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State/Territory Name: Montana

State Plan Amendments (SPA) #: MT-18-0021

This file contains the following documents in the order listed:

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



Children and Adults Health Programs Group

NOV 27 2019

Marie Matthews
State Medicaid and CHIP Director
Montana Department of Public Health and Human Services
Post Office Box 4210
Helena, MT 59604

Dear Ms. Matthews:

Your title XXI Children's Health Insurance Program (CHIP) state plan amendment (SPA), MT-18-0021, submitted on June 29, 2018, with additional information submitted on November 8, 2019, has been approved. Through this SPA, Montana implements mental health parity requirements to ensure that treatment limitations applied to mental health (MH) and substance use disorder (SUD) benefits are no more restrictive than those applied to medical/surgical (M/S) benefits. This SPA also added applied behavior analysis as a benefit and removed a copay for ambulance services. This SPA has an effective date of October 1, 2017.

Sections 2103(c)(7)(A) of the Social Security Act (the Act), as implemented through regulations at 42 CFR 457.496(d)(3)-(5), requires states that provide both M/S and MH/SUD benefits to ensure that financial requirements (FRs) and treatment limitations applied to MH/SUD benefits covered under the state child health plan are consistent with the mental health parity requirements of section 2705(a) of the Public Health Service Act, in the same manner that such requirements apply to a group health plan. Montana demonstrated compliance by removing limitations applied to extended mental health services, effective October 1, 2017, and providing the necessary assurances and supporting documentation that the state's application of FRs and non-quantitative treatment limitations to MH/SUD benefits are consistent with section 2103(c)(7)(A) of the Act. This SPA approval relates only to benefits provided under the CHIP state plan; Medicaid benefits will be analyzed separately.

Your title XXI project officer is Ms. Joyce Jordan. She is available to answer questions concerning this amendment and other CHIP-related issues. Ms. Jordan's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-3413
E-mail: Joyce.Jordan@cms.hhs.gov

Page 2 – Ms. Marie Matthews

Official communications regarding program matters should be sent simultaneously to Ms. Jordan and to Mr. Richard Allen, Director, Division of Medicaid Field Operations West. Mr. Allen's address is:

Centers for Medicare & Medicaid Services
1961 Stout Street
Room 08-148
Denver, Colorado 80294

If you have additional questions, please contact Amy Lutzky, Director, Division of State Coverage Programs at (410) 786-0721.

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

Sincerely,

/signed Anne Marie Costello/

Anne Marie Costello
Director

cc:

Mr. Richard Allen, Director, Division of Medicaid Field Operations West

TEMPLATE FOR CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT CHILDREN'S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory: Montana
(Name of State/Territory)

SPA 18-0021

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, (42 CFR, 457.40(b))

(Signature of Governor, or designee, of State/Territory, Date Signed)

submits the following Child Health Plan for the Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following State officials are responsible for program administration and financial oversight (42 CFR 457.40(c)):

Name: Marie Matthews
Name: Duane Preshinger

Position/Title: State Medicaid and CHIP Director
Position/Title: Division Administrator, Health Resources Division

***Disclosure. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 09380707. The time required to complete this information collection is estimated to average 160 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, write to: CMS, 7500 Security Blvd., Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.**

Introduction: Section 4901 of the Balanced Budget Act of 1997 (BBA), public law 1005-33 amended the Social Security Act (the Act) by adding a new title XXI, the Children’s Health Insurance Program (CHIP). In February 2009, the Children’s Health Insurance Program Reauthorization Act (CHIPRA) renewed the program. The Patient Protection and Affordable Care Act of 2010 further modified the program.

This template outlines the information that must be included in the state plans and the state plan amendments (SPAs). It reflects the regulatory requirements at 42 CFR Part 457 as well as the previously approved SPA templates that accompanied guidance issued to States through State Health Official (SHO) letters. Where applicable, we indicate the SHO number and the date it was issued for your reference. The CHIP SPA template includes the following changes:

- Combined the instruction document with the CHIP SPA template to have a single document. Any modifications to previous instructions are for clarification only and do not reflect new policy guidance.
- Incorporated the previously issued guidance and templates (see the Key following the template for information on the newly added templates), including:
 - Prenatal care and associated health care services (SHO #02-004, issued November 12, 2002)
 - Coverage of pregnant women (CHIPRA #2, SHO # 09-006, issued May 11, 2009)
 - Tribal consultation requirements (ARRA #2, CHIPRA #3, issued May 28, 2009)
 - Dental and supplemental dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
 - Premium assistance (CHIPRA # 13, SHO # 10-002, issued February 2, 2010)
 - Express lane eligibility (CHIPRA # 14, SHO # 10-003, issued February 4, 2010)
 - Lawfully Residing requirements (CHIPRA # 17, SHO # 10-006, issued July 1, 2010)
- Moved sections 2.2 and 2.3 into section 5 to eliminate redundancies between sections 2 and 5.
- Removed crowd-out language that had been added by the August 17 letter that later was repealed.

The Centers for Medicare & Medicaid Services (CMS) is developing regulations to implement the CHIPRA requirements. When final regulations are published in the Federal Register, this template will be modified to reflect those rules and States will be required to submit SPAs illustrating compliance with the new regulations. States are not required to resubmit their State plans based on the updated template. However, States must use the updated template when submitting a State Plan Amendment.

Federal Requirements for Submission and Review of a Proposed SPA: (42 CFR Part 457 Subpart A)

In order to be eligible for payment under this statute, each State must submit a Title XXI plan for approval by the Secretary that details how the State intends to use the funds and fulfill other requirements under the law and regulations at 42 CFR Part 457. A SPA is approved in 90 days unless the Secretary notifies the State in writing that the plan is disapproved or that specified additional information is needed. Unlike Medicaid SPAs, there is only one 90 day review period, or clock for CHIP SPAs, which may be stopped by a request for additional information and restarted after a complete response is received. More information on the SPA review process is found at 42 CFR 457 Subpart A.

When submitting a State plan amendment, states should redline the changes that are being made to the existing State plan and provide a “clean” copy including changes that are being made to the existing state plan.

The template includes the following sections:

1. **General Description and Purpose of the Children’s Health Insurance Plans and the Requirements-** This section should describe how the State has designed their program. It also is the place in the template that a State updates to insert a short description and the proposed effective date of the SPA, and the proposed implementation date(s) if different from the effective date. (Section 2101); (42 CFR, 457.70)
2. **General Background and Description of State Approach to Child Health Coverage and Coordination-** This section should provide general information related to the special characteristics of each state’s program. The information should include the extent and manner to which children in the State currently have creditable health coverage, current State efforts to provide or obtain creditable health coverage for uninsured children and how the plan is designed to be coordinated with current health insurance, public health efforts, or other enrollment initiatives. This information provides a health insurance baseline in terms of the status of the children in a given State and the State programs currently in place. (Section 2103); (42 CFR 457.410(A))
3. **Methods of Delivery and Utilization Controls-** This section requires a description that must include both proposed methods of delivery and proposed utilization control systems. This section should fully describe the delivery system of the Title XXI program including the proposed contracting standards, the proposed delivery systems and the plans for enrolling providers. (Section 2103); (42 CFR 457.410(A))
4. **Eligibility Standards and Methodology-** The plan must include a description of the standards used to determine the eligibility of targeted low-income children for child health assistance under the plan. This section includes a list of potential eligibility standards the State can check off and provide a short description of how those standards will be applied. All eligibility standards must be consistent with the provisions of Title XXI and may not discriminate on the basis of diagnosis. In addition, if the standards vary within the state, the State should describe how they will be applied and under what circumstances they will be applied. In addition, this section provides information on income eligibility for Medicaid expansion programs (which are exempt from Section 4 of the State plan template) if applicable. (Section 2102(b)); (42 CFR 457.305 and 457.320)
5. **Outreach-** This section is designed for the State to fully explain its outreach activities. Outreach is defined in law as outreach to families of children likely to be eligible for child health assistance under the plan or under other public or private health coverage programs. The purpose is to inform these families of the availability of, and to assist them in enrolling their children in, such a program. (Section 2102(c)(1)); (42CFR, 457.90)
6. **Coverage Requirements for Children’s Health Insurance-** Regarding the required scope of health insurance coverage in a State plan, the child health assistance provided must consist of any of the four types of coverage outlined in Section 2103(a) (specifically, benchmark coverage; benchmark-equivalent coverage; existing comprehensive state-based coverage; and/or Secretary-

approved coverage). In this section States identify the scope of coverage and benefits offered under the plan including the categories under which that coverage is offered. The amount, scope, and duration of each offered service should be fully explained, as well as any corresponding limitations or exclusions. (Section 2103); (42 CFR 457.410(A))

7. **Quality and Appropriateness of Care-** This section includes a description of the methods (including monitoring) to be used to assure the quality and appropriateness of care and to assure access to covered services. A variety of methods are available for State's use in monitoring and evaluating the quality and appropriateness of care in its child health assistance program. The section lists some of the methods which states may consider using. In addition to methods, there are a variety of tools available for State adaptation and use with this program. The section lists some of these tools. States also have the option to choose who will conduct these activities. As an alternative to using staff of the State agency administering the program, states have the option to contract out with other organizations for this quality of care function. (Section 2107); (42 CFR 457.495)
8. **Cost Sharing and Payment-** This section addresses the requirement of a State child health plan to include a description of its proposed cost sharing for enrollees. Cost sharing is the amount (if any) of premiums, deductibles, coinsurance and other cost sharing imposed. The cost-sharing requirements provide protection for lower income children, ban cost sharing for preventive services, address the limitations on premiums and cost-sharing and address the treatment of pre-existing medical conditions. (Section 2103(e)); (42 CFR 457, Subpart E)
9. **Strategic Objectives and Performance Goals and Plan Administration-** The section addresses the strategic objectives, the performance goals, and the performance measures the State has established for providing child health assistance to targeted low income children under the plan for maximizing health benefits coverage for other low income children and children generally in the state. (Section 2107); (42 CFR 457.710)
10. **Annual Reports and Evaluations-** Section 2108(a) requires the State to assess the operation of the Children's Health Insurance Program plan and submit to the Secretary an annual report which includes the progress made in reducing the number of uninsured low income children. The report is due by January 1, following the end of the Federal fiscal year and should cover that Federal Fiscal Year. In this section, states are asked to assure that they will comply with these requirements, indicated by checking the box. (Section 2108); (42 CFR 457.750)
11. **Program Integrity-** In this section, the State assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Sections 2101(a) and 2107(e); (42 CFR 457, subpart I)
12. **Applicant and Enrollee Protections-** This section addresses the review process for eligibility and enrollment matters, health services matters (i.e., grievances), and for states that use premium assistance a description of how it will assure that applicants and enrollees are given the opportunity at initial enrollment and at each redetermination of eligibility to obtain health benefits coverage other than through that group health plan. (Section 2101(a)); (42 CFR 457.1120)

Program Options. As mentioned above, the law allows States to expand coverage for children through a separate child health insurance program, through a Medicaid expansion program, or through a combination of these programs. These options are described further below:

- **Option to Create a Separate Program-** States may elect to establish a separate child health program that are in compliance with title XXI and applicable rules. These states must establish enrollment systems that are coordinated with Medicaid and other sources of health coverage for children and also must screen children during the application process to determine if they are eligible for Medicaid and, if they are, enroll these children promptly in Medicaid.
- **Option to Expand Medicaid-** States may elect to expand coverage through Medicaid. This option for states would be available for children who do not qualify for Medicaid under State rules in effect as of March 31, 1997. Under this option, current Medicaid rules would apply.

Medicaid Expansion- CHIP SPA Requirements

In order to expedite the SPA process, states choosing to expand coverage only through an expansion of Medicaid eligibility would be required to complete sections:

- 1 (General Description)
- 2 (General Background)

They will also be required to complete the appropriate program sections, including:

- 4 (Eligibility Standards and Methodology)
- 5 (Outreach)
- 9 (Strategic Objectives and Performance Goals and Plan Administration including the budget)
- 10 (Annual Reports and Evaluations).

Medicaid Expansion- Medicaid SPA Requirements

States expanding through Medicaid-only will also be required to submit a Medicaid State Plan Amendment to modify their Title XIX State plans. These states may complete the first check-off and indicate that the description of the requirements for these sections are incorporated by reference through their State Medicaid plans for sections:

- 3 (Methods of Delivery and Utilization Controls)
- 4 (Eligibility Standards and Methodology)
- 6 (Coverage Requirements for Children's Health Insurance)
- 7 (Quality and Appropriateness of Care)
- 8 (Cost Sharing and Payment)
- 11 (Program Integrity)
- 12 (Applicant and Enrollee Protections) indicating State

- **Combination of Options-** CHIP allows states to elect to use a combination of the Medicaid program and a separate child health program to increase health coverage for children. For example, a State may cover optional targeted-low income children in families with incomes of up to 133 percent of poverty through Medicaid and a targeted group of children above that level through a separate child

health program. For the children the State chooses to cover under an expansion of Medicaid, the description provided under “Option to Expand Medicaid” would apply. Similarly, for children the State chooses to cover under a separate program, the provisions outlined above in “Option to Create a Separate Program” would apply. States wishing to use a combination of approaches will be required to complete the Title XXI State plan and the necessary State plan amendment under Title XIX.

Proposed State plan amendments should be submitted electronically and one signed hard copy to the Centers for Medicare & Medicaid Services at the following address:

Name of Project Officer
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, Maryland 21244
Attn: Children and Adults Health Programs Group
Center for Medicaid, CHIP and Survey & Certification
Mail Stop - S2-01-16

Section 1. General Description and Purpose of the Children’s Health Insurance Plans and the Requirements

1.1. The state will use funds provided under Title XXI primarily for (Check appropriate box) (Section 2101(a)(1)); (42 CFR 457.70):

Guidance: Check below if child health assistance shall be provided primarily through the development of a separate program that meets the requirements of Section 2101, which details coverage requirements and the other applicable requirements of Title XXI.

1.1.1 Obtaining coverage that meets the requirements for a separate child health program (Sections 2101(a)(1) and 2103); OR

Guidance: Check below if child health assistance shall be provided primarily through providing expanded eligibility under the State’s Medicaid program (Title XIX). Note that if this is selected the State must also submit a corresponding Medicaid SPA to CMS for review and approval.

1.1.2. Providing expanded benefits under the State’s Medicaid plan (Title XIX) (Section 2101(a)(2)); OR

Guidance: Check below if child health assistance shall be provided through a combination of both 1.1. and 1.2. (Coverage that meets the requirements of Title XXI, in conjunction with an expansion in the State’s Medicaid program). Note that if this is selected the state must also submit a corresponding Medicaid state plan amendment to CMS for review and approval.

1.1.3. A combination of both of the above. (Section 2101(a)(2))

Montana has had a separate child health program since 1999. Effective October 1, 2009, income eligibility guidelines increased from 175% of the federal poverty level (FPL) to 250% of the FPL. The name of the program changed from Montana Children’s Health Insurance Plan (CHIP) to the Healthy Montana Kids (HMK) coverage group of the Healthy Montana Kids Plan. Effective January 1, 2014, the income eligibility guidelines increased to 261% of the FPL.

Effective October 1, 2009, DPHHS implemented a CHIP-funded Medicaid Expansion Program for children 6-18 years of age whose family’s income is at or below 133% of the FPL. Children enrolled in the CHIP-funded Medicaid Expansion Program must meet all Medicaid eligibility requirements. They will receive the Medicaid package of benefits and access to the Medicaid network of providers. Provider reimbursement will be at the Medicaid provider rates. The CHIP-funded Medicaid Expansion Program will be part of the Healthy Montana Kids *Plus* coverage group of the Healthy Montana Kids Plan.

Effective January 1, 2014, the CHIP-funded Medicaid Expansion income eligibility guidelines for children 6-18 years of age increased to include family incomes at or below 143% of the FPL.

- 1.1-DS** The State will provide dental-only supplemental coverage. Only States operating a separate CHIP program are eligible for this option. States choosing this option must also complete sections 4.1-DS, 4.2-DS, 6.2-DS, 8.2-DS, and 9.10 of this SPA template. (Section 2110(b)(5))
- 1.2** Check to provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. (42 CFR 457.40(d))
- 1.3** Check to provide an assurance that the State complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. (42CFR 457.130)

Guidance: The effective date as specified below is defined as the date on which the State begins to incur costs to implement its State plan or amendment. (42 CFR 457.65) The implementation date is defined as the date the State begins to provide services; or, the date on which the State puts into practice the new policy described in the State plan or amendment. For example, in a State that has increased eligibility, this is the date on which the State begins to provide coverage to enrollees (and not the date the State begins outreach or accepting applications).

- 1.4** Provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this SPA (42 CFR 457.65). A SPA may only have one effective date, but provisions within the SPA may have different implementation dates that must be after the effective date.

Original Plan

Effective Date: January 1, 1998

Implementation Date: January 1, 1998

SPA # 1. Purpose:

Established an enrollment cap of 10,100 children effective 1/1/2001; adoption of a universal application form; modification of definition of countable income; elimination of the annual enrollment fee; exclusion of coverage for contraceptives; addition of a \$350 dental benefit and an eyeglass benefit; an increase in the annual maximum copayment from \$200 to \$215; and elimination of cost-sharing for Native American children enrolled in CHIP.

Effective Date: June 1, 2000

Implementation Date: June 1, 2000

SPA #2. Purpose:

Updated and amended to indicate Montana's compliance with final CHIP regulations. Amendment reduced mental health benefits although the following benefits remained—inpatient and outpatient mental health services and prescription drugs.

Effective Date: July 1, 2002

Implementation Date: July 1, 2002

SPA #3. Purpose:

SPA #3 made clarifying, administrative and technical changes to the State Plan. It reinstated additional mental health benefits to the benchmark-equivalent plan for children diagnosed as seriously emotionally disturbed (SED); provided for private donations to be used for Federal match; replaced the Universal application with a simplified CHIP application; reduced the waiting period from three months to one month; increased the enrollment cap from 10,900 to 13,900 children; and eliminated the requirement for income documentation.

Effective Date: October 1, 2005

Implementation Date: October 1, 2005

SPA #4. Purpose:

SPA #4 expanded coverage from 150 percent to 175 percent of the Federal Poverty Level (FPL); added an Extended Dental Plan (EDP) in addition to the basic dental plan, and updated the State Plan to reflect Montana's current practice of contracting with a Third Party Administrator (TPA).

Effective Date: October 1, 2006

Implementation Date: TPA contract, October 1, 2006; FPL increase, July 1, 2007;
Extended Dental Plan, October 1, 2007

SPA #5. Purpose:

SPA #5 requested approval of Federal matching funds for a \$150,000 donation by the Caring Foundation of Montana to be used to provide dental services through the Montana CHIP program. This amendment has an effective date of October 1, 2009.

Effective Date: October 1, 2009

Implementation Date: October 1, 2009

SPA #6. Purpose:

SPA #6 changed Montana's CHIP program from a separate child health program to a combination program. The Medicaid expansion program includes children 6 to 18 years

of age above 100 percent of FPL up to and including 133 percent of FPL. SPA #6 also increased the upper income level for the separate child health program from 175 percent of FPL up to and including 250 percent of FPL. SPA #6 made other changes related to program administration and eligibility determinations, and added benefits and a new source of funds. Lastly, SPA #6 changed the name of the program from Montana Children's Health Insurance Plan (CHIP) to Healthy Montana Kids and Healthy Montana Kids *Plus* (previously children's Medicaid).
Effective Date: October 1, 2009

Implementation Date: October 1, 2009

SPA #7. Purpose:

SPA #7 allowed for coverage of eligible children of State employees and Montana University System employees with family incomes within the HMK income guidelines. The coverage was provided in accordance with the "Hardship Exception to the Exclusion of Children of Employees of a Public Agency of a State" of the Patient Protection and Affordable Care Act of 2010.
Effective Date: December 1, 2010

Implementation Date: December 1, 2010

SPA #8. Purpose: SPA #8 removed some annual limits for inpatient and outpatient medical, mental health, and substance use disorder benefits. It also expanded coverage to children lawfully residing in the U.S., provided Prospective Payment for FQHCs and RHCs, and created an exception to the three-month insurance delay for children of military personnel losing eligibility for Trico and for children from families with annual out of pocket health care costs exceeding 5 percent of the family's income.

It added emergency ambulance services as a covered benefit, removed cochlear implants as a covered benefit, increased the maximum basic dental benefit to \$1,200 per member per benefit year, made programmatic updates to tribal consultation, the schedule of mailings, and the appeals process, and provided for Presumptive Eligibility.

Effective Date: October 1, 2009

Implementation Dates:

July 1, 2010 – Removed some annual limits for inpatient and outpatient medical, mental health, and substance use disorder benefits;

August 1, 2010 – Expanded Coverage to Children Lawfully Residing in the United States;

October, 1, 2009 – Provided Prospective Payment System for FQHCs and RHCs;

October 1, 2010 -- Applied as an exception to the three month insurance delay period children of military personnel who lose eligibility for Trico insurance (retroactive to

October 1, 2009); applied as an exception to the three month insurance delay period children from families with annual aggregate amount of premiums and cost-sharing exceeding 5 percent of family's income; added emergency ambulance services as a covered benefit and removed cochlear implants and associated components as covered benefits; increased the maximum basic dental benefit to \$1,200 per member per benefit year; made programmatic updates related to tribal consultation, the schedule of mailings, and the appeals process; and
January 1, 2011 -- provided for Presumptive Eligibility.

SPA # 9. Purpose:

The purpose of SPA #9 was to apply the new enrollment standard that children are enrolled the first of the month in which they are eligible if an insurance delay does not apply; to implement administrative redeterminations and Ex Parte redeterminations; to clarify the program will not pay providers outside the United States; to clarify DPHHS will send disenrollment notification to enrollees ten days prior to the termination of program benefits; to clarify enrollees are entitled to receive program benefits during the Fair Hearing process pending outcome of a review; and to add the following as covered benefits: chiropractic services; cochlear implants; durable medical equipment; home health services; hospice services; nutrition services; transplants (organ and tissue); and medical transportation/per diem.

Effective Date: October 1, 2012

Implementation Dates:

November 1, 2011 – Enrollment the first of the month children are eligible if an insurance delay does not apply;

April 1, 2012 – Administrative Redeterminations and Ex Parte Redeterminations;

October 1, 2012 – Clarification of no payment to providers outside the U.S.; and clarification disenrollment notification will be provided ten days prior to termination of program benefits;

October 1, 2012 – Addition of the following benefits: cochlear implants; home health services; hospice services; nutrition services; transplants (organ and tissue); and medical transportation/per diem;

January 1, 2013 – Addition of the following benefits: chiropractic services and durable medical equipment.

SPA #10. Purpose:

SPA #10 assured that Montana will apply methodologies based on a modified adjusted gross income (MAGI) standard for all separate CHIP covered groups; using the approved MAGI conversion plan income thresholds from above 143% through 261% of FPL.

SPA #10 Effective Date: January 1, 2014

SPA #10 Implementation Date: January 1, 2014

SPA #11 Purpose:

SPA #11 converted the state's existing income eligibility standard to a MAGI standard, by age group, for children covered in its Title XXI-funded Medicaid program. For children ages 6-19 years, the CHIP-funded Medicaid expansion group covers children from above 109% through 143% of FPL

SPA #11 Effective Date: January 1, 2014

SPA #11 Implementation Date: January 1, 2014

SPA #12 Purpose:

SPA #12 provided coverage in Montana's separate CHIP program to children who are ineligible for Medicaid due to elimination of Income Disregards.

SPA #12 Effective Date: January 1, 2014

SPA #12 Implementation Date: January 1, 2014

SPA #13 Purpose:

SPA #13 incorporated the MAGI-based eligibility process requirements, including the single streamlined application, into Montana's CHIP State Plan in accordance with the Affordable Care Act. The approval of this SPA includes full approval of Montana's single streamlined paper and online applications.

SPA #13 Effective Date: October 1, 2013

SPA #13 Implementation Date: October 1, 2013

SPA #14 Purpose:

SPA #14 clarified Montana's non-financial eligibility policies on residency; citizenship; social security numbers; and continuous eligibility.

SPA #14 Effective Date: January 1, 2014

SPA #14 Implementation Date: January 1, 2014

SPA #15. Purpose:

The purpose of SPA#15 was to modify the pharmacy benefits for Members. The Department will administer the pharmacy benefit and will utilize the Medicaid formulary and rules.

Effective Date: October 1, 2013

Implementation Date: October 1, 2013

SPA #16. Purpose:

The purpose of SPA #16 was to remove the Extended Dental Benefit, increase the basic dental benefit, and change the dental benefit year; add coverage of some over-the –

counter medications; add coverage of enteral formula for the medically necessary conditions in addition to inborn errors of metabolism; add a telemedicine benefit; clarify that mammograms, services provided by physician assistants, supplies, surgical supplies, maternity services, hospital services related to pregnancy, I.V. injections and set up for I.V. solutions, respiratory therapy, cleft/cranial, metabolic, and cystic fibrosis clinics, dental implants, limited physician consultation, limited therapeutic family care, and limited day treatment are covered; and that sterilizations are not covered.

Effective Date: July 1, 2014

Implementation Date: July 1, 2014

SPA #15-0017. Purpose:

The purpose of SPA #15-0017 was to remove the 3 month waiting period for enrollment of insured children, comply with federal provider credentialing rules, allow per diem and transportation for one adult companion for a child receiving medically necessary out-of-town or out-of-state medical services, clarify that organ and tissue procurement and transplant related medical services for living donors are part of the transplant benefit, clarify that weight gain drugs are covered when medically necessary, allow over-the-counter steroid nasal sprays and benzoyl peroxide, and modify the reference to the Drug Use Education (DUE) Concurrent and Retrospective Evaluation (CARE) Board to reflect the current title of Drug Utilization Review (DUR) Board.

Effective Date: July 1, 2015

Implementation Date: July 1, 2015

Reimbursement for services provided by naturopathic physicians will be eliminated effective October 1, 2015.

SPA #15-0018. Purpose:

The purpose of SPA #15-0018 was to add folic acid as a covered nonprescription product, and to amend the reference to CHIP provider screening and enrollment requirements to CFR 457.990(a).

Implementation Date: January 1, 2016

SPA #16-0019. Purpose:

The purpose of SPA #16-0019 was to give contracted tribal entities the authority to determine CHIP eligibility under the direction of the Montana Department of Public Health and Human Services.

Implementation Date: January 1, 2016

SPA #17-0020. Purpose:

The purpose of SPA #17-0020 is to allow contracted primary care practices to provide their care coordination services to Healthy Montana Kids members.

