

EXHIBIT 2
DATE 1-28-09

DEPARTMENT OF
PUBLIC HEALTH AND HUMAN SERVICES



Brian Schweitzer
GOVERNOR

Anna Whiting Sorrell
DIRECTOR

STATE OF MONTANA

www.dphhs.mt.gov

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January 27, 2009

Representative Teresa Henry, Chairman
Appropriation Subcommittee
Health & Human Services
State Capitol Building
Helena, MT 59620

Dear Chairman Henry:

Enclosed with this letter is a packet of information that you or Subcommittee members have requested from the Health Resources Division. The enclosed documents include a letter responding to questions posed about the Healthy Montana Kids Plan; a letter responding to questions posed about the HIFA waiver and the System of Care Grant and the Division's vacancy savings and retirement report.

Attached to this letter is a sample of measures that the Health Resource Division regularly collects and evaluates. These measures may be a starting point for the Subcommittee to look at prior to discussing with the Division what kind of measures they would like to see tracked during the upcoming biennium.

I would note that one of the difficulties with tracking measures for a Division such as Health Resources, which provides no direct services, is whether the Subcommittee wants to track performance of the Division or health measures for clients whose services are reimbursed by the Division. Things that are directly controlled by the Division include areas such as timeliness of payments to providers, timeliness of rule promulgation, timeliness of collection of drug rebate, timeliness of eligibility determination for CHIP or Big Sky RX, and compliance with federal or state rules as measured by audits.

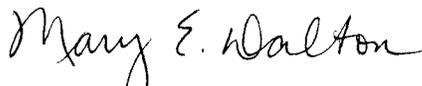
The Division can influence, but has much less control over measures such as the number of children receiving a well-child visit or the number of health care professionals who will accept Medicaid or CHIP clients.

Access to health care providers and percentage of children receiving a well-child visit remain important measures, however, even though the Division has a limited influence in these areas. Access to care is a sentinel measure that tells us

whether clients can see a provider if they need to and access measures also provide a gross measure of adequacy of rates. Well-child visits are a well-accepted proxy for access to care and to a lesser degree to health status. Well-child visits are one of the "HEDIS" measures used by almost all major health insurers.

I hope that these documents answer your questions. Please feel free to contact me if you need any additional information.

Sincerely,



Mary E. Dalton, Manager
Medicaid and Health Services

enclosures

cc: Subcommittee members

Med/leg/subcom resp measures 012909

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PUBLIC HEALTH AND HUMAN SERVICES

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2



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Representative Teresa Henry, Chairman
Appropriation Subcommittee
Health & Human Services
State Capitol Building
Helena, MT 59620

RE: Healthy Montana Kids Plan

Dear Chairman Henry:

I am responding to questions that you posed through your Legislative Fiscal Analyst, Lois Steinbeck, following the Health Resources Division hearings. I have also included the answers to questions that Ms. Steinbeck posed earlier at the end of this letter because I thought it might be easier for the subcommittee to have all the responses to Healthy Montana Kids Plan in one document.

1. Will Healthy Montana Kids (HMK) be administered as a Medicaid expansion or will the department continue separate CHIP and Medicaid programs?
Response: This decision has not been made, but it is one of the options under consideration depending on the size of the CHIP federal grant and how these federal funds can best be leveraged. Many states have a combination program of CHIP Medicaid Expansion for their lower poverty level coverage and CHIP stand-alone (this is what our program currently is) for the children at a higher level of poverty.

The Department's goal is to have the Healthy Montana Kids program appear as seamless as we can make it to the children/families using the program as well as to the health care providers. However, based on the federal requirements that come with the two funding sources, Medicaid and CHIP, there will be some differences.

A "CHIP Medicaid Expansion Program" would mean that the CHIP benefit package and eligibility determination process mimic the Medicaid program. The CHIP program would also then become an entitlement and all eligible children up to whatever poverty level is chosen would be covered along with all medically necessary services. CHIP Medicaid expansion programs use the available CHIP grant first (at the CHIP matching rate which is approximately 10% more federal funds than the Medicaid rate) and then when the grant is exhausted use Medicaid funding (at the Medicaid match rate). A CHIP Medicaid expansion looks and acts exactly like a Medicaid program from the client and provider point of view. It just has two funding sources.

The Department is not contemplating using a Medicaid Expansion option for children in the higher income level categories.

- a. If HMK is administered as a Medicaid expansion, will the department continue the different service packages or adopt Medicaid services/reimbursement for all children?

