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

State Demonstrations Group

December 7, 2016

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

Dear Ms. Dalton:

The State of Montana submitted its Operations Protocol on March 1, 2016, as required by section VII. paragraph 6 in the special terms and conditions (STCs) for its section 1115 demonstration entitled, "Montana Health and Economic Livelihood Partnership (HELP) Program" (Project No. 11-W-00300/8). The Centers for Medicare & Medicaid Services (CMS) appreciates the cooperation and collaboration your staff provided during our review of your protocol.

At this time, we have no further questions about the Operations Protocol. As required by the HELP STCs, the Operations Protocol will be added in Attachment B of the STCs.

We look forward to continuing to work with you and your staff on the HELP demonstration. If you have any questions, please contact your project officer, Ms. Valisha Andrus, at either 410-786-2613 or by email at valisha.andrus@cms.hhs.gov.

We appreciate your cooperation throughout the review process.

Sincerely,

/s/

Andrea J. Casart
Director
Division of Medicaid Expansion Demonstrations

Enclosure

cc: Richard Allen, Associate Regional Administrator, Denver Regional Office

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-12
Baltimore, Maryland 21244-1850

State Demonstrations Group

November 23, 2016

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

Dear Ms. Dalton:

The Centers for Medicare & Medicaid Services (CMS) is approving Montana's Quarterly Progress Report Format, as required by section IX, paragraph 3 in the special terms and conditions (STCs) for its section 1115 demonstration entitled, "Montana Health and Economic Livelihood Partnership (HELP) Program" (Project No. 11-W-00300/8). As required by the HELP STCs, the report format will be added in Attachment D of the STCs. CMS has incorporated the report format into the latest version of the STCs. A copy of the STCs are enclosed with this letter.

We look forward to continuing to work with you and your staff on the Montana HELP demonstration. If you have any questions, please contact your project officer, Ms. Valisha Andrus, at valisha.andrus@cms.hhs.gov.

Sincerely,

/s/

Andrea J. Casart
Director
Division of Medicaid Expansion Demonstrations

Enclosure

cc: Richard Allen, Associate Regional Administrator, Denver Regional Office

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-12
Baltimore, Maryland 21244-1850

State Demonstrations Group

December 30, 2015

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

Dear Ms. Dalton:

The State of Montana submitted its Preventative Services Protocol on December 11, 2015, as required by section VII. paragraph 8 in the special terms and conditions (STCs) for its section 1115 demonstration entitled, "Montana Health and Economic Livelihood Partnership (HELP) Program" (Project No. 11-W-00300/8). The Centers for Medicare & Medicaid Services (CMS) appreciates the cooperation and collaboration your staff provided during our review of your protocol.

At this time, we have no further questions about the Preventative Services Protocol. As required by the HELP STCs, the Preventative Services Protocol will be added in Attachment C of the STCs.

We look forward to continuing to work with you and your staff on the HELP demonstration. If you have any questions, please contact your project officer, Ms. Megan Lepore, at either 410-786-4113 or by email at megan.lepore@cms.hhs.gov.

We appreciate your cooperation throughout the review process.

Sincerely,

/s/

Andrea J. Casart
Acting Director
Division of Medicaid Expansion Demonstrations

Enclosure

cc: Richard Allen, Associate Regional Administrator, Denver Regional Office

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

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

Dear Ms. Dalton:

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

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

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

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

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

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

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

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

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

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

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

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

Sincerely,

[redacted]

Andrew M. Slavitt
Acting Administrator

Enclosures

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

CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER LIST

NUMBER: **No. 11-W-00300/8**

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

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

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived in this list, shall apply to the demonstration populations. The waiver will continue through December 30, 2020, unless otherwise stated.

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

Title XIX Waivers

1. Premiums **Section 1902(a)(14) and Section 1916**

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

2. Comparability **Section 1902(a)(17)**

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

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: **No. 11-W-00300/8**

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

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

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the state for the items identified below (which would not otherwise be included as matchable expenditures under section 1903 of the Act) shall, for the period beginning January 1, 2016, through December 31, 2020, unless otherwise specified, be regarded as matchable expenditures under the state's Medicaid state plan:

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

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

CENTERS FOR MEDICARE AND MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: **No. 11-W-00300/8**

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

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

I. PREFACE

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

The STCs have been arranged into the following subject areas:

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

II. PROGRAM DESCRIPTION AND OBJECTIVES

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

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

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

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

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

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

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

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

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

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

III. GENERAL PROGRAM REQUIREMENTS

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

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

3. **Changes in Federal Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid or CHIP program that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes of an operational nature without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 days in advance of the expected approval date of the amended STCs to allow the state to provide comment.

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

    a. If changes in requirements under federal law need state legislation to be implemented, the changes must take effect on the earlier of: 1) the day such state legislation becomes effective, 2) the last day of the first legislative session that meets on or after the 60th day following the change in federal law; 3) the day specified in federal law for implementation of the change.

    b. Should there be changes in the federal financial participation (FFP) associated with the demonstration, the state may seek to end the demonstration (as per paragraph 8.b of this section) or seek an amendment (as per paragraph 7 of this section).

5. **State Plan Amendments.** Medicaid eligibility will be determined in accordance with the approved Medicaid state plan. Any change to eligibility must be made through an

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

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

6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, evaluation design, sources of non-federal share of funding, and budget neutrality that are specifically authorized under the demonstration project must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in this section in STC 7, except as provided in this section in STC 3.

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

    a. An explanation of the public process used by the state, consistent with the requirements applicable to amendments listed in paragraph 14 of this section, prior to submission of the requested amendment;

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

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

d. A detailed description of the amendment including impact on beneficiaries, with sufficient supporting documentation and data supporting the evaluation hypotheses as detailed in the evaluation design in section XI; and

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

8. Extension of the Demonstration. States that intend to request demonstration extensions under sections 1115(e) or 1115(f) are advised to observe the timelines contained in those statutes. Otherwise, no later than 12 months prior to the expiration date of the demonstration, the governor or chief executive officer of the state must submit to CMS either a demonstration extension request or a transition and phase-out plan consistent with the requirements of paragraph 9 of this section.

a. Compliance with transparency requirements at 42 CFR 431.412.

b. As part of the demonstration extension requests the state must provide documentation of compliance with the transparency requirements at 42 CFR 431.412 and the public notice and tribal consultation requirements outlined in STC 14 of this section.

9. Demonstration Phase Out. The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

a. **Notification of Suspension or Termination.** The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft plan to CMS. The state must submit the notification letter and a draft plan to CMS no less than six (6) months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with 42 CFR 431.408. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment and the extent to which the state incorporated the received comment into the revised plan. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of the phase-out activities. Implementation of activities must be no sooner than 14 days after CMS approval of the plan.

b. **Transition and Phase-out Plan Requirements**. The state must include, at a minimum, in its plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights, if any), the process by which the state will conduct administrative reviews of Medicaid eligibility prior to the termination of the program for the affected beneficiaries, and ensure ongoing coverage for those beneficiaries determined

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

c. **Phase-out Procedures**. The state must comply with all applicable notice requirements found in 42 CFR 431.206, 431.210, and 431.213. In addition, the state must assure all applicable appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR 431.220 and 431.221. If a demonstration participant is entitled to and requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as outlined in 42 CFR 435.916.

d. **Exemption from Public Notice Procedures 42.CFR 431.416(g).** CMS may expedite the federal and state public notice requirements in the event it determines that the objectives of title XIX would be served or under circumstances described in 42 CFR 431.416(g).

e. **Federal Financial Participation (FFP).** If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services, continued benefits as a result of beneficiaries' appeals and administrative costs of dis-enrolling beneficiaries.

10. Post Award Forum. Within six months of the demonstration's implementation, and annually thereafter, the state shall afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state can either use its Medical Care Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of this STC. The state must include a summary of the comments in the quarterly report associated with the quarter in which the forum was held. The state must also include the summary in its annual report.

11. Expiring Demonstration Authority. For demonstration authority that expires prior to the demonstration's expiration date, the state must submit a transition plan to CMS no later than 6 months prior to the applicable demonstration authority's expiration date, consistent with the following requirements:

a. **Expiration Requirements.** The state must include, at a minimum, in its demonstration expiration plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights, if any), the process by which the state shall conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and

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

b. **Expiration Procedures.** The state must comply with all applicable notice requirements found in 42 CFR Sections 431.206, 431.210 and 431.213. In addition, the state must assure all applicable appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR Sections 431.220 and 431.221. If a demonstration participant requests and is entitled to a hearing before the date of action, the state must maintain benefits as required in 42 CFR Section 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.

c. **Federal Public Notice.** CMS will conduct a 30-day federal public comment period consistent with the process outlined in 42 CFR Section 431.416 in order to solicit public input on the state's demonstration expiration plan. CMS will consider comments received during the 30-day period during its review and approval of the state's demonstration expiration plan. The state must obtain CMS approval of the demonstration expiration plan prior to the implementation of the expiration activities. Implementation of expiration activities must be no sooner than 14 days after CMS approval of the plan.

d. **Federal Financial Participation (FFP).** FFP shall be limited to normal closeout costs associated with the expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals and administrative costs of dis-enrolling participants.

12. **Withdrawal of Waiver Authority.** CMS reserves the right to amend and withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of Title XIX. CMS will promptly notify the state in writing of the determination and the reasons for the amendment and withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn or amended, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued benefits as a result of beneficiaries' appeals and administrative costs of dis-enrolling participants.

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

14. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249

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

a. In states with federally recognized Indian tribes, consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the state's approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers (42 CFR Section 431.408(b)(2)).

b. In states with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal and/or renewal of this demonstration (42 CFR Section 431.408(b)(3)).

c. The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

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

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

IV. POPULATIONS AFFECTED

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

   All affected groups derive their eligibility through the Medicaid state plan, and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan, except as expressly listed as waived in this demonstration, subject to the operational limits as described in these STCs. All Medicaid eligibility standards and methodologies for these eligibility groups remain applicable.

Table 1. Medicaid State Plan Groups Affected by the Demonstration		
Medicaid State Plan Group	**Population Description**	**Funding Stream**
New adult group.	Individuals ages 19 through 64 who are eligible in the new adult group under the state plan that is described in 1902(a)(10)(A)(i)(VIII) of the Act.	Title XIX

2. The following populations are excluded from all portions of the demonstration other than continuous eligibility provisions in Section VIII.

a. Individuals who are medically frail;

b. Individuals who the state determines (as described in the TPA ABP SPA) have exceptional health care needs, including but not limited to a medical, mental health, or developmental condition;

c. Individuals who live in a region (that may include all or part of an Indian reservation), where the TPA is unable to contract with sufficient providers (as described in the TPA ABP SPA);

d. Individuals who the state determines, in accordance with objective standards approved by CMS (as described in the TPA ABP), require continuity of coverage that is not available or could not be effectively delivered through the TPA;

e. Individuals exempted by federal law from premium or cost sharing obligations, whose exemption is not waived by CMS, including all individuals with incomes up to 50 percent of the FPL.

V. BENEFITS

1. Montana HELP Program Demonstration Benefits. Individuals in the demonstration will either receive benefits through the state plan ABP or those who are enrolled in the TPA will receive all benefits as described in the TPA ABP approved in the state plan.

2. Minimum Essential Coverage. All individuals affected by this demonstration receive coverage that meets the requirements of minimum essential coverage (MEC).

VI. DELIVERY SYSTEM

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

VII. PREMIUMS AND COPAYMENTS

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

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

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

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

    a. That eligibility will begin consistent with state plan rules.

    b. How premium payments should be made and the impact of change of income on premium payments owed.

c. The income guidelines for each component of the program (above 100 percent of the FPL and at and below 100 percent of the FPL and the relevant monthly income dollar figures so that applicants can understand which group they are likely to be in).

d. How the premium credit against copayments works.

e. The consequences of non-payment of premiums for each income group.

f. The consequences of non-payment of co-payments for each income group.

g. How to re-enroll, if dis-enrolled for non-payment of premiums.

3. **Beneficiary Outreach.** The state must conduct an outreach and education campaign to potential applicants and beneficiaries to ensure that they understand the program policies regarding premiums and associated consequences.

4. **Copayments.** Enrollees are subject to premiums and copayments up to 5 percent of income, calculated quarterly as described in 42 CFR 447.56(f) (both premiums and copayments count against the 5 percent aggregate cap). Copayment amounts shall be consistent with federal requirements regarding Medicaid cost sharing and are described in Attachment A.

   a. Enrollees will receive a credit toward their copayment obligations in the amount of their premiums, such that they shall not accrue out of pocket expenses for copayments until accumulated copayments exceed 2 percent of aggregate household income.

   b. The following service categories are exempt from copayments:
      i. Preventive health care services, including primary, secondary and tertiary preventive services as described in the operational protocol;
      ii. Immunizations; and
      iii. Medically necessary health screenings ordered by a health care provider.

   c. Consistent with federal law, providers may not deny services for failure to receive beneficiary copayments from individuals at or below 100 percent of the FPL.

5. **Beneficiary Protections.**

   a. The TPA and/or state may attempt to collect unpaid premiums and the related debt from beneficiaries, but may not report the debt to credit reporting agencies, place a lien on an individual's home, refer the case to debt collectors, file a lawsuit, seek a court order to seize a portion of the individual's earnings for enrollees at any income level. The TPA and/or state also may not "sell" the debt for collection by a third-party.

b. Beneficiaries described in 42 CFR 447.56(a) (including American Indians/Alaska Natives, as described therein) must be exempt from all copayments and premium contribution requirements, as applicable.

c. Beneficiaries may not incur family cost sharing or premiums that exceeds 5 percent of the aggregate family's income, following rules established in 42 CFR 447.56(f).

d. Copayment amounts will not exceed Medicaid cost sharing permitted by federal law and regulation.

e. The state may not pass along the cost of any surcharge associated with processing payments to the beneficiary. Any surcharges or other fees associated with payment processing must be considered an administrative expense by the state.

f. The state will ensure that all payments from the beneficiary, or on behalf of the individual, are accurately and timely credited toward unpaid premiums and related debt, and will provide the beneficiary an opportunity to review and seek correction of the payment history.

6. **Operations Protocol**. By March 1, 2016 the state will submit for approval a protocol describing the state's policies and procedures for implementing the premiums and copayments and monitor operations of, and the effects of, the policy. This approval will be included as Attachment B to these STCs. As the operational protocol will be submitted after the state begins operating the demonstration, approval of the protocol may be contingent upon the state's agreement to make changes to any of the items included in the protocol. Compliance with the agreed upon protocol will be monitored via the processes described in section IX in paragraphs 2 and 3. The protocol shall include:

   a. A detailed description of the outreach campaign that the state conducts to explain the program policies.
   b. Copies of program, applicant and beneficiary communication materials
   c. Copies of the notices beneficiaries receive regarding premiums and copayments and the schedule for such notices.
   d. The process by which beneficiaries remit payment, including ways individuals who cannot pay by check will be accommodated.
   e. The process by which the state operates the premium credit against copayments, including the list of services exempt from copayments.
   f. A description of the state's collection activities including the process by which the state assesses past due premiums.
   g. A description and assurance of how the state accurately tracks cost sharing and the aggregate cap.
   h. Design for the beneficiary survey described in the Evaluation Section XII.

i. A description of how state will comply with the requirements of 42 CFR 447.54 to implement a copayment for non-emergency use of the emergency department.

8. **Preventive Services Protocol**. By December 11, 2015, the state will submit for approval, a protocol describing the process by which the state will ensure that certain beneficiaries are not charged for preventive health care services, including the list of services and drugs that will be exempted. This protocol will be included as Attachment C to these STCs.

VIII. CONTINUOUS ELIGIBILITY

1. **Duration**. The state is authorized to provide a 12 month continuous eligibility period to the group of individuals specified in Table 1, regardless of the delivery system through which they receive Medicaid benefits.

2. **Exceptions**. Notwithstanding subparagraph (a), if any of the following circumstances occur during an individual's 12 month continuous eligibility period, the individual's Medicaid eligibility shall, after appropriate process, be terminated:

   i. The individual cannot be located for a period of more than one month, after good faith efforts by the state to do so.
   ii. The individual is no longer a Montana resident.
   iii. The individual requests termination of eligibility.
   iv. The individual dies.
   v. The individual fails to provide, or cooperate in obtaining a Social Security Number, if otherwise required.
   vi. The individual provided an incorrect or fraudulent Social Security Number.
   vii. The individual was determined eligible for Medicaid in error.
   viii. The individual fails to provide the documentation of citizenship or immigration status required under federal law.
   ix. Consistent with section VII STC 1, the state may terminate individuals with incomes above 100 percent of the FPL due to nonpayment of premiums.

3. **Income for Purposes of Premium Calculation**. If an individual's income changes during the continuous eligibility period, the individual may report the change and the premium amount shall be recalculated for the following quarter.

IX. GENERAL REPORTING REQUIREMENTS

1. **General Financial Requirements.** The state must comply with all general financial requirements under Title XIX outlined in Section XI of these STCs.

2. **Monthly Monitoring Calls**. CMS will convene periodic conference calls with the state. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration; including planning for future changes in the program or intent to further implement the Montana HELP Program beyond December 31, 2020.

CMS will provide updates on any amendments or concept papers under review, as well as federal policies and issues that may affect any aspect of the demonstration. The state and CMS will jointly develop the agenda for the calls. Areas to be addressed may include, but are not limited to:

a. Transition and implementation activities,
b. Stakeholder concerns,
c. Demonstration operations and performance,
d. Enrollment,
e. Copayments,
f. Audits,
g. Lawsuits,
h. Financial reporting issues,
i. Progress on evaluations,
j. Legislative developments, and
k. Any demonstration amendments the state is considering submitting.

