and the state's implementation of the waivers and expenditure authorities, and the state's responsibilities to CMS during the demonstration period. Our approval of the demonstration is conditioned upon the state's compliance with these STCs. Our approval is further subject to CMS receiving your written acknowledgement of the award and acceptance of these STCs within 30 days of the date of this letter.

Your project officer for this demonstration is Ms. Megan Lepore. She is available to answer any questions concerning your section 1115 demonstration. Ms. Lepore's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-4113
E-mail: Megan.Lepore@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Lepore and to Mr. Richard Allen, Associate Regional Administrator for the Division of Medicaid and Children's Health Operations in our Colorado Regional Office. Mr. Allen's contact information is as follows:

Centers for Medicare & Medicaid Services
1961 Stout Street
Denver, CO 80294
Telephone: (303) 844-2111
E-mail: Richard.Allen@cms.hhs.gov

If you have questions regarding this approval, please contact Mr. Eliot Fishman, Director, State Demonstrations Group, Center for Medicaid & CHIP Services, at (410) 786-5647.

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Thank you for all your work with us over the past several months on developing this important demonstration. Congratulations on this approval.

Sincerely,

A handwritten signature in blue ink, appearing to read "Andrew M. Slavitt".

Andrew M. Slavitt
Acting Administrator

Enclosures

cc: Richard Allen, Associate Regional Administrator, CMS Colorado Regional Office

**CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER LIST**

NUMBER: No. 11-W-00300/8

TITLE: Montana Health and Economic Livelihood Partnership (HELP)
Program Demonstration

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 this list, shall apply to the demonstration populations. The waiver will continue through December 30, 2020, unless otherwise stated.

The following waivers shall enable Montana to implement the Montana HELP Program section 1115 demonstration.

Title XIX Waivers

1. Premiums

**Section 1902(a)(14) and
Section 1916**

To enable the state to charge premiums at levels not more than 2 percent of household income to individuals with income greater than 50 percent of the federal poverty level. Total cost-sharing (including premiums) for a household is subject to a quarterly aggregate cap of 5 percent of household income.

2. Comparability

Section 1902(a)(17)

To the extent necessary to enable the state to vary cost sharing requirements for individuals from cost sharing to which they otherwise would be subject under the state plan to enable the state to charge targeted cost sharing to non-exempt individuals in the demonstration with income greater than 50 percent of the federal poverty level, as described in these terms and conditions.

**CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY**

NUMBER: No. 11-W-00300/8

TITLE: Montana Health and Economic Livelihood Partnership (HELP)
Program Demonstration

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 would not otherwise be included as matchable expenditures under section 1903 of the Act) shall, for the period beginning January 1, 2016, through December 31, 2020, unless otherwise specified, be regarded as matchable expenditures under the state's Medicaid state plan:

- 1. Twelve-Month Continuous Eligibility Period.** Expenditures for health care related costs for individuals in the new adult population determined financially eligible under the Modified Adjusted Gross Income (MAGI) based eligibility methods. This population will receive continued benefits during any periods within a twelve month eligibility period when these individuals would be found ineligible if subject to redetermination. The state shall make a downward adjustment of 2.6 percent in claimed expenditures for federal matching at the enhanced federal matching rate and will instead claim those expenditures at the regular matching rate.

This expenditure authority promotes the objectives of title XIX by increasing overall coverage of low-income individuals in the state.

**CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS**

NUMBER: No. 11-W-00300/8

TITLE: Montana Health and Economic Livelihood Partnership (HELP)
Program Demonstration

AWARDEE: Montana Department of Public Health and Human Services

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Montana Health and Economic Livelihood Partnership (HELP) Program section 1115(a) Medicaid demonstration (hereinafter “demonstration”) to enable Montana to operate this demonstration program. The Centers for Medicare & Medicaid Services (CMS) has granted a waiver of requirements under section 1902(a) of the Social Security Act (the Act). These 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 on the date of the signed approval. Enrollment activities for the new adult population will begin on November 1, 2015, at which time Medicaid eligible adults can receive services through a third party administrator (TPA) with coverage effective January 1, 2016. This demonstration will sunset after June 30, 2019, consistent with the current legislative time frame for the Montana Health Economic Livelihood Partnership (HELP) Act, but may continue through December 31, 2020, if the Montana legislature authorizes the state to continue the demonstration and the state provides notice to CMS, as described in these STCs.

The STCs have been arranged into the following subject areas:

- I. Preface
- II. Program Description and Objectives
- III. General Program Requirements
- IV. Populations Affected
- V. Benefits
- VI. Delivery System
- VII. Premiums and Copayments
- VIII. Continuous Eligibility
- IX. General Reporting Requirements
- X. General Financial Requirements
- XI. Monitoring Budget Neutrality
- XII. Evaluation
- XIII. Health Information Technology
- XIV. T-MSIS Requirements
- XV. Schedule of Deliverables

Additional attachments have been included to provide supplementary information and guidance for specific STCs.

II. PROGRAM DESCRIPTION AND OBJECTIVES

The state intends to use a third party administrator (TPA) that will limit providers to a preferred provider network and will pay in accordance with the state plan for healthcare services for most individuals in the demonstration. This section 1115(a) demonstration provides authority for the state to charge premiums and copayments to enrollees in the new adult group receiving services under the TPA. The state will seek CMS approval to limit the provider network to the TPA's network through a 1915(b)(4) waiver subject to separate approval by CMS.

The demonstration also provides authority to extend 12 month continuous eligibility to all enrollees in the new adult group.

Montana expects to achieve the following to promote the objectives of title XIX:

- Premiums and copayment liability will encourage HELP Program enrollees to be discerning health care purchasers, take personal responsibility for their health care decisions and develop health-conscious behaviors as consumers of health care services.
- 12 month continuous eligibility will improve continuity of care.

Over the life of the demonstration, Montana seeks to demonstrate the following:

- Premiums will not pose a barrier to accessing care for HELP Program beneficiaries.
- HELP Program enrollees will exhibit health-conscious health care behaviors without harming beneficiary health.
- 12 month continuous eligibility will promote continuity of coverage and reduce churn rates.