Implementation Date: April 1, 2017

SPA #18-0021. Purpose:

The purpose of SPA #18-0021 is to add Applied Behavior Analysis as a benefit, remove the limits on the extended mental health services, remove the ambulance copay, and affirm that Healthy Montana Kids meets mental health parity requirements.

Implementation Date: October 1, 2017

- 1.4- TC Tribal Consultation (Section 2107(e)(1)(C))** Describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment, when it occurred and who was involved.

TN No: 14-0046 Approval Date: 1/15/15 Effective Date : 12/1/14

Section 2. General Background and Description of Approach to Children’s Health Insurance Coverage and Coordination

Guidance: The demographic information requested in 2.1. can be used for State planning and will be used strictly for informational purposes. THESE NUMBERS WILL NOT BE USED AS A BASIS FOR THE ALLOTMENT.

Factors that the State may consider in the provision of this information are age breakouts, income brackets, definitions of insurability, and geographic location, as well as race and ethnicity. The State should describe its information sources and the assumptions it uses for the development of its description.

- Population
- Number of uninsured
- Race demographics
- Age Demographics
- Info per region/Geographic information

- 2.1.** Describe the extent to which, and manner in which, children in the State (including targeted low-income children and other groups of children specified) identified by income level and other relevant factors, such as race, ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, distinguish between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). (Section 2102(a)(1)); (42 CFR 457.80(a))

The 2003 Montana Household Survey was conducted as a stratified random digit dial telephone survey. The data were collected by the Survey Research Center at the University of Montana – Missoula, Bureau of Business and Economic Research. The survey collected information on the health insurance status of each person in the household and some demographic information about the primary wage earner in the household. Seventeen percent (17%) or approximately 41,723 children between ages 0 through 18 were uninsured at all income levels and approximately 35,900 uninsured children lived in households at or below 200% FPL.

Guidance: Section 2.2 allows states to request to use the funds available under the 10 percent limit on administrative expenditures in order to fund services not otherwise allowable. The health services initiatives must meet the requirements of 42 CFR 457.10.

2.2. Health Services Initiatives- Describe if the State will use the health services initiative option as allowed at **42 CFR 457.10**. If so, describe what services or programs the State is proposing to cover with administrative funds, including the cost of each program, and how it is currently funded (if applicable), also update the budget accordingly. (Section 2105(a)(1)(D)(ii)); (42 CFR 457.10)

2.3-TC Tribal Consultation Requirements- (Sections 1902(a)(73) and 2107(e)(1)(C)) ; (ARRA #2, CHIPRA #3, issued May 28, 2009) Section 1902(a)(73) of the Social Security Act (the Act) requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular, ongoing basis from designees of Indian health programs, whether operated by the Indian Health Service (IHS), Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA), or Urban Indian Organizations under the Indian Health Care Improvement Act (IHCA). Section 2107(e)(1)(C) of the Act was also amended to apply these requirements to the Children’s Health Insurance Program (CHIP). Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

Describe the process the State uses to seek advice on a regular, ongoing basis from federally-recognized tribes, Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments, waiver proposals, waiver extensions, waiver amendments, waiver renewals and proposals for demonstration projects prior to submission to CMS. Include information about the frequency, inclusiveness and process for seeking such advice.

Section 3. Methods of Delivery and Utilization Controls

Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State’s Medicaid plan, and continue on to Section 4.

Guidance: In Section 3.1., discussion may include, but is not limited to: contracts with managed health care plans (including fully and partially capitated plans); contracts with indemnity health insurance plans; and other arrangements for health care delivery. The State should

describe any variations based upon geography, as well as the State methods for establishing and defining the delivery systems.

- 3.1. Delivery Standards** Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of financing and the methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. (Section 2102)(a)(4) (42CFR 457.490(a))

Montana's population is approximately 957,861. Of this number, excluding Medicare Advantage Plan enrollees, there are approximately 43,693 HMO certificate holders receiving health care services through a Health Maintenance Organization (HMO). A low penetration rate for managed care required that Montana rely primarily on indemnity insurance plans for coverage. DPHHS offered to contract with indemnity plans willing to meet the contracting criteria. In this way, DPHHS hoped to offer clients a choice in the more populated areas of the state. Until September 2006, DPHHS contracted with one indemnity plan, Blue Cross Blue Shield of Montana, and no HMOs.

In an effort to decrease administrative expenses, DPHHS issued a Request for Proposal (RFP) for Third Party Administrative (TPA) Services in early 2006. DPHHS contracted with Blue Cross Blue Shield of Montana for TPA services effective October 1, 2006.

The third party administrative (TPA) contract addresses the following areas: cost sharing, enrollment, marketing, benefits, provider network, utilization management, quality of care, access to care, member rights, civil rights, and grievance procedures. Contract standards are based on a review of standards from the following sources: National Association of Insurance Commissioners (NAIC) Model Acts, National Committee for Quality Assurance (NCQA) Accreditation Standards, and existing Medicaid contracts.

Montana may vary significantly from provider standards established in other states. Montana is a frontier state characterized in the east by sparsely populated plains and in the west by small clusters of populations separated by mountain ranges. Given the diversity in geography and population density, Montana is unable to use a single distance and/or travel time to gauge adequacy of a provider network. Instead, availability of primary care practitioners and specialists in the normal service delivery area is decided for each town or locale. This model which is used by HMK has proven successful in our Medicaid PASSPORT program (our primary care case management model) that has been in operation since 1993. We find in a frontier state such as Montana this case-by-case approach is more meaningful to clients who are accustomed to, and often choose to, live extended distances from services.

Essential Community Providers

The TPA contractor is required to offer a provider network contract to Title X Family Planning

providers, Indian Health Service providers, Tribal Health providers, Urban Indian Centers, Migrant Health Centers and county public health departments. The contract must offer terms and conditions at least as favorable as those offered to other entities providing the same or similar services. This provision is only in effect, however, if the afore-named entities substantially meet the same access and credentialing criteria as other contract providers and only for geographic areas jointly served by the entities and the plan.

- Check here if the State child health program delivers services using a managed care delivery model. The State provides an assurance that its managed care contract(s) complies with the relevant provisions of section 1932 of the Act, including section 1932(a)(4), Process for Enrollment and Termination and Change of Enrollment; section 1932(a)(5), Provision of Information; section 1932(b), Beneficiary Protections; section 1932(c), Quality Assurance Standards; section 1932(d), Protections Against Fraud and Abuse; and section 1932(e), Sanctions for Noncompliance. The State also assures that it will submit the contract(s) to the CMS' Regional Office for review and approval. (Section 2103(f)(3))

Guidance: In Section 3.2., note that utilization control systems are those administrative mechanisms that are designed to ensure that enrollees receiving health care services under the State plan receive only appropriate and medically necessary health care consistent with the benefit package.

Examples of utilization control systems include, but are not limited to: requirements for referrals to specialty care; requirements that clinicians use clinical practice guidelines; or demand management systems (e.g., use of an 800 number for after-hours and urgent care). In addition, the State should describe its plans for review, coordination, and implementation of utilization controls, addressing both procedures and State developed standards for review, in order to assure that necessary care is delivered in a cost-effective and efficient manner. (42CFR, 457.490(b))

- 3.2.** Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children. Describe the systems designed to ensure that enrollees receiving health care services under the State plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved State plan. (Section 2102)(a)(4) (42CFR 457.490(b))

The TPA contractor performs primary utilization management functions. Contract standards require adequate staff and procedures to ensure services provided to enrollees are medically necessary and appropriate. At a minimum, the TPA Contractor must address the use of referrals, prior authorizations, and client educational services.

The TPA Contractor must comply with requirements of applicable Montana law and rules governing health care quality control.

The TPA contractor's physician incentive plans shall include no specific payment directly or indirectly to a physician or physician group as an inducement to reduce or limit medically necessary benefits furnished to a child.

The TPA Contractor is required to have an external quality review process.

DPHHS must approve the complaint resolution process for addressing enrollees' complaints and appeals. Upon enrollment, and at least annually thereafter, the TPA Contractor must inform enrollees of the complaint resolution process. The TPA Contractor must submit quarterly reports to DPHHS summarizing any complaint handled during the previous quarter. DPHHS must review all contractor complaint decisions.

The TPA Contractor must submit Healthcare Management Reports on a quarterly basis and the following HEDIS measures on an annual basis: access to primary care, childhood immunization status, adolescent immunization status, appropriate use of asthma medications, well-child visits (in the first 15 months and annually from age three to six) and adolescent well-care visits.

The TPA Contractor encourages the use of a primary care provider (PCP) to serve as a child's medical home. The PCP should perform all routine non-emergency care for the child and make necessary arrangements for a child who needs referral to a specialist or hospital. A specialist could serve as a child's primary care provider. The state Medicaid program has extensive experience in using a PCP system and offers technical assistance.

The TPA Contractor includes in its educational materials for enrollees and providers information about additional services available to children with special health care needs. Examples of these services are the Children's Mental Health Services Plan, Children's Special Health Services (Title V), public health case management services for pregnant women and children.

Section 4. Eligibility Standards and Methodology

Guidance: The plan must include a description of the standards used to determine the eligibility of targeted low-income children for child health assistance under the plan. Included on the template is a list of potential eligibility standards. Please check off the standards that will be used by the state and provide a short description of how those standards will be applied. All eligibility standards must be consistent with the provisions of Title XXI and may not discriminate on the basis of diagnosis. In addition, if the standards vary within the state, describe how they will be applied and under what circumstances they will be applied.

States electing to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan or combination plan should check the appropriate box and provide the ages and income level for each eligibility group.

If the State is electing to take up the option to expand Medicaid eligibility as allowed under section 214 of CHIPRA regarding lawfully residing, complete section 4.1-LR as well as update the budget to reflect the additional costs if the state will claim title XXI match for these children until and if the time comes that the children are eligible for Medicaid.

4.0. **Medicaid Expansion**

4.0.1. Ages of each eligibility group and the income standard for that group:

4.1. **Separate Program** Check all standards that will apply to the State plan. (42CFR 457.305(a) and 457.320(a))

4.1.0 Describe how the State meets the citizenship verification requirements. Include whether or not State has opted to use SSA verification option.

4.1.1 Geographic area served by the Plan if less than Statewide:

4.1.2 Ages of each eligibility group, including unborn children and pregnant women (if applicable) and the income standard for that group:

The HMK coverage group (separate CHIP program) is available to children ages zero through eighteen. Coverage for a child will continue through the end of the month of the child's 19th birthday.

4.1.2.1-PC Age: _____ through birth (SHO #02-004, issued November 12, 2002)

4.1.3 Income of each separate eligibility group (if applicable):

Income: Children from families whose adjusted gross income is at or below 261% of the federal poverty level are eligible for the HMK coverage group (CHIP) effective October 1, 2009. Earned (wages, tips, salaries, etc.) and unearned (child support, unemployment, etc.) income is counted when determining adjusted gross income. Any income excluded by other federal statute is not counted.

The current HMK *Plus* (Medicaid) eligibility guidelines are up to 143% FPL for children less than 6 years of age and above 109% FPL for children between 6 and 19 years of age.

The CHIP-funded Medicaid expansion program provides HMK *Plus* coverage group benefits for children 6 -18 years of age with family incomes above 109% and up to and including 143% FPL. All eligible children in a family regardless of

the age of the children have HMK *Plus* coverage if the family income is 143% FPL or less. This standard eligibility guideline makes it easier for families because the children are enrolled in the same coverage group, have the same benefits and provider network.

Beginning January 1, 2014 all eligible children with family incomes at or below 143% FPL will be enrolled in HMK *Plus* and those with family incomes 143% and up to and including 261% will be in the HMK coverage group.

For purposes of determining financial eligibility for the HMK coverage group, a family unit consists of:

1. The child for whom the family is applying
2. The natural or adoptive parents of the child
3. The spouse of the child's natural or adoptive parent
4. The child's siblings (natural, adoptive, half, or step) from ages zero through eighteen, with the following exception: If a sibling between ages 19 through 22 is attending school, he or she may be counted in the family unit.
5. The child's (i.e., emancipated minor) spouse

An unmarried emancipated minor who applies for the program is considered his or her own family.

Effective October 1, 2009, DPHHS requires income verification when a family applies for the HMK Plan. Families are required to provide documentation for all countable income.

4.1.3.1-PC 0% of the FPL (and not eligible for Medicaid) through _____% of the FPL (SHO #02-004, issued November 12, 2002)

4.1.4 Resources of each separate eligibility group (including any standards relating to spend downs and disposition of resources):

4.1.5 Residency (so long as residency requirement is not based on length of time in state):

U.S. Citizenship and Montana residency are required. A Montana resident is anyone who declares him-or-herself to live in the state, including migrant and other seasonal workers. The parent is required to certify on the application that the child is a U.S. citizen, or Qualified Alien and a Montana resident. Montana follows federal guidelines in determining whether a child is a U.S. citizen, or Qualified Alien.

DPHHS requires citizenship verification for the HMK Plus coverage group including the CHIP-funded Medicaid expansion program. DPHHS is implementing citizenship verification for the HMK coverage group effective October 2009. DPHHS allows enrollment in the HMK Plan (HMK and HMK Plus) with a reasonable opportunity to verify citizenship or residency status. If the HMK application states the child was born in Montana, DPHHS will verify citizenship through Montana vital records. As of January 1, 2010, HMK is successfully using the SVES interface to verify citizenship and identity on 97 percent of all new applicants.

4.1.6 Disability Status (so long as any standard relating to disability status does not restrict eligibility):

No child is denied eligibility based on disability status. If the child receives SSI and is eligible for Medicaid, the child is denied coverage because of Medicaid eligibility not for disability status.

4.1.7 Access to or coverage under other health coverage:

A child is found ineligible when: 1) the child is covered under a group health plan or under health insurance coverage as defined in section 2791 of the Public Health Service Act; or 2) the child is eligible for Medicaid.

Eligible children of State of Montana and Montana University System employees are covered in accordance with the Patient Protection & Affordable Care Act of 2010 “Hardship Exception to the Exclusion of Children of Employees of a Public Agency in a State”.

The methodology for determining eligibility for State of Montana and Montana University System employee’s children is a two-fold test. First, the program determines if the family meets all financial and HMK coverage group (CHIP) eligibility requirements.

Second, the program compares the family’s income to a reference table for their health insurance plan out of pocket expense requirement. It is a reasonable expectation out of pocket expenses, including premiums, deductibles, coinsurance and copayments, will exceed 5% of a family’s income for families with income at or below 261% of the FPL.

The program assures an annual review of the updated state employees’ health insurance plans’ reference table. This review will evaluate the out of pocket

expense requirements to assure this reasonable expectation remains valid for families at or below 261% of FPL.

4.1.8 Duration of eligibility, not to exceed 12 months:

Eligibility is re-determined every 12 months. Once a child is determined eligible, he or she remains eligible unless the child moves from the state, moves in-state and DPHHS is unable to locate the family, family initiates an application and is found eligible for the HMK *Plus*/children's Medicaid coverage group, is found to have other creditable health insurance coverage, turns 19, dies, becomes an inmate of a public institution, or reapplies and the child is determined ineligible. Should a child become ineligible, DPHHS will send written notification of disenrollment ten days prior to the termination of program benefits.

Eligible children on the initial application will have the same 12 month continuous eligibility period. Children who enroll at a later date may receive less than 12 months of continuous eligibility during their first year of enrollment. DPHHS chose to add the new child to the existing eligibility period in order to synchronize the reapplication/renewal period for all children in the family. Without this policy, a family would be required to re-apply for coverage for various children in the family at multiple times throughout the year.

4.1.9 Other Standards- Identify and describe other standards for or affecting eligibility, including those standards in 457.310 and 457.320 that are not addressed above. For instance:

Administrative Redetermination. DPHHS will send a pre-populated renewal form with all available eligibility information to the family 11 months after a child(ren) is determined eligible for HMK in order to allow time for a new eligibility span to be established. The child(ren)'s coverage will continue unless the family responds with more current information that affects eligibility. If there are changes to household composition, annual income, or health insurance coverage, the renewal form must be completed, signed, dated and returned by a specified date for purposes of eligibility redetermination.

Ex Parte Redetermination. DPHHS will determine ongoing eligibility through ex parte redeterminations in which all information available to the agency is reviewed and the parent/representative is only contacted for information DPHHS is unable to obtain or verify.

Guidance: States may only require the SSN of the child who is applying for coverage. If SSNs are required and the State covers unborn children, indicate that the unborn children are exempt from providing a SSN. Other standards include, but are not limited to presumptive eligibility and deemed newborns.

4.1.9.1 States should specify whether Social Security Numbers (SSN) are required.

A Social Security Number (SSN) is required for a child who applies for benefits. Services are not denied or delayed to an otherwise eligible child pending issuance of the child's SSN. The program follows all HIPAA related confidentiality standards and restricts the use or disclosure of information concerning applicants and enrollees to purposes directly connected with administration of the plan.

Guidance: States should describe their continuous eligibility process and populations that can be continuously eligible.

4.1.9.2 Continuous eligibility

4.1-PW **Pregnant Women Option** (section 2112)- The State includes eligibility for one or more populations of targeted low-income pregnant women under the plan. Describe the population of pregnant women that the State proposes to cover in this section. Include all eligibility criteria, such as those described in the above categories (for instance, income and resources) that will be applied to this population. Use the same reference number system for those criteria (for example, 4.1.1-P for a geographic restriction). Please remember to update sections 8.1.1-PW, 8.1.2-PW, and 9.10 when electing this option.

Guidance: States have the option to cover groups of “lawfully residing” children and/or pregnant women. States may elect to cover (1) “lawfully residing” children described at section 2107(e)(1)(J) of the Act; (2) “lawfully residing” pregnant women described at section 2107(e)(1)(J) of the Act; or (3) both. A state electing to cover children and/or pregnant women who are considered lawfully residing in the U.S. must offer coverage to all such individuals who meet the definition of lawfully residing, and may not cover a subgroup or only certain groups. In other words, a State that chooses to cover pregnant women under this option must otherwise cover pregnant women under their State plan as described in 4.1.11. In addition, states may not cover these new groups only in CHIP, but must also extend the coverage option to Medicaid. **States will need to update their budget to reflect the additional costs for coverage of these children.** If a State has been covering these children with State only funds, it is helpful to indicate that so CMS

understands the basis for the enrollment estimates and the projected cost of providing coverage. Please remember to update section 9.10 when electing this option.

- 4.1- LR** **Lawfully Residing Option** (Sections 2107(e)(1)(J) and 1993(v)(4)(A); (CHIPRA # 17, SHO # 10-006 issued July 1, 2010) Check if the State is electing the option under section 214 of the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) regarding lawfully residing to provide coverage to the following otherwise eligible pregnant women and children as specified below who are lawfully residing in the United States including the following:
A child or pregnant woman shall be considered lawfully present if he or she is:
- (1) A qualified alien as defined in section 431 of PRWORA (8 U.S.C. §1641);
 - (2) An alien in nonimmigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission;
 - (3) An alien who has been paroled into the United States pursuant to section 212(d)(5) of the Immigration and Nationality Act (INA) (8 U.S.C. §1182(d)(5)) for less than 1 year, except for an alien paroled for prosecution, for deferred inspection or pending removal proceedings;
 - (4) An alien who belongs to one of the following classes:
 - (i) Aliens currently in temporary resident status pursuant to section 210 or 245A of the INA (8 U.S.C. §§1160 or 1255a, respectively);
 - (ii) Aliens currently under Temporary Protected Status (TPS) pursuant to section 244 of the INA (8 U.S.C. §1254a), and pending applicants for TPS who have been granted employment authorization;
 - (iii) Aliens who have been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24);
 - (iv) Family Unity beneficiaries pursuant to section 301 of Pub. L. 101-649, as amended;
 - (v) Aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;
 - (vi) Aliens currently in deferred action status; or
 - (vii) Aliens whose visa petition has been approved and who have a pending application for adjustment of status;
 - (5) A pending applicant for asylum under section 208(a) of the INA (8 U.S.C. § 1158) or for withholding of removal under section 241(b)(3) of the INA (8 U.S.C. § 1231) or under the Convention Against Torture who has been granted employment authorization, and such an applicant under the age of 14 who has had an application pending for at least 180 days;
 - (6) An alien who has been granted withholding of removal under the Convention Against Torture;
 - (7) A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C. §

1101(a)(27)(J));

(8) An alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. § 1806(e); or

(9) An alien who is lawfully present in American Samoa under the immigration laws of American Samoa.

Elected for pregnant women.

Elected for children under age 19.

4.1.1-LR The State provides assurance that for an individual whom it enrolls in Medicaid under the CHIPRA Lawfully Residing option, it has verified, at the time of the individual's initial eligibility determination and at the time of the eligibility redetermination, that the individual continues to be lawfully residing in the United States. The State must first attempt to verify this status using information provided at the time of initial application. If the State cannot do so from the information readily available, it must require the individual to provide documentation or further evidence to verify satisfactory immigration status in the same manner as it would for anyone else claiming satisfactory immigration status under section 1137(d) of the Act.

CHIP and Medicaid work collaboratively and closely on policies relating to lawfully residing children. Both programs define "lawfully residing" in the same manner. The State is not choosing the enhanced match, since Medicaid estimates no more than six children in the state will meet the LAPR criteria and the administrative expenses added for separately tracking those children exceed the costs of receiving an enhanced match. Currently only one child meets these criteria in Medicaid, and the Medicaid policy has been in effect since January, 2010.

4.1-DS **Supplemental Dental** (Section 2103(c)(5) - A child who is eligible to enroll in dental-only supplemental coverage, effective January 1, 2009. Eligibility is limited to only targeted low-income children who are otherwise eligible for CHIP but for the fact that they are enrolled in a group health plan or health insurance offered through an employer. The State's CHIP plan income eligibility level is at least the highest income eligibility standard under its approved State child health plan (or under a waiver) as of January 1, 2009. All who meet the eligibility standards and apply for dental-only supplemental coverage shall be provided benefits. States choosing this option must report these children separately in SEDS. Please update sections 1.1-DS, 4.2-DS, and 9.10 when electing this option.

4.2. Assurances The State assures by checking the box below that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102(b)(1)(B) and 42 CFR 457.320(b))

4.2.1. These standards do not discriminate on the basis of diagnosis.

4.2.2. Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income. This applies to pregnant women included in the State plan as well as targeted low-income children.

4.2.3. These standards do not deny eligibility based on a child having a pre-existing medical condition. This applies to pregnant women as well as targeted low-income children.

4.2-DS Supplemental Dental Please update sections 1.1-DS, 4.1-DS, and 9.10 when electing this option. For dental-only supplemental coverage, the State assures that it has made the following findings with standards in its plan: (Section 2102(b)(1)(B) and 42 CFR 457.320(b))

4.2.1-DS These standards do not discriminate on the basis of diagnosis.

4.2.2-DS Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.

4.2.3-DS These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3 Methodology. Describe the methods of establishing and continuing eligibility and enrollment. The description should address the procedures for applying the eligibility standards, the organization and infrastructure responsible for making and reviewing eligibility determinations, and the process for enrollment of individuals receiving covered services, and whether the State uses the same application form for Medicaid and/or other public benefit programs. (Section 2102)(b)(2)) (42CFR, 457.350)

Guidance: The box below should be checked as related to children and pregnant women.

Please note: A State providing dental-only supplemental coverage may not have a waiting list or limit eligibility in any way.

DPHHS will implement a combined application for the HMK Plan. This application will be distributed statewide and is accessible on the Internet. Both the HMK Plan office and county Offices of Public Assistance will continue accepting and processing previous versions of the programs' applications.

DPHHS will accept and determine eligibility for all applications for children's health coverage provided by the Healthy Montana Kids Plan. Applications may be submitted directly to the Healthy Montana Kids Plan office or any county Office of Public Assistance (OPA). DPHHS staff in each location will screen for potential eligibility for the HMK Plan. Staff at the OPA and

HMK Plan offices will coordinate eligibility determination activities and enroll eligible children in the appropriate HMK Plan coverage group, HMK or HMK *Plus*.

DPHHS is developing and implementing a computerized eligibility determination system for DPHHS health and social service programs e.g. Medicaid, Supplemental Nutrition Assistance Program (SNAP), etc. The HMK Plan will be a module in this eligibility determination system. The system will improve the accuracy and coordination between the HMK Plan coverage groups and with other DPHHS programs.

DPHHS performs the following functions as part of the eligibility determination process:

- Log and scan applications and pertinent documents into the electronic file system;
- Process applications;
- Determine eligibility;
- Refer applicants to Children's Special Health Services, Children's Mental Health Services, Montana Community Health Centers, or private health plans, as appropriate (Referral to other programs will not stop the HMK Plan eligibility determination process.);
- Staff a toll-free information number families may call to receive information about children's health coverage and eligibility;
- Send annual renewal notices to enrollees;
- Provide support for application and outreach sites;
- Provide a complaint process for applicants;
- Facilitate a smooth transition between different DPHHS providers and private insurances;
- Provide eligibility data needed for annual reports;
- Conduct Quality Assurance Audits; and
- Provide a listing of HMK Enrollment Partners and CHIPRA Coalition Partners.

Eligibility Determination:

Eligibility for HMK will be determined by DPHHS or its contracted tribal designee. Any tribal eligibility determinations will be done according to DPHHS standards and under the supervision of DPHHS.

Children ages 0 to 19 in families whose countable income is at or below 261% of the federal poverty level are eligible if all other eligibility criteria are met.

HMK eligibility is determined within 45 calendar days after receipt of a completed application. By the forty-fifth calendar day, a letter is sent to the family notifying them of the children's eligibility status or requesting more information to complete the application process.

The 45-day eligibility determination time period begins the day the application is received and date stamped.

Enrollment in the Health Plan:

Except for a newborn child, an eligible child’s HMK enrollment begins the later of:

1. The first day of the month an application is received;
2. The first day of the month the family reports a new child joined the family; or
3. The first day of the month after an insurance delay period has ended.

A newborn from a family with siblings enrolled in HMK will be enrolled effective the date of birth when the family reports the birth during the birth month or within ten days of birth. If the family reports the birth of the newborn more than ten days after birth, or not within the month of birth, the newborn will be enrolled on the first day of the month notification is received. Per Section 2112(e) of the Social Security Act, children born to HMK enrollees are deemed eligible as of their date of birth for a period of 31 days, when eligibility is evaluated. Based on eligibility, they are either referred to HMK *Plus* (children’s Medicaid), or they remain enrolled in HMK.