3. **Quarterly Progress Reports**. By December 15, 2015, the state will submit for approval a Quarterly Progress Report Format describing the states' plan for submitting quarterly progress reports. This approval will be included as Attachment D to these STCs. The state shall submit progress reports in a format agreed upon by CMS and the state no later than 60 days following the end of each quarter. The intent of these reports is to present the state's analysis and the status of the various operational areas. These quarterly reports shall include, but not be limited to:

   a. A description of the population included in the demonstration (distribution of age, sex, racial/ethnic distribution, etc.).

   b. Completed Quarterly Report Template Workbook, included with Appendix D, with data on: enrollment and dis-enrollment stratified by premium experience and demographics associated with the demonstration populations. There should also be an accompanying brief narrative for each of these areas which address the pertinent issues outlined in Appendix D: Quarterly Report Format.

   c. A discussion of events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, enrollment, or other operational issues.

   d. Summary of the progress of evaluation activities, including key milestones accomplished as well as challenges encountered and how they were addressed. To the extent possible, the state should present this information to CMS in tables. The discussion should also include interim findings, when available; status of contracts with independent evaluator(s), if applicable; and status of study participant recruitment, if applicable.

e. A discussion of key operational and other challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed.

f. Describe any additional events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including, but not limited to: benefits, enrollment and dis-enrollment, complaints and grievances, quality of care, and access that is relevant to the demonstration, pertinent legislative or litigation activity. This should include action plans for any events identified as requiring corrective action.

g. Oversight and monitoring conducted, such as TPA or provider site visits, reports, or requests for corrective actions plans pertaining to either the TPA or FFS demonstration population; complaints, grievances and appeals filed during the quarter by type, highlighting any patterns that are concerning; and actions being taken to address any significant issues evidenced by patterns of complaints or appeals.

h. Enrollment figures for the quarter including enrollment figures for individuals by income level.

i. The number of individuals reaching their cost sharing limitations.

j. A summary of the post award forums and solicited comments from the public, when applicable.

k. Updated timeline for submitting monitoring and evaluation deliverables to CMS.

l. The state must provide a work plan included in each quarterly report, which outlines when monitoring activities occur. Each work plan should include:

    i. Dates for the time periods that data collection will take place for all data sources, including data pulls, surveys collection, interview and focus groups conducting, as well as any other sources for collecting data that are not otherwise specified;
    ii. Estimated time periods which data analyses will take place;
    iii. Dates when the state will submit deliverables and reports;
    iv. The individual responsible for each monitoring activity; and
    v. Other relevant information associated with demonstration monitoring.

m. The data to be reported to CMS in quarterly reports includes, but is not limited to, the following:

    i. The number of individuals subject to premium requirements (i.e., number of nonexempt individuals);

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

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

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

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

    a. All items included in the quarterly report must be summarized to reflect the operation/activities throughout the DY;

    b. Total annual expenditures for the demonstration population for each DY, with administrative costs reported separately;

    c. Yearly enrollment reports for demonstration beneficiaries for each DY (beneficiaries include all individuals enrolled in the demonstration); and

    d. Data related to the comprehensive quality strategy as described in paragraph 7 of this section.

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

X. GENERAL FINANCIAL REQUIREMENTS

1. Quarterly Expenditure Reports. The state must report quarterly expenditures associated with the populations affected by this demonstration on the Form CMS-64.

2. **Reporting Expenditures under the Demonstration**. The following describes the reporting of expenditures:

   a. **Tracking Expenditures**. In order to track expenditures under this demonstration, Montana must report demonstration expenditures through the Medicaid Budget and Expenditure System (MBES) and state Children's Health Insurance Program Budget and Expenditure System (CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the state Medicaid Manual. All demonstration expenditures claimed under the authority of title XIX of the Act must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS, including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made. For this purpose, DY 1 is defined as the year beginning January 1, 2016, and ending December 31, 2016. DY 2 and subsequent DYs are defined accordingly. All title XIX service expenditures that are not demonstration expenditures and are not part of any other title XIX waiver program should be reported on Forms CMS-64.9 Base/64.9P Base.

   b. **Cost Settlements**. For monitoring purposes, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any cost settlements not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the state Medicaid Manual.

   c. **Use of Waiver Forms**. The following one (1) waiver Form CMS-64.9 Waiver and/or 64.9P Waiver must be submitted each quarter (when applicable) to report title XIX expenditures for individuals enrolled in the demonstration. The

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

i. "Continuous Eligibility for New Adult Group" expenditures

3. **Administrative Costs**. Administrative costs will not be included in the budget neutrality limit, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration, using Forms CMS-64.10 Waiver and/or 64.10P Waiver, with waiver name "ADM".

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

5. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the demonstration. The state must estimate matchable demonstration expenditures (total computable and federal share) and separately report these expenditures by quarter for each federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS will make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS will reconcile expenditures reported on the Form CMS-64 quarterly with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

6. **Extent of FFP for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the demonstration as a whole as outlined below:

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

   b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved state plan.

   c. Medical Assistance expenditures made under section 1115 demonstration authority, including those made in conjunction with the demonstration, cost sharing, pharmacy rebates, and all other types of third party liability or CMS payment adjustments.

7. **Sources of Non-Federal Share.** The state must certify that the matching non-federal share of funds for the demonstration are state/local monies. The state further certifies that such funds shall not be used as the match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

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

    b. Any amendments that impact the financial status of the program shall require the state to provide information to CMS regarding all sources of the non-federal share of funding.

    c. The state assures that all health care-related taxes comport with section 1903(w) of the Act and all other applicable federal statutory and regulatory provisions, as well as the approved Medicaid state plan.

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

8. **State Certification of Funding Conditions.** The state must certify that the following conditions for non-federal share of demonstration expenditures are met:

    a. Units of government, including governmentally operated health care providers, may certify that state or local tax dollars have been expended as the non-federal share of funds under the demonstration.

    b. To the extent the state utilizes certified public expenditures (CPEs) as the funding mechanism for Title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under Title XIX (or under section 1115 authority) for purposes of certifying public expenditures.

    c. To the extent the state utilizes CPEs as the funding mechanism to claim federal match

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

d. The state may use intergovernmental transfers to the extent that such funds are derived from state or local tax revenues and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of Title XIX payments.

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

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

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

XI. MONITORING BUDGET NEUTRALITY

1. **Limit on Title XIX Funding.** The state shall be subject to a limit on the amount of federal Title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit is determined by using the per capita cost method described in STC 4 in this section, and budget neutrality expenditure limits are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. The data supplied by the state to CMS to set the annual caps is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the state's compliance with these annual limits will be done using the Schedule C report from the CMS-64.

2. **Risk**. The state will be at risk for the per capita cost (as determined by the method described below) for demonstration populations as defined in section 16, but not at risk for the number of enrollees in the demonstration population. By providing FFP without regard to enrollment in the demonstration populations, CMS will not place the state at risk for changing economic conditions that impact enrollment levels. However, by placing the state at risk for the per capita costs of current eligibles, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.

3. **Calculation of the Budget Neutrality Limit.** For the purpose of calculating the overall budget neutrality limit for the demonstration, separate annual budget limits will be calculated for each DY on a total computable basis, as described in STC 4 below. In the event that there is more than one DY, the annual limits will then be added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality limit by the composite federal share, which is defined in STC 4 in this section below.

4. **Demonstration Populations Used to Calculate the Budget Neutrality Limit**. For each DY, separate annual budget limits of demonstration service expenditures will be calculated as the product of the trended monthly per person cost times the actual number of eligible/member months as reported to CMS by the state under the guidelines set forth in STC. The trend rates and per capita cost estimates for each Mandatory Enrollment Group (MEG) for each year of the demonstration are listed in the table below.

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

a. If the state's experience of the take up rate for the new adult group and other factors that affect the costs of this population indicates that the per member per month (PMPM) limit described above in paragraph (a) may underestimate the actual costs of medical assistance for the new adult group, the state may submit an adjustment to paragraph (a), along with detailed expenditure data to justify this, for CMS review without submitting an amendment pursuant to STC 7. Adjustments to the PMPM limit for a demonstration year must be submitted to CMS by no later than October 1 of the demonstration year for which the adjustment would take effect.

b. The budget neutrality cap is calculated by taking the PMPM cost projection for the above group in each DY, times the number of eligible member months for that group and DY, and adding the products together across DYs. The federal share of the budget neutrality cap is obtained by multiplying total computable budget neutrality cap by the federal share.

c. The state will not be allowed to obtain budget neutrality "savings" from this population.

5. **Composite Federal Share Ratio**. The composite federal share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period, as reported through the MBES/CBES and summarized on schedule C (with consideration of additional allowable demonstration offsets such as, but not limited to, premium collections) by total computable demonstration expenditures for the same period as reported on the same forms. Should the demonstration be terminated prior to the end of the extension approval period (see section 0 STC 8.b), the Composite Federal Share will be determined based on actual expenditures for the period in which the demonstration was active. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of composite federal share may be developed and used through the same process or through an alternative mutually agreed upon method.

6. **Calculating the Federal Medical Assistance Percentage (FMAP) for Continuous Eligibility for the Adult Group.** CMS anticipates that states that adopt continuous eligibility for adults would experience a 2 percent increase in enrollment. Based on this estimate, CMS has determined that 97.4 percent of the member months for newly eligibility in the adult group will be made at the enhanced FMAP rate and 2.6 percent will be matched at the regular FMAP rate.

7. **State Reporting for the FMAP Adjustment.** Newly eligible individuals in the Adult Group shall be claimed at the enhanced FMAP rate. The state must make an adjustment in the CMS-64W that accounts for the proportion of member months in which beneficiaries are enrolled due to continuous eligibility and could have been dis-enrolled due to excess income in absence of continuous eligibility (i.e. 2.6 percent). For the purposes of budget neutrality, the members for the adult group within the 2.6 percent of the population described in this STC will be treated as a hypothetical population.

8. **Future Adjustments to the Budget Neutrality Expenditure Limit**. CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under the demonstration.

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

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

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

XII. EVALUATION

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

a. A discussion of the goals, objectives, and specific hypotheses that are being tested, including those that focus specifically on the target populations for the demonstration.

b. The evaluation design must include the research questions and proposed measures listed below. The state must use measures from nationally-recognized sources and those from national measures sets (including CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Healthcare Providers and Systems (CAHPS) and the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; and/or measures endorsed by National Quality Forum (NQF) where possible. At least one research question must be proposed for each waiver and expenditure authority approved by CMS. For questions that cover broad subject areas, the state may propose a more narrow focus for the evaluation.

    i. How has the implementation of premiums affected program enrollment?
    ii. Have premiums and cost sharing made beneficiaries more likely to exhibit health-conscious consumption behavior?
        1. Percent of individuals accessing primary care
        2. Percent of individuals accessing behavior health services
        3. Pharmacy (overall costs, brand vs. generic dispensing rate)
        4. Percent of individuals using TPA Wellness Program services
        5. Percent of individuals using primary care for chronic disease management services (if chronic disease present)
        6. Percent of unique individuals accessing preventive services
        7. Percent of preventive care visits, total and average per person
        8. Percent of specialty care visits, total and average per person
        9. Percent of individuals taking brand name medications when generic medication is available
    iii. Does continuous eligibility promote better continuity of coverage for the new adult group?
        1. Enrollment rates;
        2. Churn rates.

c. Addressing the research questions will require qualitative and, where applicable, quantitative research methodologies. The state must develop a research plan for each research question, and provide a rationale for its selection. The research plan for each question must include the following:
    i. Proposed baseline and control comparison groups, where applicable. If randomization is not used, methods to adjust for the non-equivalence of the control and comparison group must be proposed.
    ii. Data sources, collection frequency, and process for demonstrating the accuracy and completeness of the data.
    iii. Sampling methodology for selecting the population being included in your analysis (e.g., controlled before-and-after studies, interrupted time series design, and comparison group analyses). If an experimental design is

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

iv. Draft of instruments used for collecting data, including survey designs, interview questions, and focus group questions.

v. Analysis plan that describes the statistical methods that will be employed to evaluate differences between the demonstration and comparison groups in key outcomes. The evaluation design must also demonstrate how the state will analyze data.

    1. Description of statistics that will be utilized including whether the analysis will be at the beneficiary, provider, and aggregate program level, as appropriate, and include population stratifications to the extent feasible, for further depth and to glean potential non-equivalent effects on different sub-groups.

vi. Identify the contractor that will be conducting the evaluation. The state should describe the qualifications of the outside contractor and the process to ensure the contractor will be an independent evaluator with no conflict of interest.

vii. Budget that details the estimated cost for staffing, data collection, and analysis over the course of the entire evaluation.

viii. A diagram, process flow and logic model or driver diagram illustrating the specific quantifiable aims and how the state plans to meet the identified aims/outcomes of the demonstration.

ix. Timeline for submitting evaluation and monitoring deliverables.

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

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

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

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

In the event the state requests to extend the demonstration beyond the current approval period under the authority of section 1115(a), (e), or (f) of the Act, the state must submit an interim evaluation report as part of its request for each subsequent renewal, as outlined in CFR 431.412 (c)(2)(vi).

5. **Final Interim Evaluation Report.** The state must submit their final Interim Evaluation Report within 60 days after receipt of CMS' comments on their draft Interim Evaluation report.

6. **Draft Final Evaluation Submission**. The state must submit to CMS a draft of the final evaluation report within 120 days of expiration of the demonstration. The report must include the required criteria listed in section XI paragraph 3 of the STCs, including final evaluation findings.

7. **Final Evaluation Report**. The state must submit the final evaluation report within 60 days after receipt of CMS' comments on their draft submission.

8. **Cooperation with Federal Evaluators.** Should CMS conduct an evaluation of any component of the demonstration; the state will cooperate fully with CMS or the independent evaluator selected by CMS. The state will submit the required data to CMS or the contractor at no cost to CMS or the contractor.

9. **Cooperation with Federal Learning Collaboration Efforts.** The state will cooperate with improvement and learning collaboration efforts by CMS.

10. **Evaluation Budget.** A budget for the evaluation shall be provided with the evaluation design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses, and reports generation. A justification of the costs may be required by CMS if the

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

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

XIII. HEALTH INFORMATION TECHNOLOGY

1. **Health Information Technology (HIT).** The state shall use HIT to link services and core providers across the continuum of care to the greatest extent possible. The state is expected to achieve minimum standards in foundational areas of HIT and to develop its own goals for the transformational areas of HIT use.

    a. Montana must have plans for health IT adoption for providers. This will include creating a pathway (and/or a plan) to adoption of certified electronic health record (EHR) technology and the ability to exchange data through the state's health information exchanges. If providers do not currently have this technology, there must be a plan in place to encourage adoption, especially for those providers eligible for the Medicare and Medicaid EHR Incentive Program.

    b. The state must participate in all efforts to ensure that all regions (e.g., counties or other municipalities) have coverage by a health information exchange. Federal funding for developing health information exchange (HIE) infrastructure may be available, per State Medicaid Director letter #11-004, to the extent that allowable costs are properly allocated among payers.

    c. All requirements must also align with Montana's State Medicaid HIT Plan, as applicable, and other planning efforts such as the Office of National Coordinator HIE Operational Plan.

XIV. T-MSIS REQUIREMENTS

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

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

XV. SCHEDULE OF DELIVERABLES

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

Per award letter - Within 30 days of the date of award	Confirmation Letter to CMS Accepting Demonstration STCs
Per Section VII, Paragraph 8	Preventive Services Protocol
Per Section VII, Paragraph 6	Operations Protocol
Per Section XII, Paragraph 1	Submit Draft Evaluation Design
Per Section III, Paragraph 8	Submit Demonstration Extension Application
Per Section III, Paragraph 10	Post-award Forum
Per Section IX, Paragraph 3	Quarterly Operations Report

ATTACHMENT A

Copayment Schedule and Exempt Services

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

Service Description	Copayments for Individuals With Incomes At or Below 100 Percent FPL	Copayments for Individuals with Incomes Above 100 Percent FPL
Outpatient Facility	$4	10 percent of the payment the State makes for the service
Primary Care Physician	$4	10 percent of the payment the State makes for the service
Specialty Physician	$4	10 percent of the payment the State makes for the service
Pharmacy - Generics	-	-
Pharmacy – Preferred Brand Drugs	$4	$4
Pharmacy – Non-Preferred Brand Drugs, including specialty drugs	$8	$8

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

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

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

Attachment B
Montana HELP Demonstration
Operations Protocol

I. Purpose

The Operations Protocol describes Montana's policies and procedures for implementing premiums and co-payments for HELP Plan participants.

II. Overview

HELP Plan participants enrolled through the Third Party Administrator (TPA) will be required to pay premiums and co-payments. Responsibility for paying premiums and co-payments will encourage HELP Plan participants to be more discerning health care purchasers, take personal responsibility for their health care decisions and develop health-conscious behaviors as consumers of health care services.

The following participants are excluded from the TPA and not subject to premiums: participants who (1) have been determined to be medically frail; (2) live in a region (which could include all or part of an Indian reservation) where the TPA was unable to contract with sufficient providers; (3) require continuity of coverage that is not available or could not be effectively delivered through the provider network offered by the TPA; and, (4) are otherwise exempted from premiums or cost sharing by federal law, and not within the scope of a waiver of that exemption, including participants with incomes at or below 50% of the federal poverty level (FPL). New adults who are excluded from the TPA or who have incomes at or below 50% of the FPL are not subject to premiums, but are subject to co-payments as set forth in the Cost Sharing State Plan Amendment (SPA).

Household cost sharing for all participants under the Demonstration will be consistent with Medicaid regulations, and premium and co-payments will be subject to an aggregate cap of 5% of household income. TPA participants will receive a credit toward their co-payment obligation in the amount of their total premiums, such that they shall not accrue out of pocket expenses for co-payments until accumulated co-payments exceed 2% of aggregate household income.