For individuals served under the TPA, premiums and copayments combined may not exceed 5 percent of family household income. Enrollees will receive a credit toward their copayment obligations in the amount of their premiums. In order to promote wellness, in accordance with the STCs and state legislation, the state will exempt preventive services from copayments. Participants with income at or below 100 percent of the FPL who fail to pay premiums will not be dis-enrolled from coverage. Participants with incomes above 100 percent of the FPL who fail to pay premiums may be dis-enrolled from coverage. Such individuals may re-enroll for coverage when payment is made for the overdue premiums or after the state assesses past-due premium amounts. Assessments must occur no later than the end of the quarter.

The following individuals are excluded from the TPA and all provisions of this demonstration other than the Continuous Eligibility provisions in Section VIII. Individuals who: 1) have been determined to be medically frail; 2) live in a region (which could include all or part of an Indian reservation) where the TPA was unable to contract with sufficient providers; 3) require continuity of coverage that is not available or could not be effectively delivered through the provider network offered by the TPA; and 4) are otherwise exempted from premiums or cost

sharing by federal law, and not within the scope of a waiver of that exemption, including individuals with incomes up to 50 percent of the FPL. These individuals, hereinafter referred to as “Excluded Populations,” will be served under the Medicaid state plan and subject to the terms and conditions therein.

This demonstration provides authority for the state to implement 12 month continuous eligibility for all individuals in the new adult group.

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 and Children’s Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid program and CHIP, 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), apply to the demonstration.
- 3. Changes in Federal 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 or CHIP program that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes of an operational nature without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 days in advance of the expected approval date of the amended STCs to allow the state to provide comment.
- 4. Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**
 - a. If changes in requirements under federal law need state legislation to be implemented, the changes must take effect on the earlier of: 1) the day such state legislation becomes effective, 2) the last day of the first legislative session that meets on or after the 60th day following the change in federal law; 3) the day specified in federal law for implementation of the change.
 - b. Should there be changes in the federal financial participation (FFP) associated with the demonstration, the state may seek to end the demonstration (as per paragraph 9 of this section) or seek an amendment (as per paragraph 7 of this section).
- 5. State Plan Amendments.** Medicaid eligibility will be determined in accordance with the approved Medicaid state plan. Any change to eligibility must be made through an

amendment to the Medicaid state plan. The Medicaid state plan shall be the controlling authority except to the extent that a requirement is waived or listed as inapplicable to an expenditure authority. These STCs do not waive Medicaid requirements, but contain operational limits and instructions on how the state may implement waivers of Medicaid requirements.

Should the state amend the state plan to make any changes to eligibility for any population affected by the demonstration, upon submission of the state plan amendment, the state must notify CMS demonstration staff in writing of the pending state plan amendment, and request any necessary corresponding technical corrections to the demonstration.

- 6. Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, evaluation design, sources of non-federal share of funding, and budget neutrality that are specifically authorized under the demonstration project 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 Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid state plan or amendment to the demonstration. 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 this section in STC 7, except as provided in this section in STC 3.
- 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 applicable to amendments listed in paragraph 14 of this section, prior to submission of the requested amendment;
 - b. A data analysis worksheet which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include total computable “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 detail 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 data supporting the evaluation hypotheses as detailed in the evaluation design in section X; and
 - e. If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.
- 8. Extension of the Demonstration.** States that intend to request demonstration extensions under sections 1115(e) or 1115(f) are advised to observe the timelines contained in those statutes. Otherwise, no later than 12 months prior to the expiration date of the demonstration, the governor or chief executive officer of the state must submit to CMS either a demonstration extension request or a transition and phase-out plan consistent with the requirements of paragraph 9 of this section.
- a. Compliance with transparency requirements at 42 CFR 431.412.
 - b. As part of the demonstration extension requests the state must provide documentation of compliance with the transparency requirements at 42 CFR 431.412 and the public notice and tribal consultation requirements outlined in STC 14 of this section.
- 9. Demonstration Phase Out.** The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.
- a. **Notification of Suspension or Termination.** The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft plan to CMS. The state must submit the notification letter and a draft plan to CMS no less than six (6) months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with 42 CFR 431.408. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment and the extent to which the state incorporated the received comment into the revised plan. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of the phase-out activities. Implementation of activities must be no sooner than 14 days after CMS approval of the plan.
 - b. **Transition and Phase-out Plan Requirements.** The state must include, at a minimum, in its plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights, if any), the process by which the state will conduct administrative reviews of Medicaid eligibility prior to the termination of the program for the affected beneficiaries, and ensure ongoing coverage for those beneficiaries determined

eligible, as well as any community outreach activities including community resources that are available.

- c. **Phase-out Procedures.** The state must comply with all applicable notice requirements found in 42 CFR 431.206, 431.210, and 431.213. In addition, the state must assure all applicable appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR 431.220 and 431.221. If a demonstration participant is entitled to and requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as outlined in 42 CFR 435.916.
 - d. **Exemption from Public Notice Procedures 42.CFR 431.416(g).** CMS may expedite the federal and state public notice requirements in the event it determines that the objectives of title XIX would be served or under circumstances described in 42 CFR 431.416(g).
 - e. **Federal Financial Participation (FFP).** If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services, continued benefits as a result of beneficiaries' appeals and administrative costs of disenrolling beneficiaries.
- 10. 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. The state must include a summary of the comments in the quarterly report associated with the quarter in which the forum was held. The state must also include the summary in its annual report.
- 11. Expiring Demonstration Authority.** For demonstration authority that expires prior to the demonstration's expiration date, the state must submit a transition plan to CMS no later than 6 months prior to the applicable demonstration authority's expiration date, consistent with the following requirements:
- a. **Expiration Requirements.** The state must include, at a minimum, in its demonstration expiration plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights, if any), the process by which the state shall conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and

ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

- b. **Expiration Procedures.** The state must comply with all applicable notice requirements found in 42 CFR Sections 431.206, 431.210 and 431.213. In addition, the state must assure all applicable appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR Sections 431.220 and 431.221. If a demonstration participant requests and is entitled to a hearing before the date of action, the state must maintain benefits as required in 42 CFR Section 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.
 - c. **Federal Public Notice.** CMS will conduct a 30-day federal public comment period consistent with the process outlined in 42 CFR Section 431.416 in order to solicit public input on the state's demonstration expiration plan. CMS will consider comments received during the 30-day period during its review and approval of the state's demonstration expiration plan. The state must obtain CMS approval of the demonstration expiration plan prior to the implementation of the expiration activities. Implementation of expiration activities must be no sooner than 14 days after CMS approval of the plan.
 - d. **Federal Financial Participation (FFP).** FFP shall be limited to normal closeout costs associated with the expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals and administrative costs of dis-enrolling participants.
- 12. Withdrawal of Waiver Authority.** CMS reserves the right to amend and 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 amendment and 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 or amended, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued benefits as a result of beneficiaries' appeals and administrative costs of dis-enrolling participants.
- 13. 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.
- 14. Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249

(September 27, 1994). The state must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009, the implementing regulations for the Review and Approval Process for Section 1115 demonstrations at 42 CFR Section 431.408, and the tribal consultation requirements contained in the state's approved state plan when any program changes to the demonstration are proposed by the state.