Redetermination of Eligibility:

Children are continuously eligible unless the child’s status changes (see Section 4.1.8).

The following is a schedule of the administrative renewal mailing sent to families:

- A renewal form pre-populated with all available eligibility information is mailed to the family one month before HMK coverage is scheduled to end. The child’s coverage will continue unless the family responds with more current information that affects eligibility.
- HMK may determine ongoing eligibility through ex parte redeterminations in which all information available to the agency is reviewed and the parent/representative is only contacted for information HMK is unable to obtain or verify.

4.3.1. Limitation on Enrollment Describe the processes, if any, that a State will use for instituting enrollment caps, establishing waiting lists, and deciding which children will be given priority for enrollment. If this section does not apply to your state, check the box below. (Section 2102(b)(4)) (42CFR, 457.305(b))

Check here if this section does not apply to your State.

Montana currently has no waiting list, but our enrollment is limited by federal and state funds that have been appropriated to the program. If Montana should need to establish a waiting list in the future, the following procedure will be implemented. When the maximum number of children is enrolled, the enrollment is capped and a waiting list is established. The waiting list is for children determined eligible but for whom space is not available. Children are placed on the waiting list in the order in which they are determined eligible. Applicants are notified in writing if their children are eligible and placed on the waiting list. Applicants are also informed that they can contact DPHHS to inquire about their child’s position on the waiting list. Spaces become available at the

end of each month when enrollment ends for currently enrolled children who:

1. turned age 19;
2. became eligible for HMK Plus coverage;
3. obtained coverage under another insurance;
4. moved out of state;
5. failed to reapply;
6. reapplied but were determined ineligible;
7. moved within the state and DPHHS is unable to locate the family; or
8. died.

When space becomes available, children are removed from the waiting list and enrolled until all spaces are filled. Applicants are notified in writing when their children are taken off the waiting list and are enrolled. Children on the waiting list are enrolled based on when they are determined eligible.

If space is available for at least one child, families with more than one eligible child on the waiting list will have all children enrolled at the same time. The children will all have the same enrollment date.

A child determined eligible who has a sibling already enrolled will not be placed on the waiting list. The newly eligible child is enrolled the first of the month after the Healthy Montana Kids Plan is notified. The renewal date for the newly eligible child will be the same as currently enrolled sibling.

Note: There is no waiting list for the HMK Plus coverage group, including the CHIP Medicaid expansion program.

Guidance: Note that for purposes of presumptive eligibility, States do not need to verify the citizenship status of the child. States electing this option should indicate so in the State plan. (42 CFR 457.355)

4.3.2. Check if the State elects to provide presumptive eligibility for children that meets the requirements of section 1920A of the Act. (Section 2107(e)(1)(L)); (42 CFR 457.355)

DPHHS will provide temporary HMK coverage group benefits to uninsured children under age 19 during a period of presumptive eligibility following a determination by a qualified presumptive eligibility provider. The effective date for implementing presumptive eligibility is January 1, 2011.

Temporary HMK coverage group benefits will begin on the date a qualified entity trained

and certified by HMK makes a determination of presumptive eligibility based on information provided by the child’s parent or guardian on a presumptive eligibility application. Presumptive eligibility will end on the earlier of the date HMK makes a determination of eligibility for HMK group coverage, or the last day of the month following the month presumptive eligibility begins. During the first phase of implementing presumptive eligibility, DPHHS will train and certify Montana hospital staff members to serve as qualified entities.

The state has developed a presumptive eligibility application and will distribute the presumptive eligibility and HMK Plan applications to qualified entities. The qualified entity will provide a presumptive eligibility application to the family and will make a determination of presumptive eligibility based on information self-declared by a child’s parent or guardian. The qualified entity will give the parent or guardian a copy of the presumptive eligibility determination to use for verification of HMK eligibility. The family will show the presumptive eligibility confirmation when seeking health care services during the presumptive eligibility period. The qualified entity also will give the parent or guardian an HMK Plan application which must be submitted to DPHHS prior to the end of the presumptive eligibility period so “regular” enrollment in the HMK Plan can be evaluated.

If the child’s family does not return the HMK Plan application within the presumptive eligibility period, the child will be disenrolled at the end of the presumptive eligibility span. When the presumptively eligible family submits an HMK Plan application within the appropriate timeline, DPHHS will determine eligibility for the HMK coverage group and the HMK *Plus* coverage group. If the child is ineligible for either coverage group, the child will be disenrolled on the date ineligibility is determined.

Guidance: Describe how the State intends to implement the Express Lane option. Include information on the identified Express Lane agency or agencies, and whether the State will be using the Express Lane eligibility option for the initial eligibility determinations, redeterminations, or both.

4.3.3-EL Express Lane Eligibility Check here if the state elects the option to rely on a finding from an Express Lane agency when determining whether a child satisfies one or more components of CHIP eligibility. The state agrees to comply with the requirements of sections 2107(e)(1)(E) and 1902(e)(13) of the Act for this option. Please update sections 4.4-EL, 5.2-EL, 9.10, and 12.1 when electing this option. This authority may not apply to eligibility determinations made before February 4, 2009, or after September 30, 2013. (Section 2107(e)(1)(E))

4.3.3.1-EL Also indicate whether the Express Lane option is applied to (1) initial eligibility determination, (2) redetermination, or (3)

both.

4.3.3.2-EL List the public agencies approved by the State as Express Lane agencies.

4.3.3.3-EL List the components/components of CHIP eligibility that are determined under the Express Lane. In this section, specify any differences in budget unit, deeming, income exclusions, income disregards, or other methodology between CHIP eligibility determinations for such children and the determination under the Express Lane option.

4.3.3.3-EL List the component/components of CHIP eligibility that are determined under the Express Lane.

4.3.3.4-EL Describe the option used to satisfy the screen and enrollment requirements before a child may be enrolled under title XXI.

Guidance: States should describe the process they use to screen and enroll children required under section 2102(b)(3)(A) and (B) of the Social Security Act and 42 CFR 457.350(a) and 457.80(c). Describe the screening threshold set as a percentage of the Federal poverty level (FPL) that exceeds the highest Medicaid income threshold applicable to a child by a minimum of 30 percentage points. (NOTE: The State may set this threshold higher than 30 percentage points to account for any differences between the income calculation methodologies used by an Express Lane agency and those used by the State for its Medicaid program. The State may set one screening threshold for all children, based on the highest Medicaid income threshold, or it may set more than one screening threshold, based on its existing, age-related Medicaid eligibility thresholds.) Include the screening threshold(s) expressed as a percentage of the FPL, and provide an explanation of how this was calculated. Describe whether the State is temporarily enrolling children in CHIP, based on the income finding from an Express Lane agency, pending the completion of the screen and enroll process.

In this section, states should describe their eligibility screening process in a way that addresses the five assurances specified below. The State should consider including important definitions, the relationship with affected Federal, State and local agencies, and other applicable criteria that will describe the State's ability to make assurances. (Sections 2102)(b)(3)(A) and 2110(b)(2)(B)), (42 CFR 457.310(b)(2), 42CFR 457.350(a)(1) and 457.80(c)(3))

4.4 Eligibility screening and coordination with other health coverage programs
States must describe how they will assure that:

- 4.4.1. Only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance (including access to a State health benefits plan) are furnished child health assistance under the plan. (Sections 2102)(b)(3)(A), 2110(b)(2)(B)) (42 CFR 457.310(b), 42 CFR 457.350(a)(1) and 42 CFR 457.80(c)(3)) Confirm that the State does not apply a waiting period for pregnant women.

The application asks if a child applying for health coverage was covered by health insurance within the past three months. If the answer is yes and the coverage did not end due to one of the allowable exceptions, the child is not eligible for enrollment until the three-month uninsured period passes.

Montana's high number of families living below 261% FPL and high rate of uninsured children, coupled with Montana's economy, are indicators that Montana's low-income children are uninsured because their parents are unable to afford dependent health insurance. More than 50% of Montana's employers are small employers (less than 50 employees) and most are unable to provide health insurance benefits for their employees.

The application asks the applicant to report any health insurance coverage. If the family reports creditable coverage as defined in section 2791 of the Public Health Service Act, the child is found ineligible. The TPA Contractor, Blue Cross Blue Shield of Montana (BCBSMT) is the largest health insurance carrier in Montana and is required contractually to notify DPHHS whenever they have reason to believe an enrollee has other coverage. DPHHS staff will investigate and if the child has other creditable insurance coverage, coverage will end.

- 4.4.2. Children found through the screening process to be potentially eligible for medical assistance under the State Medicaid plan are enrolled for assistance under such plan; (Section 2102)(b)(3)(B)) (42CFR, 457.350(a)(2))

DPHHS staff screen applicants for HMK *Plus* eligibility.

- 4.4.3. Children found through the screening process to be ineligible for Medicaid are enrolled in CHIP; (Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR, 431.636(b)(4))

If department staff determine a child is ineligible for HMK *Plus*, the staff will evaluate the application for HMK eligibility.

- 4.4.4. The insurance provided under the State child health plan does not substitute for coverage under group health plans; states should check the appropriate box. (Section 2102)(b)(3)(C)) (42CFR, 457.805) (42CFR 457.810(a)-(c))

4.4.4.1. (formerly 4.4.4.4) If the State provides coverage under a premium assistance program, describe: 1) the minimum period without coverage under a group health plan. This should include any allowable exceptions to the waiting period; 2) the expected minimum level of contribution employers will make; and 3) how cost-effectiveness is determined.

4.4.5 Child health assistance is provided to targeted low-income children in the State who are American Indian and Alaska Native. (Section 2102)(b)(3)(D)) (42 CFR 457.125(a))

DPHHS works directly with tribes, the Indian Health Service, Tribal Health Services, and Urban Indian Centers to inform Native Americans in Montana about the HMK Plan. The TPA Contractor is required to offer a provider contract to Urban Indian Centers, Indian Health Service and Tribal Health Service providers who meet certification qualifications. See Sections 3.1 and 9.9 for more information.

If any child determined eligible is identified as Native American or an Alaska Native, there is no cost-sharing for that family. The identification card each child receives from the TPA Contractor indicates that no co-payment is required when that child receives services.

Guidance: When the State is using an income finding from an Express Lane agency, the State must still comply with screen and enroll requirements before enrolling children in CHIP. The State may either continue its current screen and enroll process, or elect one of two new options to fulfill these requirements.

4.4-EL The State should designate the option it will be using to carry out screen and enroll requirements:

The State will continue to use the screen and enroll procedures required under section 2102(b)(3)(A) and (B) of the Social Security Act and 42 CFR 457.350(a) and 42 CFR 457.80(c). Describe this process.

The State is establishing a screening threshold set as a percentage of the Federal poverty level (FPL) that exceeds the highest Medicaid income threshold applicable to a child by a minimum of 30 percentage points. (NOTE: The State may set this threshold higher than 30 percentage points to account for any differences between the income calculation methodologies used by the Express Lane agency and those used by the State for its Medicaid program. The State may set one screening threshold for all children, based on the highest Medicaid income threshold, or it may set more than one screening threshold, based on its existing, age-related Medicaid eligibility thresholds.) Include the screening threshold(s) expressed as a percentage of the FPL, and provide an explanation of how this was calculated.

The State is temporarily enrolling children in CHIP, based on the income finding from the Express Lane agency, pending the completion of the screen and enroll process.

Section 5. Outreach and Coordination

5.1. (formerly 2.2) Describe the current State efforts to provide or obtain creditable health coverage for uninsured children by addressing sections 5.1.1 and 5.1.2. (Section 2102)(a)(2) (42CFR 457.80(b))

Guidance: The information below may include whether the state elects express lane eligibility a description of the State’s outreach efforts through Medicaid and state-only programs.

5.1.1. (formerly 2.2.1.) The steps the State is currently taking to identify and enroll all uninsured children who are eligible to participate in public health insurance programs (i.e., Medicaid and state-only child health insurance):

Montana has several efforts in place to identify and enroll all uninsured children who are eligible to participate in public health coverage programs.

Montana developed and maintains a statewide network of over 700 community partners, including health care providers, community advocacy groups, and other related agencies to increase awareness of the program, distribute applications, and offer enrollment assistance to families. In 2008, DPHHS distributed over 13,000 brochures and applications through this network.

In early 2006 DPHHS conducted a statewide media campaign, including television, radio, and print advertising. Department staff produced all of the campaign materials in-house. A similar campaign will be conducted in support of the implementation of the Healthy Montana Kids program in 2009 and 2010.

DPHHS staffs a telephone help-line for calls from Montanans in response to outreach campaigns, marketing, etc. Our staff is knowledgeable about requirements and services available from public health programs and Medicaid-funded programs. The staff responds to public inquiries, coordinates with these programs, and makes referrals.

Montana’s services and programs intended to assure health care access include:

1. Public health referral systems—Women, Infants and Children (WIC) Nutrition programs and public health home visiting services include assessment of high-risk conditions such as developmental, nutritional, psycho-social, and income factors. Clients

with health care needs are referred to eligibility workers in local settings who determine whether the client is eligible to be covered by Medicaid-funded or CHIP-funded programs. In the case of programs for high-risk pregnant women, home visiting services and others may also do an initial screen for Medicaid eligibility authorizing clients for presumptive eligibility. WIC is funded with United States Department of Agriculture funding and public health home visiting is funded with a combination of Title V and State general fund resources.

2. Federally Qualified Health Centers—Montana has twenty-three (23) federally qualified health centers, forty-six (46) rural health clinics, twenty-six (26) Community Health Centers (CHCs) (fifteen centers and eleven satellites), five (5) Urban Indian Clinics and one (1) Migrant Health Clinic (with several satellite sites operated seasonally). Each facility has the resources to determine presumptive Medicaid eligibility for pregnant women, and distribute applications for Medicaid-funded and CHIP-funded programs. CHCs must also provide services regardless of the client's ability to pay. Four of the Community Health Centers are co-located with public health departments and make referrals to assure access to health care. Community Health Centers use standard procedures to determine appropriate pay level for each client including providing a financial screen for each new patient or family, providing information on and explanation of services for which family members are eligible, assisting with completing applications and collecting required documentation, determining eligibility on-site or forwarding applications to the determining agency, communicating with family members about eligibility status, and assisting families when their financial situation and eligibility changes. Healthy Montana Kids is implementing Medicaid's outpatient prospective payment system rate for FQHCs and RHCs for health care services provided effective October 1, 2009.

3. Children's Special Health Services (CSHS)—CSHS provides coverage for a limited number of children who have special health care needs. This program sponsors multi-specialty clinics and provides reimbursement for health care services if Medicaid or other health care insurance does not cover the services. The application for the CSHS program includes income determination to screen for Medicaid eligibility. CSHS program activities are funded with Title V resources.

4. Family Planning programs are contract services that identify clients in need of primary care services. They specifically target low-income clients. These clinics identify funding sources available to pay for preventive health services, including Medicaid and other insurance, and refer clients appropriately to those resources. The state supports Family Planning clinics with Title X funding, and local contributions may include Title V and other resources.

5. Rural Health Clinics (RHC) and National Health Service Corp (NHSC) providers are a loose network of primary care services throughout the state that allows clients to pay on

a sliding fee scale. Forty-six (46) RHCs provide services on a sliding fee scale, and 18 NHSC providers, located in federally designated shortage areas, provide services on a sliding fee scale. RHCs may refuse service to clients, but NHSC must accept any client regardless of ability to pay.

As previously mentioned, Healthy Montana Kids is implementing Medicaid's outpatient prospective payment system rate for FQHCs and RHCs for health care services provided effective October 1, 2009.

6. Part C of the Individuals with Disabilities Education Act provides statewide early intervention services to meet the needs of Montana's infants and toddlers with diagnosed disabilities or with developmental delays that warrant concern for a child's future development. Children deemed eligible for Part C Services in Montana who appear Medicaid eligible are referred to the local county office for a Medicaid eligibility determination.

7. Montana's Supplemental Services Program (SSP) and the Children's Mental Health Bureau Room and Board Account (RBA) provide limited state funds for room and board in Therapeutic Group Homes and coverage for other mental health services not covered by HMK. To access the funds, the child must have a qualifying Serious Emotional Disturbance (SED) diagnosis and meet income guidelines. These programs are funded by capped appropriations.

8. Medicaid provides health coverage for low-income, elderly, blind and disabled Montanans who have limited resources. Infants born to Medicaid-enrolled women typically remain Medicaid eligible for twelve months. Family income for children ages zero (0) through eighteen cannot exceed 133% of poverty. Children are enrolled in the HMK *Plus* coverage group (formerly children's Medicaid program). DPHHS administers the Medicaid Program and county public assistance offices determine eligibility for Medicaid or HMK *Plus*, Temporary Aid to Needy Families (TANF), and Supplemental Nutrition Assistance Program (SNAP).

9. Federally Qualified Health Centers, Health Care Clinics, Migrant Health Clinics, Tribal Health Clinics, and Indian Health Services facilities are presumptive Medicaid eligibility sites for pregnant women. Staff at these sites helps people apply for Medicaid by providing assistance in completing the application and then forwarding the application to county public assistance offices for eligibility determination.

Outreach to inform potential recipients about Medicaid is accomplished through the previously noted resources and by distributing Medicaid information to many health care advocacy groups and providers in Montana. Montana reaches thousands of children in the CHIP-funded outreach process, many of whom are Medicaid eligible.

Guidance: The State may address the coordination between the public-private outreach and the public health programs that is occurring statewide. This section will provide a historic record of the steps the State is taking to identify and enroll all uninsured children from the time the State's plan was initially approved. States do not have to rewrite this section but may instead update this section as appropriate.

5.1.2. (formerly 2.2.2.) The steps the State is currently taking to identify and enroll all uninsured children who are eligible to participate in health insurance programs that involve a public-private partnership:

Montana has no health insurance programs that involve a public-private partnership.

Guidance: The State should describe below how it's Title XXI program will closely coordinate the enrollment with Medicaid because under Title XXI, children identified as Medicaid-eligible are required to be enrolled in Medicaid. Specific information related to Medicaid screen and enroll procedures is requested in Section 4.4. (42CFR 457.80(c))

5.2. (formerly 2.3) Describe how CHIP coordinates with other public and private health insurance programs, other sources of health benefits coverage for children, and other relevant child health programs, (such as title V), that provide health care services for low-income children to increase the number of children with creditable health coverage. Section 2102(a)(3) and 2102(c)(2) and 2102(b)(3)(E))(42CFR 457.80(c)). This item requires a brief overview of how Title XXI efforts - particularly new enrollment outreach efforts will be coordinated with and improve upon existing State efforts described in Section 5.2.

Special outreach and coordination efforts are in place among HMK, Children's Mental Health Services Plan and Children's Special Health Services. If a child applies for one program and doesn't qualify, or if the child may be served by more than one program, the child is appropriately referred. The state continues to streamline enrollment procedures and collaborative outreach efforts to further the plan's goal to coordinate with other public and private programs. Families that do not qualify for HMK coverage receive information about other health care resources, which include Community Health Clinics, Shriners' Hospital, Angel Flight, and many other health care resources, as appropriate.

Montana's outreach and enrollment efforts are designed to maximize the number of children served under the Medicaid-funded and CHIP-funded programs. (We have no health insurance programs that involve a public-private partnership.) The state coordinates enrollment efforts with:

- Local public health departments
- WIC
- School Nutrition and Health Programs
- Federally Qualified Health Care Centers which include Community, Urban Indian, and

Migrant Health Centers

- Case Management Providers
- Family Planning and Planned Parenthood Centers
- Rural Health Clinics
- Children's Special Health Service Plan
- County Eligibility Case Managers and TANF Case Managers
- Indian Health Services
- Tribal Health Services
- Early Intervention Services (Part C)
- Child Support Enforcement
- Child Protective Services
- Head Start and Early Head Start
- State of Montana and Montana University System Employee Health Care Benefits
- Other Programs as they are identified

These providers:

- Inform participants in their programs of the Healthy Montana Kids Plan
- Distribute brochures and applications for the Healthy Montana Kids Plan

5.2-EL The State should include a description of its election of the Express Lane eligibility option to provide a simplified eligibility determination process and expedited enrollment of eligible children into Medicaid or CHIP.

5.3 Strategies

Guidance: Describe the procedures used by the State to accomplish outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program: (Section 2102(c)(1)) (42CFR 457.90) The description should include information on how the State will inform the target of the availability of the programs, including American Indians and Alaska Natives, and assist them in enrolling in the appropriate program.

Outreach strategies may include, but are not limited to, community outreach workers, outstationed eligibility workers, translation and transportation services, assistance with enrollment forms, case management and other targeting activities to inform families of low-income children of the availability of the health insurance program under the plan or other private or public health coverage.

Montana conducted a media campaign to reach families with children potentially eligible for health coverage in FFY 2009 and 2010. Media message commercials were broadcast on radio and television and news releases published in daily and weekly newspapers, specialty publications and professional association newsletters. Additionally, many

DPHHS providers displayed applications in their waiting rooms.

Assumptions about the target population are based on the experience of the Medicaid Program, social services programs, health care agencies and providers. For an audience consisting of families with a variety of financial needs, DPHHS must appeal both to those who have regular interaction with human service agencies, and to working low-income families who traditionally avoid government programs. Outreach efforts emphasize this is a low cost health coverage plan that is a collaborative effort between families and the state and federal governments to ensure children receive health care.

Direct Appeal to Eligible Families through Press Releases, Public Service Announcements, Brochures, Posters, and Videos:

DPHHS airs radio and television public service announcements about health care coverage programs for children. A toll-free number to call for more information is featured in the public service announcements, printed materials, and press releases. Occasional news releases are sent to the media about the increased insurance coverage available to children. Radio stations, TV and cable stations, Montana daily and weekly newspapers, and specialty publications and newsletters for professional associations in children's health care, parenting, day care, and education receive the press releases and news items.

Outreach methods, other than written materials, are employed whenever possible. All outreach materials prominently feature DPHHS toll-free telephone number. Callers to the toll free number speak to a customer service representative or leave their name and address to receive an application. Brochures and posters are prominently displayed in locations frequented by low-income families with children.

Outreach through Schools:

DPHHS collaborates with Healthy Mothers Healthy Babies (Covering Kids grantee) and the Office of Public Instruction to conduct back-to-school enrollment campaigns in school districts statewide. Information is sent to schools to help conduct outreach. School nurses and counselors are an important part of school-based outreach. Articles and information in school newspapers is another way to reach families. DPHHS works with the Free-and-Reduced School Lunch Programs to distribute information to families.

Outreach through Collaboration with Local Agencies, Grassroots Organizations, and Providers:

Outreach training sessions on eligibility are provided to a variety of staff including: county public health departments, county social services, WIC coordinators, county public assistance offices, family resource centers, churches, the program for Children with Special Health Care Needs, community-centered boards of grassroots organizations, Child Care Resource and Referral agencies, tribal health and social services staff, and Head Start.

Outreach is conducted through DPHHS home visits and case management programs. Home visitors give HMK Plan information and answer questions from pregnant women, parents and families.

DPHHS works with Native American leaders, both urban and reservation, to develop specific outreach activities for this population.

Outreach through Collaboration with Statewide Maternal Child Health Organizations:
DPHHS staff members operate the Maternal Child Health (MCH) toll-free help line which dispenses information about MCH programs, HMK and other health coverage programs and resources.

The Montana Council for Maternal and Child Health does a series of community forums every other year where family health care issues are discussed. They prominently feature children's health coverage program information in these forums.

Applications are available to families at FQHCs, community health and public health centers, IHS tribal sites, county Offices of Public Assistance, WIC offices, health care providers' offices, numerous community locations, and on the Internet at www.HMK.mt.gov. While many of these sites have personnell or advocates available to assist families in completing the application, the eligibility determination is not actually performed at these sites.

The Healthy Montana Kids Plan staff work closely with the Family and Community Health Bureau, which administers Montana's MCH Title V Block Grant to ensure maximum coordination between programs.

Outreach through HMK Plan Enrollment Partners:
The department will also conduct outreach through the following qualified entities: licensed health care providers, school districts, community-based organizations, government agencies and Indian Health Services. The department will consider requests to act as an Enrollment Partner from other entities and approve requests on a case by case basis.

A qualified entity becomes an Enrollment Partner by contacting the department and indicating an interest in becoming an enrollment partner. The department will provide an Enrollment Partner with HMK and HMK Plus materials and applications. Enrollment Partners must complete department sponsored training and provide application assistance to Healthy Montana Kids Plan applicants. The department will maintain a list of the names, addresses, and telephone numbers of its enrollment partners and publish the list on its web site.

Section 6. Coverage Requirements for Children’s Health Insurance

Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State’s Medicaid plan and proceed to Section 7 since children covered under a Medicaid expansion program will receive all Medicaid covered services including EPSDT.

6.1. The State elects to provide the following forms of coverage to children: (Check all that apply.) (Section 2103(c)); (42CFR 457.410(a))

Guidance: Benchmark coverage is substantially equal to the benefits coverage in a benchmark benefit package (FEHBP-equivalent coverage, State employee coverage, and/or the HMO coverage plan that has the largest insured commercial, non-Medicaid enrollment in the state). If box below is checked, either 6.1.1.1., 6.1.1.2., or 6.1.1.3. must also be checked. (Section 2103(a)(1))

6.1.1. Benchmark coverage; (Section 2103(a)(1) and 42 CFR 457.420)

Guidance: Check box below if the benchmark benefit package to be offered by the State is the standard Blue Cross/Blue Shield preferred provider option service benefit plan, as described in and offered under Section 8903(1) of Title 5, United States Code. (Section 2103(b)(1) (42 CFR 457.420(b))

6.1.1.1. FEHBP-equivalent coverage; (Section 2103(b)(1) (42 CFR 457.420(a)) (If checked, attach copy of the plan.)

Guidance: Check box below if the benchmark benefit package to be offered by the State is State employee coverage, meaning a coverage plan that is offered and generally available to State employees in the state. (Section 2103(b)(2))

6.1.1.2. State employee coverage; (Section 2103(b)(2)) (If checked, identify the plan and attach a copy of the benefits description.)

Guidance: Check box below if the benchmark benefit package to be offered by the State is offered by a health maintenance organization (as defined in Section 2791(b)(3) of the Public Health Services Act) and has the largest insured commercial, non-Medicaid enrollment of covered lives of such coverage plans offered by an HMO in the state. (Section 2103(b)(3) (42 CFR 457.420(c)))

6.1.1.3. HMO with largest insured commercial enrollment (Section 2103(b)(3)) (If checked, identify the plan and attach a copy of the benefits description.)