In accordance with the Special Terms and Conditions (STCs), Federal regulation, and State legislation, the State will exempt certain services from co-payments. Preventive services that are exempt from co-payments are recorded in Attachment C of the STCs.

III. Premiums

1. Overview

TPA participants will be charged premiums equal to 2% of their household income. The TPA will notify participants of their required monthly premium upon enrollment and that their cost sharing obligation of premiums and co-payments will not exceed 5% of their income, through a

monthly premium invoice and in the Participant Guide and, when applicable, through scripts used by the TPA's customer service representatives.

2. Payment

The TPA will administer and collect TPA participant premiums, providing multiple options for participants to remit payments. Participants can pay their premiums by check and money order. The TPA is currently developing an option for online payment of premiums via Automated Clearing House payments through the participant portal, which is scheduled to be implemented by the end of September 2016.

The TPA also has a process in place to accept third party contributions on behalf of participants. This includes ensuring that any amounts received are credited to the appropriate participant and the entity or individual who made the payment is tracked. State law does not limit which individuals or entities may contribute on the participant's behalf, and any third party's contribution will be applied directly to the participant's premium requirement; the contributions cannot be used to offset the State's share. Any individual or entity may initiate the process. In the event excess funds are received, funds will be returned to the appropriate remitter as required by relevant law and regulation.

There are no limits on the amounts third parties can contribute toward a beneficiary's premium obligation. Such third party contributions offset required beneficiary premium or copayment obligations only, and may not be used for any other purpose.

3. Consequences of Non-Payment

Consequences of non-payment of premiums vary depending on a participant's household income.

i. Participants with Incomes above 50% up to and including 100% FPL

Participants with income above 50% up to and including 100% of the FPL who fail to pay premiums will not be dis-enrolled from coverage. Unpaid premiums will be considered a collectible debt that may be collected or assessed by the State. Assessment occurs when the Department of Revenue sends a notice of debt to the participant and must occur no later than the end of each calendar quarter in which a person has collectible debt.

ii. Participants with Incomes above 100% up to and including 133% FPL

Participants with incomes above 100% and up to and including 133% FPL who fail to pay premiums will be dis-enrolled from coverage after appropriate notice and a 90 day grace period. All participants will receive monthly premium invoices via mail documenting their owed premiums; participants with premiums past due 90 days will receive a 90 day premium invoice via mail as well as a letter outlining circumstances under which they may avoid disenrollment.

Participants will also receive a letter from the Department of Revenue upon assessment of their debt. Individuals will have a right to appeal an adverse decision at any time.

Participants may re-enroll in coverage in the month that payment is made for the overdue premiums or in the month after the month that the Department of Revenue assesses overdue premium amounts (e.g., if the Department of Revenue assesses in March, the participant may re-enroll in April). Assessment occurs when the Department of Revenue sends a notice of debt to the participant and must occur no later than the end of each calendar quarter. For example, if a monthly premium is due on June 1st, the grace period clock runs for 90 days from July through September. If the premium remains unpaid the individual's coverage will be terminated on October 31st and the first day of non-coverage will be November 1st.

In order to re-enroll in the HELP Plan, the individual need not file a new application if they are within the 12 month continuous eligibility period; he or she must simply visit an enrollment office, call a toll-free number dedicated to re-activating enrollment, or go online to apply.mt.gov and opt back into the HELP Plan. In the month the individual successfully opts back in, eligibility is effective the first day of that same month.

4. **Assessment**
   When a participant has a premium payment that is over 90 days past due the debt will be transferred to the Department of Revenue to be assessed quarterly for tax offset. When the Department of Revenue has a tax refund, a notification will be sent to the participant to inform them that their tax return will be reduced by the assessed debt.

5. **Premium Examples**

Examples A and B illustrate how premiums will be applied to participants.

Example A: Participants with Incomes above 50%up to and including 100% FPL
A participant with no dependents has an annual income of $8,830, around 75% FPL. The participant's annual premium contribution is approximately $176 or $14 per month. Upon enrollment in the TPA, the participant is notified of their monthly premium and options for payment through a welcome package issued by the TPA, as well as a monthly invoice. If the participant fails to make monthly premium payments, the unpaid amount will be considered a collectible debt subject to assessment and collection by the Department of Revenue. The participant will not be dis-enrolled for failure to pay the monthly premium.
Example B: Participants with Incomes above 100% up to and including 133% FPL
A participant has an annual income of $25,000, around 125% FPL. The participant's annual premium contribution is $500 or approximately $41 per month. Upon enrollment in the TPA, the participant is notified of their monthly premium and options for payment through a welcome package issued by the TPA, as well as a monthly invoice. Participants are billed for premiums on approximately the 12th of each month, with a request to pay the premium by the 1st of the following month. If a participant enrolls after the cutoff for the current

month's billing cycle, they will be billed for three months of premiums in the subsequent month.

Example B1:

- **A participant enrolls on May 4th (before the billing cutoff) and is billed for their May and June premium on May 12th.**
- **If the participant does not pay by June 1st, the bill they receive in June will request payment for three months of premiums (May, June, and July).**
- **Should the participant not pay, the grace period will cover July, August, and September. The participant will be disenrolled in October with coverage lasting through October 31st. November 1st will be the first day of non-coverage, assuming the participant did not pay the first premium amount in full or any other premium amounts.**

Example B2:

- **A participant enrolls on May 15th (after the billing cutoff around the 10th of the month) and is billed on June 12th for both May, June and July premium payments.**
- **If the participant does not pay by July 1st, the bill they receive in July will request payment for four months of premiums (May, June, July, and August).**
- **Should the participant not pay, the grace period will last the months of August, September, and October, and the participant will be disenrolled in November with coverage lasting through November 30th. In this example, December 1st will be the first day of non-coverage, assuming the participant did not pay the first premium amount in full or any other premium amounts.**

Premium payments are always credited toward a participant's oldest debt. If the participant fails to make monthly premium payments, and the premium becomes more than 90 days past due, and does not meet exemptions listed in SB405,[1] the participant will be dis-enrolled from the HELP Plan. In addition, the participant's outstanding premium balance will be transferred to the Department of Revenue for assessment and collection from their state income tax refund. The participant may re-enroll in the HELP Plan once they have remitted payment for unpaid premiums or after the Department of Revenue has assessed their debt. The Department of Revenue will assess participants' debt on a quarterly basis.

IV. Co-payments

1. Overview

Participants in the HELP Demonstration will be subject to maximum allowable cost sharing under federal regulations subject to an aggregate cap of 5% of household income. In addition, all TPA participants will receive a credit toward their co-payment obligations in the amount of the 2% of income in premiums they owe, such that they shall not accrue out of pocket expenses for

[1] Montana Legislature, Senate Bill 405, http://leg.mt.gov/bills/2015/billpdf/SB0405.pdf.

co-payments until accumulated co-payments exceed 2% of aggregate quarterly household income. Certain health care services, preventive services, and drugs will be exempt from co-payments; these services and drugs are documented in the Preventive Services Protocol.

2. Co-payment Billing and Payment

Co-payment is assessed based on the date of payment. The State will utilize the following billing and payment process:

- Providers will not charge co-payments to participants at the point of service.
- Providers will submit claims to claims payment vendors (TPA, Pharmacy Benefit Manager, and MMIS) in compliance with International Classification of Diseases (ICD) coding guidelines.
- The claims payment vendors will review the claims, consulting the list of healthcare services, preventive services, and drugs to determine whether the claim is subject to a co-payment.
    - Preventive health care services including primary, secondary, and tertiary preventive services will be identified by diagnosis codes and/or procedure codes.
    - Pharmacy claims will be identified through drug classes. DPHHS will maintain the list of exempt preventive services and drug classes and review and update the list at least annually.
- The claims payment vendors will process claims, taking into consideration the 2% credit toward co-payment obligations and the 5% aggregate household cap to ensure participants are not inappropriately billed for co-payments.
- The claims payment vendors will send remittance advice to the provider with co-payment information.
- Providers will bill participants for applicable co-payments after receiving remittance advice from the claims payment vendors.
- If the participant has reached the 5% aggregate household cap, the provider will not bill the participant for the service.
- The TPA will include direction in the provider manual outlining the requirement to monitor uncollected co-pay amounts for HELP Plan participants. The TPA will send an annual survey to providers requesting a summary of uncollected co-payments from HELP Plan participants and their efforts to collect the co-payments.
- The enterprise data exchange should prevent overcharging of participants as well as the process described above in which participants are not charged at the point of service. However, if a participant is overcharged, the State will re-process the claim, notify the provider, and, if the provider has collected payment, the provider will reimburse the participant. If the participant's incurred co-payments exceed the 5% aggregate cap, the State will also send the participant a notice stating the participant may have been overcharged and instructing them to reach out to the provider to seek reimbursement.

Hospitals are required to comply with federal requirements to screen and provide services to individuals who require emergency care. The State presumes all visits to the emergency

department are not subject to cost sharing, unless the provider provides a written attestation to the State that the provider meets the State's requirements for imposing co-payments for emergency department services. Co-payments for non-emergent use of the emergency department can only be charged if the hospital completes all of the below steps (per 42 CFR § 447.54(d).

1. Conducts an EMTALA-compliant medical screening examination that concludes the participant's condition is non-emergent;
2. Provides the participant with the name and location of an alternative non-emergency services provider;
3. Determines that the alternative provider can provide services at a lower cost sharing amount; and
4. Provides a referral to schedule treatment by the alternative provider.

In the event a visit is determined to be a non-emergency, before providing non-emergency services, the hospital will inform the individual that they may be subject to cost sharing and that the participant will receive a bill from the hospital once the co-pay amount is determined after adjudication of the claim. The State instructed hospitals of these requirements through written notice, posting the policy on the Medicaid website, incorporating the policy into the provider process, and establishing a hospital attestation process. Beneficiaries will not be charged a co-payment for non-emergency use of the ER unless the conditions detailed above and in compliance with 42 CFR § 447.54(d) are met. This policy is described in the HELP Plan Participant Guide.

3. Co-payment Examples

Examples C and D below illustrate how the co-payments will operate for participants with income above 50% up to and including 100% FPL, and participants with incomes above 100 up to and including 133% FPL.

Example C: Participants with Incomes above 50%up to and including 100% FPL

The participant is married without children (household size of two) with a household income of 75% FPL. The participant has a premium credit of approximately $239 or 2% of household income per year, or approximately $60 per quarter. During the participant's first quarter in the HELP Demonstration, the participant is billed for the following services:

- **One preventive care visit (No co-payment) = $0**
- **One outpatient visit for a sinus infection ($4 co-payment) = $4**
- **One preferred prescription drug ($4 co-payment) = $4**
- **One outpatient physical therapy visit ($4 co-payment) = $4**
- **Two non-preferred prescription drugs ($8 co-payment per drug) = $16**

Total co-payment: **$28**

The participant is not charged co-payment for any of the above services at the point of service. Rather, the corresponding providers submit claims for the services and, upon

processing by the claims vendor, receive remittance advice indicating that (1) the preventive care visit does not have a co-payment; and (2) the participant's premium credit is being applied to the remaining co-payment, such that the provider is being paid in full for the service and does not have to collect a co-payment from the patient. The participant will not owe a co-payment.

Example D: Participants with Incomes above 100% up to and including 133% FPL

The participant is a single male with an annual income of $11,888, or 101% FPL, and has a premium credit of approximately $237 per year, or $59 per quarter. The participant has a maximum out of pocket cap of 5% of quarterly income, so will not be obligated to pay over $148 each quarter for all out of pocket expenses (or $59 in premiums plus $89 in co-payments). The participant is billed for the following services during the first quarter of enrollment:

- **1 preventive care visit (No co-payment) = $0**
- **2 outpatient visits ($20 co-payment per visit, or 10% of the $200 payment the State makes for each outpatient service) = $40**
- **6 preferred prescription drugs ($4 co-payment per drug) = $24**
- **12 preferred non-prescription drugs ($8 co-payment per drug) = $96**

Total co-payment: $160
Premium credit for the quarter applied to co-payment: $59
Maximum quarterly co-payments owed by participant: $89
Cost sharing waived (amount above 5% cost share max allowed by CMS): $12

The participant is not charged for any of the above services at the point of service. Rather, the corresponding providers submit claims for the services and, upon processing by the claims vendor, receive remittance advice indicating that (1) the preventive care visit does not have a co-payment; (2) the participant's premium credit is applied to the first $59 in co-payment, such that the provider is being paid in full for the service and does not have to collect a co-payment from the patient; and (3) the participant will owe his maximum quarterly co-payments totaling $90.

When the participant pays their premium, the payment is applied to the cap during the quarter for which the premium is due. In this example, if the participant is billed for $59 in premiums in March, the payment is applied to the first quarter.

V. Tracking of Premiums and Co-payments Against the 5% Aggregate Household Cap

On a quarterly basis, the State, working with its claims payment vendors (Xerox and Blue Cross Blue Shield of Montana) and through the enterprise data exchange detailed in Figure 1, will calculate the total incurred premiums and co-payments by each TPA participant to ensure that participants' total out-of-pocket payments do not exceed the aggregate 5% household cap. The State will track premiums and co-payments of all household members, including members who

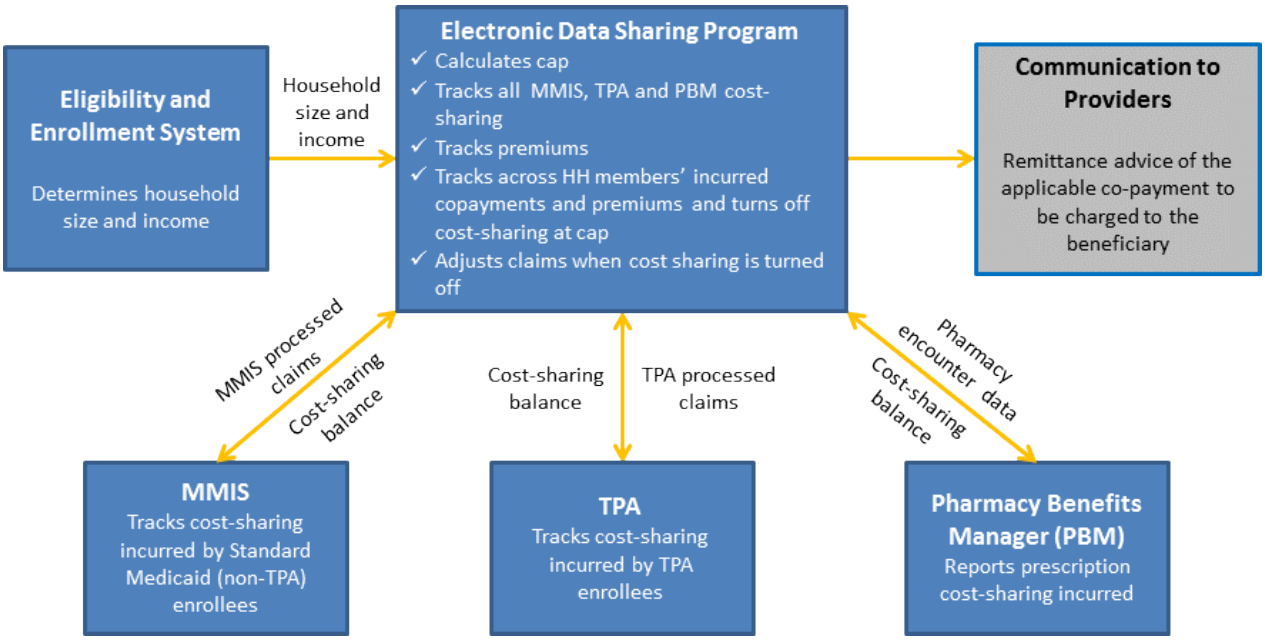
are not enrolled in the TPA, against the aggregate cap through data sharing across the TPA, MMIS, and Pharmacy Benefit Manager (PBM).

After each claim is received, a TPA participant will receive an Explanation of Benefits that summarizes service utilization as well as total amount of incurred premiums and co-payments obligation. The State is committed to ensuring the format and content of Explanation of Benefits are both responsive to the needs of the participant and support the purpose of the HELP Demonstration; any consumer feedback that is received on the Explanation of Benefits or notices is carefully considered and used to inform revisions. Participants will have access to a Participant Help Line to assess whether they have reached their 5% aggregate household cap. The TPA is currently developing an enhancement to the participant portal which will display premiums, premium credit, and amount accumulated towards 5% maximum out of pocket expense.

If the State, through its electronic data sharing among the MMIS, TPA, and PBM, identifies a participant whose household has paid over the 5% aggregate limit, claims for which co-payments were inappropriately collected will be re-adjudicated and the provider will be required to refund the previously collected co-payment.

Providers will receive beneficiary co-payments based on the date of claims adjudication, until a participant reaches their 5% aggregate limit.

Figure 1. **Electronic Data Sharing Exchange**



If a participant would like a reassessment of his or her family's aggregate limit due to a change in circumstances or a termination of enrollment due to failure to pay a premium, the participant will be directed to contact the Office of Public Assistance (OPA) and follow their outlined

request for review process. The premium amount shall be recalculated for the following month and the participant will be notified of the change in premium, if applicable.

If a participant disagrees with a decision on the aggregate limit or termination of enrollment for failure to pay premiums, the participant has the right to a fair hearing; a participant may request a fair hearing on the aggregate limit or premium amounts after their initial eligibility determination. To request a fair hearing the participant will be directed to call the Office of Fair Hearings or submit a form with their complaint. The fair hearing process is documented in ARM 37.5.307. Information regarding how to access a fair hearing is also documented in the Participant Guide and each Explanation of Benefits.