- a. In states with federally recognized Indian tribes, consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the state's approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers (42 CFR Section 431.408(b)(2)).
- b. 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 demonstration proposal and/or renewal of this demonstration (42 CFR Section 431.408(b)(3)).
- c. The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

15. Federal Financial Participation (FFP). No federal matching for service expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter.

16. Deferral for Failure to Provide Deliverables on Time. The state agrees that CMS may require the state to cease drawing down federal funds until such deliverables are timely submitted in a satisfactory form, until the amount of federal funds not drawn down would exceed \$5,000,000.

IV. POPULATIONS AFFECTED

1. Eligibility Groups Affected By the Demonstration. This demonstration affects individuals ages 19 through 64 who are eligible in the new adult group under the state plan that is described in 1902(a)(10)(A)(i)(VIII) of the Act, and 42 CFR 435.119, and who receive all benefits described in an alternative benefit plan (ABP) under the state plan.

All affected groups 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 listed as waived in this demonstration, subject to the operational limits as described in these STCs. All Medicaid eligibility standards and methodologies for these eligibility groups remain applicable.

Medicaid State Plan Group	Population Description	Funding Stream
New adult group.	Individuals ages 19 through 64 who are eligible in the new adult group under the state plan that is described in 1902(a)(10)(A)(i)(VIII) of the Act.	Title XIX

2. The following populations are excluded from all portions of the demonstration other than continuous eligibility provisions in Section VIII.
 - a. Individuals who are medically frail;
 - b. Individuals who the state determines (as described in the TPA ABP SPA) have exceptional health care needs, including but not limited to a medical, mental health, or developmental condition;
 - c. Individuals who live in a region (that may include all or part of an Indian reservation), where the TPA is unable to contract with sufficient providers (as described in the TPA ABP SPA);
 - d. Individuals who the state determines, in accordance with objective standards approved by CMS (as described in the TPA ABP), require continuity of coverage that is not available or could not be effectively delivered through the TPA;
 - e. Individuals exempted by federal law from premium or cost sharing obligations, whose exemption is not waived by CMS, including all individuals with incomes up to 50 percent of the FPL.

V. BENEFITS

1. **Montana HELP Program Demonstration Benefits.** Individuals in the demonstration will either receive benefits through the state plan ABP or those who are enrolled in the TPA will receive all benefits as described in the TPA ABP approved in the state plan.
2. **Minimum Essential Coverage.** All individuals affected by this demonstration receive coverage that meets the requirements of minimum essential coverage (MEC).

VI. DELIVERY SYSTEM

1. **Third Party Administrator.** Eligible enrollees in the Montana HELP Program will receive services through a TPA to the extent authorized under a 1915(b)(4) waiver.

VII. PREMIUMS AND COPAYMENTS

1. **Premiums.** Authority to charge premiums is contingent upon the state demonstrating the ability to electronically track aggregate out-of-pocket costs (both premiums and copayments) for all household members, on a quarterly basis, and CMS's approval of the preventive services protocol. The state is permitted to charge demonstration beneficiaries monthly premiums of 2 percent of aggregate household income. In families with two enrolled individuals, the total of both beneficiaries' required premium contributions cannot exceed 2 percent of the household income. Notwithstanding the premium obligations, eligibility shall be determined consistent with state plan rules.

- a. **Premiums for Individuals with Income at or Below 100 percent of the FPL.**

- i. Non-payment of premiums by individuals at or below 100 percent of the FPL shall not result in dis-enrollment. Unpaid premiums may be considered a collectible debt that may be assessed by the state, as the state must describe in the operational protocol.
- ii. All individuals shall receive a credit in the amount of their premium obligation towards the first 2 percent of copayments accrued.

- b. **Premiums for Individuals with Income Above 100 percent of the FPL.**

- i. After appropriate notice and a 90-day grace period, individuals with income above 100 percent of the FPL who fail to make a premium payment may be dis-enrolled.
- ii. Re-enrollment shall be permitted upon payment of arrears or when the debt is assessed. Assessment occurs when the Department of Revenue sends notice of debt to the individual, as the state will describe in the Operations Protocol in Attachment B and described in section VII STC 7.
- iii. Assessment shall occur no less frequently than quarterly on a calendar basis; re-enrollment after assessment shall not require a new application for Medicaid.
- iv. The state shall establish a process to exempt individuals from dis-enrollment for good cause.
- v. All individuals shall receive a credit in the amount of their premium obligation towards the first 2 percent of copayments accrued.

2. **Beneficiary Education.** Program information, applicant information, and beneficiary information shall be tested to ensure it is comprehensible by the target audience and shall make clear:

- a. That eligibility will begin consistent with state plan rules.
- b. How premium payments should be made and the impact of change of income on premium payments owed.