- Guidance: States choosing Benchmark-equivalent coverage must check the box below and ensure that the coverage meets the following requirements:
- the coverage includes benefits for items and services within each of the categories of basic services described in 42 CFR 457.430:
 - dental services
 - inpatient and outpatient hospital services,
 - physicians' services,
 - surgical and medical services,
 - laboratory and x-ray services,
 - well-baby and well-child care, including age-appropriate immunizations, and
 - emergency services;
 - the coverage has an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark benefit packages (FEHBP-equivalent coverage, State employee coverage, or coverage offered through an HMO coverage plan that has the largest insured commercial enrollment in the state); and
 - the coverage has an actuarial value that is equal to at least 75 percent of the actuarial value of the additional categories in such package, if offered, as described in 42 CFR 457.430:
 - coverage of prescription drugs,
 - mental health services,
 - vision services and
 - hearing services.

If 6.1.2. is checked, a signed actuarial memorandum must be attached. The actuary who prepares the opinion must select and specify the standardized set and population to be used under paragraphs (b)(3) and (b)(4) of 42 CFR 457.431. The State must provide sufficient detail to explain the basis of the methodologies used to estimate the actuarial value or, if requested by CMS, to replicate the State results.

The actuarial report must be prepared by an individual who is a member of the American Academy of Actuaries. This report must be prepared in accordance with the principles and standards of the American Academy of Actuaries. In preparing the report, the actuary must use generally accepted actuarial principles and methodologies, use a standardized set of utilization and price factors, use a standardized population that is representative of privately insured children of the age of children who are expected to be covered under the State child health plan, apply the same principles and factors in comparing the value of different coverage (or categories of services), without taking into account any differences in coverage based on the method of delivery or means of cost control or

utilization used, and take into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered under the State child health plan that results from the limitations on cost sharing under such coverage. (Section 2103(a)(2))

- 6.1.2. Benchmark-equivalent coverage; (Section 2103(a)(2) and 42 CFR 457.430) Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431.

DPHHS continues to offer benchmark-equivalent coverage of Montana state employee health insurance. The actuarial report and supporting documentation were submitted with the state plan amendment dated August 1, 2000, and remain unchanged.

Guidance: A State approved under the provision below, may modify its program from time to time so long as it continues to provide coverage at least equal to the lower of the actuarial value of the coverage under the program as of August 5, 1997, or one of the benchmark programs. If "existing comprehensive state-based coverage" is modified, an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of August 5, 1997, or one of the benchmark plans must be attached. Also, the fiscal year 1996 State expenditures for "existing comprehensive state-based coverage" must be described in the space provided for all states. (Section 2103(a)(3))

- 6.1.3. Existing Comprehensive State-Based Coverage; (Section 2103(a)(3) and 42 CFR 457.440) This option is only applicable to New York, Florida, and Pennsylvania. Attach a description of the benefits package, administration, and date of enactment. If existing comprehensive State-based coverage is modified, provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 State expenditures for existing comprehensive state-based coverage.

Guidance: Secretary-approved coverage refers to any other health benefits coverage deemed appropriate and acceptable by the Secretary upon application by a state. (Section 2103(a)(4) (42 CFR 457.250)

- 6.1.4. Secretary-approved Coverage. (Section 2103(a)(4)) (42 CFR 457.450)

6.1.4.1. Coverage the same as Medicaid State plan

6.1.4.2. Comprehensive coverage for children under a Medicaid Section 1115 demonstration waiver

- 6.1.4.3. Coverage that either includes the full EPSDT benefit or that the State has extended to the entire Medicaid population

Guidance: Check below if the coverage offered includes benchmark coverage, as specified in 457.420, plus additional coverage. Under this option, the State must clearly demonstrate that the coverage it provides includes the same coverage as the benchmark package, and also describes the services that are being added to the benchmark package.

- 6.1.4.4. Coverage that includes benchmark coverage plus additional coverage

- 6.1.4.5. Coverage that is the same as defined by existing comprehensive state-based coverage applicable only New York, Pennsylvania, or Florida (under 457.440)

Guidance: Check below if the State is purchasing coverage through a group health plan, and intends to demonstrate that the group health plan is substantially equivalent to or greater than to coverage under one of the benchmark plans specified in 457.420, through use of a benefit-by-benefit comparison of the coverage. Provide a sample of the comparison format that will be used. Under this option, if coverage for any benefit does not meet or exceed the coverage for that benefit under the benchmark, the State must provide an actuarial analysis as described in 457.431 to determine actuarial equivalence.

- 6.1.4.6. Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Provide a sample of how the comparison will be done)

Guidance: Check below if the State elects to provide a source of coverage that is not described above. Describe the coverage that will be offered, including any benefit limitations or exclusions.

- 6.1.4.7. Other (Describe)

Guidance: All forms of coverage that the State elects to provide to children in its plan must be checked. The State should also describe the scope, amount and duration of services covered under its plan, as well as any exclusions or limitations. States that choose to cover unborn children under the State plan should include a separate section 6.2 that specifies benefits for the unborn child population. (Section 2110(a)) (42CFR, 457.490)

If the state elects to cover the new option of targeted low income pregnant women, but chooses to provide a different benefit package for these pregnant women under the CHIP plan, the state must include a separate section 6.2 describing the benefit package for pregnant women. (Section 2112)

- 6.2.** The State elects to provide the following forms of coverage to children: (Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) (Section 2110(a)) (42CFR 457.490)

For the separate CHIP program the following statements apply to all services covered in this section (6.2):

1. There are no pre-existing condition limitations.
2. Experimental procedures, custodial care, personal comfort, hygiene, or convenience items that are not primarily medical in nature, whirlpools, TMJ treatment, acupuncture, biofeedback, neurofeedback, elective abortions, in vitro fertilization, gamete or zygote intrafallopian transfer, artificial insemination, sterilization or the reversal of voluntary sterilization, transsexual surgery, fertility enhancing treatment beyond diagnosis, cosmetic surgery, radial keratotomy, private duty nursing, all invasive medical procedures undertaken for the purpose of weight reduction such as gastric bypass, gastric banding or bariatric surgery (including all revisions), treatment for which another coverage such as workers compensation is responsible, routine foot care, services for members confined in criminal justice institutions, and any treatment not medically necessary are not covered benefits. These exclusions are in addition to any exclusion noted in the individual coverage descriptions.
3. Per Section 6505 of the Affordable Care Act, which amends section 1902(a) of the Social Security Act, HMK will disallow payment to any provider or entity located outside of the United States for services provided to an HMK enrollee.

6.2.1. Inpatient services (Section 2110(a)(1))

Semi-private room; intensive and coronary care units; general nursing; drugs; supplies, surgical supplies, I.V. injections and set up of I.V. solutions; oxygen; blood transfusions; laboratory; imaging services; maternity services; hospital services directly related to pregnancy, physical, speech, occupational, heat, respiratory and inhalation therapy; operating, recovery, birthing and delivery rooms; routine and intensive nursery care for newborns; cochlear implants and associated components; organ and tissue transplants including the transplant surgery, evaluation of the patient as a potential transplant candidate, pre-transplant preparation including histo-compatibility testing procedures, post-

surgical hospitalization, and outpatient care relative to approved medications or resulting complications, transplant organ and tissue procurement and transplant-related medical care for a living donor; and other medically necessary services and supplies for treatment of injury or illness are covered.

Coverage of postpartum care for at least forty-eight hours for vaginal delivery and ninety-six hours for cesarean section is guaranteed.

Services for mental and chemical dependency disorders are outlined in Sections 6.2.10 and 6.2.18.

6.2.2. ☒ Outpatient services (Section 2110(a)(2))

All services described in 6.2.1 which are provided on an outpatient basis in a hospital (including but not limited to observation beds and partial hospitalization services) or ambulatory surgical center; chemotherapy; I.V. injections and set up of I.V. solutions; emergency room services for surgery, accident or medical emergency; mammograms, and other services for diagnostic or outpatient treatment of a medical condition, accident, or illness are covered.

Services for mental and chemical dependency disorders are outlined in Sections 6.2.11 and 6.2.19.

6.2.3. ☒ Physician services (Section 2110(a)(3))

Office, clinic, home, outpatient surgical center and hospital treatment for a medical condition, accident, or illness by a physician, physician assistant, or advance-practice registered nurse are covered.

Well-child, well-baby, and immunization services as recommended by the American Academy of Pediatrics are covered.

Routine physicals for sports, employment, or required by a government authority are covered.

Anesthesia services rendered by a physician anesthesiologist (other than the attending physician or assistant) or by a nurse anesthetist are covered provided that surgical and/or hospital benefits are also covered. Hypnosis, local anesthesia (unless it is included as part of a global procedure charge) and consultations prior to surgery are not covered.

6.2.4. ☒ Surgical services (Section 2110(a)(4))

Covered as described in 6.2.1, 6.2.2, and 6.2.3. In addition, professional services rendered by a physician, surgeon, or doctor of dental surgery for treatment of a fractured jaw or other accidental injury to sound natural teeth and gums are covered.

6.2.5. ☒ Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))

Covered as described for other services summarized in this Section (6.2).

6.2.6. ☒ Prescription drugs (Section 2110(a)(6))

Drugs covered by the Healthy Montana Kids Program are those allowed under 42 USC 1396r-8 and are subject to the following limitations:

1. Drugs must be prescribed by a physician or other licensed practitioner who is authorized by law to prescribe drugs and is recognized by the Healthy Montana Kids program;
2. Maintenance medications may be dispensed in quantities sufficient for a 90-day supply or 100 units, whichever is greater. Other medications may not be dispensed in quantities greater than a 34-day supply except where manufacturer packaging cannot be reduced to a smaller quantity. The Department will post a list of current drug classes which will be considered maintenance medications on the department's web site at <http://medicaidprovider.hhs.mt.gov>.
3. Drugs are not covered if they:
 - a. Have been classified as “less than effective” by the FDA (DESI drugs);
 - b. Are produced by manufacturers who have not signed a rebate agreement with CMS;
 - c. Not filled at a participating Montana Health Care Programs Pharmacy.
4. Healthy Montana Kids will cover vaccines administered in an outpatient pharmacy setting.
5. The Department may reimburse for compounded nonrebutable API bulk powders and excipients on the Department’s maintained drug formulary.
6. The Department will cover nonprescription folic acid, pyridoxine, and bronchosaline.
7. The Healthy Montana Kids program provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Healthy Montana Kids members.

The following excluded drugs are covered:

- (a) agents when used for anorexia, weight loss, weight gain. Weight gain agents are covered when medically necessary. Agents when used for anorexia and weight loss continue as excluded drugs.
- (b) agents when used to promote fertility
- (c) agents when used for cosmetic purposes or hair growth
- (d) agents when used for the symptomatic relief cough and colds
- (e) prescription vitamins and mineral products, except prenatal vitamins and fluoride
- (f) nonprescription drugs
Aspirin, laxatives, antacids, head lice treatment, H2 antagonist GI products, proton pump inhibitors, non-sedating antihistamines, diphenhydramine, over-the-counter contraceptive drugs, ketotifen ophthalmic solution, doxylamine, steroid nasal sprays, benzoyl peroxide, and oxybutynin transdermal.
- (g) covered outpatient drugs which the manufacturer seeks to require as

a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee

Services considered experimental are not a benefit of the Healthy Montana Kids Program.

Experimental services include:

1. All procedures and items, including prescribed drugs, considered experimental by the U.S. Department of Health and Human Services or any other appropriate federal agency.
2. All procedures and items, including prescribed drugs, provided as part of a control study, approved by the Department of Health and Human Services or any other appropriate federal agency to demonstrate whether the item, prescribed drug or procedure is safe and effective in curing/preventing, correcting or alleviating the effects of certain medical conditions.

3. All procedures and items, including prescribed drugs, which may be subject to question but are not covered in #1 and #2 above, will be evaluated by the Department's designated medical review organization.

Product Restrictions:

The Healthy Montana Kids program restricts coverage of certain drug products through the operation of an outpatient drug formulary. The state utilizes the University of Montana, School of Pharmacy and Allied Health Sciences for literature research and the state DUR (Drug Utilization Review) Board as the formulary committee. Criteria used to include/exclude drugs from the formulary are based upon safety, efficacy and clinical outcomes as provided by the product labeling of the drug. Montana's formulary committee meets the formulary requirements that are specified in section 1927(d)(4) of the Social Security Act.

Prior Authorization:

Drugs may require prior authorization for the reimbursement of any covered outpatient drugs. Prior authorization is under the provisions of Section 1927(d)(5) of the Social Security Act. For drugs requiring prior authorization, an automated voice response system is used to meet the requirements for providing a response within 24 hours. Up to a 72-hour supply of medication requiring prior authorization may be dispensed in an emergency.

Preferred Drug List:

Certain designated therapeutic classes will be reviewed periodically to consider which products are clinically appropriate and most cost-effective. Those products within the therapeutic class that are not determined to be clinically superior and/or are not cost-effective will require prior authorization. The Department may maintain a Preferred Drug List containing the names of pharmaceutical drugs for which prior authorization will not be required under the medical assistance program. All other pharmaceutical drugs not on the Preferred Drug List, and determined by the Department to be in the same drug class and used for the treatment of the same medical condition as drug(s) placed on the Preferred Drug List, will require prior authorization.

The Department will appoint a Formulary Committee or utilize the drug utilization review committee in accordance with Federal law.

6.2.7.

Over-the-counter medications (Section 2110(a)(7))

Section 6.2.6 addresses specific covered over-the-counter medications.

- 6.2.8.** ☒ Laboratory and radiological services (Section 2110(a)(8))
Coverage includes imaging and laboratory services for diagnostic or therapeutic purposes due to accident, illness, or medical condition that are not described elsewhere in this section (6.2).

X-ray, radium, and radioactive isotope therapy are covered.

- 6.2.9.** ☒ Prenatal care and pre-pregnancy family services and supplies (Section 2110(a)(9))

Prenatal care is covered as described for other medical conditions in this Section (6.2). Pre-pregnancy family planning services are covered. Medical or surgical treatment to reverse surgically induced infertility; fertility enhancing procedures beyond diagnosis; sterilization; and sex change operations are not covered.

- 6.2.10.** ☒ Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))

HMK has removed financial and treatment limitations on inpatient mental health benefits. Enrollees receive the following mental health benefits: prescription drugs, outpatient and inpatient services as outlined in this section and 6.2.11. There are no maximum annual or lifetime limits on covered services, except for Therapeutic Youth Group Home Therapeutic Home Leave.

- 6.2.11.** ☒ Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11))

There are no maximum annual or lifetime limits on covered and medically necessary mental health benefits.

Effective July 1, 2010, the State provides mental health benefits in a manner equal to medical benefits. Extended mental health benefits for children with a serious emotional disturbance (SED) are in addition to the basic mental health benefits HMK covers. These extended mental health services are community or home-based services. Enrollees who have a serious emotional disturbance as determined by a department or department-contracted licensed mental health professional may receive extended mental health services beyond coverage provided under the basic plan. Extended mental health benefits include:

- 1) Community Based Psychiatric Rehabilitation and Support,

- 2) Respite Care,
- 3) Therapeutic Family Care/Home Support Services, and
- 4) Day Treatment.

Applied behavior analysis is covered for treatment of autism spectrum disorder.

- 6.2.12.** Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, dental implants, and adaptive devices) (Section 2110(a)(12))

Durable medical equipment medically necessary to treat a health problem or a physical condition is covered.

Eyeglasses are provided by a bulk-purchasing contractor and reimbursed directly by the State of Montana, Department of Public Health and Human Services. Eyeglasses are not paid by the TPA Contractor.

Audiological Services—Hearing exams, including newborn hearing screens in a hospital or outpatient setting, are covered. Coverage includes assessment and diagnosis. Hearing aids are covered.

Prescribed diabetic equipment and supplies including insulin, syringes, injection aids, devices for self-monitoring of glucose levels (including those for the visually impaired), test strips, visual reading and urine test strips, one insulin pump for the warranty period, accessories to insulin pumps, and glucagon emergency kits are covered.

Enteral formula is covered for children with inborn errors of metabolism or other medically necessary conditions requiring formula for treatment.

- 6.2.13.** Disposable medical supplies (Section 2110(a)(13))

Guidance: Home and community based services may include supportive services such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home.

- 6.2.14.** Home and community-based health care services (See instructions) (Section 2110(a)(14))

Home health services provided by a licensed home health agency to a member considered homebound are covered, including skilled nursing services; home health aide services; physical therapy services; occupational therapy services;

speech therapy services, and medical supplies suitable for use in the home.

Guidance: Nursing services may include nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services in a home, school or other setting.

- 6.2.15. Nursing care services (Section 2110(a)(15))
- 6.2.16. Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16))
- 6.2.17. Dental services (Section 2110(a)(17)) States updating their dental benefits must complete 6.2-DC (CHIPRA # 7, SHO # #09-012 issued October 7, 2009)
- 6.2.18. Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))

HMK benefits include inpatient substance abuse treatment and residential substance abuse treatment services. There are no maximum lifetime or annual limits for covered services.

- 6.2.19. Outpatient substance abuse treatment services (Section 2110(a)(19))
HMK benefits include outpatient substance abuse treatment services. There are no maximum lifetime or annual limits for covered services.
- 6.2.20. Case management services (Section 2110(a)(20))
- 6.2.21. Care coordination services (Section 2110(a)(21))

Montana will offer HMK-enrolled children access to the CMS Comprehensive Primary Care Plus (CPC+) program. Montana's CHIP third party administrator (TPA) will contract with Montana primary care practices. To support the delivery of comprehensive primary care, CPC+ includes three payment elements: Care Management Fee, Performance-Based Incentive Payments, and Fee-For-Service Payments.

- 6.2.22. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))

DPHHS requires prior authorization for occupational, speech and physical therapy services.

6.2.23. Hospice care (Section 2110(a)(23))

Hospice care provided by a licensed program that provides palliative care services and attends to the needs of terminally ill patients at an inpatient facility or at the patient's home, is covered.

Guidance: Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic or rehabilitative service may be provided, whether in a facility, home, school, or other setting, if recognized by State law and only if the service is: 1) prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as prescribed by State law; 2) performed under the general supervision or at the direction of a physician; or 3) furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.

6.2.24. Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) (Section 2110(a)(24))

Vision Services and Medical Eye Care—Services for the medical treatment of diseases or injury to the eye by a licensed physician or optometrist working within the scope of his or her license are covered. Vision exams and eyeglass dispensing fees are covered.

Nutrition services, including nutrition counseling with a child or responsible care giver, nutrition assessment for evaluation of a child's nutritional problems, nutrition consultation with health professionals to research or resolve special nutrition problems, and nutrition education are covered.

Chiropractic services (specific adjustment or manipulation of the articulations and tissues of the body, particularly of the spinal column and for the correction of nerve interference), are covered.

Cleft/craniofacial, metabolic, and cystic fibrosis interdisciplinary services provided during special DPHHS sponsored clinics.

6.2.25. Premiums for private health care insurance coverage (Section 2110(a)(25))

6.2.26. Medical transportation (Section 2110(a)(26))

The department will cover emergency ambulance services.

Guidance: Enabling services, such as transportation, translation, and outreach services, may

be offered only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.

- 6.2.27.** Enabling services (such as transportation, translation, and outreach services (See instructions) (Section 2110(a)(27))

Medical transportation (travel prior authorized based on medical necessity and coverage of a service prior to delivery of the service, furnished by a common carrier or private vehicle); and per diem (financial assistance with expenses for meals and lodging enroute to or from, and while receiving, medically necessary medical care), are covered for a member and one adult companion. Medical transportation and per diem are based on cost to the nearest eligible service.

HMK applicants and members have access to a bilingual interpreter for effective communication and auxiliary aids to accommodate a disability.

HMK members have access to telemedicine services provided by participating providers.

Physicians may provide limited consultation with other HMK enrolled physicians with prior approval and with a full written report.

- 6.2.28.** Any other health care services or items specified by the Secretary and not included under this Section (Section 2110(a)(28))

Nurse Advice Line access to health information and advice twenty-four hours a day seven days a week is a covered benefit.

6.2-DC Dental Coverage (CHIPRA # 7, SHO # #09-012 issued October 7, 2009) The State will provide dental coverage to children through one of the following. Please update Sections 9.10 and 10.3-DC when electing this option. Dental services provided to children eligible for dental-only supplemental services must receive the same dental services as provided to otherwise eligible CHIP children (Section 2103(a)(5)):

6.2.1-DC State Specific Dental Benefit Package. The State assures dental services represented by the following categories of common dental terminology (CDT¹) codes are included in the dental benefits:

1. Diagnostic (i.e., clinical exams, x-rays) (CDT codes: D0100-D0999) (must follow periodicity schedule)

2. Preventive (i.e., dental prophylaxis, topical fluoride treatments, sealants) (CDT codes: D1000-D1999) (must follow periodicity schedule)
3. Restorative (i.e., fillings, crowns) (CDT codes: D2000-D2999)
4. Endodontic (i.e., root canals) (CDT codes: D3000-D3999)
5. Periodontic (treatment of gum disease) (CDT codes: D4000-D4999)
6. Prosthodontic (dentures) (CDT codes: D5000-D5899, D5900-D5999, and D6200-D6999)
7. Oral and Maxillofacial Surgery (i.e., extractions of teeth and other oral surgical procedures) (CDT codes: D7000-D7999)
8. Orthodontics (i.e., braces) (CDT codes: D8000-D8999)
9. Emergency Dental Services

6.2.1.1-DC Periodicity Schedule. The State has adopted the following periodicity schedule:

- State-developed Medicaid-specific
- American Academy of Pediatric Dentistry
- Other Nationally recognized periodicity schedule
- Other (description attached)

6.2.2-DC Benchmark coverage; (Section 2103(c)(5), 42 CFR 457.410, and 42 CFR 457.420)

6.2.2.1-DC FEHBP-equivalent coverage; (Section 2103(c)(5)(C)(i)) (If checked, attach copy of the dental supplemental plan benefits description and the applicable CDT² codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

6.2.2.2-DC State employee coverage; (Section 2103(c)(5)(C)(ii)) (If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)Page - 11 – State Health Official

HMK, in accordance with CHIPRA, will provide dental benefits including dental implants. The State of Montana employee and dependent dental benefit plan is used as a benchmark.

The HMK dental benefit is increasing from \$1,412 per year to \$1,900 per year.

An HMK-enrolled child may receive dental benefits totaling up to \$1,900 in billed charges in a benefit year. Effective July 1st 2014, the dental benefit year is July 1st through June 30th of the subsequent year. The maximum reimbursement to the dental provider is 85% of billed charges or \$1,615 per benefit year.

There is no cost sharing for dental services.

HMK/CHIP is in compliance with CHIPRA requirements as defined in the CMS SHO letter dated October 7, 2009 and with the selection of 6.2.2.2-D in the dental template section of this SPA. Medically-related dental emergencies are reimbursable under medical benefits, defined in 6.2.4 of the existing SPA.

6.2.2.3-DC HMO with largest insured commercial enrollment (Section 2103(c)(5)(C)(iii)) (If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

6.2-DS **Supplemental Dental Coverage-** The State will provide dental coverage to children eligible for dental-only supplemental services. Children eligible for this option must receive the same dental services as provided to otherwise eligible CHIP children (Section 2103(a)(5). Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, and 9.10 when electing this option.

Guidance: Under Title XXI, pre-existing condition exclusions are not allowed, with the only exception being in relation to another law in existence (HIPAA/ERISA). Indicate that the plan adheres to this requirement by checking the applicable description.

In the event that the State provides benefits through a group health plan or group health coverage, or provides family coverage through a group health plan under a waiver (see Section 6.4.2.), pre-existing condition limits are allowed to the extent permitted by HIPAA/ERISA. If the State is contracting with a group health plan or provides benefits through group health coverage, describe briefly any limitations on pre-existing conditions. Previously 8.6

6.2- MHPAEA Section 2103(c)(6)(A) of the Social Security Act requires that, to the extent that it provides both medical/surgical benefits and mental health or substance use disorder benefits, a State child health plan ensures that financial requirements and treatment limitations applicable to mental health and substance use disorder benefits comply with the mental health parity requirements of section 2705(a) of the Public Health Service Act in the same manner that such requirements apply to a group health plan. If the state child health plan provides for delivery of services through a managed care arrangement, this requirement applies to both the state and managed care plans. These requirements are also applicable to any additional benefits provided voluntarily to the child health plan population by managed care entities and will be considered as part of CMS's contract review process at 42 CFR 457.1201(l).

6.2.1- MHPAEA Before completing a parity analysis, the State must determine whether each covered benefit is a medical/surgical, mental health, or substance use disorder benefit based on a standard that is

consistent with state and federal law and generally recognized independent standards of medical practice. (42 CFR 457.496(f)(1)(i))

6.2.1.1- MHPAEA Please choose the standard(s) the state uses to determine whether a covered benefit is a medical/surgical benefit, mental health benefit, or substance use disorder benefit. The most current version of the standard elected must be used. If different standards are used for different benefit types, please specify the benefit type(s) to which each standard is applied. If “Other” is selected, please provide a description of that standard.

- International Classification of Disease (ICD) Services with ICD-10 diagnosis codes of F01-F99 are considered mental health and substance use disorder services.
- Diagnostic and Statistical Manual of Mental Disorders (DSM)
- State guidelines (Describe: _____)
- Other (Describe: _____)

6.2.1.2- MHPAEA Does the State provide mental health and/or substance use disorder benefits?

- Yes
- No

Guidance: If the State does not provide any mental health or substance use disorder benefits, the mental health parity requirements do not apply ((42 CFR 457.496(f)(1)). Continue on to Section 6.3.

6.2.2- MHPAEA Section 2103(c)(6)(B) of the Social Security Act (the Act) provides that to the extent a State child health plan includes coverage of early and periodic screening, diagnostic, and treatment services (EPSDT) defined in section 1905(r) of the Act and provided in accordance with section 1902(a)(43) of the Act, the plan shall be deemed to satisfy the parity requirements of section 2103(c)(6)(A) of the Act.

6.2.2.1- MHPAEA Does the State child health plan provide coverage of EPSDT? The State must provide for coverage of EPSDT benefits, consistent with Medicaid statutory requirements, as indicated in section 6.2.26 of the State child health plan in order to answer “yes.”

- Yes
- No

Guidance: If the State child health plan *does not* provide EPSDT consistent with Medicaid statutory requirements at sections 1902(a)(43) and 1905(r) of the Act, please go to Section 6.2.3- MHPAEA to complete the required parity analysis of the State child health plan.