VI. Participant and Provider Engagement

1. Participant Education and Outreach

a. TPA-led education and outreach

The State will ensure through its contract with the TPA that the TPA has written policies regarding services exempt from co-payment and will work with the TPA to develop and disseminate information to participants, including through the Participant Guide, Welcome Letter, Welcome Brochure, and on the DPHHS HELP Plan website. Participants will be notified of the co-payment exemption policy and be provided with a list of co-payment exempted services within ten days of enrollment. The policy and list of exempted services will also be posted on the State and TPA's websites and will be available in hard copy upon a participant's request. The information provided to participants will comply with the Information and Communication Requirements detailed in the 1915(b)(4) Waiver STCs (Section 11), and will undergo revisions approved by DPHHS at least annually to ensure they are accurate and up to date. The TPA is required to comply with these requirements through its contract with DPHHS and DPHHS retains ultimate responsibility for approving materials and information provided to participants.

The TPA will be responsible for providing sufficient staffing and other administrative support to respond to participant questions regarding premiums and co-payments, and will be obligated to educate participants on these topics. TPA-led education must include information on how to interpret and use account statements; how to make payments on required premiums and co-payments; and the process for submitting questions and complaints about premiums and co-payments.

The TPA will regularly report to the State on the performance of its participant education and outreach activities. Should the State find the TPA's education and outreach activities to be ineffective, it will work with the TPA on a corrective action plan to meaningfully improve education and outreach performance.

In its Quarterly Reports to CMS, the State will describe actions the State and TPA have taken to inform participants about co-payment exempted services.

b. State-led education and outreach

The State is committed to working alongside the TPA to ensure eligible HELP Plan participants receive sufficient explanation of the Plan's policies, and the State will continue to serve as a resource for all Medicaid participants.

Upon Medicaid eligibility determination, HELP Plan participants will receive a notice from the DPHHS advising them of the following:

- Medicaid eligibility determination: The notice will include the basis of the participant's eligibility determination, effective date of eligibility, information on copayments and premiums, a review of covered services, information regarding procedures for reporting a change in circumstances, and website access to the participant guide and newsletters.
- Appeals: The notice will include information regarding the Medicaid appeals process as required under federal law.

In addition to TPA-led participant education and outreach activities, the State will ensure information regarding covered benefits and policies regarding premiums and co-payments are posted and accessible via the State's website as well as in hard copy upon participant request. Consistent with 42 CFR 447.57, the State makes available a public schedule describing current cost sharing requirements in a manner that ensures affected applicants, participants and providers have access to the information. The website will also include copies of participant materials such as the Welcome Brochure and Participant Guide, and provide contact information for dedicated Help Lines where participants may access assistance with eligibility and enrollment as well as medical, vision, dental, and prescription benefits. State staff will also be trained on the policies so that they may address or appropriately direct participant inquiries in a timely manner.

c. Copies of participant-facing materials

The following materials will undergo revisions approved by DPHHS at least annually to ensure they are accurate and up to date (any item not attached as an appendix is currently under revision):

i. **Welcome Letter** [Appendix A]
ii. **Participant Guide** [Appendix B]
iii. **Welcome Brochure** [Appendix C]

d. Copies of participant notices

The following materials will undergo revisions approved by DPHHS at least annually to ensure they are accurate and up to date:

i. **Notice of Eligibility Determination** [Appendix D]
ii. **Premium Invoice** [Appendix E]
iii. **Explanation of Benefits** [Appendices F and G]

2. Provider Education and Outreach

a. TPA-led provider education and outreach

The State will ensure through its contract with the TPA and review of TPA materials that the TPA has written provider education materials regarding co-payment exemptions. The State meets regularly with the TPA to understand how the TPA is conducting outreach to providers and works with the TPA to develop and disseminate information to providers. The TPA interacts with providers through: the provider manual; review and approval of written notices and communications; provider trainings; and the TPA's quarterly provider newsletter.

b. State-led provider education and outreach

The State of Montana uses provider Medicaid Manuals to impart provider education. These can be found on the Montana Medicaid website, medicaidprovider.mt.gov. The State will also ensure its website includes important provider information and directs providers to the TPA for additional information and general provider services. The State has designated staff responsible for maintaining the website and relevant information for providers, and has a process in place whereby any changes to provider information are converted to the website in a timely manner.

The State will also partner with various professional associations to ensure education regarding the Montana HELP Plan is consistent with program policies and procedures, and that information about the HELP Plan is distributed through existing provider communication channels.

c. Copies of provider-facing materials

The TPA conducted several provider webinars during the first two months after HELP implementation, providers may access the education slides, which contain several slides specific to premiums and co-payments [Appendix H].

3. Participant Survey Approach and Design

The State of Montana will partner with the TPA to develop and administer a yearly survey of the following populations:

1. Participants enrolled in the TPA;
2. Participants who have been dis-enrolled from the TPA; and
3. Individuals who are eligible to enroll in the TPA.

Although survey questions may be slightly altered to ensure the best quality enrollee information is gathered, the preliminary survey can be found in Appendix I.

The survey size will be large enough to produce statistically significant results and will be designed to evaluate whether potential applicants and participants understand the program policies, premiums and associated consequences, and whether the premiums affect participants' decisions about whether to apply for the program.

VII. Grievances

The State and TPA will follow participant grievance and appeals processes described in the 1915(b)(4) and 1115 Waiver STCs and consistent with federal law. In its Quarterly Reports to CMS, the State will describe actions, complaints, grievances, and appeals filed during the quarter regarding service exemptions and co-payments as well as any actions being taken to address significant issues evidenced by patterns of complaints or appeals.

Participants are provided information on the grievance and appeals process in the Participant Guide, Explanation of Benefits, and any service denial communications. Participants may initiate an appeal at any time.

Montana HELP Demonstration

Operations Protocol

Appendix A

Welcome Letter

(2 pages)

Dear HELP Plan Participant:

Welcome to the Montana Health and Economic Livelihood Partnership (HELP) Plan! The Montana Department of Public Health and Human Services (DPHHS) and Blue Cross and Blue Shield of Montana (BCBSMT), have come together to offer health coverage to Medicaid-eligible Montanans. This Welcome Kit includes the following:

1. Welcome Brochure – tells you about the HELP Plan's covered benefits. Most benefits are managed at BCBSMT, but some benefits are managed at DPHHS.
2. Blue Access for Members [SM] (BAM) Flier – tells you how to go online and check claim status, see an Explanation of Benefits (EOB), verify eligibility, request identification (ID) cards or print a temporary ID card, and more.
3. HELP Plan Participant Guide – tells you about covered benefits and gives directions about how to use your HELP Plan benefit plan.

You will get your HELP Plan participant ID card in a different mailing.

The HELP Plan encourages you to stay healthy with covered preventive health benefits such as yearly physicals and a Health Assessment. The HELP Plan only pays for care you get from HELP Plan network providers.

We encourage you to pick a health care provider from the BCBSMT HELP Plan provider network as a primary care provider to manage your health care needs. This is the best way to use your benefits to get and stay healthy. A primary care provider can help coordinate your care between different types of providers, which will help you get the most from your HELP Plan benefit plan. A list of HELP Plan providers is at www.bcbsmt.com under 'Find a Doctor or Hospital.'

Since some benefits are managed at DPHHS, providers must accept Montana Medicaid for the following services in order for you to be covered by the Montana HELP Plan:

- Audiology
- Community Health Centers/Federally Qualified Health Centers (FQHCs)
- Dental
- Eyeglasses
- Hearing Aids
- Indian Health Services (IHS)/Tribal Health

- Pharmacy
- Rural Health Clinics (RHCs)
- Transportation

A list of Montana Medicaid providers is at
https://mtaccesstohealth.acs-shc.com/mt/general/providerLocator.do

Go to HELPPlan.mt.gov to get a copy of the HELP Plan Evidence of Coverage (EOC). The EOC has more detailed information about HELP Plan coverage and benefits. Call **1-877-233-7055** to ask for a printed copy of the guide.

We look forward to serving your health care needs. Sincerely,

Blue Cross and Blue Shield of Montana
Montana HELP Plan

Claims Administrator * 560 North Park Avenue ***** PO Box 4309 ***** Helena, MT 59604-4309 ***** www.bcbsmt.com

This project is funded in whole or in part under a contract with the Montana Department of Public Health and Human Services. The statements herein do not necessarily reflect the opinion of the Department.

Montana HELP Demonstration

Operations Protocol

Appendix B

Participant Guide

(36 pages)

BlueCross BlueShield of Montana

MONTANA DPHHS
Healthy People. Healthy Communities.
Department of Public Health & Human Services

MONTANA HELP PLAN

PARTICIPANT GUIDE

www.bcbsmt.com/mthelpplan
HELPPlan.mt.gov

Update 10/01/2016

Thank you for choosing the Montana Health and Economic Livelihood Partnership (HELP) Plan as your health plan. This HELP Plan Participant Guide will help you learn more about the HELP Plan and how to use your HELP Plan benefits. The HELP Plan offers medical, behavioral health, dental, vision, prescription drug benefits, and much more. The HELP Plan works to keep you healthy, not just treat you when you are sick. When this HELP Plan Participant Guide is updated with covered services, copayment, or plan changes, it will be posted to **www.bcbsmt.com/mthelpplan** and **HELPPlan.mt.gov**.

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Montana HELP Plan

The HELP Plan is just one of many programs sponsored by the Montana Department of Public Health and Human Services (DPHHS) to provide health care coverage to Montanans. Most HELP Plan medical services are administered by Blue Cross and Blue Shield of Montana (BCBSMT). A small set of medical services will be administered by Xerox.

Services for the HELP Plan Processed by BCBSMT (must be a BCBSMT provider):

- Behavioral Health (Mental Health and Substance Use Disorder)
- Convalescent Home (excludes Custodial Care)
- Durable Medical Equipment/Supplies
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)
- Emergency
- Hospital
- Lab and X-Ray (Medical)
- Medical Vision and Exams
- Mid-Level
- Physician
- Preventive
- Rehabilitative and Habilitative
- Surgical

Services for the HELP Plan Processed by Xerox (must be a Montana Medicaid provider):

- Audiology
- Dental
- Diabetes Prevention Program
- Eyeglasses
- Federally Qualified Health Center
- Hearing Aids
- Home Infusion
- Indian Health Services/Tribal Health
- Pharmacy
- Rural Health Clinic
- Transportation (Including ambulance)

Health Care Providers

The HELP Plan has many quality health care providers to serve you, from family doctors and dentists to physical therapists, behavioral health counselors, and most everything in between. When you are looking for care, check to see if a provider is a HELP Plan or Montana Medicaid in-network provider. The HELP Plan only pays for services if you use an in-network provider, unless you have preauthorization.

For Medical and Behavioral Health Care Providers

Before seeing a medical or behavioral health provider, ask the provider if he or she is enrolled as a HELP Plan or Montana Medicaid provider. You can access provider and HELP Plan information at **www.bcbsmt.com/mthelpplan**. If you don't have internet access, call BCBSMT Participant Services at **1-877-233-7055**.

Online Access to Claims

Register today with Blue Access for Members℠ at **www.bcbsmt.com/mthelpplan** to see medical and behavioral claim status, medical benefits and eligibility information. You can also submit questions to Participant Services online. Participant Services is available Monday through Saturday from 6 a.m. to 10 p.m. and Sunday from 9 a.m. to 6 p.m. Mountain Standard Time.

For medical or behavioral health benefit or claim questions, call BCBSMT Participant Services at **1-877-233-7055**.

For Other Health Care Services Providers

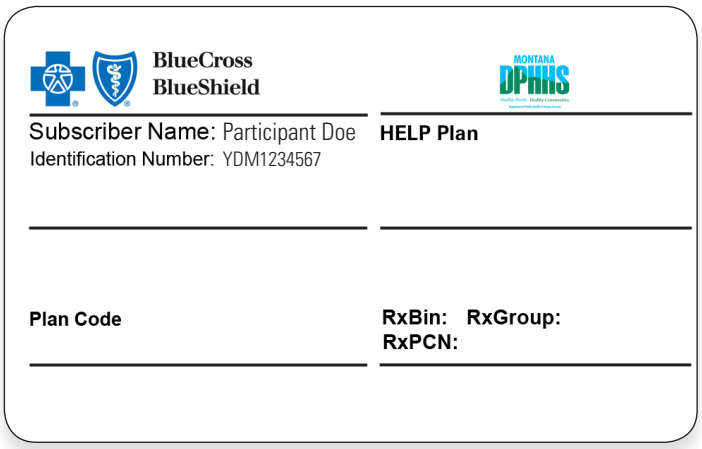
You can visit **HELPPlan.mt.gov** where you'll find information for Medicaid enrolled health providers for: dental, pharmacy, eyeglasses, Rural Health Clinics, Federally Qualified Health Centers, hearing aids/audiology, transportation, Indian Health Services (IHS)/Tribal Health, and Community Health Center Services. You can access Montana Medicaid information at **http://mtaccesstohealth.acs-shc.com/mt/general/providerlocator.do**. If you don't have internet access, call the Montana Healthcare Programs Help Line at **1-800-362-8312**.

For benefit or claim questions, call the Montana Healthcare Programs Help Line at **1-800-362-8312**.

Getting Started with the HELP Plan

Your HELP Plan Identification (ID) Card

BCBSMT will send you a HELP Plan ID card. Carry this card with you at all times and show it to your provider when you get care. This card is also used for buying prescription drugs. Call BCBSMT at **1-877-233-7055** if you do not receive a card in the mail within 4 weeks, or if you lose the card. You may also access Blue Access for Members at **www.bcbsmt.com/mthelpplan** to request an ID card or to print a temporary ID card.



Moving?

If you move, please let us know by calling the Montana Public Assistance Helpline at **1-888-706-1535**. Participants who move out of Montana are not eligible for the HELP Plan.

Coverage for Newborn Children

When a HELP Plan participant has a baby, the baby will automatically be enrolled in Montana Medicaid.

Your HELP Plan Rights

You have the right to:

- Expect quality medical care.
- Be treated politely and with respect by health care providers and their staff.
- Be told about your medical condition.
- Be told about the treatment your doctor advises before it happens.
- Refuse treatment.
- Be told of possible results before accepting or refusing treatment.
- Talk to your HELP Plan provider and expect your records and conversations are kept confidential.
- Choose your own HELP Plan provider.
- Make a complaint about the HELP Plan and receive an answer.
- Be informed how the HELP Plan works.
- Know what medical services are covered by the HELP Plan.
- Be informed of your copay responsibility for services received.
- Be informed of your premium responsibility and how it affects your copay amounts and out-of-pocket maximum.

Getting Started with the HELP Plan

Your HELP Plan Responsibilities

You and your HELP Plan health care provider are a team in protecting your health. Your job is to help your HELP Plan health care provider give you the best health care. So, keep the following in mind:

- Call ahead for an appointment when you need to see a HELP Plan provider. Providers often have busy schedules and cannot always see drop-in patients.
- Be on time for your appointments. Call your HELP Plan health care provider ahead of time if you are going to be late or can't keep your appointment.
- Tell your HELP Plan provider about your medical problems. Tell them the signs of trouble, pain, or changes you have noticed.
- Tell your provider about allergies and unusual health needs. Ask questions. Sometimes it helps to write a list of questions before you go to your appointment. Ask about risks, choices, and costs before treatment is given or drugs are prescribed.
- Fill all your prescriptions at the same pharmacy when possible. The pharmacist can answer questions about your prescriptions.
- Get complete directions about all medications, treatments, or tests. Write them down, or ask your provider to write them down.
- Pay your HELP Plan health care provider the copayment after the claim has been processed and you have been billed by the provider.
- Take time to decide about having a treatment before it happens. Be careful to review your treatment choices. Discuss your options with your HELP Plan health care provider. For many procedures, your HELP Plan provider will need time to get preauthorization.
- The HELP Plan does not cover some services. Please refer to the HELP Plan Services Chart in this guide for HELP Plan covered and non-covered services. You are responsible to pay for services that are experimental, investigational, unproven, not provided in the right setting, not medically necessary, or services that are not covered if you have signed an Advance Benefit Notice (ABN). If you don't see the service listed or you are not sure if a service is covered, call Participant Services at **1-877-233-7055**.
- HELP Plan providers may not bill you for services that are denied as not medically necessary, not provided in the right setting, experimental, unproven, investigational, and not covered unless you have signed an ABN (excludes ambulance).

HELP Plan Nondiscrimination Policy

The HELP Plan does not discriminate on the basis of race, color, national origin, age, disability or sexual orientation in admission or access to, or treatment or employment in, its programs and activities. The BCBSMT Section 504 ADA Coordinator can be reached at **(406) 437-5285**.

Premiums, Copayments, and Maximum Out-of-Pocket Costs

Premiums

As a participant of the HELP Plan you pay a monthly premium. Your premium helps cover the cost of your health insurance. The HELP Plan premium cannot exceed two (2%) of your yearly individual income. This total amount will be broken into monthly payments. BCBSMT will mail premium notices within the month prior to the due date. Premiums are due by the first of each month. Return the invoice stub and a check payment to the mailing address indicated on the invoice.

For participants at or below one hundred (100%) percent of the Federal Poverty Level (FPL), which equals approximately $990 per month for an individual, or $2,025 per month for a family of four, failure to pay premiums will not result in dis-enrollment. Unpaid premiums for all participants become a debt to the State and will be collected against future tax refunds. You can call Participant Services at **1-877-233-7055** to ask about your premium status.

Copayments

A copayment is a payment owed by you to your health care provider for health care services that you receive. You will be responsible to pay the provider after the claim has been processed. All participants will receive a credit toward copayments equal to the total owed premium amount for the quarter. Copayments will not be charged until the credit is met. You can call Participant Services at **1-877-233-7055** to ask about your copayment credit amount or other copayment questions.