- c. The income guidelines for each component of the program (above 100 percent of the FPL and at and below 100 percent of the FPL and the relevant monthly income dollar figures so that applicants can understand which group they are likely to be in).
 - d. How the premium credit against copayments works.
 - e. The consequences of non-payment of premiums for each income group.
 - f. The consequences of non-payment of co-payments for each income group.
 - g. How to re-enroll, if dis-enrolled for non-payment of premiums.
- 3. Beneficiary Outreach.** The state must conduct an outreach and education campaign to potential applicants and beneficiaries to ensure that they understand the program policies regarding premiums and associated consequences.
- 4. Copayments.** Enrollees are subject to premiums and copayments up to 5 percent of income, calculated quarterly as described in 42 CFR 447.56(f) (both premiums and copayments count against the 5 percent aggregate cap). Copayment amounts shall be consistent with federal requirements regarding Medicaid cost sharing and are described in Attachment A.
- a. Enrollees will receive a credit toward their copayment obligations in the amount of their premiums, such that they shall not accrue out of pocket expenses for copayments until accumulated copayments exceed 2 percent of aggregate household income.
 - b. The following service categories are exempt from copayments:
 - i. Preventive health care services, including primary, secondary and tertiary preventive services as described in the operational protocol;
 - ii. Immunizations; and
 - iii. Medically necessary health screenings ordered by a health care provider.
 - c. Consistent with federal law, providers may not deny services for failure to receive beneficiary copayments from individuals at or below 100 percent of the FPL.
- 5. Beneficiary Protections.**
- a. The TPA and/or state may attempt to collect unpaid premiums and the related debt from beneficiaries, but may not report the debt to credit reporting agencies, place a lien on an individual's home, refer the case to debt collectors, file a lawsuit, seek a court order to seize a portion of the individual's earnings for enrollees at any income level. The TPA and/or state also may not "sell" the debt for collection by a third-party.

- b. Beneficiaries described in 42 CFR 447.56(a) (including American Indians/Alaska Natives, as described therein) must be exempt from all copayments and premium contribution requirements, as applicable.
 - c. Beneficiaries may not incur family cost sharing or premiums that exceeds 5 percent of the aggregate family's income, following rules established in 42 CFR 447.56(f).
 - d. Copayment amounts will not exceed Medicaid cost sharing permitted by federal law and regulation.
 - e. The state may not pass along the cost of any surcharge associated with processing payments to the beneficiary. Any surcharges or other fees associated with payment processing must be considered an administrative expense by the state.
 - f. The state will ensure that all payments from the beneficiary, or on behalf of the individual, are accurately and timely credited toward unpaid premiums and related debt, and will provide the beneficiary an opportunity to review and seek correction of the payment history.
- 6. Operations Protocol.** By March 1, 2016 the state will submit for approval a protocol describing the state's policies and procedures for implementing the premiums and copayments and monitor operations of, and the effects of, the policy. This approval will be included as Attachment B to these STCs. As the operational protocol will be submitted after the state begins operating the demonstration, approval of the protocol may be contingent upon the state's agreement to make changes to any of the items included in the protocol. Compliance with the agreed upon protocol will be monitored via the processes described in section IX in paragraphs 2 and 3. The protocol shall include:
- a. A detailed description of the outreach campaign that the state conducts to explain the program policies.
 - b. Copies of program, applicant and beneficiary communication materials
 - c. Copies of the notices beneficiaries receive regarding premiums and copayments and the schedule for such notices.
 - d. The process by which beneficiaries remit payment, including ways individuals who cannot pay by check will be accommodated.
 - e. The process by which the state operates the premium credit against copayments, including the list of services exempt from copayments.
 - f. A description of the state's collection activities including the process by which the state assesses past due premiums.
 - g. A description and assurance of how the state accurately tracks cost sharing and the aggregate cap.
 - h. Design for the beneficiary survey described in the Evaluation Section XII.

- i. A description of how state will comply with the requirements of 42 CFR 447.54 to implement a copayment for non-emergency use of the emergency department.
- 8. Preventive Services Protocol.** By December 11, 2015, the state will submit for approval, a protocol describing the process by which the state will ensure that certain beneficiaries are not charged for preventive health care services, including the list of services and drugs that will be exempted. This protocol will be included as Attachment C to these STCs.

VIII. CONTINUOUS ELIGIBILITY

- 1. Duration.** The state is authorized to provide a 12 month continuous eligibility period to the group of individuals specified in Table 1, regardless of the delivery system through which they receive Medicaid benefits.
- 2. Exceptions.** Notwithstanding subparagraph (a), if any of the following circumstances occur during an individual's 12 month continuous eligibility period, the individual's Medicaid eligibility shall, after appropriate process, be terminated:
 - i. The individual cannot be located for a period of more than one month, after good faith efforts by the state to do so.
 - ii. The individual is no longer a Montana resident.
 - iii. The individual requests termination of eligibility.
 - iv. The individual dies.
 - v. The individual fails to provide, or cooperate in obtaining a Social Security Number, if otherwise required.
 - vi. The individual provided an incorrect or fraudulent Social Security Number.
 - vii. The individual was determined eligible for Medicaid in error.
 - viii. The individual fails to provide the documentation of citizenship or immigration status required under federal law.
 - ix. Consistent with section VII STC 1, the state may terminate individuals with incomes above 100 percent of the FPL due to nonpayment of premiums.
- 3. Income for Purposes of Premium Calculation.** If an individual's income changes during the continuous eligibility period, the individual may report the change and the premium amount shall be recalculated for the following quarter.

IX. GENERAL REPORTING REQUIREMENTS

- 1. General Financial Requirements.** The state must comply with all general financial requirements under Title XIX outlined in Section XI of these STCs.
- 2. Monthly Monitoring Calls.** CMS will convene periodic conference calls with the state. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration; including planning for future changes in the program or intent to further implement the Montana HELP Program beyond December 31, 2020.

CMS will provide updates 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 will jointly develop the agenda for the calls. Areas to be addressed may include, but are not limited to:

- a. Transition and implementation activities,
 - b. Stakeholder concerns,
 - c. Demonstration operations and performance,
 - d. Enrollment,
 - e. Copayments,
 - f. Audits,
 - g. Lawsuits,
 - h. Financial reporting issues,
 - i. Progress on evaluations,
 - j. Legislative developments, and
 - k. Any demonstration amendments the state is considering submitting.
- 3. Quarterly Progress Reports.** By December 15, 2015, the state will submit for approval a Quarterly Progress Report Format describing the states' plan for submitting quarterly progress reports. This approval will be included as Attachment D to these STCs. The state shall submit progress reports in a format agreed upon by CMS and the state 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 shall include, but not be limited to:
- a. A description of the population included in the demonstration (distribution of age, sex, racial/ethnic distribution, etc.).
 - b. Completed Quarterly Report Template Workbook, included with Appendix D, with data on: enrollment and dis-enrollment stratified by premium experience and demographics associated with the demonstration populations. There should also be an accompanying brief narrative for each of these areas which address the pertinent issues outlined in Appendix D: Quarterly Report Format.
 - c. A discussion of events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, enrollment, or other operational issues.
 - d. Summary of the progress of evaluation activities, including key milestones accomplished as well as challenges encountered and how they were addressed. To the extent possible, the state should present this information to CMS in tables. The discussion should also include interim findings, when available; status of contracts with independent evaluator(s), if applicable; and status of study participant recruitment, if applicable.