If the state *does* provide EPSDT benefits consistent with Medicaid requirements, please continue this section to demonstrate compliance with the statutory requirements of section 2103(c)(6)(B) of the Act and the mental health parity regulations of 42 CFR 457.496(b) related to deemed compliance. Please provide supporting documentation, such as contract language, provider manuals, and/or member handbooks describing the state's provision of EPSDT.

6.2.2.2- MHPAEA EPSDT benefits are provided to the following:

- All children covered under the State child health plan.
- A subset of children covered under the State child health plan.

Please describe the different populations (if applicable) covered under the State child health plan that are provided EPSDT benefits consistent with Medicaid statutory requirements.

Guidance: If only a subset of children are provided EPSDT benefits under the State child health plan, 42 CFR 457.496(b)(3) limits deemed compliance to those children only and Section 6.2.3- MHPAEA must be completed as well as the required parity analysis for the other children.

6.2.2.3- MHPAEA To be deemed compliant with the MHPAEA parity requirements, States must provide EPSDT in accordance with sections 1902(a)(43) and 1905(r) of the Act (42 CFR 457.496(b)). The State assures each of the following for children eligible for EPSDT under the separate State child health plan:

- All screening services, including screenings for mental health and substance use disorder conditions, are provided at intervals that align with a periodicity schedule that meets reasonable standards of medical or dental practice as well as when medically necessary to determine the existence of suspected illness or conditions. (Section 1905(r))
- All diagnostic services described in 1905(a) of the Act are provided as needed to diagnose suspected conditions or illnesses discovered through screening services,

whether or not those services are covered under the Medicaid state plan. (Section 1905(r))

All items and services described in section 1905(a) of the Act are provided when needed to correct or ameliorate a defect or any physical or mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the Medicaid State plan. (Section 1905(r)(5))

Treatment limitations applied to services provided under the EPSDT benefit are not limited based on a monetary cap or budgetary constraints and may be exceeded as medically necessary to correct or ameliorate a medical or physical condition or illness. (Section 1905(r)(5))

Non-quantitative treatment limitations, such as definitions of medical necessity or criteria for medical necessity, are applied in an individualized manner that does not preclude coverage of any items or services necessary to correct or ameliorate any medical or physical condition or illness. (Section 1905(r)(5))

EPSDT benefits are not excluded on the basis of any condition, disorder, or diagnosis. (Section 1905(r)(5))

The provision of all requested EPSDT screening services, as well as any corrective treatments needed based on those screening services, are provided or arranged for as necessary. (Section 1902(a)(43))

All families with children eligible for the EPSDT benefit under the separate State child health plan are provided information and informed about the full range of services available to them. (Section 1902(a)(43)(A))

Guidance: For states seeking deemed compliance for their entire State child health plan population, please continue to Section 6.3. If not all of the covered populations are offered EPSDT, the State must conduct a parity analysis of the benefit packages provided to those populations. Please continue to 6.2.3-MHPAEA.

Mental Health Parity Analysis Requirements for States Not Providing EPSDT to All Covered Populations

Guidance: The State must complete a parity analysis for each population under the State child health plan that is not provided the EPSDT benefit consistent with the requirements 42 CFR 457.496(b). If the State provides benefits or limitations that vary within the child or pregnant woman populations, states should perform a parity analysis for each of the benefit packages. For example, if different financial requirements are applied according to a beneficiary's income, a separate parity analysis is needed for the benefit package provided at each income level.

Please ensure that changes made to benefit limitations under the State child health plan as a result of the parity analysis are also made in Section 6.2.

6.2.3- MHPAEA In order to conduct the parity analysis, the State must place all medical/surgical and mental health and substance use disorder benefits covered under the State child health plan into one of four classifications: Inpatient, outpatient, emergency care, and prescription drugs. (42 CFR 457.496(d)(2)(ii); 42 CFR 457.496(d)(3)(ii)(B)) Montana's parity analysis is attached as Appendix A.

6.2.3.1 MHPAEA Please describe below the standard(s) used to place covered benefits into one of the four classifications. The inpatient classification is used when a child has been placed in either an inpatient hospital or a psychiatric residential treatment facility. Emergency care is classified as an outpatient visit to a hospital for an acute episode. Prescription drug category includes all drugs dispensed through a pharmacy. Outpatient care is categorized as all other care provided outside of an inpatient stay or emergency visit to a hospital.

6.2.3.1.1 MHPAEA The State assures that:

- The State has classified all benefits covered under the State plan into one of the four classifications.
- The same reasonable standards are used for determining the classification for a mental health or substance use disorder benefit as are used for determining the classification of medical/surgical benefits.

6.2.3.1.2- MHPAEA Does the State use sub-classifications to distinguish between office visits and other outpatient services?

- Yes
- No

6.2.3.1.2.1- MHPAEA If the State uses sub-classifications to distinguish between outpatient office visits and other outpatient services, the State assures the following:

The sub-classifications are only used to distinguish office visits from other outpatient items and services, and are not used to distinguish between similar services on other bases (ex: generalist vs. specialist visits).

Guidance: For purposes of this section, any reference to “classification(s)” includes sub-classification(s) in states using sub-classifications to distinguish between outpatient office visits from other outpatient services.

6.2.3.2 MHPAEA The State assures that:

Mental health/ substance use disorder benefits are provided in all classifications in which medical/surgical benefits are provided under the State child health plan.

Guidance: States are not required to cover mental health or substance use disorder benefits (42 CFR 457.496(f)(2)). However, if a state does provide any mental health or substance use disorder benefits, those mental health or substance use disorder benefits must be provided in all the same classifications in which medical/surgical benefits are covered under the State child health plan (42 CFR 457.496(d)(2)(ii).

Annual and Aggregate Lifetime Dollar Limits

6.2.4- MHPAEA A State that provides both medical/surgical benefits and mental health and/or substance use disorder benefits must comply with parity requirements related to annual and aggregate lifetime dollar limits for benefits covered under the State child health plan. (42 CFR 457.496(c))

6.2.4.1- MHPAEA Please indicate whether the State applies an aggregate lifetime dollar limit and/or an annual dollar limit on any mental health or substance abuse disorder benefits covered under the State child health plan.

Aggregate lifetime dollar limit is applied

Aggregate annual dollar limit is applied

No dollar limit is applied

Guidance: A monetary coverage limit that applies to *all* CHIP services provided under the State child health plan is not subject to parity requirements.

If there are no aggregate lifetime or annual dollar limits on any mental health or substance use disorder benefits, please go to section 6.2.5- MHPAEA.

6.2.4.2- MHPAEA Are there any medical/surgical benefits covered under the State child health plan that have either an aggregate lifetime dollar limit or an annual dollar limit? If yes, please specify what type of limits apply.

Yes (Type(s) of limit: _____)

No Dental services are the only services with an annual limit.

Guidance: If no aggregate lifetime dollar limit is applied to medical/ surgical benefits, the State may not impose an aggregate lifetime dollar limit on *any* mental health or substance use disorder benefits. If no aggregate annual dollar limit is applied to medical/surgical benefits, the State may not impose an aggregate annual dollar limit on *any* mental health or substance use disorder benefits. (42 CFR 457.496(c)(1))

6.2.4.3 – MHPAEA. States applying an aggregate lifetime or annual dollar limit on medical/surgical benefits and mental health or substance use disorder benefits must determine whether the portion of the medical/surgical benefits to which the limit applies is less than one-third, at least one-third but less than two-thirds, or at least two-thirds of all medical/surgical benefits covered under the State plan (42 CFR 457.496(c)). The portion of medical/surgical benefits subject to the limit is based on the dollar amount expected to be paid for all medical/surgical benefits under the State plan for the State plan year or portion of the plan year after a change in benefits that affects the applicability of the aggregate lifetime or annual dollar limits. (42 CFR 457.496(c)(3))

The State assures that it has developed a reasonable methodology to calculate the portion of covered medical/surgical benefits which are subject to the aggregate lifetime and/or annual dollar limit, as applicable.

Guidance: Please include the state’s methodology to calculate the portion of covered medical/surgical benefits which are subject to the aggregate lifetime and/or annual dollar limit and the results as an attachment to the State child health plan.

6.2.4.3.1- MHPAEA Please indicate the portion of the total costs for medical and surgical benefits covered under the State plan which are subject to a lifetime dollar limit:

Less than 1/3

At least 1/3 and less than 2/3

At least 2/3

6.2.4.3.2- MHPAEA Please indicate the portion of the total costs for medical and surgical benefits covered under the State plan which are subject to an annual dollar limit:

Less than 1/3

At least 1/3 and less than 2/3

At least 2/3

Guidance: If an aggregate lifetime limit is applied to less than one-third of all medical/surgical benefits, the State may not impose an aggregate lifetime limit on *any* mental health or substance use disorder benefits. If an annual dollar limit is applied to less than one-third of all medical surgical benefits, the State may not impose an annual dollar limit on *any* mental health or substance use disorder benefits (42 CFR 457.496(c)(1)). Skip to section 6.2.5-MHPAEA.

If the State applies an aggregate lifetime or annual dollar limit to at least one-third of all medical/surgical benefits, please continue below to provide the assurances related to the determination of the portion of total costs for medical/surgical benefits that are subject to either an annual or lifetime limit.

6.2.4.3.2.1- MHPAEA If the State applies an aggregate lifetime or annual dollar limit to at least 1/3 and less than 2/3 of all medical/surgical benefits, the State assures the following (42 CFR 457.496(c)(4)(i)(B)); (42 CFR 457.496(c)(4)(ii)):

The State applies an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is no more restrictive than an average limit calculated for medical/surgical benefits.

Guidance: The state's methodology for calculating the average limit for medical/surgical benefits must be consistent with 42 CFR 457.496(c)(4)(i)(B) and 42 CFR 457.496(c)(4)(ii). Please include the state's methodology and results as an attachment to the State child health plan.

6.2.4.3.2.2- MHPAEA If at least 2/3 of all medical/surgical benefits are subject to an annual or lifetime limit, the State assures either of the

following (42 CFR 457.496(c)(2)(i)); (42 CFR 457.496(c)(2)(ii)):

The aggregate lifetime or annual dollar limit is applied to both medical/surgical benefits and mental health and substance use disorder benefits in a manner that does not distinguish between medical/surgical benefits and mental health and substance use disorder benefits; or

The aggregate lifetime or annual dollar limit placed on mental health and substance use disorder benefits is no more restrictive than the aggregate lifetime or annual dollar limit on medical/surgical benefits.

Quantitative Treatment Limitations

6.2.5- MHPAEA Does the State apply quantitative treatment limitations (QTLs) on any mental health or substance use disorder benefits in any classification of benefits? If yes, specify the classification(s) of benefits in which the State applies one or more QTLs on any mental health or substance use disorder benefits.

Yes (Specify: _____)

No

Guidance: If the state does not apply any type of QTLs on any mental health or substance use disorder benefits in any classification, the state meets parity requirements for QTLs and should continue to Section 6.2.6 - MHPAEA. If the state does apply QTLs to any mental health or substance use disorder benefits, the state must conduct a parity analysis. Please continue.

6.2.5.1- MHPAEA Does the State apply any type of QTL on any medical/surgical benefits?

Yes

No

Guidance: If the State does not apply QTLs on any medical/surgical benefits, the State may not impose quantitative treatment limitations on mental health or substance use disorder benefits, please go to Section 6.2.6- MHPAEA related to non-quantitative treatment limitations.

6.2.5.2- MHPAEA Within each classification of benefits in which the State applies a type of QTL on any mental health or substance use disorder benefits, the State must determine the portion of medical and surgical benefits in the classification which are subject to the limitation.

More specifically, the State must determine the ratio of (a) the dollar amount of all payments expected to be paid under the State plan for medical and surgical benefits within a classification which are subject to the type of quantitative treatment limitation for the plan year (or portion of the plan year after a mid-year change affecting the applicability of a type of quantitative treatment limitation to any medical/surgical benefits in the class) to (b) the dollar amount expected to be paid for all medical and surgical benefits within the classification for the plan year. For purposes of this paragraph, all payments expected to be paid under the State plan includes payments expected to be made directly by the State and payments which are expected to be made by MCEs contracting with the State. (42 CFR 457.496(d)(3)(i)(C))

The State assures it has applied a reasonable methodology to determine the dollar amounts used in the ratio described above for each classification within which the State applies QTLs to mental health or substance use disorder benefits. (42 CFR 457.496(d)(3)(i)(E))

Guidance: Please include the state’s methodology and results as an attachment to the State child health plan.

6.2.5.3- MHPAEA For each type of QTL applied to any mental health or substance use disorder benefits within a given classification, does the State apply the same type of QTL to “substantially all” (defined as at least two-thirds) of the medical/surgical benefits within the same classification? (42 CFR 457.496(d)(3)(i)(A))

Yes

No

Guidance: If the State does not apply a type of QTL to substantially all medical/surgical benefits in a given classification of benefits, the State may not impose that type of QTL on mental health or substance use disorder benefits in that classification. (42 CFR 457.496(d)(3)(i)(A))

6.2.5.3.1- MHPAEA For each type of QTL applied to mental health or substance use disorder benefits, the State must determine the predominant level of that type which is applied to medical/surgical benefits in the classification. The “predominant level” of a type of QTL in a classification is the level (or least restrictive of a combination of levels) that applies to more than one-half of the medical/surgical benefits in that classification, as described in 42 CFR 457.496(d)(3)(i)(B). The portion of medical/surgical benefits in a classification to which a given level of a QTL type is applied is based on the dollar amount of payments expected to be paid for medical/surgical benefits subject to that level as compared to all medical/surgical benefits in the classification, as described in 42 CFR 457.496(d)(3)(i)(C). For each type of quantitative treatment limitation applied to mental health or substance use disorder benefits, the State assures:

The same reasonable methodology applied in determining the dollar amounts used to determine whether substantially all medical/surgical benefits within a classification are subject to a type of quantitative treatment limitation also is applied in determining the dollar amounts used to determine the predominant level of a type of quantitative treatment limitation applied to medical/surgical benefits within a classification. (42 CFR 457.496(d)(3)(i)(E))

The level of each type of quantitative treatment limitation applied by the State to mental health or substance use disorder benefits in any classification is no more restrictive than the predominant level of that type which is applied by the State to medical/surgical benefits within the same classification. (42 CFR 457.496(d)(2)(i))

Guidance: If there is no single level of a type of QTL that exceeds the one-half threshold, the State may combine levels within a type of QTL such that the combined levels are applied to at least half of all medical/surgical benefits within a classification; the predominant level is the least restrictive level of the levels combined to meet the one-half threshold. (42 CFR 457.496(d)(3)(i)(B)(2))

Non-Quantitative Treatment Limitations

6.2.6- MHPAEA The State may utilize non-quantitative treatment limitations (NQTLs) for mental health or substance use disorder benefits, but the State must ensure that those NQTLs comply with all the mental health parity requirements. (42 CFR 457.496(d)(4)); (42 CFR 457.496(d)(5))

6.2.6.1 – MHPAEA If the State imposes any NQTLs, complete this subsection. If the State does not impose NQTLs, please go to Section 6.2.7-MHPAEA.

The State assures that the processes, strategies, evidentiary standards or other factors used in the application of any NQTL to mental health or substance use disorder benefits are no more stringent than the processes, strategies, evidentiary standards or other factors used in the application of NQTLs to medical/surgical benefits within the same classification.

Guidance: Examples of NQTLs include medical management standards to limit or exclude benefits based on medical necessity, restrictions based on geographic location, provider specialty, or other criteria to limit the scope or duration of benefits and provider network design (ex: preferred providers vs. participating providers). Additional examples of possible NQTLs are provided in 42 CFR 457.496(d)(4)(ii). States will need to provide a summary of its NQTL analysis, as

well as supporting documentation as requested.

6.2.6.2 – MHPAEA The State or MCE contracting with the State must comply with parity if they provide coverage of medical or surgical benefits furnished by out-of-network providers.

6.2.6.2.1- MHPAEA Does the State or MCE contracting with the State provide coverage of medical or surgical benefits provided by out-of-network providers?

Yes

No

Guidance: The State can answer no if the State or MCE only provides out of network services in specific circumstances, such as emergency care, or when the network is unable to provide a necessary service covered under the contract.

6.2.6.2.2- MHPAEA If yes, the State must provide access to out-of-network providers for mental health or substance use disorder benefits. Please assure the following:

The State attests that when determining access to out-of-network providers within a benefit classification, the processes, strategies, evidentiary standards, or other factors used to determine access to those providers for mental health/ substance use disorder benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards or other factors used to determine access for out- of-network providers for medical/surgical benefits.

Availability of Plan Information

6.2.7- MHPAEA The State must provide beneficiaries, potential enrollees, and providers with information related to medical necessity criteria and denials of payment or reimbursement for mental health or substance use disorder services (42 CFR 457.496(e)) in addition to existing notice requirements at 42 CFR 457.1180.

6.2.7.1- MHPAEA Medical necessity criteria determinations must be made available to any current or potential enrollee or contracting provider, upon request. The state attests that the following entities provide this information:

State

Managed Care entities

Both

Other

6.2.7.2- MHPAEA Reason for any denial for reimbursement or payment for mental health or substance use disorder benefits must be made available to the enrollee by the health plan or the State. The state attests that the following entities provide denial information:

- State
- Managed Care entities
- Both
- Other

6.3 The State assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan: (42CFR 457.480)

- 6.3.1.** The State shall not permit the imposition of any pre-existing medical condition exclusion for covered services (Section 2102(b)(1)(B)(ii)); OR
- 6.3.2.** The State contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.6.2. (formerly 6.4.2) of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA (Section 2103(f)). Describe: Previously 8.6

Guidance: States may request two additional purchase options in Title XXI: cost effective coverage through a community-based health delivery system and for the purchase of family coverage. (Section 2105(c)(2) and (3)) (457.1005 and 457.1010)

6.4 Additional Purchase Options- If the State wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate option. To be approved, the State must address the following: (Section 2105(c)(2) and (3)) (42 CFR 457.1005 and 457.1010)

- 6.4.1.** **Cost Effective Coverage-** Payment may be made to a State in excess of the 10% limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in Section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the State to administer the plan, if it demonstrates the following (42CFR 457.1005(a)):

6.4.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; Describe the coverage provided by the alternative delivery system. The State may cross reference Section 6.2.1 - 6.2.28. (Section 2105(c)(2)(B)(i)) (42CFR 457.1005(b))

6.4.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above; Describe the cost of such coverage on an average per child basis. (Section 2105(c)(2)(B)(ii)) (42CFR 457.1005(b))

Guidance: Check below if the State is requesting to provide cost-effective coverage through a community-based health delivery system. This allows the State to waive the 10% limitation on expenditures not used for Medicaid or health insurance assistance if coverage provided to targeted low-income children through such expenditures meets the requirements of Section 2103; the cost of such coverage is not greater, on an average per child basis, than the cost of coverage that would otherwise be provided under Section 2103; and such coverage is provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under Section 330 of the Public Health Services Act or with hospitals such as those that receive disproportionate share payment adjustments under Section 1886(c)(5)(F) or 1923.

If the cost-effective alternative waiver is requested, the State must demonstrate that payments in excess of the 10% limitation will be used for other child health assistance for targeted low-income children; expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); expenditures for outreach activities as provided in Section 2102(c)(1) under the plan; and other reasonable costs incurred by the State to administer the plan. (42CFR, 457.1005(a))

6.4.1.3. The coverage must be provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under Section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under Section 1886(c)(5)(F) or 1923 of the Social Security Act. Describe the community-based delivery system. (Section 2105(c)(2)(B)(iii)) (42CFR 457.1005(a))

Guidance: Check 6.6.2 if the State is requesting to purchase family coverage. Any State

requesting to purchase such coverage will need to include information that establishes to the Secretary's satisfaction that: 1) when compared to the amount of money that would have been paid to cover only the children involved with a comparable package, the purchase of family coverage is cost effective; and 2) the purchase of family coverage is not a substitution for coverage already being provided to the child. (Section 2105(c)(3)) (42CFR, 457.1010)

6.4.2. **Purchase of Family Coverage-** Describe the plan to purchase family coverage. Payment may be made to a State for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: (Section 2105(c)(3)) (42CFR 457.1010)

6.4.2.1. Purchase of family coverage is cost-effective. The State's cost of purchasing family coverage, including administrative expenditures, that includes coverage for the targeted low-income children involved or the family involved (as applicable) under premium assistance programs must not be greater than the cost of obtaining coverage under the State plan for all eligible targeted low-income children or families involved; and (2) The State may base its demonstration of cost effectiveness on an assessment of the cost of coverage, including administrative costs, for children or families under premium assistance programs to the cost of other CHIP coverage for these children or families, done on a case-by-case basis, or on the cost of premium assisted coverage in the aggregate.

6.4.2.2. The State assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. (Section 2105(c)(3)(B)) (42CFR 457.1010(b))

6.4.2.3. The State assures that the coverage for the family otherwise meets title XXI requirements. (42CFR 457.1010(c))

6.4.3-PA: Additional State Options for Providing Premium Assistance (CHIPRA # 13, SHO # 10-002 issued February, 2, 2010) A State may elect to offer a premium assistance subsidy for qualified employer-sponsored coverage, as defined in Section 2105(c)(10)(B), to all targeted low-income children who are eligible for child health assistance under the plan and have access to such coverage. No subsidy shall be provided to a targeted low-income child (or the child's parent) unless the child voluntarily elects to receive such a subsidy. (Section 2105(c)(10)(A)). Please remember to update section 9.10 when electing this option. Does the State provide this option to targeted low-income children?

Yes
 No

6.4.3.1-PA Qualified Employer-Sponsored Coverage and Premium Assistance Subsidy

6.4.3.1.1-PA Provide an assurance that the qualified employer-sponsored insurance meets the definition of qualified employer-sponsored coverage as defined in Section 2105(c)(10)(B), and that the premium assistance subsidy meets the definition of premium assistance subsidy as defined in 2105(c)(10)(C).

6.4.3.1.2-PA Describe whether the State is providing the premium assistance subsidy as reimbursement to an employee or for out-of-pocket expenditures or directly to the employee's employer.

6.4.3.2-PA: Supplemental Coverage for Benefits and Cost Sharing Protections Provided under the Child Health Plan.

6.4.3.2.1-PA If the State is providing premium assistance for qualified employer-sponsored coverage, as defined in Section 2105(c)(10)(E)(i), provide an assurance that the State is providing for each targeted low-income child enrolled in such coverage, supplemental coverage consisting of all items or services that are not covered or are only partially covered, under the qualified employer-sponsored coverage consistent with 2103(a) and cost sharing protections consistent with Section 2103(e).

6.4.3.2.2-PA Describe whether these benefits are being provided through the employer or by the State providing wraparound benefits.

6.4.3.2.3-PA If the State is providing premium assistance for benchmark or benchmark-equivalent coverage, the State ensures that such group health plans or health insurance coverage offered through an employer will be certified by an actuary as coverage that is equivalent to a benchmark benefit package described in Section 2103(b) or benchmark equivalent coverage that meets the requirements of Section 2103(a)(2).

6.4.3.3-PA: Application of Waiting Period Imposed Under State Plan: States are required to apply the same waiting period to premium assistance as is applied to direct coverage for children under their CHIP State plan, as specified in Section 2105(c)(10)(F).

6.4.3.3.1-PA Provide an assurance that the waiting period for children in premium assistance is the same as for those children in direct coverage (if State has a waiting period in place for children in direct CHIP coverage).

6.4.3.4-PA: Opt-Out and Outreach, Education, and Enrollment Assistance

6.4.3.4.1-PA Describe the State's process for ensuring parents are permitted to disenroll their child from qualified employer-sponsored coverage and to enroll in CHIP effective on the first day of any month for which the child is eligible for such assistance and in a manner that ensures continuity of coverage for the child (Section 2105(c)(10)(G)).

6.4.3.4.2-PA Describe the State’s outreach, education, and enrollment efforts related to premium assistance programs, as required under Section 2102(c)(3). How does the State inform families of the availability of premium assistance, and assist them in obtaining such subsidies? What are the specific significant resources the State intends to apply to educate employers about the availability of premium assistance subsidies under the State child health plan? (Section 2102(c))

6.4.3.5-PA: Purchasing Pool- A State may establish an employer-family premium assistance purchasing pool and may provide a premium assistance subsidy for enrollment in coverage made available through this pool (Section 2105(c)(10)(I)). Does the State provide this option?

- Yes
 No

6.6.3.5.1-PA Describe the plan to establish an employer-family premium assistance purchasing pool.

6.6.3.5.2-PA Provide an assurance that employers who are eligible to participate: 1) have less than 250 employees; 2) have at least one employee who is a pregnant woman eligible for CHIP or a member of a family that has at least one child eligible under the State’s CHIP plan.

6.6.3.5.3-PA Provide an assurance that the State will not claim for any administrative expenditures attributable to the establishment or operation of such a pool except to the extent such payment would otherwise be permitted under this title.

6.4.3.6-PA Notice of Availability of Premium Assistance- Describe the procedures that assure that if a State provides premium assistance subsidies under this Section, it must: 1) provide as part of the application and enrollment process, information describing the availability of premium assistance and how to elect to obtain a subsidy; and 2) establish other procedures to ensure that parents are fully informed of the choices for child health assistance or through the receipt of premium assistance subsidies (Section 2105(c)(10)(K)).

6.4.3.6.1-PA Provide an assurance that the State includes information about premium assistance on the CHIP application or enrollment form.

Section 7. Quality and Appropriateness of Care

Guidance: Methods for Evaluating and Monitoring Quality- Methods to assure quality include the application of performance measures, quality standards consumer information strategies, and other quality improvement strategies.

Performance measurement strategies could include using measurements for external reporting either to the State or to consumers and for internal quality improvement purposes. They could be based on existing measurement sets that have undergone

rigorous evaluation for their appropriateness (e.g., HEDIS). They may include the use of standardized member satisfaction surveys (e.g., CAHPS) to assess members' experience of care along key dimensions such as access, satisfaction, and system performance.

Quality standards are often used to assure the presence of structural and process measures that promote quality and could include such approaches as: the use of external and periodic review of health plans by groups such as the National Committee for Quality Assurance; the establishment of standards related to consumer protection and quality such as those developed by the National Association of Insurance Commissioners; and the formation of an advisory group to the State or plan to facilitate consumer and community participation in the plan.

Information strategies could include: the disclosure of information to beneficiaries about their benefits under the plan and their rights and responsibilities; the provision of comparative information to consumers on the performance of available health plans and providers; and consumer education strategies on how to access and effectively use health insurance coverage to maximize quality of care.