Response: Regardless of whether we choose to do a CHIP Medicaid expansion or a regular Medicaid expansion, the Medicaid federal requirements will apply to children covered by Medicaid. We don't believe that CMS (Medicaid federal partner) would allow two different reimbursement rates for children – one for regular Medicaid and then a higher reimbursement rate for the children who are in a CHIP Medicaid expansion. The Medicaid package and reimbursement rate will be adopted for all children who are funded by Medicaid, regardless of whether their services are reimbursed with Medicaid or CHIP Medicaid Expansion funding.

We do not anticipate changing the CHIP stand-alone program package of benefits or reimbursement at this time.

One of the key components to making HMK as seamless as possible from the client and provider stand point will be the length of time the child is enrolled. It will not be nearly as confusing for families or health care providers if a child is in the Medicaid option or the CHIP option for a longer period of time as it will be if they switch back and forth between programs on a monthly basis.

- b. What is the difference in average cost per child for CHIP and Medicaid, not including services for disabled children?

Response: The estimated FFY 2010 cost for benefits is \$138/month for Medicaid and \$172/month for CHIP. The major difference between the program costs is due to different provider reimbursement rates. The Medicaid benefit cost also does not reflect the effect of the hospital tax collections. If the hospital tax was included, the Medicaid benefit costs would increase.

2. Provide the assumptions and work statistics, including cases per worker, for HMK to show:

- a. Computation for Medicaid eligibility - 54.00 FTE (most labor intensive scenario)

Response: The number of staff needed to determine Medicaid or CHIP eligibility is different due to the programs' current policies. For example, Medicaid requires income verification and CHIP accepts self-declaration of income. Medicaid has a 12-month renewal period with change reporting and ex parte review for consideration of continuous eligibility and CHIP provides 12-months of continuous coverage. (Ex parte means that if a client notifies an eligibility worker of any changes in income, e.g. the SNAP program, this information is used to re-determine Medicaid eligibility.)

The Medicaid estimate of 54 FTE is based on the number of cases approved/enrolled in the Medicaid program. The current Medicaid eligibility system does not capture the number of applications that a FTE must "work" in order to come up with an approved case.

The 54 FTE requested consist of 48 Social Service Specialists and 6 Supervisors. This estimate is based upon 1 Social Service Specialist for every 226 cases. (A case is based on the TANF caseload where the typical case is one adult and one child.) The estimate for supervisors is based on 1 supervisor per 8 Social Service Specialists. Cost: \$2,330,604 per year personal services and \$530,990 per year operating expenses for a total of \$2,861,594/year.

b. Calculation for additional:

i. CHIP eligibility - 3 FTE

Response: This estimate is based on the number of children enrolled per FTE in SFY 2008. One CHIP FTE determined eligibility and enrolled approximately 735 cases. (An average case consists of 2 children so each worker enrolls approximately 1470 children in CHIP annually.) These numbers do not include the number of applications processed per FTE. Cost: \$139,008 per year personal services and \$33,018 per year operating expenses for a total of \$172,026/year for FFY 2010.

ii. Hearings Officer - 1 FTE

Response: DPHHS Hearing Officers are working at maximum capacity now and we estimate an additional 29,817 children will be enrolled in HMK. Therefore, the department anticipates an increase in the number of requests for fair hearings. Cost: \$55,686/year personal services and \$11,006/year operating services for a total of \$66,692/year for FFY 2010.

iii. Attorney - 1 FTE

Response: DPHHS attorneys are currently working at maximum capacity. As a result of the increased enrollment in HMK, an attorney is needed for administrative rule development, consultation with program and eligibility staff and responsibilities related to HMK-related fair hearings and court cases. Costs: \$83,209/year personal services and \$11,006/year operating services for a total of \$94,215 for FY2010.

3. Provide the anticipated timeline by date for implementation of HMK showing the following milestones:

a. Submissions and type of submission to the Centers for Medicaid and Medicare Services (CMS) including expected final response date

Response: The CHIP state plan and the Medicaid state plan cannot be submitted until we know the size of the CHIP federal grant and the amount of matching funds appropriated by the Montana legislature. The state plans must specify the exact federal poverty level each program plans to implement in order to determine if a child is eligible for the program.

DPHHS intends to submit the State Plan Amendments after the size of the federal grant and the state matching funds is known.