- e. A discussion of key operational and other challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed.
- f. Describe any additional events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including, but not limited to: benefits, enrollment and dis-enrollment, complaints and grievances, quality of care, and access that is relevant to the demonstration, pertinent legislative or litigation activity. This should include action plans for any events identified as requiring corrective action.
- g. Oversight and monitoring conducted, such as TPA or provider site visits, reports, or requests for corrective actions plans pertaining to either the TPA or FFS demonstration population; complaints, grievances and appeals filed during the quarter by type, highlighting any patterns that are concerning; and actions being taken to address any significant issues evidenced by patterns of complaints or appeals.
- h. Enrollment figures for the quarter including enrollment figures for individuals by income level.
- i. The number of individuals reaching their cost sharing limitations.
- j. A summary of the post award forums and solicited comments from the public, when applicable.
- k. Updated timeline for submitting monitoring and evaluation deliverables to CMS.
- l. The state must provide a work plan included in each quarterly report, which outlines when monitoring activities occur. Each work plan should include:
 - i. Dates for the time periods that data collection will take place for all data sources, including data pulls, surveys collection, interview and focus groups conducting, as well as any other sources for collecting data that are not otherwise specified;
 - ii. Estimated time periods which data analyses will take place;
 - iii. Dates when the state will submit deliverables and reports;
 - iv. The individual responsible for each monitoring activity; and
 - v. Other relevant information associated with demonstration monitoring.
- m. The data to be reported to CMS in quarterly reports includes, but is not limited to, the following:
 - i. The number of individuals subject to premium requirements (i.e., number of nonexempt individuals);

- ii. The number of individuals with overdue premiums including those with premiums past due less than and greater than 90 days;
- iii. The number of individuals who have premiums that have become collectible debt;
- iv. The number and average amount of contributions from incorporated public or private third parties toward beneficiary premiums, by type of entity, and by beneficiary income level;
- v. The number of individuals who are dis-enrolled for failure to pay premiums, including;
 - 1. The number of individuals who have re-enrolled due to payment of full arrears;
 - 2. The number of individuals who have re-enrolled due to assessment, and;
 - 3. The number of individuals who have paid partial arrears.
- vi. The number of enrollees that are exempt from dis-enrollment due to good cause.

4. Rapid Cycle Assessments. The state shall specify for CMS approval a set of performance and outcome metrics, including their specifications, reporting cycles, level of reporting (e.g., the state, delivery system and provider level, and segmentation by population) to support rapid cycle assessment in trends and for monitoring and evaluation of the demonstration.

5. Compliance with Federal Systems Innovation. As MACBIS or other federal systems continue to evolve and incorporate 1115 demonstration reporting and analytics, the state shall work with CMS to revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems.

6. Demonstration Annual Report. The annual report must, at a minimum, include the requirements outlined below. The State shall submit the draft annual report no later than 90 days after the end of each demonstration year. Within 30 days of receipt of comments from CMS, a final annual report must be submitted for the DY to CMS. A delay in submitting the draft or final annual report could subject the state to penalties described in paragraph 16 of section III.

- a. All items included in the quarterly report must be summarized to reflect the operation/activities throughout the DY;
- b. Total annual expenditures for the demonstration population for each DY, with administrative costs reported separately;
- c. Yearly enrollment reports for demonstration beneficiaries for each DY (beneficiaries include all individuals enrolled in the demonstration); and
- d. Data related to the comprehensive quality strategy as described in paragraph 7 of this section.

7. **Final Report.** Within 60 days after the end of the demonstration, the state must submit a draft final report to CMS for comments. The final report should provide a comprehensive presentation of all key components of the demonstration that were addressed in quarterly and annual reports, and reflect the entire demonstration approval period from its inception until the final expiration date. The state must take into consideration CMS' comments for incorporation into the final report. The final report is due to CMS no later than 120 days after receipt of CMS' comments. A delay in submitting the draft final report or final report could subject the state to penalties described in paragraph 16 of section III.

X. GENERAL FINANCIAL REQUIREMENTS

1. **Quarterly Expenditure Reports.** The state must report quarterly expenditures associated with the populations affected by this demonstration on the Form CMS-64.
2. **Reporting Expenditures under the Demonstration.** The following describes the reporting of expenditures:
 - a. **Tracking Expenditures.** In order to track expenditures under this demonstration, Montana must report demonstration expenditures through the Medicaid Budget and Expenditure System (MBES) and state Children's Health Insurance Program Budget and Expenditure System (CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the state Medicaid Manual. All demonstration expenditures claimed under the authority of title XIX of the Act must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS, including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made. For this purpose, DY 1 is defined as the year beginning January 1, 2016, and ending December 31, 2016. DY 2 and subsequent DYs are defined accordingly. All title XIX service expenditures that are not demonstration expenditures and are not part of any other title XIX waiver program should be reported on Forms CMS-64.9 Base/64.9P Base.
 - b. **Cost Settlements.** For monitoring purposes, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P 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.
 - c. **Use of Waiver Forms.** The following one (1) waiver Form CMS-64.9 Waiver and/or 64.9P Waiver must be submitted each quarter (when applicable) to report title XIX expenditures for individuals enrolled in the demonstration. The

expression in quotation marks is the waiver name to be used to designate these waiver forms in the MBES/CBES system.

i. “Continuous Eligibility for New Adult Group” expenditures

- 3. Administrative Costs.** Administrative costs will not be included in the budget neutrality limit, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration, using Forms CMS-64.10 Waiver and/or 64.10P Waiver, with waiver name “ADM”.
- 4. Claiming Period.** All claims for expenditures (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 on the CMS-64 waiver forms the net expenditures related to dates of service during the operation of the section 1115 demonstration, in order to account for these expenditures properly to determine budget neutrality.
- 5. Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the demonstration. The state must estimate matchable demonstration expenditures (total computable and federal share) and separately report these expenditures by quarter for each federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS will 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 will reconcile expenditures reported on the Form CMS-64 quarterly with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.
- 6. Extent of FFP for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the demonstration as a whole as outlined below:

 - a. Administrative costs, including those associated with the administration of the demonstration.
 - b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved state plan.
 - c. Medical Assistance expenditures made under section 1115 demonstration authority, including those made in conjunction with the demonstration, cost sharing, pharmacy rebates, and all other types of third party liability or CMS payment adjustments.