Quality improvement strategies should include the establishment of quantified quality improvement goals for the plan or the State and provider education. Other strategies include specific purchasing specifications, ongoing contract monitoring mechanisms, focus groups, etc.

Where States use managed care organizations to deliver CHIP care, recent legal changes require the State to use managed care quality standards and quality strategies similar to those used in Medicaid managed care.

Tools for Evaluating and Monitoring Quality- Tools and types of information available include, HEDIS (Health Employer Data Information Set) measures, CAHPS (Consumer Assessments of Health Plans Study) measures, vital statistics data, and State health registries (e.g., immunization registries).

Quality monitoring may be done by external quality review organizations, or, if the State wishes, internally by a State board or agency independent of the State CHIP Agency. Establishing grievance measures is also an important aspect of monitoring.

- Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan, and continue on to Section 8.

Guidance: The State must specify the qualifications of entities that will provide coverage and the conditions of participation. States should also define the quality standard they are using, for example, NCQA Standards or other professional standards. Any description of the

information strategies used should be linked to Section 9. (Section 2102(a)(7)(A)) (42CFR, 457.495)

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. (Section 2102(a)(7)(A)) (42CFR 457.495(a)) Will the State utilize any of the following tools to assure quality? (Check all that apply and describe the activities for any categories utilized.)

- 7.1.1. Quality standards
- 7.1.2. Performance measurement
 - 7.1.2 (a) CHIPRA Quality Core Set
 - 7.1.2 (b) Other
- 7.1.3. Information strategies
- 7.1.4. Quality improvement strategies

DPHHS uses HEDIS performance measurements to evaluate care effectiveness for enrollees.

HMK *Plus* and HMK management staff are interested in assuring both programs adhere to continuity and comparability between the measures used. HMK *Plus* currently uses HEDIS measures for its Primary Care Case Management Program (PASSPORT). The contract with the TPA Contractor requires them to collect and report HEDIS data and utilization reports.

DPHHS uses performance measures, HEDIS, utilization and complaint data to evaluate the TPA Contractor's performance.

Consumer education tools ensure enrollees have adequate information regarding eligibility and enrollment. DPHHS staff approves the member handbook to assure that benefit, provider network, and complaint procedures are communicated effectively. Other consumer education materials are developed as part of DPHHS's quality assurance program and based on performance measures' results.

Guidance: Provide a brief description of methods to be used to assure access to covered services, including a description of how the State will assure the quality and appropriateness of the care provided. The State should consider whether there are sufficient providers of care for the newly enrolled populations and whether there is reasonable access to care. (Section 2102(a)(7)(B))

7.2. Describe the methods used, including monitoring, to assure: (Section 2102(a)(7)(B)) (42CFR 457.495)

7.2.1 Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. (Section 2102(a)(7)) (42CFR 457.495(a))

DPHHS staff monitors the HEDIS reports to evaluate and assure access to preventive care.

7.2.2 Access to covered services, including emergency services as defined in 42 CFR 457.10. (Section 2102(a)(7)) 42CFR 457.495(b))

Access Assurance for Care Delivered through Insurers and the CHIP Provider Network:

Access to services is measured by evaluating and monitoring the adequacy of provider networks and by analyzing the results of complaint data and performance measures. Provider network analysis looks at the number and types of physicians, hospitals and allied health providers of health care for children, their locations, and their hours. The TPA contractor is required to produce a provider network access plan. DPHHS staff evaluates this network as described in Section 3.1. DPHHS staff also annually evaluates access-related performance measures such as access-related complaints and access to primary care physicians (HEDIS).

The TPA contractor submits information each month about the number, type and geographic distribution of network providers. This information is posted on the program's website.

Emergency Services Access:

The contract with the TPA Contractor specifies prior authorization for emergency medical conditions is not required. An emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- placing the health of the child (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
- serious impairment to bodily functions, or
- serious dysfunction of any bodily organ or part.

Access to emergency services is monitored by analysis of complaint data and utilization data.

7.2.3 Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to

specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. (Section 2102(a)(7)) (42CFR 457.495(c))

The DPHHS contract with the TPA contractor requires medically appropriate second opinions, which may include major diagnoses or courses of treatment, as a covered benefit. The TPA Contractor is also required to have a system to assure prompt referrals for medically necessary, specialty, secondary, and tertiary care.

- 7.2.4** Decisions related to the prior authorization of health services are completed in accordance with State law or, in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. (Section 2102(a)(7)) (42CFR 457.495(d)) Exigent medical circumstances may require more rapid response according to the medical needs of the patient.

Decisions related to the prior authorization of health services are completed in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. The TPA Contractor aims for a turnaround time of five (5) days.

No prior authorization is required for most dental services. The one exception is for dental implants. Member must meet the implant criteria outlined in the Montana State Employees Benefit Plan which is in attachment C. Turnaround time for prior authorization is less than a week

Section 8. Cost-Sharing and Payment

Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan, and continue on to Section 9.

- 8.1.** Is cost-sharing imposed on any of the children covered under the plan? (42CFR 457.505) Indicate if this also applies for pregnant women. (CHIPRA #2, SHO # 09-006, issued May 11, 2009)

- 8.1.1.** Yes
8.1.2. No, skip to question 8.8.
- 8.1.1-PW** Yes
8.1.2-PW No, skip to question 8.8.

Guidance: It is important to note that for families below 150% of poverty, the same limitations on cost sharing that are under the Medicaid program apply. (These cost-sharing limitations have been set forth in Section 1916 of the Social Security Act, as implemented by regulations at 42 CFR 447.50-.59). For families with incomes of 150% of poverty and

above, cost sharing for all children in the family cannot exceed 5% of a family's income per year. Include a statement that no cost sharing will be charged for pregnancy-related services. (CHIPRA #2, SHO # 09-006, issued May 11, 2009) (Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(c))

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge by age and income (if applicable) and the service for which the charge is imposed or time period for the charge, as appropriate. (Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(c))

8.2.1. Premiums: NONE

8.2.2. Deductibles: NONE

8.2.3. Coinsurance or copayments:

Copayments:

- A. No copayment is assessed for families with household incomes equal to or less than 100% of the federal poverty level.
- B. No copayment is assessed for families with at least one enrollee who is a Native American or Native Alaskan.
- C. Copayments do not exceed the maximum allowable cost-sharing charges in accordance with 42 CFR Part 457.555.
- D. Copayments for inpatient hospital services are in accordance with 42 CFR 457.555 (b)
- E. For families with household incomes above 100% of the federal poverty level, the following copayments will apply:

Benefit	Copayment
Inpatient hospital services (includes hospitalization for physical, mental and substance abuse reasons)	\$25 per visit
Emergency room visit	\$5 per visit
Outpatient hospital visit (includes outpatient treatment for physical, mental, and substance abuse reasons. Excludes outpatient visits for X-ray or laboratory services only)	\$5 per visit
Physician, mid-level practitioner, advanced-practice registered nurse, optometrist, audiologist, mental health professional, or substance abuse counselor services (excludes dental, pathology, radiology, or anesthesiology services)	\$3 per visit
Outpatient prescription drugs	No Copayment
No copayment applies to well-baby or well-child care, including age-appropriate immunizations.	

Copayments are capped at \$215 per family per benefit year (October 1 – September 30) for families with incomes up to 261% FPL. When the \$215 maximum copayment has been met, the TPA contractor issues new member cards indicating no copayment is required for the remainder of the benefit year.

8.2.4. Other: NONE

8.2-DS **Supplemental Dental** (CHIPRA # 7, SHO # #09-012 issued October 7, 2009) For children enrolled in the dental-only supplemental coverage, describe the amount of cost-sharing, specifying any sliding scale based on income. Also describe how the State will track that the cost sharing does not exceed 5 percent of gross family income. The 5 percent of income calculation shall include all cost-sharing for health insurance and dental insurance (Section 2103(e)(1)(A)) (42 CFR 457.505(a), 457.510(b), and (c), 457.515(a) and (c), and 457.560(a)) Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, 6.2-DS, and 9.10 when electing this option.

8.2.1-DS Premiums:

8.2.2-DS Deductibles:

8.2.3-DS Coinsurance or copayments:

8.2.4-DS Other:

8.3 Describe how the public will be notified, including the public schedule, of this cost sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. (Section 2103(e)(1)(A)) (42CFR 457.505(b))

A description of cost sharing (including the cumulative maximum) is contained in the outreach and educational materials which are distributed to the general public. This information is contained in the Member Handbook which is updated and distributed to all members annually. The copayment requirement, if applicable, is indicated on the ID cards families receive from the TPA Contractor. If a member's copayment requirement changes, the TPA contractor issues a new ID card which reflects the change.

DPHHS informs enrollees, applicants, providers and the general public of changes to cost sharing by revisions to the above-mentioned documents and revision of the Administrative Rules of Montana (ARM).

Prior public notice of proposed copayment changes is provided in a form and manner provided under applicable State law. Public notice is published prior to the requested effective date of the change.

Guidance: The State should be able to demonstrate upon request its rationale and justification

regarding these assurances. This section also addresses limitations on payments for certain expenditures and requirements for maintenance of effort.

8.4 The State assures that it has made the following findings with respect to the cost sharing in its plan: (Section 2103(e))

8.4.1. Cost-sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B)) (42CFR 457.530)

8.4.2. No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2)) (42CFR 457.520)

8.4.3 No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. (Section 2103(e)(1)(A)) (42CFR 457.515(f))

8.4.1- MHPAEA There is no separate accumulation of cumulative financial requirements, as defined in 42 CFR 457.496(a), for mental health and substance abuse disorder benefits compared to medical/surgical benefits. (42 CFR 457.496(d)(3)(iii))

8.4.2- MHPAEA If applicable, any different levels of financial requirements that are applied to different tiers of prescription drugs are determined based on reasonable factors, regardless of whether a drug is generally prescribed for medical/surgical benefits or mental health/substance use disorder benefits. (42 CFR 457.496(d)(3)(ii)(A))

There is no cost sharing for the pharmacy benefit.

8.4.3- MHPAEA Cost sharing applied to benefits provided under the State child health plan will remain capped at five percent of the beneficiary's income as required by 42 CFR 457.560 (42 CFR 457.496(d)(3)(i)(D)).

8.4.4- MHPAEA Does the State apply financial requirements to any mental health or substance use disorder benefits? If yes, specify the classification(s) of benefits in which the State applies financial requirements on any mental health or substance use disorder benefits.

Yes (Specify: Cost sharing is applied to all outpatient psychotherapy, therapies, and for each inpatient hospitalization, but not for extended mental health services.)

No

Guidance: For the purposes of parity, financial requirements include deductibles, copayments, coinsurance, and out of pocket maximums; premiums are excluded from the definition. If the state does not apply financial requirements on any mental health or substance use disorder benefits, the state meets parity requirements for financial requirements. If the state does apply financial requirements to mental health or substance use disorder benefits, the state must conduct a parity analysis. Please continue below.

Please ensure that changes made to financial requirements under the State child health plan as a result of the parity analysis are also made in Section 8.2.

8.4.5- MHPAEA Does the State apply any type of financial requirements on any medical/surgical benefits?

Yes Cost sharing is applied to 100% of office visits and therapy visits and for each inpatient hospitalization.

No

Guidance: If the State does not apply financial requirements on any medical/surgical benefits, the State may not impose financial requirements on mental health or substance use disorder benefits.

8.4.6- MHPAEA Within each classification of benefits in which the State applies a type of financial requirement on any mental health or substance use disorder benefits, the State must determine the portion of medical and surgical benefits in the class which are subject to the limitation.

The State assures it has applied a reasonable methodology to determine the dollar amounts used in the ratio described above (Section 6.2.5.2-MHPAEA) for each classification or within which the State applies financial requirements to mental health or substance use disorder benefits. (42 CFR 457.496(d)(3)(i)(E))

Guidance: Please include the state's methodology and results of the parity analysis as an attachment to the State child health plan.

8.4.7- MHPAEA For each type of financial requirement applied to any mental health or substance use disorder benefits within a given classification, does the State apply the same type of financial requirement to at least two-thirds ("substantially all") of all the medical/surgical benefits within the same classification? (42 CFR 457.496(d)(3)(i)(A))

Yes

No

Guidance: If the State does not apply a type of financial requirement to substantially all medical/surgical benefits in a given classification of benefits, the State may not impose financial requirements on mental health or substance use disorder benefits in that classification. (42 CFR 457.496(d)(3)(i)(A))

8.4.8- MHPAEA For each type of financial requirement applied to substantially all medical/surgical benefits in a classification, the State must determine the predominant level (as defined in 42 CFR 457.496(d)(3)(i)(B)) of that type which is applied to medical/surgical benefits in the classification. For each type of financial requirement applied to substantially all medical/surgical benefits in a classification, the State assures:

The same reasonable methodology applied in determining the dollar amounts used in determining whether substantially all medical/surgical benefits within a classification are subject to a type of financial requirement also is applied in determining the dollar amounts used to determine the predominant level of a type of financial requirement applied to medical/surgical benefits within a classification. (42 CFR 457.496(d)(3)(i)(E))

The level of each type of financial requirement applied by the State to mental health or substance use disorder benefits in any classification is no more restrictive than the predominant level of that type which is applied by the State to medical/surgical benefits within the same classification. (42 CFR 457.496(d)(2)(i))

Guidance: If there is no single level of a type of financial requirement that exceeds the one-half threshold, the State may combine levels within a type of financial requirement such that the combined levels are applied to at least half of all medical/surgical benefits within a classification; the predominant level is the least restrictive level of the levels combined to meet the one-half threshold. (42 CFR 457.496(d)(3)(i)(B)(2))

8.5 Describe how the State will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the State for overpayment by an enrollee: (Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))

Enrollees in the HMK coverage group have copayments if their family income is greater than 100% of FPL. The insurance card each child receives from the TPA Contractor indicates whether or not a child has a copayment when services are used. The TPA Contractor tracks the copayments charged to the family. When the \$215 annual family maximum is reached, the TPA Contractor sends the family a letter indicating that the maximum copayment has been met and a copayment is not required for the remainder of the benefit year. The TPA contractor issues new ID cards which indicate no copayment is required for the remainder of the benefit year. Enrollment materials notify families how to recoup any excess copayments they have paid. Families charged more than \$215 in copayments must submit copayment receipts to DPHHS in order to be reimbursed for copayments they paid above the maximum. DPHHS reimburses the family for any copayment paid above the \$215 maximum payment.

Enrollees in the HMK *Plus* coverage group do not have a copayment requirement.

- 8.6** Describe the procedures the State will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. (Section 2103(b)(3)(D)) (42CFR 457.535)

The DPHHS contract with the TPA Contractor requires that families with Native American or Alaska Native children have no copayment for services. ID cards for these children state that copayments are not required.

No enrollees in the HMK *Plus* coverage group, regardless of race, have a copayment requirement.

- 8.7** Provide a description of the consequences for an enrollee or applicant who does not pay a charge. (42CFR 457.570 and 457.505(c))

Guidance: Section 8.8.1 is based on Section 2101(a) of the Act provides that the purpose of title XXI is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children.

- 8.7.1** Provide an assurance that the following disenrollment protections are being applied:

Guidance: Provide a description below of the State's premium grace period process and how the State notifies families of their rights and responsibilities with respect to payment of premiums. (42CFR 457.570(a))

- State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment.

Not Applicable – Enrollees are not disenrolled for non-payment for cost sharing charges.

- The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non-payment of cost-sharing charges. (42CFR 457.570(b))

Not Applicable – Enrollees are not disenrolled for non-payment for cost sharing charges.

- In the instance mentioned above, that the State will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. (42CFR 457.570(b))

Not Applicable – Enrollees are not disenrolled for non-payment for cost sharing charges.

- The State provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42CFR 457.570(c))

Enrollees are not disenrolled for non-payment for cost sharing charges.

A Fair Hearing is granted to any enrollee or guardian when an adverse action results in disenrollment. (refer to Section 12.1 for additional detail.)

- 8.8.** The State assures that it has made the following findings with respect to the payment aspects of its plan: (Section 2103(e))

- 8.8.1.** No Federal funds will be used toward State matching requirements. (Section 2105(c)(4)) (42CFR 457.220)
- 8.8.2.** No cost-sharing (including premiums, deductibles, copayments, coinsurance and all other types) will be used toward State matching requirements. (Section 2105(c)(5) (42CFR 457.224) (Previously 8.4.5)
- 8.8.3.** No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. (Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))
- 8.8.4.** Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1)) (42CFR 457.622(b)(5))
- 8.8.5.** No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105(c)(7)(B)) (42CFR 457.475)
- 8.8.6.** No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). (Section 2105(c)(7)(A)) (42CFR 457.475)

Section 9. Strategic Objectives and Performance Goals and Plan Administration

Guidance: States should consider aligning its strategic objectives with those discussed in Section II of the CHIP Annual Report.

- 9.1.** Describe strategic objectives for increasing the extent of creditable health coverage among

targeted low-income children and other low-income children: (Section 2107(a)(2)) (42CFR 457.710(b))

DPHHS's strategic objectives are to:

1. Improve the health status of children with a focus on preventive and early primary care treatment.
2. Increase the number of children who are enrolled in the Healthy Montana Kids Plan.
3. Prevent "crowd out" of employer coverage.
4. Coordinate and consolidate with other health care programs providing services to children to create a seamless health care delivery system for low-income children.

Guidance: Goals should be measurable, quantifiable and convey a target the State is working towards.

9.2. Specify one or more performance goals for each strategic objective identified: (Section 2107(a)(3)) (42CFR 457.710(c))

1. Improve health status of children with a focus on preventive and early primary care treatment.
Performance goal: 96% of children 12-24 months of age will receive preventive or primary care treatment each year.
2. Increase the number of children who are enrolled in the Healthy Montana Kids Plan.
Performance goal: Enroll 29,000 additional children in the Healthy Montana Kids Plan.
3. Prevent "crowd-out" of employer coverage.
Performance Goal: Maintain the proportion of children \leq 261% of federal poverty who are covered under an employer-based plan taking into account decrease due to health care costs or a downturn in the economy.
4. Coordinate and consolidate with other health care programs providing services to children to create a seamless health care delivery system for low-income children.
Performance Goal: Coordinate with the Title V Children's Special Health Services program to ensure 95% of eligible children who need care beyond what is offered under HMK coverage group are referred to these programs.

Guidance: The State should include data sources to be used to assess each performance goal. In addition, check all appropriate measures from 9.3.1 to 9.3.8 that the State will be utilizing to measure performance, even if doing so duplicates what the State has already discussed in Section 9.

It is acceptable for the State to include performance measures for population subgroups chosen by the State for special emphasis, such as racial or ethnic minorities, particular

high-risk or hard to reach populations, children with special needs, etc.

HEDIS (Health Employer Data and Information Set) 2008 contains performance measures relevant to children and adolescents younger than 19. In addition, HEDIS 3.0 contains measures for the general population, for which breakouts by children's age bands (e.g., ages < 1, 1-9, 10-19) are required. Full definitions, explanations of data sources, and other important guidance on the use of HEDIS measures can be found in the HEDIS 2008 manual published by the National Committee on Quality Assurance. So that State HEDIS results are consistent and comparable with national and regional data, states should check the HEDIS 2008 manual for detailed definitions of each measure, including definitions of the numerator and denominator to be used. For states that do not plan to offer managed care plans, HEDIS measures may also be able to be adapted to organizations of care other than managed care.

- 9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the State's performance, taking into account suggested performance indicators as specified below or other indicators the State develops: (Section 2107(a)(4)(A),(B)) (42CFR 457.710(d))

Objective One: Improve health status of children with a focus on preventive and early primary treatment:

The TPA Contractor is required to collect and report HEDIS data and utilization data. The Department of Public Health and Human Services will use this data to measure success of the plan in establishing baseline data and reaching the performance goals regarding immunization and well-child care.

DPHHS conducts an Enrollee Satisfaction Survey. Surveys are mailed to randomly selected current enrollees. The purpose of the survey is to assess enrollees' satisfaction with the program. The survey measures enrollees' perception of services received from providers and program staff. In addition, it measures the use and effectiveness of program materials.

Objective Two: Decrease the proportion of children in Montana who are uninsured and reduce financial barriers to affordable health care coverage:

Performance goals under this objective are measured based on the decrease in the number of uninsured children in families with incomes $\leq 261\%$ of the federal poverty level compared with the number uninsured before the State Plan's effective date. First, baseline numbers of uninsured children will be calculated from a three-year average of the 2005, 2006, and 2007 March supplement to the Current Population Survey produced by the Bureau of the Census. New estimates of uninsured children will be calculated as more current data become available and will be used to compare trends from year to year.

Objective Three: Prevent "crowd-out" of employer coverage:

Performance goals under this objective will be measured based on the proportion of children at

or below 261% of federal poverty who are covered under an employer based plan taking into account decreases due to increases in health care costs or a downturn in the economy. The proportion of children covered under the employer-based plan will be evaluated, and analysis will be conducted to test for evidence of “crowd-out”. The baseline for comparison will be obtained from a 3 year average of the 2005, 2006, and 2007 March Current Population Survey.

In addition, the eligibility determination process includes questions relating to parents’ access to and coverage by health insurance. This allows the state to track the number of children who have access to employer-based coverage, monitor that children enrolling in the program are not dropping affordable employment based coverage, and/or apply a three month insurance delay wait period if the children do not meet one of the state’s exceptions.

Objective Four: Coordinate and consolidate with other health care programs providing services to children to create a seamless health care delivery system for low-income children:

Performance goals under this objective are based on the enrollment of children receiving care through the Children’s Mental Health Services Plan, HMK *Plus*, Health Insurance for Montana University System Dependent Care Premium Waiver Program, and Insure Montana. DPHHS staff provides information about Community Health Centers, Urban Indian Clinics, Migrant Health Clinics, National Health Service Corps sites and Montana Youth Care. DPHHS staff makes referrals to Children’s Special Health Services, and other health care programs for children.

The Healthy Montana Kids Plan (HMK) will create a seamless health care delivery system for CHIP-funded and Medicaid-funded services provided by the Healthy Montana Kids Plan. The new computerized eligibility determination system for DPHHS health and social service programs will assist the department to meet this objective.

Objective Five: Increase the enrollment of currently eligible, but not participating, children in HMK *Plus*:

Extensive outreach efforts including Community Enrollment Partners will be implemented to increase enrollment of currently eligible, but un-enrolled children.

Check the applicable suggested performance measurements listed below that the State plans to use: (Section 2107(a)(4))

- 9.3.1. The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.
- 9.3.2. The reduction in the percentage of uninsured children.
- 9.3.3. The increase in the percentage of children with a usual source of care.
- 9.3.4. The extent to which outcome measures show progress on one or more of the health problems identified by the state.
- 9.3.5. HEDIS Measurement Set relevant to children and adolescents younger than 19.
- 9.3.6. Other child appropriate measurement set. List or describe the set used.
- 9.3.7. If not utilizing the entire HEDIS Measurement Set, specify which measures will

be collected, such as:

- 9.3.7.1. Immunizations
- 9.3.7.2. Well child care
- 9.3.7.3. Adolescent well visits
- 9.3.7.4. Satisfaction with care
- 9.3.7.5. Mental health
- 9.3.7.6. Dental care
- 9.3.7.7. Other, list:

Children's access to primary care providers

9.3.8. Performance measures for special targeted populations.

9.4. The State assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. (Section 2107(b)(1)) (42CFR 457.720)

Guidance: The State should include an assurance of compliance with the annual reporting requirements, including an assessment of reducing the number of low-income uninsured children. The State should also discuss any annual activities to be undertaken that relate to assessment and evaluation of the program.

9.5. The State assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the State's plan for these annual assessments and reports. (Section 2107(b)(2)) (42CFR 457.750)

DPHHS completes the annual assessments and evaluations required in Section 2108(a). The Annual Report includes an assessment of the operation of the program and its progress toward meeting its strategic objectives and performance goals.

DPHHS completes and submits quarterly statistical reports through the SCHIP Statistical Enrollment Data System (SEDS). These statistics of unduplicated ever-enrolled children is reported by gender, race and ethnicity.

9.6. The State assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. (Section 2107(b)(3)) (42CFR 457.720)

Guidance: The State should verify that they will participate in the collection and evaluation of data as new measures are developed or existing measures are revised as deemed necessary by CMS, the states, advocates, and other interested parties.

9.7. The State assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. (42CFR 457.710(e))

9.8. The State assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a State under Title XIX: (Section 2107(e)) (42CFR 457.135)

9.8.1. Section 1902(a)(4)(C) (relating to conflict of interest standards)

9.8.2. Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)

9.8.3. Section 1903(w) (relating to limitations on provider donations and taxes)

9.8.4. Section 1132 (relating to periods within which claims must be filed)

Guidance: Section 9.9 can include discussion of community-based providers and consumer representatives in the design and implementation of the plan and the method for ensuring ongoing public involvement. Issues to address include a listing of public meetings or announcements made to the public concerning the development of the children's health insurance program or public forums used to discuss changes to the State plan.

9.9. Describe the process used by the State to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. (Section 2107(c)) (42CFR 457.120(a) and (b))

Since implementation, DPHHS advisory councils have provided important advice, comments, and recommendations.

The department revised the HMK state rules in accordance with the Montana Administrative Rules process. This process includes letters to interested parties, a public comment period and public hearing. When DPHHS proposes changes to the Administrative Rules of Montana notice is given and a public hearing is scheduled to allow interested parties to comment and provide input.

In November, 2008, a citizens' initiative, Montana Initiative I-155, Healthy Montana Kids Plan Act, was approved by 70% of all voters. The HMK Plan Act increased the income eligibility guideline for HMK (formerly known as CHIP) enrollees to 250% of the FPL. Included in HMK Plan Act was the elimination of the Medicaid asset test for children. The department also implemented a CHIP-funded/Medicaid Expansion Program for children ages 6-18 years of age whose family incomes were at or below 133% of the FPL.

Other provisions in the Healthy Montana Kids Act included the following:

- Enrollment Partners
- Increase the "insurance delay period" from one month to three months

- Coordinate enrollment and application for CHIP-funded and Medicaid-funded benefits
- Presumptive eligibility
- Premium assistance
- Assistance to employers to implement Premium Only Health Benefit Plans (“Section 125 Plans”)

Legislative Input:

- During the 2009 legislative session, the legislature appropriated State Special Revenue funds as the state match for the HMK initiative described above.
- DPHHS provides quarterly program updates to legislative interim committees.