If your income is at or above 100% of the FPL, and you have an outstanding copayment balance, a provider does not have to provide services for you again.

You may be charged for more than one copayment for a visit to your doctor. For example, your visit may result in the following copayments: x-rays, lab work, doctor visit, and for a facility fee (depending on the place of service). Contact Participant Services at **1-877-233-7055** if you have copayment questions.

Premium Credit Examples

Participants with Incomes 50 - 100% FPL

The participant is married without children (household size of two) with a household income of 75% FPL. The participant has a premium credit of approximately $239 or 2% of household income per year, or approximately $60 per quarter. During the participant's first quarter in the HELP Plan, the participant is billed for the following services:

- 1 preventive care visit (No copayment)
- 1 outpatient visit for a sinus infection ($4 copayment)
- 1 preferred prescription drug ($4 copayment)
- 1 outpatient physical therapy visit ($4 copayment)
- 2 non-preferred prescription drugs ($8 copayment per drug)

Total copayment: $28

The participant is not charged copayment for any of the above services at the point of service. Rather, the corresponding providers submit claims for the services and, upon processing by the claims vendor, receive remittance advice indicating that (1) the preventive care visit does not have a copayment; and (2) the participant's premium credit is being applied to the remaining copayment, such that the provider is being paid in full for the service and does not have to collect a copayment from the patient. The participant will not owe a copayment.

Participants with Incomes 101 - 138% FPL

The participant is a single male with an annual income of $11,888, or 101% FPL, and has a premium credit of $238 per year, or approximately $59 per quarter. The participant has a maximum out-of-pocket cap of 5% of quarterly income, so will not be obligated to pay over $149 each quarter for all out-of-pocket expenses (or $59 in premiums plus $90 in copayments). The participant is billed for the following services during the first quarter of enrollment:

- 1 preventive care visit (No copayment) = $0
- 2 outpatient visits ($20 copayment per visit, or 10% of the $200 payment the State makes for each outpatient service) = $40
- 6 preferred prescription drugs ($4 copayment per drug) = $24
- 12 preferred non-prescription drugs ($8 copayment per drug) = $96

Total copayment: $160
Premium credit for the quarter applied to copayment: $59
Maximum quarterly copayments owed by participant: $90
Cost sharing waived (amount above 5% cost share max allowed by CMS): $11

The participant is not charged for any of the above services at the point of service. Rather, the corresponding providers submit claims for the services and, upon processing by the claims vendor, receive remittance advice indicating that (1) the preventive care visit does not have a copayment; (2) the participant's premium credit is applied to the first $59 in copayment, such that the provider is being paid in full for the service and does not have to collect a copayment from the patient; and (3) the participant will owe his maximum quarterly copayments totaling $90.

The HELP Plan Services chart on the next few pages will let you know what the copayment cost is for services, if there is a copayment. A separate letter was sent to you when you enrolled that indicates what FPL level you are under, so you can look at your copayment column on the chart.

Copayment and Maximum Out-of-Pocket Costs

If your income is at or below 100% of the FPL, and you have an outstanding copayment balance, a provider does not have to provide services for you again.

Individuals Not Responsible For Copayment

- Pregnant women;
- Those age 20 and under;
- American Indians/Alaska Natives who are eligible for, currently receiving, or have ever received an item or service furnished by:
  - an Indian Health Service (IHS) provider;
  - a Tribal 638 provider;
  - an IHS Tribal or Urban Indian Health provider; or
  - through referral under contract health services.
- Terminally ill receiving hospice services;
- Receiving services under the Medicaid breast and cervical cancer treatment category;
- Institutionalized persons who are inpatients in a skilled nursing facility, intermediate care facility, or other medical institution if the person is required to spend for the cost of care all but his or her personal needs allowance

Services With No Copayment

- Preventive health screenings,
- Family planning,
- Eyeglasses,
- Transportation,
- Emergencies in the emergency room, and
- Medically necessary health screenings ordered by a health care provider.

Maximum Out-of-Pocket Costs

Payments toward premiums and copayments will be applied to your maximum out-of-pocket amount. The maximum out-of-pocket amount is 5% of the total household income. This is calculated on a quarterly basis. You can check with BCBSMT at any time to find out about your premiums, credit status, copayment, or expected cost of copayments.

Copayment and Maximum Out-of-Pocket Costs

Premium Rights and Obligations

Even if you cannot pay your premium, you may still be able to keep HELP Plan coverage. You will remain in the HELP Plan if:

A. Your income is under 100% of the FPL, which is approximately $990 a month for an individual, or $2,025 a month for a family of four; or

B. If your income is above 100% of the federal poverty level, you may lose your coverage if you fail to pay your premiums. You are still responsible for the payment of your premiums. The unpaid premium balance will be transferred to the State of Montana for collection from your state income tax refund.

Even if you cannot pay your premiums, you may still be able to keep HELP Plan coverage under certain circumstances including:

- You have been discharged from the United States military service within the previous 12 months;
- You are enrolled for credit in any Montana University System unit, a tribal college, or any other accredited college within Montana offering at least an associate degree;
- You see a primary care provider who is part of a patient-centered medical home;
- You are in a substance use treatment program; or
- You are in a DPHHS approved healthy behavior activity program administered by DPHHS or BCBSMT. The list of approved programs is located at HELPPlan.mt.gov or call **1-855-324-6259**.

If Montana DPHHS determines that you meet two or more of these conditions, you will continue to have access to the health care services covered by the HELP Plan. You will still be responsible for payment of your premiums.

If two of the following describe you, call **888-706-1535**:

• You have been discharged from the United States military service within the past 12 months; or	**To let us know you were in college or in the military go to apply.mt.gov, or call 888-706-1535 or visit any local Office of Public Assistance.**
• You are enrolled for credit in a Montana university, tribal college, or any other accredited college in Montana that offers at least a two-year degree; or	
• You are in an approved HELP Healthy Behavior Plan wellness program; or You are in a substance use treatment program; or You see a primary care provider who is part of a patient-centered medical home. You can find out by asking your doctor's office.	To find out more about the Healthy Behavior programs or to sign up please go to HELPPlan.mt.gov or call **BCBSMT Participant Services at 1-877-233-7055**. You can find out by asking your doctor's office. To let us know, go to **apply.mt.gov, or call 888-706-1535 or visit any local Office of Public Assistance**.

If you are disenrolled because you have unpaid (delinquent) premiums, you may reenroll in the HELP Plan after:

A. You have paid your unpaid premium balance in full; or

B. You have received notice from the State of Montana that your unpaid premium balance has been assessed against your future state income tax. This assessment occurs once per calendar quarter.

Participants that would like to reenroll should contact the Montana Public Assistance Help Line at **844-792-2460** or **apply.mt.gov**.

HELP Plan Services

This section tells if a service is covered by the HELP Plan. For details on these covered services, turn to the pages after the HELP Plan Services Chart. There may be other services that the HELP Plan will pay for that are not listed. Ask your HELP Plan provider if you're not sure if something is covered or requires preauthorization. HELP Plan Participant Services will also be able to help; call BCBSMT at **1-877-233-7055**.

Lifetime Maximum Benefit

There is no lifetime maximum benefit.

Preauthorization

Some HELP Plan services need to be approved before the HELP Plan will pay for them. Refer to the HELP Plan Services Chart to see if the services you need require preauthorization by your HELP Plan provider.

If you fail to get preauthorization for a service, you may be responsible to pay for that service if you signed an Advance Benefit Notification (ABN).

The description of the HELP Plan covered and non-covered services presented here is a guide and not a contract to provide medical care. Administrative Rules of Montana, Title 37, governs access and payment for HELP Plan services. The rules can be found at **mtrules.org**.

HELP Plan Services Chart – Services Must Be Medically Necessary.

Service	Covered by the HELP Plan	Copayments for Participants with Incomes at or below 100% Federal Poverty Level	Copayments for Participants with Incomes above 100% Federal Poverty Level	Preauthorization Needed
Acupressure	No	—	—	—
Acupuncture	No	—	—	—
Adaptive Equipment (reachers, appliances)	No	—	—	—
Ambulance (Emergency)	Yes	$0	$0	No. Call 1-800-292-7114 within 30 days.
Ambulance (Non-Emergency)	Yes	$0	$0	Call 1-800-292-7114 for authorization
Audiology Services (see Hearing Exams and Hearing Aids)	Yes	$4	10% of the Allowable Fee	No
Bio-Feedback	No	—	—	—
Birth Center Services	Yes	$0	$0	No
Birth Control	Yes	$0	$0	No
Cardiac Rehabilitation	Yes	$4	10% of the Allowable Fee	Yes
Case Management	Yes	$0	$0	No

Service	Covered by the HELP Plan	Copayments for Participants with Incomes at or below 100% Federal Poverty Level	Copayments for Participants with Incomes above 100% Federal Poverty Level	Preauthorization Needed
Chemical Dependency Treatment (CD facility inpatient)	Yes	$4	10% of the Allowable Fee	Yes
Chemical Dependency Treatment (CD facility outpatient)	Yes	$4	10% of the Allowable Fee	Yes, for some services
Chiropractic (for Adults through age 20. Must be ordered or referred by a HELP Plan provider)	No	—	—	—
Clinic Services	Yes	$4	10% of the Allowable Fee	No
Cochlear Implants	Yes	$75 hospital, $4 provider	10% of the Allowable Fee	Yes
Comfort and Convenience Items	No	—	—	—
Community Health Centers Services	Yes	$4	10% of the Allowable Fee	No
Comprehensive School and Community Treatment (CSCT)	No	—	—	—
Contact Lenses	No	—	—	—
Convalescent Home Subject to a 60-day limit	Yes	$0	$0	Yes
Corrective Lenses (see Eyeglasses)	—	—	—	—
Cosmetic Surgery	Only under rare circumstances	$75 hospital, $4 provider	10% of the Allowable Fee	Yes
Dental Anesthesia	Yes	$4	10% of the Allowable Fee	No
Dental Braces (orthodontia) through age 20 if medically necessary	Yes	—	—	Yes
Dental Implants	No	—	—	—
Dental Preventive/Diagnostic	Yes	$0	$0	No
Dental Treatment Subject to a $1,125 limit (excluding: preventive/diagnostic, dentures and anesthesia)	Yes	$4	10% of the Allowable Fee	No
Denturist	Yes	$4	10% of the Allowable Fee	No, check service limits
Developmental Disability Services	No	—	—	—
Diabetes Education	Yes	$0	$0	No

Service	Covered by the HELP Plan	Copayments for Participants with Incomes at or below 100% Federal Poverty Level	Copayments for Participants with Incomes above 100% Federal Poverty Level	Preauthorization Needed
Dialysis (outpatient and training for self-dialysis)	Yes	$4	10% of the Allowable Fee	No
Doctor Visits	Yes	$4	10% of the Allowable Fee	No
Drugs/Medications (over-the counter)	Yes	$4	$4	No
Drugs/Medications (require prescription - generic)	Yes	$0	$0	Yes, for some drugs
Drugs/Medications (require prescription - preferred brand name)	Yes	$4	$4	Yes, for some drugs
Drugs/Medications (require prescription - nonpreferred brand name)	Yes	$8	$8	Yes, for some drugs
Durable Medical Equipment (DME) and Medical Supplies	Yes	$4	10% of the Allowable Fee	Yes (for services over $2,500)
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), through age 20 if medically necessary	Yes	$0	$0	Yes, for some services
Emergency Room Services Emergency Services	Yes	$0	$0	No
Emergency Room Services Non-Emergency Services	Yes	$8	$8	No
Environmental Controls (air cleaners, heaters)	No	—	—	—
Exercise Programs or Equipment	No	—	—	—
Experimental Drugs or Treatments	No	—	—	—
Eye Exams	Yes	$4	10% of the Allowable Fee	No
Eyeglasses (frames and lenses)	Yes	$0	$0	Yes, for some features
Family Planning	Yes	$0	$0	No
Genetic Testing and/or Counseling	Yes	$4	10% of the Allowable Fee	Yes
Hearing Aids	Yes	$4	10% of the Allowable Fee	Yes
Hearing Exams	Yes	$4	10% of the Allowable Fee	No

Service	Covered by the HELP Plan	Copayments for Participants with Incomes at or below 100% Federal Poverty Level	Copayments for Participants with Incomes above 100% Federal Poverty Level	Preauthorization Needed
Home Health	Yes	$4	10% of the Allowable Fee	Yes
Home Infusion Therapy	Yes	$4	10% of the Allowable Fee	Yes
Homemaker	No	—	—	—
Homeotherapy	No	—	—	—
Hospice	Yes	$0	$0	Yes
Hospital (inpatient)	Yes	$75	10% of the Allowable Fee	Yes
Hospital (outpatient)	Yes	$4	10% of the Allowable Fee	No
Hot Tubs or Spas	No	—	—	—
Hypnotherapy	No	—	—	—
Inclusive Services	No	—	—	—
Indian Health Services/ Tribal Health Services	Yes	$0	$0	Yes, for some services
Infertility Treatment	No	—	—	—
Interpreter	Yes	$0	$0	No
Lab (laboratory services)	Yes	$4	10% of the Allowable Fee	No
Massage	No	—	—	—
Medical Marijuana	No	—	—	—
Medical Services Received Outside the U.S.A.	No	—	—	—
Medical Supplies and Equipment (see Durable Medical Equipment)	Yes	$4 provider	10% of the Allowable Fee	Yes (for services over $2,500)
Mental Illness Treatment (MI facility inpatient; hospital only)	Yes	$75	10% of the Allowable Fee	Yes
Mental Illness Treatment (MI facility outpatient)	Yes	$4	10% of the Allowable Fee	Yes, for some services
Naturopathic Physician Services	No	—	—	—
Neurofeedback	No	—	—	—
Nurse Advice Services	Yes	$0	$0	No
OB (obstetric) Services	Yes	$0	$0	No

Service	Covered by the HELP Plan	Copayments for Participants with Incomes at or below 100% Federal Poverty Level	Copayments for Participants with Incomes above 100% Federal Poverty Level	Preauthorization Needed
Occupational Therapy	Yes	$4	10% of the Allowable Fee	Yes
Orthodontia (dental braces) through age 20 if medically necessary	Yes	$0	$0	Yes
Orthotics	No	—	—	—
Out-of-State Services (only if emergency or not available in state)	No	—	—	—
Paternity Tests	No	—	—	—
Personal Assistant	No	—	—	—
Personal Transportation (Emergency)	Yes	$0	$0	Call Medicaid Transportation at 1-800-292-7114 for authorization.
Personal Transportation (Nonemergency)	Yes	$0	$0	Call Medicaid Transportation at 1-800-292-7114 for authorization.
Pharmacy (see Drugs)	—	—	—	—
Physical Therapy	Yes	$4	10% of the Allowable Fee	Yes
Pregnancy and Childbirth	Yes	$0	$0	No
Prescription Drugs (see Drugs)	—	—	—	—
Preventive Care Services	Yes	$0	$0	No
Private Duty Nursing (through age 20 if medically necessary, must be ordered or referred by a HELP Plan provider)	Yes	—	—	No
Professional Counselor	Yes	$4	10% of the Allowable Fee	No
Psychiatric	Yes	$4	10% of the Allowable Fee	No
Psychology Services	Yes	$4	10% of the Allowable Fee	No
Public Health Clinic Services	Yes	$4	10% of the Allowable Fee	No
Radial Keratotomy	No	—	—	—
Radiology (MRI, PET Scans, GI Radiology, CT Scans)	Yes	$4	10% of the Allowable Fee	Yes
Respiratory Therapy	Yes	$4	10% of the Allowable Fee	No
School-Based Services (through age 20 if medically necessary)	Yes	—	—	Yes

Service	Covered by the HELP Plan	Copayments for Participants with Incomes at or below 100% Federal Poverty Level	Copayments for Participants with Incomes above 100% Federal Poverty Level	Preauthorization Needed
Service Animals (including purchase, training and maintenance costs)	No	—	—	—
Shots (immunizations)	Yes	$0	$0	No
Social Work (see clinical)	Yes	$4	10% of the Allowable Fee	No
Speech Therapy	Yes	$4	10% of the Allowable Fee	Yes
Sterilization (excludes reversal of voluntary sterilization)	Yes	$0	$0	No
Stress Management	No	—	—	—
Surgery (inpatient)	Yes	$75 hospital, $4 provider	10% of the Allowable Fee	Yes
Surgery (outpatient)	Yes	$4	10% of the Allowable Fee	Yes, for some services
Telemedicine Services	Yes	$4	10% of the Allowable Fee	No
Telephone Service	No	—	—	—
Temporomandibular Joint Treatment (TMJ) Surgery	Yes	$75 hospital, $4 provider	10% of the Allowable Fee	Yes
Tobacco Cessation Counseling	Yes	$0	$0	No
Tobacco Cessation Drugs	Yes	$0	$0	No
Transplants	Yes	$75 hospital, $4 provider	10% of the Allowable Fee	Yes
Urgent Care	Yes	$4	10% of the Allowable Fee	No
Vitamins (requires prescription and includes prenatals for pregnant women)	Yes	$0	$0	Yes, for some vitamins
Weight Loss Clubs or Clinics	No	—	—	—
Weight Loss Surgery (gastric bypass, gastric banding or bariatric surgery, including all revisions)	No	—	—	—
Weight Scales	No	—	—	—
Wellness Programs	Yes	$0	$0	No
Whirlpools	No	—	—	—
X-Rays	Yes	$4	10% of the Allowable Fee	No

HELP Plan Services Described

This list includes examples of HELP Plan services. Not all services are listed and not all details about a service are shown. Ask your doctor or health care provider for more information. You can also call BCBSMT at **1-877-233-7055** for more information.

All covered treatments and services must be medically necessary. The participant receiving services must be enrolled at the time the service is delivered.