- 7. Sources of Non-Federal Share.** The state must certify that the matching non-federal share of funds for the demonstration are state/local monies. The state further certifies that such funds shall not be used as the match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.
- a. CMS may 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. Any amendments that impact the financial status of the program shall require the state to provide information to CMS regarding all sources of the non-federal share of funding.
 - c. The state assures that all health care-related taxes comport with section 1903(w) of the Act and all other applicable federal statutory and regulatory provisions, as well as the approved Medicaid state plan.
 - d. Under all circumstances, health care providers must retain 100 percent of the Montana HELP Program 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 payments. This confirmation of Medicaid 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 and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.
- 8. State Certification of Funding Conditions.** The state must certify that the following conditions for non-federal share of demonstration expenditures are met:
- a. Units of government, including governmentally operated health care providers, may certify that state or local tax dollars have been expended as the non-federal share of funds under the demonstration.
 - b. To the extent the state utilizes certified public expenditures (CPEs) as the funding mechanism for Title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under Title XIX (or under section 1115 authority) for purposes of certifying public expenditures.
 - c. To the extent the state utilizes CPEs as the funding mechanism to claim federal match

for payments under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such tax revenue (state or local) used to fund the non-federal share of demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match.

- d. The state may use intergovernmental transfers to the extent that such funds are derived from state or local tax revenues and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of Title XIX payments.
- e. 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 payments. This confirmation of Medicaid 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 and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

9. Monitoring the Demonstration. The state shall provide CMS with information to effectively monitor the demonstration, upon request, in a reasonable timeframe using continuous quality improvement approaches and that aligns with achieving the final goals and aims.

10. Contributions from third parties. Third parties are permitted to contribute toward a beneficiary's premium or copayments obligation. There are no limits on the amounts third parties can contribute toward a beneficiary's premium obligation. Such third party contributions offset required beneficiary premium or copayment obligations only, and may not be used for any other purpose. Contributions that exceed such obligations will be returned to the contributing third party. The contribution must be used to offset the beneficiary's required contributions only, not the state's share. Health care providers or provider-related entities making contributions on individuals' behalf must have criteria for providing assistance that do not distinguish between individuals based on whether or not they receive or will receive services from the contributing provider(s) or class of providers. Providers may not include the cost of such payments in the cost of care for purposes of Medicare and Medicaid cost reporting and cannot be included or as part of a Medicaid shortfall or uncompensated care for any purpose.

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 the per capita cost method described in STC 4 in this section, and budget neutrality expenditure limits are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. The data supplied by the state to CMS to set the annual caps is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the state's compliance with these annual limits will be done using the Schedule C report from the CMS-64.
2. **Risk.** The state will be at risk for the per capita cost (as determined by the method described below) for demonstration populations as defined in section IV, but not at risk for the number of enrollees in the demonstration population. By providing FFP without regard to enrollment in the demonstration populations, CMS will not place the state at risk for changing economic conditions that impact enrollment levels. However, by placing the state at risk for the per capita costs of current eligibles, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.
3. **Calculation of the Budget Neutrality Limit.** For the purpose of calculating the overall budget neutrality limit for the demonstration, separate annual budget limits will be calculated for each DY on a total computable basis, as described in STC 4 below. In the event that there is more than one DY, the annual limits will then be added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality limit by the composite federal share, which is defined in STC 4 in this section below.
4. **Demonstration Populations Used to Calculate the Budget Neutrality Limit.** For each DY, separate annual budget limits of demonstration service expenditures will be calculated as the product of the trended monthly per person cost times the actual number of eligible/member months as reported to CMS by the state under the guidelines set forth in STC. The trend rates and per capita cost estimates for each Mandatory Enrollment Group (MEG) for each year of the demonstration are listed in the table below.

MEG	TREND	DY 1 - PMPM	DY 2 - PMP M	DY 3 - PMP M	DY 4 - PMP M	DY 5 - PMP M
Continuous Eligibility - New Adult Group	4.1%	\$532.79	\$554.37	\$577.37	\$601.05	\$625.69

- a. If the state’s experience of the take up rate for the new adult group and other factors that affect the costs of this population indicates that the per member per month (PMPM) limit described above in paragraph (a) may underestimate the actual costs of medical assistance for the new adult group, the state may submit an adjustment to paragraph (a), along with detailed expenditure data to justify this, for CMS review without submitting an amendment pursuant to STC 7. Adjustments to the PMPM limit for a demonstration year must be submitted to CMS by no later than October 1 of the demonstration year for which the adjustment would take effect.
 - b. The budget neutrality cap is calculated by taking the PMPM cost projection for the above group in each DY, times the number of eligible member months for that group and DY, and adding the products together across DYs. The federal share of the budget neutrality cap is obtained by multiplying total computable budget neutrality cap by the federal share.
 - c. The state will not be allowed to obtain budget neutrality “savings” from this population.
- 5. Composite Federal Share Ratio.** 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 (with consideration of additional allowable demonstration offsets such as, but not limited to, premium collections) by total computable demonstration expenditures for the same period as reported on the same forms. Should the demonstration be terminated prior to the end of the extension approval period (see section III STC 9), the Composite Federal Share will be determined based on actual expenditures for the period in which the demonstration was active. 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.
- 6. Calculating the Federal Medical Assistance Percentage (FMAP) for Continuous Eligibility for the Adult Group.** CMS anticipates that states that adopt continuous eligibility for adults would experience a 2 percent increase in enrollment. Based on this estimate, CMS has determined that 97.4 percent of the member months for newly eligibility in the adult group will be made at the enhanced FMAP rate and 2.6 percent will be matched at the regular FMAP rate.
- 7. State Reporting for the FMAP Adjustment.** Newly eligible individuals in the Adult Group shall be claimed at the enhanced FMAP rate. The state must make an adjustment in the CMS-64W that accounts for the proportion of member months in which beneficiaries are enrolled due to continuous eligibility and could have been dis-enrolled due to excess income in absence of continuous eligibility (i.e. 2.6 percent). For the purposes of budget neutrality, the members for the adult group within the 2.6 percent of the population described in this STC will be treated as a hypothetical population.