DPHHS estimates CMS will approve the state plan amendments for program expansions by August/September 2009. Implementation will occur in October 2009 after CMS approval is obtained.

b. Date of hire for FTE by type of position and number hired-

Response: CHIP eligibility staff, the attorney and the fair hearing officer will be hired between July and September 2009. Medicaid eligibility staff will begin to be hired in the same quarter. The number of Medicaid eligibility staff hired and the timing of hiring will be phased in. The Department does not intend to hire any more FTE than are necessary to process the applications received. It should also be noted that the number of FTE may shift between the CHIP and Medicaid program depending on where the federal poverty level is set as this will determine the size of both programs.

- c. **Completion of information technology system enhancements.**
Response: Modifications to the Medicaid eligibility system (CHIMES) and the CHIP eligibility system (KIDS) will be made in Phase I of the technology system enhancements. These enhancements will be completed by August 31, 2009. Additional enhancements will be made during the remainder of FFY 2009 and FFY 2010.
- d. **Estimated enrollment by month or quarter starting with month that enrollment will commence through the end of 2012.**
Response: For the purpose of the current projections, the department estimated 29,187 children will be enrolled beginning October 1, 2009. We anticipate the actual enrollments may take place at a slower pace but since we are working on projected numbers of uninsured we did not want to have inadequate funding or staffing should all of these children apply. Healthy Montana Kids is funded with state special revenue. If this state special revenue is not expended it will be placed in an account for later use by Healthy Montana Kids in accordance with I-155.
- e. **Transition of children from CHIP to Medicaid with beginning and end dates for anticipated duration of transition and number of children expected to transition from CHIP to Medicaid?**
Response: The number of children that will transition to Medicaid is unknown at this time. This number is dependent upon where we set the eligibility levels for CHIP and Medicaid. It is anticipated that at a minimum, children under 133% of the federal poverty level will transfer. Children will begin transitioning in October 2009 and continue as their eligibility for CHIP expires over the next year (October 2009 – September 2010).

Two things must occur in order for children currently on CHIP to transfer to Medicaid. CMS must "re-think" their position so children at a federal poverty level who are currently covered by CHIP can be covered by Medicaid. If they do not change their current position, children up to 175% of poverty in Montana could not transfer from CHIP to Medicaid. The other factor that determines how many children might move is the amount of the CHIP federal grant. Montana gets a better federal match for the CHIP program and would probably want to use it as the primary coverage for children because of that enhanced match.

The primary scenario in the decision package (HRD DP 11011) is based on the premise that CMS will reverse its current position on "once CHIP, always CHIP" and that the size of the CHIP grant is not large enough to cover the current CHIP enrollment plus an expansion to 250% of poverty. Under this scenario, all 17,240 children currently enrolled in CHIP would be eligible for the Medicaid funded portion of the Healthy Montana Kids plan at the time of their CHIP annual reapplication. This assumes families choose to reapply for CHIP and continue to meet the financial (<175% FPL) and non-financial (Montana resident, less than 19 years of age, etc.) eligibility criteria.

4. **Will DPHHS seek to add enrollment partners?**

Response: DPHHS currently has more than 500 "CHIP Champions" throughout the state who provide CHIP information, materials and applications. We will continue to work with these CHIP Champions to determine how many of them wish to become enrollment partners. An enrollment partner, in addition to providing information, would need to help families fill out and submit applications. The initial focus on recruiting and training enrollment partners will be CHIP and Medicaid health care providers (e.g. community health centers, hospitals, etc.) Many of these providers are already CHIP Champions.