Ambulance Services

Emergency ambulance services are covered for emergency ground or air transports. Call **911** or your local emergency number for services. An emergency means a medical condition manifesting itself by sudden symptoms of enough severity (including severe pain) 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 the following:

- Placing the health of the individuals (or, for a pregnant woman, the health of the woman and her unborn child) in serious jeopardy.
- Serious impairment of bodily functions.
- Serious dysfunction of any bodily organ or part.

Licensed ground and air ambulance services are covered to the nearest hospital equipped to provide necessary treatment when:

- The service is to treat a life-threatening illness or injury, or
- It is medically necessary – meaning other forms of getting to care would endanger the participant's health.

Ambulance services must be medically necessary. If you are not sure you should go to the emergency room, call your HELP Plan provider or Nurse Advice Line at **1-877-213-2568**. The call is free. Registered nurses are available 24 hours a day, 7 days a week to help you decide.

If you used your personal vehicle for emergency travel, you must call the Medicaid Transportation Center at **1-800-292-7114** within 30 days of the emergency in order to be considered for payment. Scheduled non-emergency use of an ambulance may be necessary in some cases, but you must receive preauthorization before travel takes place. Call the Medicaid Transportation Center at **1-800-292-7114**.

Audiology Services

(see Hearing Aids and Hearing Exams, pg. 21)

Birth Center Services

Birth center services are provided in a state-licensed health care place or hospital.

Birth Control

Pills, shots and most other types of birth control, and family planning supplies are covered. Birth control must be prescribed for you by a covered provider.

HELP Plan Services Described

Case Management

In the event of a high-cost medical problem, the HELP Plan may be able to recommend medically appropriate, cost-effective treatments for you and your provider to consider. A case manager will evaluate your condition with your HELP Plan provider. For additional information, call BCBSMT at **1-877-233-7055**.

Examples of illnesses where case management is valuable are:

- Severe diabetes,
- Cancer,
- Chronic illness (such as asthma, pneumonia, and lung problems),
- Acute injuries (such as head injuries),
- Heart problems,
- Multiple therapies (physical, speech or occupational therapies),
- Cystic fibrosis,
- Behavioral health conditions, and
- High-risk pregnancy.

Chemical Dependency Services

There are several different kinds of alcohol and drug treatment services:

- Non-hospital inpatient treatment – this service is 24 hours a day, 7 days a week, and patients live in the facility,
- Intensive non-hospital outpatient treatment,
- Hospital inpatient and outpatient treatment,
- Partial hospitalization, and
- Individual, group, or family counseling.

Preauthorization is required for inpatient services, residential treatment services, and intensive outpatient services. Call BCBSMT at **1-877-233-7055**. Your provider may also fax the preauthorization to **(406) 437-5850**.

Cochlear Implants

Cochlear implants and associated components require preauthorization. Call BCBSMT at **1-877-233-7055**.

Community Health Centers

The HELP Plan covers visits to Community Health Centers (CHC), Federally Qualified Health Clinics (FQHC), and Rural Health Centers (RHC).

If you have questions about CHC, FQHC, or RHC services, you may contact the Montana Healthcare Programs at **1-800-362-8312**.

HELP Plan Services Described

Convalescent Home Services

The HELP Plan covers services of a convalescent home as an alternative to inpatient hospital care. A convalescent home is an institution, or distinct part thereof, other than a hospital, which is licensed pursuance to state or local law. A convalescent home is:

1. A skilled nursing facility;
2. An extended care facility;
3. An extended care unit; or
4. A transitional care unit.

A convalescent home is primarily engaged in providing continuous nursing care by or under the direction and supervision of a registered nurse for sick or injured participants during the convalescent state of their illness or injuries and is not, other than incidentally, a rest home or home custodial care, or for the aged.

Convalescent home services are limited to 60 days per benefit period.

Convalescent home services must be preauthorized; call BCBSMT at **1-877-233-7055**. Your provider may also fax the preauthorization to **(406) 437-5850**.

Corrective Lenses

(see Eyeglasses, pg. 20)

Dental Services – HELP Plan Dental Treatment Services

A HELP Plan participant may receive up to $1,125 in dental treatment services per benefit year. The benefit year runs from July 1 through June 30. Each July 1st, HELP Plan participants become eligible for $1,125 of dental treatment services (treatment frequency limits apply). Services that are covered but do not count toward the $1,125 benefit period treatment limit, are preventive/diagnostic, anesthesia, and dentures.

You will have to pay for services that go over the $1,125 HELP Plan Dental Treatment limit. Any amount over the $1,125 limit is a private arrangement between you and your Medicaid dental provider.

Some dental services require Medicaid copayments. Make sure you know how much your services cost, and if you have reached your $1,125 dental treatment limit.

Most dental services are covered.

Some Dental Services That Are Not Covered:

- Dental Implants, and
- Cosmetic Dentistry.

NOTE

Surgical repair of the mouth and gums due to an accident or congenital defect may be covered under the medical benefits of your HELP Plan. Contact BCBSMT for more information at **1-877-233-7055**. Dental services needed for an accidental injury to healthy, natural teeth and gums are covered for up to 12 months from the date of the accident.

HELP Plan Services Described

Finding a HELP Plan Dentist

A list of Medicaid enrolled dentists is available at **HELPPlan.mt.gov** by clicking on the "Find a Health Care Provider" option.

Contact Medicaid enrolled dentists in your area to make an appointment and ask if they accept new HELP Plan patients. If your dentist is not currently a Medicaid enrolled dentist but would like to become one, the dentist may contact the Montana Healthcare Programs Help line at **1-800-362-8312**.

If you have questions about HELP Plan dental services, you may contact the Montana Healthcare Programs Help Line at **1-800-362-8312**.

Diabetes Education

The HELP Plan covers outpatient diabetes education services. Covered services include programs for self-management training and education as prescribed by a doctor. Diabetic supplies are covered under the section entitled 'Durable Medical Equipment and Medical Supplies'on page 19.

Dialysis

Dialysis is covered for participants who have chronic end-stage renal disease. Services covered at dialysis clinics include:

- Outpatient dialysis, and
- Training for self-dialysis.

Doctor Visits

Visits to your doctor's office are covered. When we use the term "doctor," we also mean physician assistants (PAs) and nurse practitioners (NPs), FQHCs, RHCs, IHS, tribal, and CHCs. Most services you get from a doctor are covered.

Examples of "doctor" services include:

- Treating high blood pressure,
- Office visits,
- Physicals (exams),
- Operations, and
- Shots (immunizations).

Drugs (Over-the-Counter)

The following over-the-counter drugs are covered if they are prescribed for you by your HELP Plan provider or Medicaid enrolled provider:

- Aspirin,
- Insulin,
- Laxatives, antacids, head lice treatment,
- Stomach products such as Zantac® and Prilosec OTC®,
- Allergy products such as Claritin®,
- Levonorgestrel,
- Ketotifin ophthalmic solution,
- Pyridoxine,
- Doxylamine,
- Nasacort AQ,
- Oxybutynin Transdermal, and
- Folic Acid.

HELP Plan Services Described

Drugs/Medications (Prescription)

Many prescription drugs are covered. Some prescription drugs may need preauthorization. To find out if a drug you need is covered or to find out if a drug needs preauthorization, talk to your pharmacist or the person who prescribed the drug.

The HELP Plan usually will pay for a 34-day supply of drugs. Participant may get a 90-day supply of some drugs for heart disease, high blood pressure, or birth control. Early refills may be authorized if the person who writes the prescription changes your dose. Early refills will not be granted for lost or stolen medication, or for vacation, or travel.

Prescription drugs are only covered if you go to a Montana Medicaid enrolled pharmacy. To find out if your pharmacy is enrolled, go to **HELPPlan.mt.gov**, and then click on the "Find a Health Care Provider" option.

Out-of-state pharmacy benefits will be paid only to Medicaid enrolled providers. Check the link to find out if your out-of-state provider is enrolled. Call the Montana Healthcare Programs at **1-800-362-8312** for more information.

Durable Medical Equipment (DME) and Medical Supplies

Medical supplies include things like wound dressings and diabetic needles, lancets, test strips, and devices for monitoring glucose.

DME must be ordered or referred by a HELP Plan provider. DME includes things like oxygen equipment, wheelchairs, prosthetic limbs, and orthotics. DME items must be the least costly option to treat the medical condition and used in your home, school, or work place. You will need preauthorization for DME items that cost $2,500 or more; call BCBSMT at **1-877-233-7055**. Your provider may also fax the preauthorization to **(406) 437-5850**. For answers to DME questions, ask your medical provider, your DME provider, or call BCBSMT at **1-877-233-7055**.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

EPSDT services are comprehensive and preventive health care services for Participants through age 20 and include:

- Diagnostic and treatment services that are medically necessary,
- Comprehensive health and developmental history, physical exam, immunizations, lab tests and health education,
- Vision services, including diagnosis, treatment, and eyeglasses,
- Dental services, and
- Hearing services.

Emergency Room Services, Emergency Services

Emergency services are covered in the HELP Plan. An emergency is a medical condition manifesting itself by sudden symptoms of enough severity (including severe pain) 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 the following:

- Placing the health of the individuals (or, for a pregnant woman, the health of the woman and her unborn child) in serious jeopardy.
- Serious impairment of bodily functions.
- Serious dysfunction of any bodily organ or part.

The HELP Plan pays for all medically necessary covered care that you get from HELP Plan providers. The HELP Plan covers emergency care and urgent care if you follow the rules below.

You should notify your primary care provider as soon as possible that you are receiving emergency care. You should arrange follow-up care with your primary care provider.

HELP Plan Services Described

Hospitals are required to comply with federal requirements to screen for and provide services to individuals who require emergency care. The State presumes all visits to the emergency department are not subject to cost sharing, unless the provider provides a written attestation to the State that the provider meets the State's requirements for imposing cost-sharing for emergency department services. Copayments for non-emergent use of the emergency department can only be charged if the hospital completes all of the below steps:

1. Conducts an EMTALA-compliant medical screening examination that concluded the participant's condition is non-emergent;
2. Provides the participant with the name and locations of an alternative non-emergency services provider;
3. Informs the participant of the amount of his or her cost-sharing obligation for non-emergency services provided in the emergency department;
4. Determines that the alternative provider can provide services at a lower cost sharing amount; and
5. Provides a referral to schedule treatment by the alternative provider.

In the event a visit is determined to be a non-emergency, the hospital may bill the participant for a copayment once the copayment amount is determined after adjudication of the claim. The State will instruct hospitals of these requirements, establish a hospital attestation process, and inform beneficiaries that they may only be charged a copayment for non-emergency use of the ER if these conditions are met.

Eye Exams

Eye exams and the fee to fit your eyeglasses are covered.

Optometric services for the medical treatment of diseases or injury to the eye by a licensed doctor or optometrist are covered.

To find an ophthalmologist or optometrist near you, refer to the HELP Plan Provider Directory on the website at **www.bcbsmt.com/mthelpplan**.

If you have questions, contact BCBSMT Participant Services at **1-877-233-7055**.

Eyeglasses

Eyeglasses are provided through a contract with Walman Optical Co. The HELP Plan will only pay for your eyeglasses if they are covered under the Walman contract. When ordering eyeglasses from the eyeglasses provider, make sure the provider carries eyeglasses covered under the Walman contract. If you choose to purchase frames or lenses that are not covered under the contract, it is your responsibility to pay for the purchase.

The HELP Plan pays for one pair of glasses every 365 days. However, if you have a medical condition that requires more frequent prescriptions, new lenses (but not new frames) may be covered more often.

All frames have a 24-month warranty to guard against defects. The warranty does not replace damaged frames other than manufacturer defects. You must return defective parts of the glasses for repair. Your HELP Plan provider may charge you a small handling fee for returning glasses for repair.

HELP Plan Services Described

The HELP Plan does not replace lost or stolen eyeglasses. The HELP Plan does not pay for contact lenses. If you have questions, contact the Montana Healthcare Programs at **1-800-362-8312**.

Family Planning Services

Most family planning services are covered, including, but not limited to:

- Physical exams, with breast exams,
- Pap test (to test for pre-cancerous conditions),
- Pregnancy tests,
- Birth control,
- Sexual health counseling (how to prevent or approach unintended pregnancy and sexually transmitted infections),
- Testing and treatment for sexually transmitted infections,
- Shots for German measles (to prevent pregnancy complications), and
- Shots for HPV.

You can receive most family planning services from your primary care provider or from other providers able to administer the services.

Hearing Aids

Hearing aids, hearing aid supplies, including batteries, and hearing aid repairs are covered when provided by a Medicaid enrolled provider. The Medicaid enrolled provider must request preauthorization for hearing aids. The HELP Plan participant must be enrolled on the date of the preauthorization request and on the date of service, including the date the hearing aid is provided to the HELP Plan participant. Hearing aid services must be ordered or referred by a HELP Plan provider.

For additional information on hearing aids, supplies and warranty, go to the Montana Healthcare Programs website at **HELPPlan.mt.gov**.

Cochlear implants and associated components require preauthorization. The HELP Plan provider must request preauthorization. Call BCBSMT at **1-877-233-7055**.

Hearing Exams

Hearing exams are covered and must be ordered or referred by a HELP Plan provider. For additional information on hearing exams, go to the Montana Healthcare Programs website at **HELPPlan.mt.gov**.

HELP Healthy Behavior Plan

BCBSMT has implemented a comprehensive health and wellness program for participants in the Montana Health and Economic Livelihood Partnership (HELP) Plan, with a focus on engaging participants and providers. This program is called the HELP Healthy Behavior Plan. The program has been designed to:

- Improve participant's knowledge of lifestyles that are healthy and promote wellness;
- Improve participant's understanding of chronic health conditions;
- Design programs to increase a participant's understanding of lifestyle behaviors that negatively impact their health;
- Ensure continuous health care;
- Provide easy access to health information;
- Provide participant resources to assist them in engaging in healthy lifestyle behaviors;
- Improve the participant-provider relationship;
- Improve health plan-provider communication; and

HELP Plan Services Described

- Engage existing provider and community health education programs in providing participant wellness information and in offering participant support for chronic conditions.

All participants will be offered information on health and wellness programs.

Programs offer Care Coordinator assistance on a plan of care involving diet, exercise, positive changes in lifestyle and goal setting. The goal is to encourage healthy changes and new habits that will lead to a healthier life.

Participants may call BCBSMT Participant Services **1-877-233-7055** and ask to be enrolled in one of the approved programs, or ask to speak with a Care Coordinator to learn more about this benefit. There are several DPHHS approved wellness programs available throughout the state of Montana. Descriptions of these programs are available on the BCBSMT participant portal, Blue Access for Members (BAM) at **http://bcbsmt.com/mthelpplan** and DPHHS' website at **http://dphhs.mt.gov/publichealth/chronicdisease/CommunityBasedPrograms**.

Wellness Programs in the Healthy Behavior Plan
Community Based Wellness Programs (DPHHS):
1. Montana Living Life Well Program;
2. Diabetes Self-Management Education;
3. Asthma Self-Management Education;
4. Arthritis Foundation Exercise program;
5. Walk with Ease program;
6. Diabetes Prevention Program; and
7. Montana Tobacco Quit Line.

BCBSMT Wellness Programs
The BCBSMT Wellness Programs are individualized programs designed to meet the needs of participants who may not be able to attend a community program, or prefer one-on-one interaction. Care coordinators are licensed medical professionals who provide this education and interaction over the phone.
1. Asthma Management Program;
2. Diabetes Prevention and Management'
3. Hypertension;
4. Tobacco/Smoking Cessation; and
5. Weight Loss and Healthy Lifestyles

Home Health Services

Home health services are provided by a licensed and certified agency. The services must be ordered by a HELP Plan provider. These services are covered but must be preauthorized. Call BCBSMT at **1-877-233-7055**. Your provider may also fax the preauthorization to **(406) 437-5850**.

Covered services include:
- Part-time care in your home from a skilled nurse,
- Home health aide care – services for a short, definite period of time to assist in the activities of daily living and care of the household to keep you in your home,
- Physical, occupational, or speech therapy,
- Non-routine medical supplies suitable for home use, and

HELP Plan Services Described

- Medical social worker services.

Home Infusion Therapy

Home infusion therapy must be ordered or referred by a HELP Plan provider. Some drug treatments must be given in your veins (intravenously). These treatments may be given in your home. Infusion therapy in your home is covered, along with the cost of the person who comes to your home to give you the drug treatments. For additional information on Home Infusion Therapy, go to the Montana Healthcare Programs website at **HELPPlan.mt.gov**.

Hospice

Hospice is end-of-life comfort care. Hospice manages all care related to the illness. Grief counseling is also available for the family. Hospice is provided by a licensed and certified agency. Hospice services are covered, but must be preauthorized. Call BCBSMT at **1-877-233-7055**. Your provider may also fax the preauthorization to **(406) 437-5850**.

Hospital Services

Services you get in a hospital, whether you stay in the hospital overnight or not, are covered. However, services must be ordered or referred by a HELP Plan provider. Some examples of services you might get in a hospital are:

- Emergency Room services,
- Medical or behavioral health services for which your HELP Plan provider admits you to the hospital,
- Physical therapy,
- Lab services,
- X-Rays,
- Cardiac rehabilitation,
- Pulmonary rehabilitation, and
- Surgery.

When you know ahead of time that you are going in the hospital, call BCBSMT at **1-877-233-7055**. Your provider may also fax the preauthorization to **(406) 437-5850**. Hospital services must be preauthorized before you go. If you have an emergency and are admitted to the hospital, BCBSMT should be contacted within 24 hours or the next working day. If the hospital you are admitted to is a participating provider, it is the provider's responsibility to notify BCBSMT. If the hospital you are admitted to is not a participating provider, it is your responsibility to notify BCBSMT for preauthorization.