- 8. 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 the demonstration.
- 9. Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality over the life of the demonstration rather than on an annual basis, in the event that there is more than one demonstration year. However, if the state’s expenditures exceed the calculated cumulative budget neutrality expenditure cap by the percentage identified below for any of the demonstration years, the state must submit a corrective action plan to CMS for approval. The state will subsequently implement the approved corrective action plan.

Year	Cumulative target definition	Percentage
DY 1	Cumulative budget neutrality limit plus:	2.0%
DY 2	Cumulative budget neutrality limit plus:	1.5%
DY 3	Cumulative budget neutrality limit plus:	1.0%
DY 4	Cumulative budget neutrality limit plus:	0.5%
DY 5	Cumulative budget neutrality limit plus:	0%

- 10. Exceeding Budget Neutrality.** If at the end of the demonstration period the cumulative budget neutrality limit has been exceeded, the excess federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision will be based on the time elapsed through the termination date.

XII. EVALUATION

- 1. Submission Evaluation Design.** The state must submit to CMS for approval, by March 1, 2016, a draft evaluation design. At a minimum, the state must submit their draft evaluation design in accordance with the following criteria:

- a. A discussion of the goals, objectives, and specific hypotheses that are being tested, including those that focus specifically on the target populations for the demonstration.
- b. The evaluation design must include the research questions and proposed measures listed below. The state must use measures from nationally-recognized sources and those from national measures sets (including CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Healthcare Providers and Systems (CAHPS) and the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; and/or measures endorsed by National Quality Forum (NQF) where possible. At least one research question must be proposed for each waiver and expenditure authority approved by CMS. For questions that cover broad subject areas, the state may propose a more narrow focus for the evaluation.
 - i. How has the implementation of premiums affected program enrollment?
 - ii. Have premiums and cost sharing made beneficiaries more likely to exhibit health-conscious consumption behavior?
 - 1. Percent of individuals accessing primary care
 - 2. Percent of individuals accessing behavior health services
 - 3. Pharmacy (overall costs, brand vs. generic dispensing rate)
 - 4. Percent of individuals using TPA Wellness Program services
 - 5. Percent of individuals using primary care for chronic disease management services (if chronic disease present)
 - 6. Percent of unique individuals accessing preventive services
 - 7. Percent of preventive care visits, total and average per person
 - 8. Percent of specialty care visits, total and average per person
 - 9. Percent of individuals taking brand name medications when generic medication is available
 - iii. Does continuous eligibility promote better continuity of coverage for the new adult group?
 - 1. Enrollment rates;
 - 2. Churn rates.
- c. Addressing the research questions will require qualitative and, where applicable, quantitative research methodologies. The state must develop a research plan for each research question, and provide a rationale for its selection. The research plan for each question must include the following:
 - i. Proposed baseline and control comparison groups, where applicable. If randomization is not used, methods to adjust for the non-equivalence of the control and comparison group must be proposed.
 - ii. Data sources, collection frequency, and process for demonstrating the accuracy and completeness of the data.
 - iii. Sampling methodology for selecting the population being included in your analysis (e.g., controlled before-and-after studies, interrupted time series design, and comparison group analyses). If an experimental design is

selected, the state must ensure that a statistically reliable/significant sample size is selected.

- iv. Draft of instruments used for collecting data, including survey designs, interview questions, and focus group questions.
- v. Analysis plan that describes the statistical methods that will be employed to evaluate differences between the demonstration and comparison groups in key outcomes. The evaluation design must also demonstrate how the state will analyze data.
 1. Description of statistics that will be utilized including whether the analysis will be at the beneficiary, provider, and aggregate program level, as appropriate, and include population stratifications to the extent feasible, for further depth and to glean potential non-equivalent effects on different sub-groups.
- vi. Identify the contractor that will be conducting the evaluation. The state should describe the qualifications of the outside contractor and the process to ensure the contractor will be an independent evaluator with no conflict of interest.
- vii. Budget that details the estimated cost for staffing, data collection, and analysis over the course of the entire evaluation.
- viii. A diagram, process flow and logic model or driver diagram illustrating the specific quantifiable aims and how the state plans to meet the identified aims/outcomes of the demonstration.
- ix. Timeline for submitting evaluation and monitoring deliverables.

2. Beneficiary Survey. Beginning in the first demonstration year, the state shall conduct at least one survey per year of individuals enrolled in the demonstration, individuals who have been dis-enrolled from the demonstration, and of individuals who are eligible but unenrolled. The survey size must produce statistically significant results, and the design will be described in the operations protocol. The purpose of the survey shall be to determine whether potential applicants and beneficiaries understand the program policies regarding premiums and associated consequences, and whether the premiums affect individuals' decisions about whether to apply for the program.

3. Final Evaluation Design and Implementation. The state's evaluation design may be subject to multiple revisions until a format is agreed upon by CMS. The state must submit the final evaluation design within 60 days after receipt of CMS' comments. Upon CMS approval of the evaluation design, the state must implement the evaluation design and submit their evaluation implementation progress in each of the quarterly and annual progress reports as outlined in STC section 8 paragraph 2. The final evaluation design will be included as Attachment E to these STCs.

4. Draft Interim Evaluation Reports. The state must submit a draft Interim Evaluation Report at the midpoint of each demonstration approval period. The report should include the following criteria:

- a. An executive summary, including the programmatic goals, objectives, and hypotheses being tested;
- b. A description of the demonstration including interventions implemented appropriate to each population and/or condition, and resulting changes to the health care system
- c. A summary of the evaluation design, including, program benchmarks, outcomes, data sources, analysis, challenges, etc.
- d. A description of the population included in the evaluation (distribution of age, sex, racial/ethnic distribution, etc.)
- e. Preliminary evaluation findings including key outcome results and/or trends
- f. A discussion of the findings, including findings in quarterly and annual reports (including interpretation of findings and policy implications)
- g. Implementation successes, challenges and lessons learned
- h. A discussion of whether there would be any barriers to implementing any or all demonstration features under the state plan, and any advantages to doing so.