5. With the change to Healthy Montana Kids will there be a name recognition challenge?
Response: Our media campaign, press releases and marketing materials will promote the Healthy Montana Kids name and what it represents (health care coverage for children funded by Medicaid and CHIP dollars). Education of families and providers will be key to avoid confusion about the programs.
6. Can Montana enroll children above 175% of the federal poverty level prior to federal approval of the state plans?
Response: No, DPHHS must submit and receive approval of a state plan amendment in order to access federal matching funds for an increase in the CHIP eligibility level above 175% FPL.
7. Will Montana begin actively recruiting children above 175% of the federal poverty level now and create a waiting list prior to October 1, 2009?
Response: DPHHS will begin active marketing the summer of 2009. We need to make changes in the eligibility determination system (see response to question 3c) before we can enroll children. Families who are determined to be over income for CHIP prior to the implementation of HMK will be contacted during the July to September 2009 quarter if their children appear to be eligible under the new guidelines to see if they still wish to enroll. If eligible, children will be enrolled effective October 1, 2009.
8. Is DPHHS anticipating eligibility and payment systems changes to be complete by September 1 and tested and ready to go by October 1?
Response: Yes, the projected date of eligibility systems enhancement completion is August 31, 2009. We anticipate that the eligibility systems for Medicaid (CHIMES) and CHIP (KIDS) will be ready to "go live" by October 1, 2009.
9. Are the system changes being made for October 1, 2009 the minimum necessary to implement Healthy Montana Kids?
Response: Yes
10. Will more extensive system changes be undertaken after implementation?
Response: Yes, Montana will continue to refine our eligibility systems to make them as efficient and seamless for applicants as we can.
11. Is DPHHS creating an online application for enrollment partners' use to provide eligibility information?
Response: DPHHS is creating an online application which families may use to apply for HMK. Some families may request application assistance from enrollment partners. Enrollment partners will be able to use the online application and submit the information to DPHHS.
12. Will DPHHS manage the eligibility and enrollment processes "by hand" if the systems are not up and running by October 1?
Response: Yes, we intend to actively enroll children beginning October 1, 2009 regardless of whether the system changes are completed.
13. When will DPHHS begin an information campaign to help persons recognize that CHIP is transitioning to HMK? What types of activities will be undertaken?
Response: DPHHS will run newspaper advertisements with the CHIP income guidelines after the annual federal FPL change (February/March 2009). In the summer of 2009 DPHHS will issue press releases regarding the change to HMK and send HMK information to Medicaid and CHIP health care providers as well as

families whose children are currently enrolled in CHIP and Medicaid. In addition, DPHHS will provide information to "CHIP Champions" and Medicaid outreach partners for distribution in local communities. (The CHIP and Medicaid partners include schools, food banks, advocacy groups, health care providers, IHS, Tribal Health, community health centers, etc.)

14. Are there tasks that need to be completed prior to outreach for HMK (other than potential system development issues)? If so, what are those tasks?
Response: DPHHS needs to hire and train staff to process the increased number of applications which will result from the summer 2009 "ramped up" outreach activities (see #3).
15. At what date will DPHHS begin active outreach to increase enrollment in HMK? How and when will outreach "ramp up"? What steps will be taken to encourage enrollment?
Response: In addition to the HMK outreach activities listed in the response to question #13. We plan an aggressive "Back to School" campaign and a media campaign in July and August. The media campaign will include newspaper, radio, and television "spots" promoting HMK. The department will also consider other innovative outreach activities to promote HMK and welcomes all suggestions that legislators, advocates, or the public might make.
16. Will enrollment partners be given an expanded role in helping to determine eligibility for HMK compared to the current CHIP program? If so, what are the roles?
Response: DPHHS has not yet finalized the roles/responsibilities of enrollment partners. We anticipate enrollment partners will assist families complete the on-line HMK application, if the family requests assistance. Enrollment partners, as well as the current CHIP Champions and Medicaid community partners, will also provide HMK informational brochures and applications to their clients who have uninsured children.
17. When will DPHHS begin enrolling children in HMK (not including incremental changes in CHIP and Medicaid enrollment under current state plan eligibility levels)? If a waiting list is established to facilitate enrollment in HMK, at what point would DPHHS establish a waiting list?
Response: Children will be enrolled in HMK beginning October 1, 2009. DPHHS does not anticipate implementation of a waiting list. Families who are determined to be over income for CHIP prior to the implementation of the increased eligibility guidelines will be contacted if their children appear to be eligible under the new guidelines. See the response to question #7 for further detail.
18. Does DPHHS have a monthly enrollment target? If so, what is it?
Response: At this time DPHHS does not have a monthly enrollment target, per se. Please see response to Question #3d.

For your reference, I've attached the department's response to the committee's earlier questions regarding the implementation of the Healthy Montana Kids plan to this memo.

Please contact me if you have questions or would like additional information.