In January, 2014, Montana implemented the Affordable Care (ACA) Act standards that increased the income eligibility guideline for HMK to 261% of the FPL. The incomes guidelines for the CHIP-funded Medicaid expansion for children ages 6-18 years of age are above 109% and up to and including 143% of the FPL.

Meetings with Interested Parties:

DPHHS staff meets with other statewide association advisory boards and interested parties, including: Montana Hospital Association, Primary Care Association, Health Advisory Council, Public Health Association, Family Planning State Council, Montana Council for Maternal and Child Health, Montana Children’s Alliance, Children’s Committee of the Mental Health Association, Head Start, Public Health and School Nurses, Governor’s Council on Children and Families, the Montana Association of Counties, Human Services Committee, Montana People’s Action, Working for Equality and Economic Liberation, Montana Migrant Council, and the Native American Advisory Council. At the request of several organizations, a program update is provided at each meeting, allowing time for questions, comments, and problem solving.

- 9.9.1** Describe the process used by the State to ensure interaction with Indian Tribes and organizations in the State on the development and implementation of the procedures required in 42 CFR 457.125. States should provide notice and consultation with Tribes on proposed pregnant women expansions. (Section 2107(c)) (42CFR 457.120(c))

DPHHS works directly with tribes, the Indian Health Service, Tribal Health Services, Bureau of Indian Affairs, Urban Indian Clinics and the Governor’s Native American Advisory Council to inform Native Americans in Montana about the program. DPHHS staff provides annual updates and training at each of the seven Montana reservations and five Urban Indian clinics. In addition, DPHHS staff participates in the annual CMS/IHS Medicare, Medicaid and CHIP training.

DPHHS staff presented a web-based seminar to Tribal Council Chairpersons, IHS and

Tribal Health Directors, Urban Indian Clinic Directors and IHS administrators regarding the Healthy Montana Kids Plan. The department invited comment from all Tribal Chairpersons and Presidents, Tribal Health Directors, IHS Directors and Urban Center Directors regarding the HMK State Plan amendments. The department provided a draft of State Plan Amendments number 7 and number 8 on the department's website.

- 9.9.2** For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), describe how and when prior public notice was provided as required in 42 CFR457.65(b) through (d).

Prior public notice of proposed changes is provided in a form and manner provided under applicable State law. Public notice will be published prior to the requested effective date of the change.

- 9.9.3** Describe the State's interaction, consultation, and coordination with any Indian tribes and organizations in the State regarding implementation of the Express Lane eligibility option.

- 9.10** Provide a 1-year projected budget. A suggested financial form for the budget is below. The budget must describe: (Section 2107(d)) (42CFR 457.140)

- Planned use of funds, including:
 - Projected amount to be spent on health services;
 - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
 - Assumptions on which the budget is based, including cost per child and expected enrollment.
 - Projected expenditures for the separate child health plan, including but not limited to expenditures for targeted low income children, the optional coverage of the unborn, lawfully residing eligibles, dental services, etc.
 - All cost sharing, benefit, payment, and eligibility need to be reflected in the budget.
- Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.
- Include a separate budget line to indicate the cost of providing coverage to pregnant women.
- States must include a separate budget line item to indicate the cost of providing coverage to premium assistance children.
- Include a separate budget line to indicate the cost of providing dental-only supplemental coverage.
- Include a separate budget line to indicate the cost of implementing Express Lane

Eligibility.

- Provide a 1-year projected budget for all targeted low-income children covered under the state plan using the attached form. Additionally, provide the following:
 - Total 1-year cost of adding prenatal coverage
 - Estimate of unborn children covered in year 1

CHIP Budget

STATE:	FFY Budget
Federal Fiscal Year 2018	
State's enhanced FMAP rate	98.77%
Benefit Costs	
Insurance payments	
Managed care	0
per member/per month rate	
Fee for Service	95,149,093
Health Services Initiatives	
Cost of Proposed SPA changes	917,062
Total Benefit Costs	96,066,155
(Offsetting beneficiary cost sharing payments)	0
Net Benefit Costs	96,066,155
Administration Costs	
Personnel	246,894
General administration	3,622
Contractors/Brokers	0
Claims Processing	1,684,650
Outreach/marketing costs	0
Other (e.g., indirect costs)	3,515,275
Total Administration Costs	5,450,441
10% Administrative Cap	10,674,017
Federal Share	100,267,942
State Share	1,248,654
Total Costs of Approved CHIP Plan	101,516,596
NOTE: Include the costs associated with the current SPA.	
The Source of State Share Funds: General Fund and State Special Revenue Funds (see Funding, below)	

Budget Assumptions

Benefits

Montana contracts with Blue Cross Blue Shield of Montana (BCBSMT) for third party administrative services (TPA) for medical benefits. The department provides eyeglasses, dental services, pharmacy benefits and community based psychiatric rehabilitation and support (CBPRS) services on a fee for service basis. Reimbursement is made through the Medicaid Management Information System (MMIS).

The estimated monthly enrollment is 28,078 for FY2018. The cost per member per month includes the separate CHIP program and the CHIP-funded Medicaid Expansion Program. The projected benefit cost is \$282.40/month.

Administration

Department staff is responsible for program management including assessment, policies and procedures development, department and community programs' coordination, budgeting, eligibility determination, enrollment, contract monitoring, outreach and oversight.

Claims are paid on a fee for service (FFS) basis through a third party administrative (TPA) contract. There was no change in cost-sharing.

Funding

General fund and State Special Revenue Funds are used as the non-Federal share of plan expenditures. These funds are appropriated by the legislature for the program.

Montana's State Legislature gave the Department of Public Health and Human Services authority to match federal dollars with private donations. Montana will, upon CMS approval, use private donations when available. Background information on donors will be submitted to CMS, as required, prior to the expenditure of donated funds. Montana ensures that donations used as matching funds adhere to requirements stated in 42 CFR Subpart B (433.51 – 433.74).

Section 10. Annual Reports and Evaluations

Guidance: The National Academy for State Health Policy (NASHP), CMS and the states developed framework for the annual report that states have the option to use to complete the required evaluation report. The framework recognizes the diversity in State approaches to implementing CHIP and provides consistency across states in the structure, content, and format of the evaluation report. Use of the framework and submission of this information will allow comparisons to be made between states and on a nationwide basis. The framework for the annual report can be obtained from NASHP's website at <http://www.nashp.org>. Per the title XXI statute at Section 2108(a), states must submit reports by January 1st to be compliant with requirements.

10.1. Annual Reports. The State assures that it will assess the operation of the State plan under this Title in each fiscal year, including: (Section 2108(a)(1),(2)) (42CFR 457.750)

10.1.1. The progress made in reducing the number of uninsured low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

10.2. The State assures it will comply with future reporting requirements as they are developed. (42CFR 457.710(e))

10.3. The State assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

10.3-DC Specify that the State agrees to submit yearly the approved dental benefit package and to submit quarterly current and accurate information on enrolled dental providers in the State to the Health Resources and Services Administration for posting on the Insure Kids Now! Website. Please update Sections 6.2-DC and 9.10 when electing this option.

Section 11. Program Integrity (Section 2101(a))

Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan, and continue to Section 12.

11.1. The State assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Section 2101(a)) (42CFR 457.940(b))

11.2. The State assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a State under Title XIX: (Section 2107(e)) (42CFR 457.935(b)) The items below were moved from section 9.8. (Previously items 9.8.6. - 9.8.9)

11.2.1. 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)

11.2.2. Section 1124 (relating to disclosure of ownership and related information)

11.2.3. Section 1126 (relating to disclosure of information about certain convicted individuals)

11.2.4. Section 1128A (relating to civil monetary penalties)

11.2.5. Section 1128B (relating to criminal penalties for certain additional charges)

11.2.6. Section 1128E (relating to the National health care fraud and abuse data collection)

11.2.7 program)
42 CFR 457.990(a) (relating to provider screening and enrollment)

Section 12. Applicant and Enrollee Protections (Sections 2101(a))

Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan.

12.1. Eligibility and Enrollment Matters- Describe the review process for eligibility and enrollment matters that complies with 42 CFR 457.1120. Describe any special processes and procedures that are unique to the applicant's rights when the State is using the Express Lane option when determining eligibility.

A Social Security Number is required for a child who applies for benefits. Enrollment is not denied or delayed to an otherwise eligible child pending issuance of a child's SSN. The program restricts the use of disclosure of information concerning applicants and enrollees to purposes directly connected with administration of the plan.

An applicant or enrollee has an opportunity for review of eligibility and enrollment matters. Such matters include the following: denial of eligibility, failure to make a timely determination of eligibility and termination of enrollment. The State fully complies with 42 CFR 457.1130 including the exceptions to opportunity for review. An enrollee is entitled for continuation of enrollment during the review process pending the outcome of the review as outlined in 42 CFR 457.1170.

The review process for eligibility and enrollment matters is conducted by the DPHHS Office of Fair Hearings, Quality Assurance Division, in accordance with the program's Fair Hearing Policy. Families of children who are applying for or are enrolled in the program are notified of their right to Fair Hearing.

A Fair Hearing is granted to the following individuals: 1) applicant, parent or guardian who requests a hearing because his or her application is denied, and 2) an enrollee, parent or guardian when an adverse action results in disenrollment. The hearing request must be submitted in writing within 90 days of the Department's action notice.

A hearing request is defined as a clear expression by the applicant, or authorized representative that he or she wants the opportunity to present the case to a higher authority.

The Department is responsible to assure an applicant's right to due process and hearing. Hearings are conducted by an impartial official of the Department who is not directly involved in the initial determination of the action in question.

The Hearing Officer's decision is made within 90 days of the hearing's conclusion. The Hearing Officer's decision may be appealed to the Board of Public Assistance within 15 days of the mailing of the Fair Hearing decision. No action is taken on the case until the 15-day limit for appeal passes. There is a hearing record compiled for each case and it is available to the applicant at a reasonable time for viewing and copying.

Guidance: "Health services matters" refers to grievances relating to the provision of health care.

12.2. Health Services Matters- Describe the review process for health services matters that comply with 42 CFR 457.1120.

An applicant or enrollee has an opportunity for a review of health services matters. The TPA contractor's complaint resolution policy: An enrollee may call or write to the plan to ask questions, ask for a review of a decision or make a verbal complaint. The TPA Contractor will respond to telephone inquiries within 10 working days. The TPA Contractor will acknowledge a written complaint within 10 days of receipt and send a written response or decision on the complaint within 45 days of receipt. An enrollee may make an appeal if an unfavorable decision is received from the TPA Contractor. Within 90 days of receiving a letter from the TPA Contractor about a decision, the enrollee may submit a written complaint to Montana DPHHS Office of Fair Hearings.

A hearing request is defined as a clear expression by the applicant, or authorized representative that he or she wants the opportunity to present the case to a higher authority.

The Department is responsible to assure an applicant's right to due process and hearing. Hearings are conducted by an impartial official of the Department who is not directly involved in the initial determination of the action in question.

The Hearing Officer's decision is made within 90 days the hearing's conclusion. The Hearing Officer's decision may be appealed to the Board of Public Assistance within 15 days the mailing the Fair Hearing decision. No action is taken on the case until the 15-day limit for appeal passes. There is a hearing record compiled for each case and it is available to the applicant at a reasonable time for viewing and copying.

This information is included in the Member Handbook that is provided when children are enrolled.

12.3. Premium Assistance Programs- If providing coverage through a group health plan that does not meet the requirements of 42 CFR 457.1120, describe how the State will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each redetermination of eligibility.

Key for Newly Incorporated Templates

The newly incorporated templates are indicated with the following letters after the numerical section throughout the template.

- PC- Prenatal care and associated health care services (SHO #02-004, issued November 12, 2002)
- PW- Coverage of pregnant women (CHIPRA #2, SHO # 09-006, issued May 11, 2009)
- TC- Tribal consultation requirements (ARRA #2, CHIPRA #3, issued May 28, 2009)
- DC- Dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
- DS- Supplemental dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
- PA- Premium assistance (CHIPRA # 13, SHO # 10-002, issued February 2, 2010)
- EL- Express lane eligibility (CHIPRA # 14, SHO # 10-003, issued February 4, 2010)
- LR- Lawfully Residing requirements (CHIPRA # 17, SHO # 10-006, issued July 1, 2010)

CMS Regional Offices				
CMS Regional Offices	States		Associate Regional Administrator	Regional Office Address
Region 1- Boston	Connecticut Massachusetts Maine	New Hampshire Rhode Island Vermont	Richard R. McGreal richard.mcgregal@cms.hhs.gov	John F. Kennedy Federal Bldg. Room 2275 Boston, MA 02203-0003
Region 2- New York	New York Virgin Islands	New Jersey Puerto Rico	Michael Melendez michael.melendez@cms.hhs.gov	26 Federal Plaza Room 3811 New York, NY 10278-0063
Region 3- Philadelphia	Delaware District of Columbia Maryland	Pennsylvania Virginia West Virginia	Ted Gallagher ted.gallagher@cms.hhs.gov	The Public Ledger Building 150 South Independence Mall West Suite 216 Philadelphia, PA 19106
Region 4- Atlanta	Alabama Florida Georgia Kentucky	Mississippi North Carolina South Carolina Tennessee	Jackie Glaze jackie.glaze@cms.hhs.gov	Atlanta Federal Center 4 th Floor 61 Forsyth Street, S.W. Suite 4T20 Atlanta, GA 30303-8909
Region 5- Chicago	Illinois Indiana Michigan	Minnesota Ohio Wisconsin	Verlon Johnson verlon.johnson@cms.hhs.gov	233 North Michigan Avenue, Suite 600 Chicago, IL 60601
Region 6- Dallas	Arkansas Louisiana New Mexico	Oklahoma Texas	Bill Brooks bill.brooks@cms.hhs.gov	1301 Young Street, 8th Floor Dallas, TX 75202
Region 7- Kansas City	Iowa Kansas	Missouri Nebraska	James G. Scott james.scott1@cms.hhs.gov	Richard Bulling Federal Bldg. 601 East 12 Street, Room 235 Kansas City, MO 64106-2808
Region 8- Denver	Colorado Montana North Dakota	South Dakota Utah Wyoming	Richard Allen richard.allen@cms.hhs.gov	Federal Office Building, Room 522 1961 Stout Street Denver, CO 80294-3538
Region 9- San Francisco	Arizona California Hawaii Nevada	American Samoa Guam Northern Mariana Islands	Gloria Nagle gloria.nagle@cms.hhs.gov	90 Seventh Street Suite 5-300 San Francisco Federal Building San Francisco, CA 94103
Region 10- Seattle	Idaho Washington	Alaska Oregon	Carol Peverly carol.peverly@cms.hhs.gov	2001 Sixth Avenue MS RX-43 Seattle, WA 98121

GLOSSARY

Adapted directly from SEC. 2110. DEFINITIONS.

CHILD HEALTH ASSISTANCE- For purposes of this title, the term `child health assistance' means payment for part or all of the cost of health benefits coverage for targeted low-income children that includes any of the following (and includes, in the case described in Section 2105(a)(2)(A), payment for part or all of the cost of providing any of the following), as specified under the State plan:

1. Inpatient hospital services.
2. Outpatient hospital services.
3. Physician services.
4. Surgical services.
5. Clinic services (including health center services) and other ambulatory health care services.
6. Prescription drugs and biologicals and the administration of such drugs and biologicals, only if such drugs and biologicals are not furnished for the purpose of causing, or assisting in causing, the death, suicide, euthanasia, or mercy killing of a person.
7. Over-the-counter medications.
8. Laboratory and radiological services.
9. Prenatal care and pre-pregnancy family planning services and supplies.
10. Inpatient mental health services, other than services described in paragraph (18) but including services furnished in a State-operated mental hospital and including residential or other 24-hour therapeutically planned structured services.
11. Outpatient mental health services, other than services described in paragraph (19) but including services furnished in a State-operated mental hospital and including community-based services.
12. Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices).
13. Disposable medical supplies.
14. Home and community-based health care services and related supportive services (such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home).
15. Nursing care services (such as nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services) in a home, school, or other setting.
16. Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.
17. Dental services.
18. Inpatient substance abuse treatment services and residential substance abuse treatment services.
19. Outpatient substance abuse treatment services.
20. Case management services.
21. Care coordination services.
22. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.

23. Hospice care.
24. Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services (whether in a facility, home, school, or other setting) if recognized by State law and only if the service is--
 - a. prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as defined by State law,
 - b. performed under the general supervision or at the direction of a physician, or
 - c. furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.
25. Premiums for private health care insurance coverage.
26. Medical transportation.
27. Enabling services (such as transportation, translation, and outreach services) only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.
28. Any other health care services or items specified by the Secretary and not excluded under this section.

TARGETED LOW-INCOME CHILD DEFINED- For purposes of this title--

1. **IN GENERAL-** Subject to paragraph (2), the term `targeted low-income child' means a child--
 - a. who has been determined eligible by the State for child health assistance under the State plan;
 - b. (i) who is a low-income child, or
(ii) is a child whose family income (as determined under the State child health plan) exceeds the Medicaid applicable income level (as defined in paragraph (4)), but does not exceed 50 percentage points above the Medicaid applicable income level; and
 - c. who is not found to be eligible for medical assistance under title XIX or covered under a group health plan or under health insurance coverage (as such terms are defined in Section 2791 of the Public Health Service Act).
2. **CHILDREN EXCLUDED-** Such term does not include--
 - a. a child who is a resident of a public institution or a patient in an institution for mental diseases; or
 - b. a child who is a member of a family that is eligible for health benefits coverage under a State health benefits plan on the basis of a family member's employment with a public agency in the State.
3. **SPECIAL RULE-** A child shall not be considered to be described in paragraph (1)(C) notwithstanding that the child is covered under a health insurance coverage program that has been in operation since before July 1, 1997, and that is offered by a State which receives no Federal funds for the program's operation.
4. **MEDICAID APPLICABLE INCOME LEVEL-** The term `Medicaid applicable income level' means, with respect to a child, the effective income level (expressed as a percent of the poverty line) that has been specified under the State plan under title XIX (including under a waiver authorized by the Secretary or under Section 1902(r)(2)), as of June 1, 1997, for the child to be eligible for medical

assistance under Section 1902(1)(2) for the age of such child.

5. **TARGETED LOW-INCOME PREGNANT WOMAN.**—The term ‘targeted low-income pregnant woman’ means an individual—“(A) during pregnancy and through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends; “(B) whose family income exceeds 185 percent (or, if higher, the percent applied under subsection (b)(1)(A)) of the poverty line applicable to a family of the size involved, but does not exceed the income eligibility level established under the State child health plan under this title for a targeted low-income child; and “(C) who satisfies the requirements of paragraphs (1)(A), (1)(C), (2), and (3) of Section 2110(b) in the same manner as a child applying for child health assistance would have to satisfy such requirements.

ADDITIONAL DEFINITIONS- For purposes of this title:

1. **CHILD-** The term ‘child’ means an individual under 19 years of age.
2. **CREDITABLE HEALTH COVERAGE-** The term ‘creditable health coverage’ has the meaning given the term ‘creditable coverage’ under Section 2701(c) of the Public Health Service Act (42 U.S.C. 300gg(c)) and includes coverage that meets the requirements of section 2103 provided to a targeted low-income child under this title or under a waiver approved under section 2105(c)(2)(B) (relating to a direct service waiver).
3. **GROUP HEALTH PLAN; HEALTH INSURANCE COVERAGE; ETC-** The terms ‘group health plan’, ‘group health insurance coverage’, and ‘health insurance coverage’ have the meanings given such terms in Section 2191 of the Public Health Service Act.
4. **LOW-INCOME CHILD -** The term ‘low-income child’ means a child whose family income is at or below 200 percent of the poverty line for a family of the size involved.
5. **POVERTY LINE DEFINED-** The term ‘poverty line’ has the meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.
6. **PREEXISTING CONDITION EXCLUSION-** The term ‘preexisting condition exclusion’ has the meaning given such term in section 2701(b)(1)(A) of the Public Health Service Act (42 U.S.C. 300gg(b)(1)(A)).
7. **STATE CHILD HEALTH PLAN; PLAN-** Unless the context otherwise requires, the terms ‘State child health plan’ and ‘plan’ mean a State child health plan approved under Section 2106.
8. **UNINSURED CHILD-** The term ‘uninsured child’ means a child that does not have creditable health coverage.

Superseding Pages of MAGI CHIP State Plan Material

State: Montana

Transmittal Number	PDF #	Description	Superseded Plan Section(s)
MT-13-0010 Approval Date: 12/24/13 Effective/Implementation Date: January 1, 2014 SPA Group MAGI Eligibility & Methods	CS7	Eligibility – Targeted Low Income Children	Supersedes the current sections 4.1.1, 4.1.2 and 4.1.3
	CS15	MAGI-Based Income Methodologies	Incorporate within a separate subsection under section 4.3
	CS10	Children Who Have Access to Public Employee Coverage	Supersedes the current information on dependents of public employees in section 4.1.7; supporting documentation supersede the current documentation in an Appendix to the current CHIP state plan
MT-13-0011 Approval Date: 11/05/13 Effective/Implementation Date: January 1, 2014 SPA Group XXI Medicaid Expansion	CS3	Eligibility for Medicaid Expansion Program	Supersedes the current Medicaid expansion section 4.0
MT-13-0012 Approval Date: 11/05/13 Effective/Implementation Date: January 1, 2014 SPA Group Establish 2101(f) Group	CS14	Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards	Incorporate within a separate subsection under section 4.1
MT-13-0013 Approval Date: 11/26/13 Effective/Implementation Date: October 1, 2013 SPA Group Eligibility Processing	CS24	Eligibility Process	Supersedes the current sections 4.3 and 4.4
MT-13-0014 Approval Date: 11/05/13	CS17	Non-Financial Eligibility – Residency	Supersedes the current section 4.1.5

Transmittal Number	PDF #	Description	Superseded Plan Section(s)
Effective/Implementation Date: January 1, 2014	CS18	Non-Financial Eligibility – Citizenship	Supersedes the current sections 4.1.0; 4.1.1-LR; 4.1.1-LR
SPA Group Non-Financial Eligibility	CS19	Non-Financial Eligibility – Social Security Number	Supersedes the current section 4.1.9.1
	CS27	General Eligibility – Continuous Eligibility	Supersedes the current section 4.1.9.2
MT-15-0017-MC	CS20	Non-Financial Eligibility – Substitution of Coverage	Supersedes the current section 4.4.4
Approval Date: 10/28/15 Effective/Implementation Date: July 1, 2015	CS28	Non-Financial Eligibility – Presumptive Eligibility for Children	Supersedes the current section 4.3.2
SPA Group Non-Financial Eligibility			



CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

2102(b)(1)(B)(v) of the SSA and 42 CFR 457.310, 315 and 320

Targeted Low-Income Children - Uninsured children under age 19 whose household income is within standards established by the state.

The CHIP Agency operates this covered group in accordance with the following provisions:

Age

Must be under age 19.

Income Standards

Income standards are applied statewide. Yes

Are there any exceptions, e.g. populations in a county which may qualify under either a statewide income standard or a county income standard? No

Statewide Income Standards

Begin with lowest age range first.

Please note that the lower bound for CHIP eligibility should be the highest standard used for Medicaid poverty-level children for the same age group or groups entered here.

	From Age	To Age	Above (% FPL)	Up to & including (% FPL)	
	0	19	143	261	

Age ranges may overlap. If there is an overlap, provide an explanation. Include the age ranges for each income standard that has overlapping ages and the reason for having different income standards.

Special Program for Children with Disabilities

Does the state have a special program for children with disabilities? No

PRA Disclosure Statement



CHIP Eligibility

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

2102(b)(1)(B)(v) of the SSA and 42 CFR 457.315

- The CHIP Agency will apply Modified Adjusted Gross Income methodologies for all separate CHIP covered groups, as described below, and consistent with 42 CFR 457.315 and 435.603(b) through (i).

In the case of determining ongoing eligibility for enrollees determined eligible for CHIP on or before December 31, 2013, MAGI-based income methodologies will not be applied until March 31, 2014 or the next regularly-scheduled renewal of eligibility, whichever is later.

If the state covers pregnant women, in determining family size for the eligibility determination of a pregnant woman, she is counted as herself plus each of the children she is expected to deliver.

In determining family size for the eligibility determination of the other individuals in a household that includes a pregnant woman:

- The pregnant woman is counted just as herself.
- The pregnant woman is counted just as herself, plus one.
- The pregnant woman is counted as herself, plus the number of children she is expected to deliver.

Financial eligibility is determined consistent with the following provisions:

When determining eligibility for new applicants, financial eligibility is based on current monthly income and family size.

When determining eligibility for current beneficiaries, financial eligibility is based on:

- Current monthly household income and family size.
- Projected annual household income for the remaining months of the current calendar year and family size.

In determining current monthly or projected annual household income, the state will use reasonable methods to:

- Include a prorated portion of the reasonably predictable increase in future income and/or family size.
- Account for a reasonably predictable decrease in future income and/or family size.

Except as provided at 42 CFR 457.315 and 435.603(d)(2) through (d)(4), household income is the sum of the MAGI-based income of every individual included in the individual's household.

Household income includes actually available cash support, exceeding nominal amounts, provided by the person claiming an individual described at §435.603(f)(2)(i) as a tax dependent. Yes

- The CHIP Agency certifies that it has submitted and received approval for the conversion for all separate CHIP covered group income standards to MAGI-equivalent standards.

FRA Disclosure Statement

SHA# MY-13-0010

Approval Date: _____

Effective Date: January 1, 2014

Page 1 of 2



CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Sec. 2110(b)(2)(B) and (b)(6) of the SSA

Children Who Have Access to Public Employee Coverage - Otherwise eligible targeted low-income children who have access to public employee coverage on the basis of a family member's employment.

The CHIP Agency operates this covered group in accordance with the following provisions:

Select one of the following conditions as described in Section 2110(b)(6) of the Social Security Act:

- Maintenance of agency contribution as provided in 2110(b)(6)(B) of the SSA.
- Hardship criteria as provided in section 2110(b)(6)(C) of the Social Security Act.

Coverage under this option is extended to children whose household income is:

Select one of the options for the income standard when compared to Targeted Low Income Children:

- The same as the standards for Targeted Low-Income Children
- Lower than the income standards for Targeted Low-Income Children

Indicate whether coverage under this option is extended to all children who have access to public employee coverage, or only certain children:

- All children who have access to public employee coverage
- Certain children who have access to public employee coverage:

Attach methodology the state has used to calculate financial hardship.