Indian Health Services (IHS) and Tribal Health Services

The HELP Plan partners with IHS, Tribally Operated Health Care Clinics, and Urban Indian Health Centers. These clinics provide medically necessary services for some enrolled participants. American Indian participants never have a copayment.

Interpreter Services

Interpreter services will be provided if you do not speak fluent English, are hearing impaired, or are otherwise in need. Interpreter services are covered if they are needed for you to get another covered service. You and your HELP Plan provider determine if an interpreter is required and your provider can arrange for a qualified interpreter to provide services. You may request a friend or family participant to be your interpreter. There is no cost to you for interpreter services.

Lab (Laboratory) Services

X-ray and lab services must be ordered or referred by a HELP Plan provider. Verify your HELP Plan provider is sending the

HELP Plan Services Described

X-Ray or lab work to another HELP Plan provider. Call BCBSMT at **1-877-233-7055**.

Medical Supplies and Equipment

(see Durable Medical Equipment, pg. 19)

Mental Illness Services

The HELP Plan covers these mental health services for all participants:

- Individual, group, and family counseling,
- Group therapy,
- Outpatient mental health assessments,
- Acute inpatient hospital services (preauthorization is required), and
- Psychological testing (preauthorization is required).

Preauthorization is required for inpatient services, residential treatment services, and intensive outpatient services. Call BCBSMT at **1-877-233-7055**. Your provider may also fax the preauthorization to **(406) 437-5850**.

Nurse Advice Line

Nurse Advice is a free telephone advice line you can call when you are sick, hurt or have a health question. Call **1-877-213-2568**. Nurses are there 24 hours a day, 7 days a week. Nurses at Nurse Advice can help you save time and money by guiding you to the right care at the right place and at the right time.

Nurse Advice can help you with problems like:

- Fever,
- Ear ache and headache,
- Flu and sore throat,
- Skin rash,
- Vomiting or upset stomach,
- Colds and coughing, or
- Back pain.

If you have just found out you have diabetes, heart disease, high cholesterol, or any other health issue, Nurse Advice may be able to give you some information and help answer your questions.

Don't call Nurse Advice when:

- You have a health concern you are sure is life threatening. In this case, call **911** or go directly to the emergency room.
- You've seen your doctor for a specific health problem and a follow-up appointment is needed. Call the office directly to schedule the appointment.
- You've seen your doctor for a specific health problem, and she refers you to a specialist. Call the specialist's office directly to set up an appointment.
- You need regular services such as transfusions or dialysis. Make this series of appointments directly with the doctor's office.

OB (Obstetric) Services

Prenatal visits, delivery, and checkups for the mother after she gives birth are covered. A baby's delivery must be in a

HELP Plan Services Described

licensed hospital or birth center to be covered.

Occupational Therapy
(see Therapies, pg. 26)

Out-of-State Services
You may need to get medical services outside of Montana.
- If you have an accident, crisis or something that cannot wait until you're back in Montana, seek help at a hospital. Call BCBSMT at **1-877-233-7055**; toll free, as soon as possible to see if a covered provider is close to you.
- All out-of-state hospital inpatient services need preauthorization before you get services unless you have an emergency. Call BCBSMT at **1-877-233-7055**. Your provider may also fax the preauthorization to **(406) 437-5850**.
- Other HELP Plan services require preauthorization as shown on the HELP Plan services chart in this HELP Plan Participant Guide.
- Services received outside the United States, including Canada or Mexico, are never covered.

Physical Therapy
(see Therapies, pg. 25)

Physician Services
(see Doctor Visits, pg. 18)

Pregnancy
(see OB, pg. 24)

Prescription Drugs
(see Drugs/Medications (Prescription), pg. 19)

Preventive Care Services
The HELP Plan covers preventive care services, and there are no out-of-pocket costs to you. Preventive care helps keep you healthy and includes:
- Regular checkups,
- Dental checkups,
- Eye exams,
- Mammograms, Pap tests, and other cancer screening, and
- Treatment for some chronic conditions.

Pulmonary Therapy
(see Therapies, pg. 25)

Respiratory Therapy
(see Therapies, pg. 25)

Social Work Services
Social work services are covered if provided by a licensed clinical social worker who is a HELP Plan provider. These services

HELP Plan Services Described

may be individual, group, or family therapy.

Specialty Care

Specialty care is any health care your primary care provider advises but cannot provide. Examples are X-Rays, therapy, or tests to spot a health issue. It is best if all of your health care services are managed by your primary care doctor. If you need specialty care, your primary care provider will refer you to a HELP Plan specialist. Referrals are not required for specialty care, including obstetrical and gynecological care, as long as you see a HELP Plan participating provider. However, treatment received from a provider who is not in the HELP Plan network will not be covered without preauthorization.

If specialty care is needed and a HELP Plan participating provider is not available in your area, contact BCBSMT at **1-877-233-7055**. We will give you information on how to obtain specialty care.

Speech Therapy

(see Therapies, pg. 25)

Supplies

(See Durable Medical Equipment (DME) and Medical Supplies, pg 19)

Surgery

Most medically necessary surgeries are covered, whether done in a hospital or surgery center. Some surgeries must be preauthorized; call BCBSMT at **1-877-233-7055**. Your provider may also fax the preauthorization to **(406) 437-5850**.

Telemedicine Services

Telemedicine services are covered when they are provided by HELP Plan providers. The services must be for covered benefits. Telemedicine services are provided through a secure electronic connection. The provider and the participant are not at the same site. There must be both an audio and video portion to the visit. Both the provider and participant must take part in the discussion.

Therapies

Covered therapies are:

- Occupational therapy (requires preauthorization),
- Physical therapy (requires preauthorization),
- Respiratory therapy,
- Speech therapy (requires preauthorization),
- Cardiac therapy, and
- Pulmonary therapy.

Occupational therapy, physical therapy, and speech therapy must be ordered or referred by a HELP Plan provider.

Coverage is provided for habilitative care services when the participant requires help to maintain, learn, or improve skills and functioning for daily living or to prevent deterioration. These services include, but are not limited to:

1. Physical therapy;
2. Occupational therapy;
3. Speech-language pathology; and
4. Behavioral health professional treatment.

HELP Plan Services Described

Applied behavior analysis for adults is excluded.

Habilitative care services are reimbursable if a licensed therapist is needed. Licensed therapists will only be reimbursed if the service must be provided by a therapist. Services may be provided in a variety of inpatient or outpatient settings as prescribed by a physician or mid-level practitioner.

Coverage is provided for rehabilitative care services when the participant needs help to keep, get back, or improve skills and functioning for daily living that have been lost or impaired because the individual was sick, hurt, or disabled. Rehabilitative services will include, but are not limited to:

1. Physical therapy;
2. Occupational therapy;
3. Speech-language pathology; and
4. Behavioral health professional treatment.

Applied behavior analysis for adults is excluded.

Rehabilitative care services are reimbursable if a licensed therapist is needed. Licensed therapists will only be reimbursed if the service must be provided by a therapist. Services may be provided in a variety of inpatient or outpatient settings as prescribed by a physician or mid-level practitioner.

Therapy services must be preauthorized by your HELP Plan provider; call BCBSMT at **1-877-233-7055**. Your provider may also fax the preauthorization to **(406) 437-5850**.

Tobacco Cessation

Tobacco cessation drugs and counseling are covered by the HELP Plan. You can also get help to stop smoking or chewing by calling the Montana Tobacco Quit Line at **1-800-QUIT-NOW** or **1-800-784-8669**.

Transplants

Organ and tissue transplants are covered. Transplant benefits include:

- Heart, heart/lung, single lung, double lung, liver, pancreas, kidney, simultaneous pancreas/kidney, bone marrow/stem cell, small bowel transplant, cornea and renal transplants.
- For organ and tissue transplants involving a living donor, transplant organ/tissue procurement, and transplant-related medical care for the living donor are covered.
- Transplants of a nonhuman organ or artificial organ implant are not covered.
- Donor searches are not covered.

For certain transplants, BCBSMT contracts with a number of Centers of Excellence that provide transplant services. BCBSMT highly recommends use of the Centers of Excellence because of the quality of the outcomes at these facilities. Participants being considered for a transplant procedure are encouraged to contact BCBSMT Participant Services to discuss the possible benefits of utilizing the Centers of Excellence.

Inpatient services must be preauthorized; call BCBSMT at **1-877-233-7055**. Your provider may also fax the preauthorization to **(406) 437-5850**.

HELP Plan Services Described

Transportation

The HELP Plan may pay for you to get to your health care provider or other health care service, if the service is covered by the HELP Plan, and if you have no other way to get there. The following rules are used to decide if travel funds will be given:

- Preauthorization is required for each trip.
- You must use the least costly way to travel that still meets your needs.
- All transportation must be approved before you go, and if your appointment is changed, you must get your transportation approved again. The number to call for approval is **1-800-292-7114**.
- Travel funds can be provided for out-of-town or out-of-state if the service is not available near you. Advance payments will be on a case-by-case basis.
- You must be eligible for the HELP Plan on the date of the medical appointment.
- The mileage allowed per trip is based on the nearest provider who can provide the service, regardless of where the participant receives health care.

If you used a personal vehicle for emergency travel, you must call the Medicaid Transportation Center at **1-800-292-7114** within 30 days of the emergency in order to be considered for payment.

There are different rules for different kinds of transportation, such as taxicabs, buses, wheelchair-accessible vans, and non-emergency ambulances. Sometimes friends or family members can get paid for using their cars to take you to appointments. Be sure to call the Medicaid Transportation Center at **1-800-292-7114** before you arrange travel. You will be paid after you travel, if you have followed the above steps. The Medicaid Transportation Center will contact your doctor's office to make sure that you went to your appointment before paying.

Urgent Care

Some situations require prompt medical attention although they are not emergencies. In these situations, call your primary care provider and describe the situation. He or she will help direct your care. Examples include, but are not limited to:

- Sprains,
- Non-severe bleeding,
- Sore throats, or
- Ear aches.

Unless you get preauthorization, you must receive urgent care from HELP Plan providers. If you receive services from non-HELP Plan providers, you may have to pay for the services. You may also call the Nurse Advice Line at **1-877-213-2568**. Registered nurses are available 24 hours a day, 7 days a week. There is no charge for this call.

Vitamins

Vitamins are covered for certain conditions. For example, prenatal vitamins are covered during your pregnancy. You must have a prescription and you may need preauthorization; call the Montana Healthcare Programs at **1-800-362-8312**.

Wellness Programs

(See HELP Healthy Behavior Plan, page 21)

HELP Plan Eligibility and Key Contacts

Eligibility

For any issue related to your HELP Plan eligibility, you can contact the Montana Public Assistance Help Line at **1-888-706-1535** or **apply.mt.gov**.

For any issue or question related to medically frail eligibility, you can contact the Montana Public Assistance Help Line at **1-888-706-1535** or **apply.mt.gov**. Medically Frail means an individual has a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or lives in a medical facility or nursing home.

Key Contacts

For any issue or question related to services administered by DPHHS, you can contact the Montana Healthcare Programs toll-free phone number **1-800-362-8312**.

For any issue or question related to services administered by BCBSMT, you can contact the toll-free phone number **1-877-233-7055**. The hours are 8 a.m. to 8 p.m. Monday through Friday (Mountain Time). This toll-free number will receive incoming phone calls made from anywhere in the U.S.A.

Montana Relay Services

Telecommunications assistance for the hearing impaired.

1-800-833-8503 Voice, TTY
1-406-444-1335 Voice, TTY
relay@mt.gov

Interpreter Services

For forms and information on interpreter or translator services, call BCBSMT at **1-877-233-7055** or visit **http://medicaidprovider.mt.gov/forms#240933496-forms-a--c** for forms and additional instructions.

Denials and Appeals

Do You Disagree With a Service Decision?

If you disagree with a decision made about a service, there are few things you can do. Make sure to read this HELP Plan Participant guide to see if the service is covered by the HELP Plan. If you are not sure, you can talk with the contacts listed under the Key Contacts section of this guide. If you still do not agree, you can appeal.

For Benefits Administered by Blue Cross and Blue Shield of Montana (for example, medical, behavioral health, rehabilitation therapy. Please see page 3 of this Participant Guide for complete list.)

First Level Appeal

If you do not agree with a denial, or partial denial of a claim, you have 90 days from when you received the denial to appeal. To request an appeal, the request:

- Must detail your objections, and
- Must include any documents and information which you wish BCBSMT to consider in the appeal review.

A BCBSMT representative will let you know when your request for appeal is received. You will receive a written response within 45 days of receipt of your appeal.

Mail, call, or deliver your request for appeal to:

Blue Cross and Blue Shield of Montana
Appeals and Grievances Department
PO Box 27838
Albuquerque, NM 87125-9705
Phone: **1-877-232-5520**
Fax: **1-866-643-7069**

If you do not agree with the decision, you can make a second level appeal.

Second Level Appeal

The Office of Fair Hearing will handle your second level appeal. Within 90 days of receiving the first decision, if you do not agree with the decision, you may mail or fax your second level appeal request to:

Office of Fair Hearings
Department of Public Health and Human Services
PO Box 202953
Helena, MT 59620-2953
Fax: **1-406-444-3980**

Denials and Appeals

For Benefits Administered by Xerox (for example, pharmacy, dental, eyeglasses. Please see page 3 of this Participant Guide for complete list.)

Appeal Process

The Office of Fair Hearing will handle your appeal. Within 90 days of receiving the first decision, if you do not agree with the decision, you may mail or fax your appeal request to:

Office of Fair Hearings
Department of Public Health and Human Services
PO Box 202953
Helena, MT 59620-2953
Fax: **1-406-444-3980**

Other Resources To Help You

What If It Is a Discrimination Issue?

Participants enrolled in the HELP Plan have a right to:

- Equal access to services without regard to race, color, national origin, age, physical or behavioral disability, marital status, religion, creed, sex, sexual orientation, political belief, genetic information, veteran status, culture, social origin or condition, or ancestry,
- An interpreter or translator if needed, and
- Other help understanding benefits and services.

You can file a complaint if you believe you were discriminated against. If you need additional information regarding these protections, please contact:

Office of Civil Rights
US Department of Health and Human Services
1961 Stout Street, Room 1426
Denver, CO 80294
Phone: **1-303-844-2024**
DD: **1-303-844-3439**

If You Don't Want HELP Plan Coverage Any More

You have the right to ask to end HELP Plan coverage. To end the HELP Plan, call the Montana Public Assistance Help Line at **1-888-706-1535**.

Alternative Accessible Format

Persons with disabilities who need an alternative accessible format of this information, or who require some other reasonable accommodation in order to participate in the HELP Plan, should contact BCBSMT at **1-877-233-7055**.

Other Resources

For questions about your rights, this notice or for assistance, you can contact an assistance program or ombudsman.

Montana Office of the Commissioner of Securities and Insurance
840 Helena Ave
Helena, MT 59601
www.csi.mt.gov
Phone: **(800) 332-6148**

Other Useful Programs and Services

Organization or Service	Website	Phone Number
AIDS or Sexually Transmitted Diseases Questions	dphhs.mt.gov/publichealth/hivstd	1-(406) 444-3565
Behavioral Health Ombudsman	mhombudsman.mt.gov/default.mcpx	1-888-444-9669
Child Abuse and Neglect	dphhs.mt.gov/cfsd	1-866-820-5437
Child Support Customer Service	dphhs.mt.gov/csed	1-800-346-5437
Childhood Lead Poison Prevention Information	dphhs.mt.gov/publichealth/lead	1-(406) 444-0273
Children's Special Health Services	dphhs.mt.gov/publichealth/cshs	1-800-762-9891
Citizen's Advocate (Governor's Office)	citizensadvocate.mt.gov	1-800-332-2272
HELP Plan Transportation Approval	dphhs.mt.gov	1-800-292-7114
Legal Services	montanalawhelp.org	1-800-666-6899
Medicaid Fraud Line	dphhs.mt.gov/medicaid/fraudandabuse	1-800-201-6308
National Alliance on Mental Illness – Montana	namimt.org	1-(406) 443-7871
National Domestic Violence Hotline	thehotline.org	1-800-799-7233
Offices of Public Assistance (OPA)	dphs.mt.gov/hcsd/officeofpublicassistance	1-888-706-1535
Poison Control	dphhs.mt.gov/publichhealth/emsts/poison	1-800-222-1222
Social Security	socialsecurityofficelocations.com/state/MT.html	1-800-772-1213
Suicide Prevention	prevention.mt.gov/suicide	1-800-273-8255
Teen Dating Abuse Helpline	loveisrespect.org	1-866-331-9474
Tobacco Quit Line	dphhs.mt.gov/publichealth/mtupp/quitline	1-800-784-8669
WIC Nutrition Information	dphhs.mt.gov/wic/	1-800-433-4298

For questions about this guide, contact:

BCBSMT
560 North Park Avenue
Helena, MT 59602
1-877-233-7055

352488.0216

Montana HELP Demonstration

Operations Protocol

Appendix C

Welcome Brochure

(12 pages)

BlueCross BlueShield of Montana

MONTANA DPHHS
Healthy People. Healthy Communities.
Department of Public Health & Human Services

Montana HELP Plan

Welcome

Effective January 1, 2016

www.bcbsmt.com/mthelpplan or HELPPlan.mt.gov

Revised 10/1/2016

352210.0916

Contact Us

We are glad you chose the Montana Health and Economic Livelihood Partnership (HELP) Plan as your health plan! We want you to get the health care you need, when you need it. This HELP Plan brochure will help you get started. Keep it handy to answer some of your most common health plan questions.

IMPORTANT HELP PLAN PHONE NUMBERS

BCBSMT Participant Services.....**1-877-233-7055, TTY/TDD 711**

We are open:

Monday – Friday
8 a.m. to 8 p.m. MT
Voice mail is available 24 hours a day seven days a week.
Your call will be returned within one business day.