Sincerely,


Mary E. Dalton
Medicaid and Health Services Manager
Director's Office

From the presentation on Healthy Montana Kids 1/7/09 Frequently Asked Questions and Answers

1. What is happening with federal reauthorization of CHIP?
 - The authorization and the funding for CHIP is scheduled to end March 31, 2009. The department does not know at this time, whether Congress and the President will choose to reauthorize or just extend the program. Nor do we know what funding level Montana can expect after the end of March.
2. Will CMS require Montana to use CHIP monies to pay for an expansion of Medicaid?
 - CMS current interpretation of the federal regulations is that the department would need to do so. The agency is hopeful this interpretation may change with the new administration.
3. Does DPHHS need a waiver to implement Healthy MT kids?
 - DPHHS is researching this issue. It appears CMS will not require a waiver to implement Medicaid or CHIP presumptive eligibility. Medicaid already has a premium assistance program, the Health Insurance Premium Payment (HIPP) administered through DPHHS, so a waiver will not be required for Medicaid. A Section 1115 waiver may be needed to implement CHIP premium assistance. If so, DPHHS will submit the waiver a minimum of 90 days prior to the projected implementation of the premium assistance program.
4. Is a waiver needed to implement the I-155 provision regarding assistance to employers who establish a premium-only health benefits plan under section 125 of the Internal Revenue Code, 26 U.S.C. 125, for the purpose of enrolling children in such a plan and allowing their families to pay any premium with pretax dollars?
 - It is not anticipated that a CHIP or Medicaid waiver will be needed to implement this aspect of the initiative. DPHHS will work with the State Auditor's Office regarding implementation.
5. What is the projected date for a Medicaid state plan amendment?
 - Technically, DPHHS has until the end of the first quarter after implementation (December 31, 2009) to submit Medicaid and CHIP State Plan Amendments (SPA) to CMS. DPHHS intends to submit the State Plan Amendments (SPAs) after January 20, 2009.
 - DPHHS estimates CMS will approve SPAs for program expansions by August/September 2009. Implementation will occur in October 2009 after CMS approval is obtained.
6. I-155 financial eligibility increases for Medicaid – does DPHHS need a Medicaid state plan amendment or are there other ways financial eligibility could be increased without a state plan amendment – for example additional income disregards.
 - Medicaid must submit a state plan amendment (provision 1902(r) (2)) to implement more liberal income and resource methodologies.

7. Does DPHHS need a waiver to cap enrollment in the Medicaid expansion population or do DRA changes allow the expansion program to include an enrollment cap?
 - DPHHS is not intending to cap enrollment in Medicaid. We do not believe a Medicaid cap is within the spirit or the intent of the initiative.
8. When will Healthy MT Kids begin and what is the timeline to get to full enrollment?
 - First date of enrollment is October 1, 2009. Decision package 11011 in the HRD Division is based on the enrollment that we hope to achieve by 2013. No state has reached "full" enrollment in their Medicaid or CHIP expansions. The best states are between 90-95% and that is usually after about a decade of intensive outreach.
9. How many children currently enrolled in CHIP would transition to the Medicaid expansion population if only Medicaid eligibility standards are raised (the assumption being that federal funding for CHIP is not expanded)?
 - Two things must occur in order for children currently on CHIP to transfer to Medicaid. CMS must "re-think" their position so that children at a federal poverty level who are currently covered by CHIP can be covered by Medicaid. If they do not change their current position, children up to 175% of poverty in Montana could not transfer to Medicaid. The other factor that determines a move from the program is the amount of the CHIP grant. Montana gets a better federal match for the CHIP program and would probably want to use it as the primary coverage for children because of that match.
 - The primary scenario in the decision package is based on the premise that CMS will reverse its current position on "once CHIP, always CHIP" and that the size of the CHIP grant is not large enough to cover the current CHIP enrollment plus an expansion to 250% of poverty. Under these scenarios all 17,240 children currently enrolled in CHIP would be eligible for the Medicaid funded portion of the Healthy Montana Kids plan at the time of their CHIP annual reapplication. This assumes families choose to reapply for CHIP and continue to meet the financial (<175% FPL) and non-financial (Montana resident, less than 19 years of age, etc.) eligibility criteria.
10. How many children were enrolled in Medicaid as of November 5, 2008 and in CHIP as of November 5, 2008?
 - There were 46,711 children enrolled in Medicaid and 17,240 children enrolled in CHIP as of November 1, 2008. Of the children enrolled in Medicaid, 21,376 children were in the Children-Under Age 6 and Children-Age 6 to 19 programs. The remaining Medicaid children (approximately 25,000) were in other coverage groups such as: family, transitional, foster care, subsidized adoption, pregnancy-related, disabled children and automatic newborn Medicaid programs.