The state provides assurance that the state will, on an annual basis, recalculate the financial status to determine if the hardship condition continues to be met.

Children who are eligible for public employee health benefits coverage who are not described above are excluded from eligibility under the plan.

Children considered to have access to public employee coverage, and therefore not excluded from CHIP through this option, otherwise meet the definition of targeted low income child provided at 42 CFR 457.310.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 50 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130017

SPAR-MT-13-0010

Approval Date: _____

Effective Date: January 1, 2014

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CHIP Eligibility

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

Eligibility for Medicaid Expansion Program					83
42 CFR 457.320(a)(2) and (3)					
Income eligibility for children under the Medicaid Expansion is determined in accordance with the following income standards:					
There should be no overlaps or gaps for the ages entered.					
Age and Household Income Ranges					
	From Age	To Age	Above (% FPL)	Up to & including (% FPL)	
	5	19	109	143	

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 50 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1830.

NOV 05 2013

SPA #MT-13-0011

Approval Date: _____

January 1, 2014

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CHIP Eligibility

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

Child Health Insurance Program Eligibility - Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards

Section 2101(f) of the ACA and 42 CFR 457.310(d)

Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards

The CHIP agency provides coverage for this group of children as follows:

- The state has received approval from CMS to maintain Medicaid eligibility for children who would otherwise be subject to Section 2101(f) such that no child in the state will be subject to this provision.

- The state assures that separate CHIP coverage will be provided for children ineligible for Medicaid due to the elimination of income disregards in accordance with 42 CFR 457.310(d). Coverage for this population will cease when the last child protected from loss of Medicaid coverage as a result of the elimination of income disregards has been afforded 12 months of coverage in a separate CHIP (expected to be no later than April 1, 2016).

Describe the methodology used by the state to identify and enroll children in a separate CHIP who are subject to the protection afforded by Section 2101(f) of the Affordable Care Act:

- The state has demonstrated and CMS has agreed that all children qualifying for section 2101(f) protection will qualify for the state's existing separate CHIP.
- The state will enroll all children in a separate CHIP who lose Medicaid eligibility because of an increase in family income at their first renewal applying MAGI methods.
- The state will enroll children in a separate CHIP whose family income falls above the converted MAGI Medicaid FPL but at or below the following percentage of FPL. The state has demonstrated and CMS has agreed that all or almost all the children who would have maintained Medicaid eligibility if former disregards were applied will be within this income range and therefore covered in the separate CHIP.

261 % FPL

- The state will enroll children in a separate CHIP who are found to be ineligible for Medicaid based on MAGI but whose family income has not increased since the child's last determination of Medicaid eligibility or who would have remained eligible for Medicaid (based on the 2013 Medicaid income standard) if the value of their 2013 disregards had been applied to the family income as determined by MAGI methodology.

Other.

Describe the benefits provided to this population:

- This population will be provided the same benefits as are provided to children in the state's Medicaid program.
- This population will be provided the same benefits as are provided to children in the state's separate CHIP.
- Other (consistent with Section 2103 of the SSA and 42 CFR 457 Subpart D).

Describe premiums and cost sharing required of this population:

- Cost sharing is the same as for children in the Medicaid program.

SPA # MT-13-0012

Approval Date: NOV 05 2013

Effective Date: January 1, 2014

Page 1 of 2



CHIP Eligibility

- Premiums and cost sharing are the same as for targeted low-income children in the state's separate CHIP.
- No premiums, copayments, deductibles, coinsurance or other cost sharing is required.
- Other premiums and/or cost-sharing requirements (consistent with Section 2103(e) of the SSA and 42 CFR 457 Subpart E).

PRA Disclosure Statement

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CHIP Eligibility

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2102(b)(3) & 2107(e)(1)(O) of the SSA and 42 CFR 457, subpart C

- The CHIP Agency meets all of the requirements of 42 CFR 457, subpart C for application processing, eligibility screening and enrollment.

Application Processing

Indicate which application the agency uses for individuals applying for coverage who may be eligible based on the applicable modified adjusted gross income standard:

- The single, streamlined application developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act.
- An alternative single, streamlined application developed by the state and approved by the Secretary in accordance with section 1413(b)(1)(B) of the Affordable Care Act.
- [Redacted]
- An alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single or alternative application used only for insurance affordability programs to individuals seeking assistance only through such programs.
- [Redacted]

- The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in CFR 457.340(e), by telephone, via mail, in person and other commonly available electronic means.

The agency accepts applications in the following other electronic means:

- Other electronic means:

Screen and Enroll Process

- The CHIP Agency has coordinated eligibility and enrollment screening procedures in place that are applied at time of initial application, periodic redeterminations, and follow-up eligibility determinations. The procedures ensure that only targeted low-income children are provided CHIP coverage and that enrollment is facilitated for applicants found to be potentially eligible for other insurance affordability programs.

Procedures include:

- Screening of application to identify all individuals eligible or potentially eligible for CHIP or other insurance affordability programs; and
- Income eligibility test, with calculation of household income consistent with 42 CFR 457.313 for individuals identified as potentially eligible for Medicaid or other insurance affordability programs based on household income; and

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CHIP Eligibility

- Screening process for individuals who may qualify for Medicaid on a basis other than having household income at or below the applicable MAGI standard, based on information in the single streamlined application.

The CHIP agency has entered into an arrangement with the Exchange to make eligibility determinations for advanced premium tax credits in accordance with section 1943(b)(2) of the SSA.

No

Redetermination Processing

- Redeterminations of eligibility for individuals whose financial eligibility is based on the applicable modified adjusted gross income standard are performed as follows, consistent with 42 CFR 457.343:
 - Once every 12 months.
 - Without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency.
 - If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional information to complete the redetermination, it provides the individual with a pre-populated renewal form containing the information already available.

Screening by Other Insurance Affordability Programs

- The CHIP Agency provides assurance that it has adopted procedures to accept and process electronic accounts of individuals screened as potentially eligible for CHIP by other insurance affordability programs in accordance with the requirements of 42 CFR 457.348(b) and to determine eligibility in accordance with 42 CFR 457.340 in the same manner as if the application had been submitted directly to, and processed by the state.
 - The CHIP Agency elects the option to accept CHIP eligibility decisions made by the Exchange or other agencies administering insurance affordability programs as provided in 42 CFR 457.348 and to furnish CHIP in accordance with requirements of 42 CFR 457.340 to the same extent and in the same manner as if the applicant had been determined by the state to be eligible for CHIP.
- Check all types of agencies that apply:
- The Exchange
 - Medicaid
 - Other agency administering insurance affordability programs
- The CHIP Agency has entered into an agreement with agencies administering other insurance affordability programs to fulfill the requirements of 457.348(b) and will provide this agreement to the Secretary upon request.

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CHIP Eligibility

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Expiration date: 10/31/2014

Separate Child Health Insurance Programs
Non-Financial Eligibility - Residency

07817

42 CFR 457.320

Residency

- The CHIP Agency provides CHIP to otherwise eligible residents of the state, including residents who are absent from the state under certain conditions.

A child is considered to be a resident of the state under the following conditions:

- A non-institutionalized child, if capable of indicating intent and who is emancipated or married, if the child is living in the state and:
 1. Intends to reside in the state, including without a fixed address, or
 2. Has entered the state with a job commitment or seeking employment, whether or not currently employed.
- A non-institutionalized child not described above and a child who is not a ward of the state:
 1. Residing in the state, with or without a fixed address, or
 2. The state of residency of the parent or caretaker, in accordance with 42 CFR.435.403(h)(1), with whom the individual resides.
- An institutionalized child, who is not a ward of the state, if the state is the state of residence of the child's custodial parent or caretaker at the time of placement, or
- A child who is a ward of the state regardless of where the child lives, or
- A child physically located in the state when there is a dispute with one or more states as to the child's actual state of residence.

If the state covers pregnant women, a pregnant woman is considered to be a resident under the following conditions:

- A non-institutionalized pregnant woman who is living in the state and:
 1. Intends to reside in the state, including without a fixed address, or if incapable of indicating intent, is living in the state, or
 2. Entered with a job commitment or seeking employment, whether or not currently employed.
- An institutionalized pregnant woman placed in an out-of-state-institution, as defined in 42 CFR 435.1010, including foster care homes, by an agency of the state, or
- An institutionalized pregnant woman residing in an in-state-institution, as defined in 42 CFR 435.1010, whether or not the individual established residency in the state prior to entering the institution, or
- A pregnant woman physically located in the state when there is a dispute with one or more states as to the pregnant woman's actual state of residence.

The state has in place related to the residency of children and pregnant women (if covered by the state):

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CHIP Eligibility

One or more interstate agreement(s). No

A policy related to individuals in the state only for educational purposes. No

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CHIP Eligibility

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Separate Child Health Insurance Programs Non-Financial Eligibility - Citizenship CHIP

Sections 2105(c)(9) and 2107(e)(1)(J) of the SSA and 42 CFR 457.320(b)(6), (c) and (d)

Citizenship

The CHIP Agency provides CHIP eligibility to otherwise eligible citizens and nationals of the United States and certain non-citizens, including the time period during which they are provided with reasonable opportunity to submit verification of their citizenship, national status or satisfactory immigration status.

The CHIP Agency provides eligibility under the Plan to otherwise eligible individuals:

Who are citizens or nationals of the United States; or

Who are qualified non-citizens as defined in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) (8 U.S.C. §1641), or whose eligibility is required by section 402(b) of PRWORA (8 U.S.C. §1612(b)) and is not prohibited by section 403 of PRWORA (8 U.S.C. §1613); or

Who have declared themselves to be citizens or nationals of the United States, or an individual having satisfactory immigration status, during a reasonable opportunity period pending verification of their citizenship, nationality, or satisfactory immigration status consistent with requirements of 1903(x), 1137(d), and 1902(ec) of the Act, and 42 CFR 435.406, 407, 956 and 457.380.

The reasonable opportunity period begins on and extends 90 days from the date the notice of reasonable opportunity is received by the individual.

The agency provides for an extension of the reasonable opportunity period if the individual is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency needs more time to complete the verification process. Yes

The agency begins to furnish benefits to otherwise eligible individuals during the reasonable opportunity period on a date earlier than the date the notice is received by the individual. Yes

The date benefits are furnished is:

The date of application containing the declaration of citizenship or immigration status.

The date the reasonable opportunity notice is sent.

Other date, as described:

The CHIP Agency elects the option to provide CHIP coverage to otherwise eligible children up to age 19, lawfully residing in the United States, as provided in Section 2107(e)(1)(J) of the SSA (Section 214 of CHIPRA 2009, P.L. 111-3). Yes

Otherwise eligible children means children meeting the eligibility requirements of targeted low-income children with the exception of non-citizen status.

The CHIP Agency provides assurance that lawfully residing children are also covered under the state's Medicaid program.

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CHIP Eligibility

The CHIP Agency elects the option to provide CHIP coverage to otherwise eligible pregnant women, lawfully residing in the United States, as provided in Section 214 of CHIPRA 2009, P.L. 111-3. The state may not select this option unless the state also elects to cover lawfully residing children. A state may not select this option unless the state also covers Targeted Low-Income Pregnant Women.

No

- An individual is considered to be lawfully residing in the United States if he or she is lawfully present and meets state residency requirements.
- An individual is considered to be lawfully present in the United States if he or she is:
 1. A qualified non-citizen as defined in 8 U.S.C. 1641(b) and (c);
 2. A non-citizen in a valid nonimmigrant status, as defined in 8 U.S.C. 1101(a)(15) or otherwise under the immigration laws (as defined in 8 U.S.C. 1101(a)(17));
 3. A non-citizen who has been paroled into the United States in accordance with 8 U.S.C. 1182(d)(5) for less than 1 year, except for an individual paroled for prosecution, for deferred inspection or pending removal proceedings;
 4. A non-citizen who belongs to one of the following classes:
 - (i) Granted temporary resident status in accordance with 8 U.S.C. 1160 or 1255a, respectively;
 - (ii) Granted Temporary Protected Status (TPS) in accordance with 8 U.S.C. §1254a, and individuals with pending applications for TPS who have been granted employment authorization;
 - (iii) Granted employment authorization under 8 CFR 274a.12(c);
 - (iv) Family Unity beneficiaries in accordance with section 301 of Pub. L. 101-649, as amended;
 - (v) Under Deferred Enforced Departure (DED) in accordance with a decision made by the President;
 - (vi) Granted Deferred Action status;
 - (vii) Granted an administrative stay of removal under 8 CFR 241;
 - (viii) Beneficiary of approved visa petition who has a pending application for adjustment of status;
 5. Is an individual with a pending application for asylum under 8 U.S.C. 1158, or for withholding of removal under 8 U.S.C. 1231, or under the Convention Against Torture, who:
 - (i) Has been granted employment authorization; or
 - (ii) Is under the age of 14 and has had an application pending for at least 180 days;
 6. Has been granted withholding of removal under the Convention Against Torture;
 7. Is a child who has a pending application for Special Immigrant Juvenile status as described in 8 U.S.C. 1101(a)(27)(F);
 8. Is lawfully present in American Samoa under the immigration laws of American Samoa; or
 9. Is a victim of severe trafficking in persons, in accordance with the Victims of Trafficking and Violence Protection Act of 2000, Pub. L. 106-386, as amended (22 U.S.C. 7105(b)).



CHIP Eligibility

10. **Exception:** An individual with deferred action under the Department of Homeland Security's deferred action for the childhood arrivals process, as described in the Secretary of Homeland Security's June 15, 2012 memorandum, shall not be considered to be lawfully present with respect to any of the above categories in paragraphs (1) through (9) of this definition.

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CHIP Eligibility

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

Separate Child Health Insurance Program CS19
Non-Financial Eligibility - Social Security Number

42 CFR 457.340(b)

Social Security Number

As a condition of eligibility, the CHIP Agency must require individuals who have a social security number or are eligible for one as determined by the Social Security Administration, to furnish their social security number, or numbers if they have more than one number.

- The CHIP Agency requires individuals, as a condition of eligibility, to furnish their social security number(s), with the following exceptions:

Individuals refusing to obtain a social security number (SSN) because of well established religious objections, or

Individuals who are not eligible for an SSN, or

Individuals who are issued an SSN only for a valid non-work purpose.

- The CHIP Agency assists individuals, who are required to provide their SSN, to apply for or obtain an SSN from the Social Security Administration if the individual does not have or forgot their SSN.

- The CHIP Agency informs individuals required to provide their SSN:

By what statutory authority the number is solicited; and

How the state will use the SSN.

The CHIP Agency provides assurance that it will verify each SSN furnished by an applicant or beneficiary with the Social Security Administration, not deny or delay services to an otherwise eligible applicant pending issuance or verification of the individual's SSN by the Social Security Administration and that the state's utilization of the SSNs is consistent with sections 205 and 1137 of the Social Security Act and the Privacy Act of 1974.

- The state may request non-applicant household members to voluntarily provide their SSN, if the state meets the requirements below.

The state requests non-applicant household members to voluntarily provide their SSN.

- When requesting an SSN for non-applicant household members, the state assures that:

- At the time such SSN is requested, the state informs the non-applicant that this information is voluntary and provides information regarding how the SSN will be used; and

- The state only uses the SSN for determination of eligibility for CHIP or other insurance affordability programs, or for a purpose directly connected with the administration of the state plan.

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CHIP Eligibility

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

Separate Child Health Insurance Program General Eligibility - Continuous Eligibility

C827

2105(a)(4)(A) of the SSA and 42 CFR 457.342 and 435.926

The CHIP Agency may provide that children who have been determined eligible under the state plan shall remain eligible, regardless of any changes in the family's circumstances, during a continuous eligibility period up to 12 months, or until the time the child reaches an age specified by the state (not to exceed age 19), whichever is earlier.

The CHIP Agency elects to provide continuous eligibility to children under this provision. Yes

For children up to age 19

For children up to age

The continuous eligibility period begins on the effective date of the child's most recent determination or redetermination of eligibility, and ends:

At the end of the months continuous eligibility period.

Exceptions to the continuous eligibility period:

The child attains the age specified by the state Agency or age 19.

The child or child's representative requests voluntary disenrollment.

The child is no longer a resident of the state.

The Agency determines that eligibility was erroneously granted at the most recent determination or renewal of eligibility because of Agency error or fraud, abuse, or perjury attributed to child or child's representative.

The child dies.

There is a failure to pay required premiums or enrollment fees on behalf of a child, as provided for in the state plan.

Other

	Describe	
<input checked="" type="checkbox"/>	Child is covered under a group health plan or under health insurance coverage as defined in section 2791 of the Public Health Service Act	<input checked="" type="checkbox"/>
<input checked="" type="checkbox"/>	Child is eligible for Medicaid	<input checked="" type="checkbox"/>

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CHIP Eligibility

State Name: Montana

OMB Control Number: 0938-1148

Transmittal Number: MT - 15 - 0017

Expiration date: 10/31/2014

Special CHIP Health Insurance Program
Non-Financial Eligibility - Substitution of Coverage G820

Section 2102(b)(3)(C) of the SSA and 42 CFR 457.340(d)(3), 457.350(i), and 457.805

Substitution of Coverage

The CHIP Agency provides assurance that it has methods and policies in place to prevent the substitution of group health coverage or other commercial health insurance with public funded coverage. These policies include:

Substitution of coverage prevention strategy:

Name of policy	Description
HMK 5.5 - Eligibility Determination	Montana's combined Medicaid/Healthy Montana Kids (CHIP) application asks the applicant to report any health insurance coverage. If the child is enrolled in a creditable coverage plan, the child is ineligible for Healthy Montana Kids coverage. There is no waiting period for children who drop other creditable health insurance. Healthy Montana Kids' third party administrator, Blue Cross Blue Shield of Montana (BCBSMT), compares the HMK monthly enrollment file with the claims field for their other commercial health plans. BCBSMT is Montana's largest health insurance carrier and is affiliated with the BCBS plans for four other states. BCBSMT notifies the State if members have other health insurance. If the State determines a child already has health insurance, the child is disenrolled from HMK effective the end of the month that the insurance is reported or discovered. In order to monitor substitution of coverage, a yearly report will be run to determine how many families reported insurance on their application and dropped it in order to be enrolled. This number will be reported on Montana's CHIP Annual Report. If substitution exceeds 10%, the department will work with CMS to develop a strategy to reduce substitution.

A waiting period during which an individual is ineligible due to having dropped group health coverage. No

If the state elects to offer dental only supplemental coverage, the following assurances apply:

- The other coverage exclusion does not apply to children who are otherwise eligible for dental only supplemental coverage as provided in section 2110(b)(5) of the SSA.
- The waiting period does not apply to children eligible for dental only supplemental coverage.



CHIP Eligibility

State Name:

OMH Control Number: 0938-1148

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42 CFR 457.355 and 435.1102, 2107(e)(1)(L) and 1920A of the SSA

The CHIP Agency covers children when determined presumptively eligible by a qualified entity. Yes

Describe the population of children to whom presumptive eligibility applies:

Children under the age of 19 who would be eligible for targeted low income children.

Describe the duration of the presumptive eligibility period and any limitations:

Temporary CHIP coverage group benefit will begin on the date a qualified entity trained and certified by HMK staff makes a determination of eligibility based on information provided. Presumptive eligibility will end on the earlier of the date HMK makes a determination of eligibility for CHIP or Medicaid coverage, or the last day of the month following the month presumptive eligibility begins.

Describe the application process and eligibility determination factors used:

The state has a presumptive eligibility application and will provide it to the qualified entities. Montana's Application Process: Qualified Entities (QEs) are trained and certified by the State of Montana to make Presumptive Eligibility (PE) determinations for children for Montana's CHIP program, called HMK, and Montana's Children's Medicaid program, called HMK Plus. The QEs are hospital or clinic personnel from facilities statewide. All materials for the PE determination process are provided to the QEs by the State of Montana. When a child applicant is identified or presents for services, a QE uses the following process:

- 1) Verify whether children already have HMK or HMK Plus on the web portal prior to giving family the PE application
- 2) Instruct the family to complete the application, providing self-declared information for all those in the household including name, address, phone, citizenship, residency, income, gender, date of birth, and whether or not the child applicants have insurance coverage. Child applicants also need Social Security numbers.
- 3) Verify the Temporary Coverage (PE) application is complete, signed and dated. If children are over age 19, are not U.S. citizens, or are not residents of the state of Montana, they are not eligible for PE.
- 4) Complete the Qualified Entity Income Calculation worksheet.
- 5) Compare household income to the Income Guidelines
- 6) Indicate HMK or HMK Plus eligibility in the "For Office Use Only" box on the application
- 7) Complete, sign, and date the PE Determination box. Give applicant; Copy of the PE application and Proof of Temporary Coverage letter
- 8) Collect missing information, such as Social Security numbers, prior to faxing the application to Healthy Montana Kids.
- 9) FAX the application within 5 days to the Department.

The CHIP Agency uses qualified entities, as defined in section 1920A, to determine eligibility presumptively for children.



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CHIP Eligibility

A qualified entity is an entity that is determined by the agency to be capable of making presumptive eligibility determinations based on an individual's household income and other requirements, and that meets at least one of the following requirements. Select the types of entities used to determine presumptive eligibility:

- Furnishes health care items and services covered under the approved plan and is eligible to receive payments under the approved plan
- Is authorized to determine a child's eligibility to participate in a Head Start program under the Head Start Act
- Is authorized to determine a child's eligibility to receive child care services for which financial assistance is provided under the Child Care and Development Block Grant Act of 1990
- Is authorized to determine a child's eligibility to receive assistance under the Special Supplemental Food Program for Women, Infants, and Children (WIC) under section 17 of the Child Nutrition Act of 1966
- Is authorized to determine a child's eligibility under the Medicaid state plan or for child health assistance under the Children's Health Insurance Program (CHIP)
- Is an elementary or secondary school, as defined in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801)
- Is an elementary or secondary school operated or supported by the Bureau of Indian Affairs
- Is a state or Tribal child support enforcement agency under title IV-D of the Act
- Is an organization that provides emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act
- Is a state or Tribal office or entity involved in enrollment in the program under Medicaid, CHIP, or title IV-A of the Act
- Is an organization that determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under section 8 or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437) or under the Native American Housing Assistance and Self-Determination Act of 1996 (25 U.S.C. 4101 *et seq.*)
- Any other entity the state so deems, as approved by the Secretary
- The CHIP Agency assures that it has communicated the requirements for qualified entities, at 1920A(b)(3) of the Act, and provided adequate training to the entities and organizations involved. A copy of the training materials has been included.

An attachment is submitted.

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Montana CHIP Parity Analysis- Appendix A to Montana CHIP SPA 18-0021

Montana provides mental health and substance use disorder benefits and thus is subject to the final Medicaid/CHIP parity rule that applies most provisions of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) to Montana's separate CHIP Program. Generally, MHPAEA prohibits the application of more restrictive limits and requirements to mental health/substance use disorder (MH/SUD) benefits than limits/requirements that generally apply to medical/surgical (M/S) benefits. Montana does not apply coverage of the Medicaid early and periodic screening, diagnostic, and treatment services (EPSDT) defined in section 1905(r) of the Social Security Act. Therefore, Montana cannot claim deemed compliance with parity and an analysis needs to be done.

For the purposes of analysis, Montana will classify MH/SUD use disorder services as services with ICD diagnoses of F01-F99. For analytical purposes, services must be divided into four classifications: Inpatient, outpatient, emergency care, and prescription drugs.

- The inpatient classification is used when a child has been placed in either an inpatient hospital or a psychiatric residential treatment facility.
- Emergency care is classified as an outpatient visit to a hospital for an acute episode.
- Prescription drug category includes all drugs dispensed through a pharmacy.
- Outpatient care is categorized as all other care provided outside of an inpatient stay or emergency visit to a hospital.

MH/SUD services are provided in all the above categories.

Cost Sharing Requirements

There are no annual or aggregate lifetime dollar limits in the plan except the dental care annual limit. There are per-service visit copays that do not exceed \$215 per family per year.

Copay requirements by service class follow:

- There is no cost share for the pharmacy benefit.
- There is no cost share for Federally Qualified Health Center or Rural Health Clinic visits.
- There is no cost share for Native American members.
- There is a copay for every inpatient hospital stay for both M/S and MH/SUD visits.
- There is a copay for every emergency care visit.
- There is a copay for every outpatient hospital visit, outpatient office visit, and therapy visit. There are no copays for the home and community-based extended mental health services of Home Support, Day Treatment, Respite, and Community Based Psychiatric Rehabilitation and Support.

Quantitative Treatment Limitations

The only quantitative treatment limitation on the plan, is a limit of one set of eyeglasses per year. This SPA removes limits on the extended mental health services in SPA section 6.2.11.

Non-Quantitative Treatment Limitations

The only non-quantitative treatment limitations are the requirement that members use in-state, in-

network providers, and receive authorization for some services.

The Montana CHIP plan is a health coverage plan utilizing enrolled in-state providers. Any health care provider that provides a covered service and meets licensing and credentialing standards may enroll. Services not available in Montana may be obtained out-of-state with prior authorization. The Montana third party administrator (TPA), Blue Cross and Blue Shield of Montana will authorize and assist with finding out-of-state benefits under the case management benefit.

The standards that govern authorization by service category follow:

- Emergency services do not require authorization. Additionally, members may receive emergency services out-of-state without authorization.
- The CHIP pharmacy benefit is aligned with the Montana Medicaid pharmacy benefit. The authorization standards are governed by Drug Utilization Board guidelines.
- Hospital stays are authorized using either the TPA medical policy, or the Montana Medicaid guidelines for psychiatric residential treatment facilities. Montana Medicaid guidelines were created by using federal guidelines, surveying national standard standards used by other states, and were vetted through the Montana administrative rule process allowing comments from members and providers.
- Most office visits with both M/S or MH/SUD providers do not require authorization.
- Therapies and therapeutic group home placement do require authorization. Extended mental health services and therapeutic group home stays require a check to ensure there is a Montana Medicaid defined serious emotional disturbance approved diagnosis and have demonstrated disability caused by that diagnosis. Montana Medicaid guidelines were created by using federal guidelines, surveying national standard standards used by other states, and were vetted through the Montana administrative rule process allowing comments from members and providers.
- Other therapies are governed by the TPA medical policies which are created using national treatment standards, published peer reviewed journal articles and are routinely reviewed.

Availability of Plan Information

The standards used to approve hospital stays and therapies are posted either on the Montana Medicaid Children's Mental Health Bureau website or the TPA website.

Families and providers are notified if members do not meet medical necessity criteria and appeal options are available. Information is always available upon request either through the TPA or the state program.