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 its request for each subsequent renewal, as outlined in CFR 431.412 (c)(2)(vi).

- 5. Final Interim Evaluation Report.** The state must submit their final Interim Evaluation Report within 60 days after receipt of CMS' comments on their draft Interim Evaluation report.
- 6. Draft Final Evaluation Submission.** The state must submit to CMS a draft of the final evaluation report within 120 days of expiration of the demonstration. The report must include the required criteria listed in section XI paragraph 3 of the STCs, including final evaluation findings.
- 7. Final Evaluation Report.** The state must submit the final evaluation report within 60 days after receipt of CMS' comments on their draft submission.
- 8. Cooperation with Federal Evaluators.** Should CMS conduct an evaluation of any component of the demonstration; the state will cooperate fully with CMS or the independent evaluator selected by CMS. The state will submit the required data to CMS or the contractor at no cost to CMS or the contractor.
- 9. Cooperation with Federal Learning Collaboration Efforts.** The state will cooperate with improvement and learning collaboration efforts by CMS.
- 10. Evaluation Budget.** A budget for the evaluation shall be provided with the evaluation design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses, and reports generation. A justification of the costs may be required by CMS if the

estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed.

- 11. Deferral for Failure to Provide Summative Evaluation Reports on Time.** The State agrees that when draft and final Interim and Summative Evaluation Reports are due, CMS may issue deferrals in the amount of \$5,000,000 if they are not submitted on time to CMS or are found by CMS not to be consistent with the evaluation design as approved by CMS.

XIII. HEALTH INFORMATION TECHNOLOGY

- 1. Health Information Technology (HIT).** The state shall use HIT to link services and core providers across the continuum of care to the greatest extent possible. The state is expected to achieve minimum standards in foundational areas of HIT and to develop its own goals for the transformational areas of HIT use.
 - a. Montana must have plans for health IT adoption for providers. This will include creating a pathway (and/or a plan) to adoption of certified electronic health record (EHR) technology and the ability to exchange data through the state's health information exchanges. If providers do not currently have this technology, there must be a plan in place to encourage adoption, especially for those providers eligible for the Medicare and Medicaid EHR Incentive Program.
 - b. The state must participate in all efforts to ensure that all regions (e.g., counties or other municipalities) have coverage by a health information exchange. Federal funding for developing health information exchange (HIE) infrastructure may be available, per State Medicaid Director letter #11-004, to the extent that allowable costs are properly allocated among payers.
 - c. All requirements must also align with Montana's State Medicaid HIT Plan, as applicable, and other planning efforts such as the Office of National Coordinator HIE Operational Plan.

XIV. T-MSIS REQUIREMENTS

On August 23, 2013, a State Medicaid Director Letter entitled, "Transformed Medicaid Statistical Information System (T-MSIS) Data," was released. It states that all states are expected to demonstrate operational readiness to submit T-MSIS files, transition to T-MSIS, and submit timely T-MSIS data by July 1, 2014. Among other purposes, these data can support monitoring and evaluation of the Medicaid program in Montana against which the Montana HELP Program demonstration will be compared.

Should the MMIS fail to maintain and produce all federally required program management data and information, including the required T-MSIS, eligibility, provider, and post-adjudicated claims from the TPA consistent with the STCs under the 1915(b)(4) waiver, in accordance with requirements in the SMM Part 11, FFP may be suspended or disallowed as provided for in federal regulations at 42 CFR 433 Subpart C, and 45 CFR Part 95.

XV. SCHEDULE OF DELIVERABLES

The state is held to all reporting requirements outlined in the STCs; this schedule of deliverables should serve only as a tool for informational purposes only.

Per award letter - Within 30 days of the date of award	Confirmation Letter to CMS Accepting Demonstration STCs
Per Section VII, Paragraph 8	Preventive Services Protocol
Per Section VII, Paragraph 7	Operations Protocol
Per Section XII, Paragraph 1	Submit Draft Evaluation Design
Per Section III, Paragraph 8	Submit Demonstration Extension Application
Per Section III, Paragraph 10	Post-award Forum
Per Section IX, Paragraph 3	Quarterly Operations Report

ATTACHMENT A

Copayment Schedule and Exempt Services

Service Description	Copayments for Individuals With Incomes At or Below 100 Percent FPL	Copayments for Individuals with Incomes Above 100 Percent FPL
Behavioral Health – Inpatient	\$75/stay	10 percent of the payment the State makes for the service
Behavioral Health – Outpatient	\$4	10 percent of the payment the State makes for the service
Behavioral Health – Professional	\$4	10 percent of the payment the State makes for the service
Durable Medical Equipment	\$4	10 percent of the payment the State makes for the item
Emergency Room Services	-	-
Non-Emergency Room Services	\$8	\$8
Lab and radiology	\$4	10 percent of the payment the State makes for the service
Inpatient	\$75/stay	10 percent of the payment the State makes for the service
Other	\$4	10 percent of the payment the State makes for the service
Other Medical Professionals	\$4	10 percent of the payment the State makes for the service
Outpatient Facility	\$4	10 percent of the payment the State makes for the service
Primary Care Physician	\$4	10 percent of the payment the State makes for the service
Specialty Physician	\$4	10 percent of the payment the

Service Description	Copayments for Individuals With Incomes At or Below 100 Percent FPL	Copayments for Individuals with Incomes Above 100 Percent FPL
		State makes for the service
Pharmacy - Generics	-	-
Pharmacy – Preferred Brand Drugs	\$4	\$4
Pharmacy – Non-Preferred Brand Drugs, including specialty drugs	\$8	\$8

Premiums and copayments combined may not exceed 5 percent of family household income.

Certain services, including the following, are exempt from co-pays under federal or state law:

- Emergency services
- Preventive health care services including primary, secondary or tertiary preventive health care services
- Family planning services
- Pregnancy related services
- Generic drugs
- Immunizations
- Medically necessary health screenings ordered by a health care provider

ATTACHMENT B

Operations Protocol (Reserved)

ATTACHMENT C
Preventive Services Protocol (Reserved)

ATTACHMENT D

Quarterly Progress Report Format (Reserved)

ATTACHMENT E

Evaluation Design (Reserved)