11. Please describe the anticipated eligibility process. Can an eligibility process like that of CHIP be used? If not, why not?
 - DPHHS intends to simplify the eligibility process as much as it can within the limitations of the programs. Federal regulations for Medicaid (e.g. citizenship and identity verification, etc.) are stricter than CHIP, so the differences in program requirements must be addressed.
12. What is the projected date of rule publication?
 - July/August 2009
13. What is the projected date of eligibility systems enhancement completion?
 - August 31, 2009
14. When will Outreach programs begin?
 - Summer 2009
15. When will the state begin education of enrollment partners?
 - Late Spring / Early Summer 2009
16. What process is necessary for Healthy MT Kids to be funded at the state level?
 - The legislature needs to pass two legislative bills in order to appropriate funds for the Health Montana Kids (HMK) Plan.
 - The legislature needs to approve HB157 which Representative Chuck Hunter is introducing at the request of the department. The bill provides for revisions to the Healthy Montana Kids (HMK) Plan Act, provides for extended rulemaking authority, delays implementation of the act subject to federal funding, provides an appropriation for SFY 2009*, and provides for an immediate effective date for HMK.
 - The legislature needs to approve the DPHHS Health Resources Division Decision Package (DP 11011) in the Executive Budget. This present law adjustment adds 60 new FTE and \$36 million from the state special revenue funds and \$72.6 million federal funds over the biennium to expand Medicaid and CHIP programs for children's health insurance enacted by the passage of voter Initiative 155 and effective November 4, 2008. This request is contingent upon federal approval of both CHIP and Medicaid state plan amendments and the receipt of matching federal funds.

(* The revenue for funding Healthy Montana Kids is available beginning November 4, 2008. The state needs appropriation authority to expend this revenue.)

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To: Health and Human Services Subcommittee
 Representative Teresa Henry, Chair

From: Health Resources Division

Date: January 23, 2009

Re: Questions from the Subcommittee on vacancy savings and retirement

Question #1 How many positions are vacant now (January 2009) and what do they do? Why are they open?
 Which of these positions are held open to meet vacancy savings?

This table provides the answers to all of the questions. This data is as of January 15, 2009

HRD	Advertised	Care Management Analyst	1.00
		Claims Resolution Officer	1.00
		Comm Svcs & Grant Supervisor	1.00
		Information Manager	1.00
		Program Specialist	1.00
	Interviewing	Medicaid Claims & Prog Spec	1.00
		Program Analyst	1.00
		Program Assistant	2.00
	Under review	Big Sky Rx Outreach Officer	1.00
		Care Management Prog Officer	1.00
		Division Administrator	1.00
		Eligibility Specialist	1.00
		Human Services Prog Officer	1.00
Information Manager		1.00	
Pharmacy Section Supervisor		1.00	
Program Specialist	1.00		
Will be advertised shortly	Eligibility Examiner	1.00	
	Eligibility Specialist	1.00	
HRD Total			19.00

Question #2 How many positions would have to be held open to make the 4 percent vacancy savings?
 (Annual number) What groups of positions are most likely to be open and what do they do? See LFD
 Analysis, page B 214. (Fill in page number where vacancy savings can be found)

FY09

87.00 FTE X 4% = 3.48 FTE (Based on the assumption that all FTE are funded proportionally)

(Page B-214) – The vacancy report states that this division does not have specific occupations with high turnover rates. However the division states that the groups of positions that are most likely to be open would be program officers, and eligibility workers. Of the 19 positions that are currently vacant; these positions make up 58% of the current vacancies.

Question #3 What is the division's total 7 percent vacancy savings and how many positions would have to be held open to make the 7 percent vacancy savings? What additional positions (by group) are most likely to be open and what do they do? List only the additions to the 4 percent list.

FY09

87.00 FTE X 7% = 6.09 FTE (Based on the assumption that all FTE are funded proportionally)

Additional open positions needed to achieve the 7% vacancy savings will likely be similar or the same types of positions as those listed in response to Question #2 above.

Question #4 Of the division's anticipated retirements, what positions do the retirees hold? Is the estimated payout still in line with the estimates on page B-4 of the LFD Analysis?

The division's employees eligible for retirement benefits based on projections using the data provided by DOA are 45 FTE for the biennium. The anticipated compensated absence liability of \$32,592 is still in line with the estimates on page B-4 of the LFD analysis. The following table shows the retirements that have occurred in the past two fiscal years in general job categories.

Management	Pay Bands (7,8,9)	50%
Professional/Program	Pay Bands (5,6,7)	50%
		100%

Question #5 Would the division make cuts in the operating budget to meet vacancy savings? Please identify.

If needed to achieve the target amount of vacancy savings, the division can consider reductions in travel, training, equipment purchases and other discretionary operating costs. All operating budget reductions for this purpose will be subject to the review and approval of the agency senior management team in light of overall agency priorities.

The division has already submitted a 5% Reduction Plan to the OBPP in preparation for the 2009 session which will be used to guide the initial division fiscal reductions if it becomes necessary.

Question #6 If the division should have to make cuts to services, which services would be reduced first? Does the division have the authority to eliminate any programs during the interim? Please list the programs.

Elimination of programs and services is not at the discretion of the division. If program or services reductions are required, the DPHHS senior management team will assess the agency priorities, critical service needs, federal and state mandates, as well as fiscal targets, and make recommendations to the Governor for his consideration.

EXHIBIT 1
DATE _____
HB _____

**DEPARTMENT OF
PUBLIC HEALTH AND HUMAN SERVICES**



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January 27, 2008⁹⁰

Representative Teresa Henry, Chairman
Appropriation Subcommittee
Health & Human Services
State Capitol Building
Helena, MT 59620

Dear Chairman Henry:

I am responding to questions that you posed through your Legislative Fiscal Analyst, Lois Steinbeck, following the Health Resources Division hearings.

HIFA Waiver

1. Can you provide a copy of the most recent communication with CMS about the HIFA waiver? If there is a great deal of information, the cover letter would suffice for now.

Response: CMS has very recently shown renewed interest in the HIFA waiver. The Department is actively working with CMS to further define the elements of the waiver that CMS is willing to entertain. We believe from verbal communication that they are primarily interested in areas that would affect Mental Health Services Plan enrollees in the Addictive and Mental Disorders Division. See Attachment A.

Children's Mental Health

1. Could you provide a break out of funding in children's mental health for the System of Care that shows the amount in the 2011 biennium budget by fiscal year (FTE, personal services, operating costs, grants, and benefits) and detailed funding?

Response: There are 3 FTE allocated to the System of Care at the state level. KMA funding is distributed through contracts with the 5 funded sites. The following is an outline of the detailed funding.

SAMHSA Grant

State		FY 2010	FY 2011
General Fund	61000 Personal Services	\$72,400	\$72,675
	62000 Operating Expenses	\$105,083	\$104,988
	67000 Benefits & Claims	\$162	\$162
General Fund Total		\$177,645	\$177,825
Federal Funds	61000 Personal Services	\$87,095	\$91,410
	62000 Operating Expenses	\$107,571	\$106,760
	Federal Fund Total		\$194,666
Funding provided to KMA's			
General Fund	66000 Grants	\$194,160	\$193,981
Federal Funds	66000 Grants	\$466,362	\$462,842
Total KMA funds		\$660,522	\$656,823

Total funding \$1,032,833 \$1,032,818

Please feel free to contact me if you have additional questions.

Sincerely,

Mary E. Dalton

Mary E. Dalton, Manager
Medicaid and Health Services

Attachment

Med/leg/subcom resp HIFA & SOCs

DEPARTMENT OF
PUBLIC HEALTH AND HUMAN SERVICES



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January 14, 2009

Diane Heffron
Acting Director
Department of Health & Human Services
Centers for Medicare & Medicaid Services
7500 Security Blvd., Mail Stop S2-26-12
Baltimore, MD 21244-1850

Subject: Request for 1115 Waiver Extension

Dear Ms. Heffron:

Montana formally submits this request for a temporary Section 1115 waiver extension for our Basic Medicaid for Able-Bodied Adults. The Basic Medicaid Waiver, for Able Bodied Adults, will expire on January 31, 2009. We request to continue the waiver, as it currently exists, through February 28, 2009.

We request this waiver extension while CMS and Montana discuss the possibility of adding an expansion population, to the Basic Medicaid waiver. These individuals from the Mental Health Services Plan Program (MHSP) are otherwise uninsured with incomes at or below 150% FPL. Without approval to extend the Basic Medicaid Waiver, Montana will not have the opportunity to offer a physical health benefit to MHSP individuals. Currently, the MHSP population has a limited mental health benefit and a \$425 mental health prescription drug benefit but no physical health care. MHSP individuals often have physical health care complications that go untreated until it is emergent care or reach a level of disability.

If you have any questions, please contact Duane Preshinger, Senior Medicaid Policy Manager at (406) 444-4145 or at dpreshinger@mt.gov or Jo Thompson, Medicaid Analyst at (406) 444-2584 or at jothompson@mt.gov. We appreciate your formal consideration of the waiver extension request.

Sincerely,

Mary E. Dalton
Mary Dalton, Medicaid Services Manager

Cc: Clarke Cagey, Director, Division of State Demonstrations and Waivers
Paul Boben, Technical Director, Division of State Demonstrations and Waivers
Kelly Heilman, Project Officer, Division of State Demonstrations and Waivers
Cindy Smith, Health Insurance Specialist, Centers for Medicare and Medicaid Services
Duane Preshinger, Montana Senior Medicaid Policy Manager
Jo Thompson, Montana Medicaid Analyst

Update to Figure 54 on B-258 as of January 26, 2009
Cigarette Tax Fund Balance Supporting Veterans' Services

EXHIBIT
DATE

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1-28-09

Fund Balance Deposits/Expenditures	Actual FY 2008	Appropriated FY 2009	Executive Request FY 2010	HB FY 2011	Page No.
Beginning Fund Balance (1)	\$10,474,759	\$2,000,000	\$2,000,000	\$2,000,000	258
Revenue/Transfers In (2)					
Cigarette Tax	6,626,059	6,694,000	6,758,000	6,824,000	
Other Deposits	7,586				
Consumption Reduction due to Federal Tobacco Tax Increase to Fund CHIP Expansion			??	??	
Expenditures					
<u>Veterans' Homes Operations</u>					
Montana Veterans' Home	2,947,623	3,284,652	1,886,426	1,696,411	275
22201 Contingency Fund (Biennial/OTO)			125,000	125,000	278
22210 MVH Overtime/Holidays Worked			380,165	389,160	278
22222 MVH Operating Expenses			263,650	263,650	278
22102 MVH Facility Upgrades			165,000	65,000	279
22105 MVH Safety Officer			55,470	55,488	279
22115 MVH New CNAs FTE			223,874	224,514	279
22117 MVH Additional Aggregate RNs			183,095	183,790	280
22118 MVH Additional Aggregate LPNs			30,561	30,656	280
22119 MVH Additional Aggregate CNAs			134,655	135,114	280
22120 MVH Additional Aggregate Activity Positions			110,656	111,017	280
22122 Wage Increases Based on Wage Survey			33,525	134,090	280
HB 13 - Pay Plan					
7101 Fuel Inflation Reduction - Approved			(646)	(664)	
8101 Increase Vacancy Savings to 7% - Approved			(1,556)	(1,556)	
Eastern Montana Veterans' Home	259,858	307,119	297,638	258,220	275
22114 Facility Painting and Upgrades			40,000	40,000	279
<u>Long-Range Building (3)</u>					
Administration		392,160			
Capital Funds Transfers	41,261	1,371,739			
Montana Veterans' Home	308,160	143,054			
Eastern Montana Veterans' Home	2,400	6,096			
MVH Campus Master Plan			100,000		
<u>Cost Allocated Administration</u>					
DPHHS Cost Allocated Admin.	206,163	255,642	317,047	387,749	
Division Administrative Cost	74,277	48,845	90,826	95,931	
Pay Plan and Retirement Costs	0	181,172	0	0	
Subtotal Expenditures	3,839,742	5,809,307	4,435,386	4,193,570	
Annual Rate of Change		51.3%	-23.7%	-5.5%	
Transfer to General Fund (4)	(11,261,076)	(884,693)	(2,322,614)	(2,630,430)	
Ending Fund Balance	<u>\$2,000,000</u>	<u>\$2,000,000</u>	<u>\$2,000,000</u>	<u>\$2,000,000</u>	

1. Statute requires that unexpended cash balances in excess of \$2 million be deposited to the general fund. Fund balances include other adjustments and may not equal cash balances.
2. Revenue based on estimates adopted by the Revenue Oversight Taxation and Transportation Committee. Expenditures are based on executive budget request. Estimated expenditures also include indirect costs allocated across DPHHS.
3. Long range building projects include amounts that are included in the fund balance report. The December 15 revisions to the executive budget eliminated projects from the long range building proposal, increasing the transfer to the general fund by \$3.5 million compared to the November 15 executive budget (excluding the fund reduction for federal cigarette tax increases).
4. The FY 2008 transfer is much larger than transfers in other years because it includes the transfer for both FY 2007 and FY 2008.

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