Alternate technologies (for example, voicemail) will be used on the weekends and federal holidays. The call is free.

24/7 Nurse Advice Line.....**1-877-213-2568, TTY/TDD 711**
Audiology.....**1-800-362-8312**
Behavioral Health Services.....**1-877-296-8206**
Dental.....**1-800-362-8312**
Eligibility Questions or Changes.....**1-888-706-1535, TTY/TDD 711**
Emergency Care.....**911**
Eyeglasses.....**1-800-362-8312**
Federally Qualified Health Centers (FQHCs).....**1-800-362-8312**
Fraud and Abuse.....**1-800-543-0867, TTY/TDD 711**
Grievances and Appeals.....**1-877-232-5520, TTY/TDD 711**
Hearing Aids.....**1-800-362-8312**
Indian Health Services (IHS)/Tribal Health.....**1-800-362-8312**
National Poison Control Center.....**1-800-222-1222**
Calls are routed to the office closest to you.
Pharmacy Services.....**1-800-362-8312**
Rural Health Clinics (RHCs).....**1-800-362-8312**
Transportation.....**1-800-292-7114**
Community Based Programs.....**dphhs.mt.gov/publichealth/chronicdisease/communitybasedprograms**
Web.....**www.bcbsmt.com/mthelpplan** or **HELPPlan.mt.gov**

CALL 911 IF YOU HAVE AN EMERGENCY.

PLEASE NOTE: For help to translate or understand this item, please call **1-877-233-7055** TTY/TDD **711**. You can get this document in Braille, or speak with someone by calling **1-877-233-7055**. The call is free.

The Importance of a Primary Care Provider (PCP)

YOUR PRIMARY CARE PROVIDER (PCP)

Your PCP is your main health care provider. You can see a BCBSMT in-network specialist without a referral from your PCP, but it is important that your PCP knows which doctors you see.

A PCP can be a:

- Family or general practitioner,
- Obstetrician/gynecologist (OB/GYN),
- Internist (Internal Medicine),
- Nurse Practitioner (NP) or Physician Assistant (PA), or
- A community health clinic such as a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC).

TO DO

It is recommended that you choose a PCP from the Montana HELP Plan Provider Network at **www.bcbsmt.com/mthelpplan.**

Look in the Provider Directory to:

- ☐ Choose a PCP for a pregnant participant under OB/GYN, Family Practice, Internal Medicine, or General Practice.
- ☐ Choose a PCP for adults in your family under Family Practice, Internal Medicine, or General Practice.

Note: Select FQHC/RHC through MT Medicaid Provider Finder.

You can call **Participant Services** at **1-877-233-7055** for help choosing a PCP. You can also ask Participant Services to mail you a Provider Directory. The website has an online directory and a tool called Provider Finder®.

Since some benefits are managed at DPHHS, you have to get care from providers who accept Montana Medicaid to be covered by the Montana HELP Plan. A list of Montana Medicaid providers is at the MT Medicaid Provider Finder at **https://mtaccesstohealth.acs-shc.com/mt/general/providerLocator.do**.

MAKING AN APPOINTMENT

To make an appointment, please follow these steps:

- Call your PCP's office ahead of time.
- Tell the office that you are a HELP Plan participant and have your ID card handy.
- You may also contact your assigned Care Coordinator for assistance if you have one.

If you go to your PCP's office, or another provider's office without an appointment, the provider may not be able to see you. Please call your provider before you go to the office.

YOUR CARE COORDINATOR

As a HELP Plan participant, you can get care coordination support. A Health Assessment (HA) form will be in your HELP Plan Welcome Kit. If we have not received your completed HA within 60 days of joining the HELP Plan, we will call to complete your HA over the phone. This HA will be done at least once a year after that.

The HA helps us find the level of care coordination support you may need and could mean we provide you with a care coordinator. A care coordinator will work with you and others involved in your care, like your PCP, to help with your health care needs and make a care plan that helps you reach your health care goals.

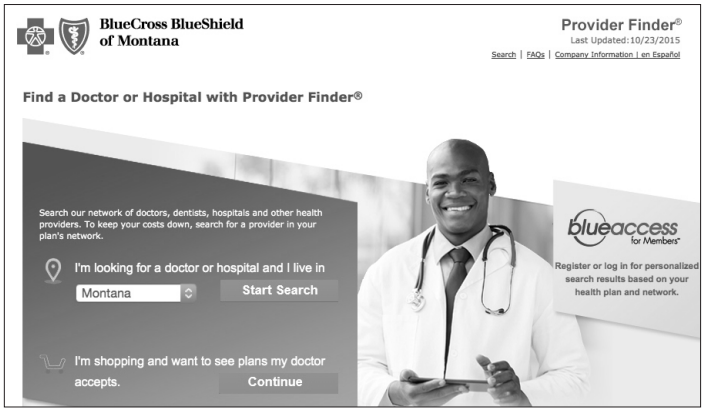
Care Coordinators also:

- Plan in-person visits or phone calls with you,
- Listen to your concerns,
- Help get you or your family the services you need, like transportation,
- Help set up care with doctors and other health care team members,
- Help you, your family and your caregiver better understand your health condition(s), medications, and treatments, and
- Refer you to managed wellness programs.

Provider Finder®

The Provider Finder lets you search for medical and behavioral health providers and hospitals in the Montana HELP Plan Network. Go online to use Provider Finder: **www.bcbsmt.com/mthelpplan** or **HELPPlan.mt.gov**.

- Search by name, city, state, or ZIP code; specialty, or service,
- Search for providers who are accepting new patients,
- Get a list of provider names, phone numbers, and addresses,
- Learn the providers' genders specialties, languages they speak, and
- Google Maps™ lets you see the provider's location and get directions.



Since some benefits are managed at DPHHS, you have to get care from providers who accept Montana Medicaid to be covered by the Montana HELP Plan. A list of Montana Medicaid providers is at the MT Medicaid Provider Finder at **https://mtaccesstohealth.acs-shc.com/mt/general/providerLocator.do**.

Getting Medical Care

WHAT DO I DO IF I NEED TO SEE A DOCTOR RIGHT AWAY?

If waiting to be seen by a doctor would endanger your health or seriously harm you, call **911** or go to the nearest emergency room (ER).

1. Call your PCP's office. Ask if he or she can see you that day.
2. If you can't see your PCP right away, call the **24/7 Nurse Advice Line** at **1-877-213-2568**. You can talk to a registered nurse about your options.
3. If you still need to see a doctor, you can also go to an urgent care provider. Call **Participant Services** at **1-877-233-7055** if you need help finding a provider.

WHEN I SHOULD GO TO THE ER?

Go to the ER or call **911** if you or a covered family member has any of these symptoms:

- Chest pain,
- Shortness of breath or severe trouble breathing,
- Heavy bleeding,
- About to deliver a baby,
- Fainting or seizures,
- Intense or sudden pain,
- Sudden dizziness, weakness, or change in vision, speech, or mental state,
- Severe or persistent vomiting or diarrhea,
- Coughing or vomiting blood,
- Head, neck, or traumatic injury (such as a gunshot or stab wound),
- Major broken bones,
- Severe burns, or
- Poisoning or drug overdose.

If you go to the ER, be sure to bring:

- Your participant ID card, and
- Your PCP's name and phone number.

If you can, also bring:

- A list of any medicines you take, and
- A list of any medical conditions and drug allergies you have.

Seeing your PCP regularly can help reduce your chances of needing to go to the ER. You can also call the **24/7 Nurse Advice Line** at **1-877-213-2568**. The nurses can help you decide if you should see your doctor, go to urgent care, or go to the ER.

Do not use the ER for routine care.

WHAT IS PREVENTIVE CARE?

Preventive care helps keep you healthy and is covered by your health plan. Preventive care includes:

- Regular checkups,
- Dental checkups,
- Eye exams,
- Immunizations,
- Mammograms, Pap tests, and other cancer screenings,
- Treatment for some chronic conditions, and
- Other services described in your HELP Plan Participant Guide.

To get preventive care, make an appointment with your PCP. There are no out-of-pocket costs for participants receiving preventive care.

NETWORK PROVIDERS AND PREAUTHORIZATION

WHAT ARE IN-NETWORK PROVIDERS?

In-network providers are providers that have contracted with BCBSMT or MT Medicaid to accept special payment rates for the services they provide to HELP Plan participants. To have your services paid by the HELP Plan, you must use in-network providers, unless you have preauthorization.

There are certain services that are covered when you use an out-of-network provider such as emergency or urgent care services. See your HELP Plan Participant Guide for details and exceptions.

WHEN DO I NEED PREAUTHORIZATION?

You will need preauthorization from BCBSMT to go outside of the plan network of providers. Your primary care doctor has to get permission from BCBSMT before you can be admitted to the hospital, or receive certain services, such as home health care. Contact **Participant Services** at **1-877-233-7055** for a complete listing. Providers may contact **Provider Services** at **1-877-296-8206**. BCBSMT may not approve the request. If the request for these types of services is denied, you and your provider will be contacted and the reason for the denial will be explained.

HOW DO I GET PREAUTHORIZATION?

Your PCP will know which procedures need preauthorization and will contact BCBSMT for you. Providers may contact **Provider Services** at **1-877-296-8206**. To find out if your preauthorization has been approved, call **Participant Services** at **1-877-233-7055**. See your HELP Plan Participant Guide for details.

WHAT IS A SPECIALIST?

Specialists treat medical conditions requiring specialized knowledge beyond that of your primary care doctor. Examples include heart problems, allergies, and diabetes. The specialist must be an in-network provider to be covered.

BEHAVIORAL HEALTH CARE

You have benefits for behavioral health services. This includes mental and emotional problems, alcoholism, and drug-related problems. A care coordinator can help you find which services are covered and if preauthorization is needed for the service.

You can call **Participant Services** at **1-877-233-7055**. They will help you find a provider or help you speak to a care coordinator to get further assistance. Providers may contact **Provider Services** at **1-877-296-8206**.

In an emergency (such as if you feel like hurting yourself or others, or if you are not able to take care of yourself) call **911** or go to the ER.

See your HELP Plan Participant Guide for more information about your behavioral health coverage.

PREMIUMS AND COPAYMENTS

As a participant of the HELP Plan, you will have to pay a monthly premium. Your premium will help cover the cost of your health insurance. The HELP Plan premium cannot be more than two percent (2%) of your yearly household income.

A premium notice will be mailed to you within the month before the due date. Premiums are due by the first of each month. You must return the invoice stub and payment to the mailing address on the invoice. Unpaid premiums become a debt to the State and will be collected against future tax refunds.

A copayment is a payment owed by you to your health care provider for health care services that you receive. Your monthly premiums will go toward any copayments you owe. You will get a statement/bill for the copayment from your provider after the health care service claim has been processed. If the amounts of your copayments are more than your premiums in a given quarter, you will get a bill for your copayments after your provider visit.

You may be charged for more than one copayment for a visit to your doctor. For example, your visit may result in the following copayments: X-rays, lab work, doctor visit and for a facility fee (depending on the place of service). Contact **Participant Services** at **1-877-233-7055** if you have copayment questions.

Premiums and copayments will not exceed more than five percent (5%) of the total yearly household income. Please refer to the HELP Plan Participant Guide for more detailed information on premium, copayments, and consequences of non-payment of premiums.

The following individuals are exempt from copayments:

a. persons under 21 years of age;

b. pregnant women;

c. American Indians/Alaska Natives who are eligible for, currently receiving, or have ever received an item or service furnished by:

   i. an Indian Health Service (IHS) provider;

   ii. a Tribal 638 provider;

   iii. an IHS Tribal or Urban Indian Health provider; or

   iv. through referral under contract health services.

d. persons who are terminally ill receiving hospice services;

e. persons who are receiving services under the Medicaid breast and cervical cancer treatment category; and

f. institutionalized persons who are inpatients in a skilled nursing facility, intermediate care facility, or other medical institution if the person is required to spend for the cost of care all but their personal needs allowance, as defined in ARM 37.82.1320.

Getting Medical Care

The following service categories are exempt from copayments:

- Preventive health screenings,
- Family planning,
- Eyeglasses,
- Transportation,
- Emergencies in the emergency room,
- Immunizations, and
- Medically necessary health screenings ordered by a health care provider.

Mail your HELP Plan monthly premium to:

The Montana HELP Plan
P.O. Box 650213
Dallas, TX 75265-0213

If you have questions about your copayments or premiums, call **Participant Services** at **1-877-233-7055**.

DISENROLLMENT

Even if you cannot pay your premium, you may still be able to keep HELP Plan coverage. You will remain in the HELP Plan if:

A. Your income is under 100% of the federal poverty level, which is approximately $990 a month for an individual, or $2,025 a month for a family of four; or

B. If your income is above 100% of the federal poverty level, you may lose your coverage if you fail to pay your premiums. You are still responsible for the payment of your premiums. The unpaid premium balance will be transferred to the State of Montana for collection from your state income tax refund.

Even if you cannot pay your premiums, you may be able to keep HELP Plan coverage under certain circumstances including:

- You have been discharged from the United States military service within the previous 12 months;
- You are enrolled for credit in any Montana University System unit, a tribal college, or any other accredited college within Montana offering at least an associates degree;
- You see a primary care provider who is part of a patient-centered medical home;
- You are in a substance use treatment program; or
- You are in a DPHHS approved healthy behavior activity program administered by DPHHS or BCBSMT. The list of approved programs is located at **HELPPlan.mt.gov** or call **1-855-324-6259**.

If Montana DPHHS determines that you meet two or more of these conditions, you will continue to have access to the health care services covered by the HELP Plan. You will still be responsible for payment of your premiums.

If two of the following describe you, call **888-706-1535**.

You have been discharged from the United States military service within the past 12 months; or	To let us know you were in college or in the military go to apply.mt.gov, or call **888-706-1535** or visit any local Office of Public Assistance.
You are enrolled for credit in a Montana university, tribal college, or any other accredited college in Montana that offers at least a two-year degree; or	
You are in an approved HELP Healthy Behavior Plan wellness program; or You are in a substance use treatment program; or You see a primary care provider who is part of a patient- centered medical home. You can find out by asking your doctor's office.	To find out more about the Healthy Behavior programs or to sign up please go to **HELPPlan.mt.gov** or call BCBSMT Participant Services at **1-877-233-7055**. You can find out by asking your doctor's office. To let us know, go to **apply.mt.gov**, or call **888-706-1535** or visit any local Office of Public Assistance.

As long as you are in the HELP Plan, you have access to the health care services covered by the plan. You are still responsible for the payment of your premiums and copayments.

If you are disenrolled because you have unpaid premiums, you may reenroll in the HELP Plan after:

A. You have paid your unpaid premium balance in full; or

B. You have received notice from the State of Montana that your unpaid premium balance has been assessed against your future state income tax. This assessment occurs once per calendar quarter.

Participants that would like to reenroll should contact the Montana Public Assistance Help Line at **844-792-2460** or **apply.mt.gov**.

Premiums unpaid for more than 30 days will be transferred to the State of Montana for collection from any future state income tax refunds to which you are entitled. Premiums unpaid for more than 90 days will result in an end to your health care coverage unless you have individual circumstances, described above, that allow you to remain in the HELP Plan.

HELP HEALTHY BEHAVIOR PLAN

BCBSMT has implemented a comprehensive health and wellness program for participants in the HELP Plan, with a focus on engaging participants and providers. This program is called the BCBSMT HELP Healthy Behavior Plan.

Participants may call BCBSMT Participant Services 1-877-233-7055 and ask to be enrolled in one of the approved programs, or ask to speak with a Care Coordinator to learn more about this benefit. There are several DPHHS approved wellness programs available throughout the state of Montana. Descriptions of these programs are available on the BCBSMT participant portal, Blue Access for Members (BAM) at **http://www.bcbsmt.com/mthelpplan** and DPHHS' website at **http://dphhs.mt.gov/publichealth/chronicdisease/CommunityBasedPrograms** or by calling **1-855-324-6259**.

NOTES

The benefit information provided is a brief summary, not a complete description of benefits. For more information refer to your HELP Plan Participant Guide included in your Welcome Kit or at **www.bcbsmt.com/mthelpplan**.

Blue Cross and Blue Shield of Montana, a Division of Health Care Service Corporation,
a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

This project is funded in whole or in part under a contract with the Montana Department of Public Health and Human Services.
The statements herein do not necessarily reflect the opinion of the Department.

Montana HELP Demonstration

Operations Protocol

Appendix D

Notice of Eligibility Determination

(4 pages)

Office of Public Assistance
PO BOX 202925
Helena, Montana 59620-2959

[redacted]

DEPARTMENT OF
PUBLIC HEALTH AND HUMAN SERVICES

Steve Bullock
GOVERNOR

Richard H. Opper
DIRECTOR

STATE OF MONTANA

www.dphhs.mt.gov

PO BOX 4210
HELENA, MT 59604-4210

Case #:
Document #: [redacted]
Print Date: 05/23/2016
Contact Phone: 1-888-706-1535

About Your Case

Dear [redacted],

The first part of this letter is a summary of your benefits.

Please report changes according to each program's reporting requirements so your benefits can be determined correctly.

Health Coverage

Your health coverage information is listed below. Please read this entire letter.

Date of Application: 04/26/2016

Effective Date	Action	Person(s)	Monthly Charge	Explanation
04/01/2016	Approved	[redacted]	$10.00	For more information, please see the **Information on Your Health Coverage**, **Additional Services Available to You**, **Your Health Coverage Change Reporting Requirements**, and **Estate Recovery** Section.

[1]This health coverage is dependent upon waiver approval from Centers for Medicare and Medicaid Services (CMS).The premium amount may be reduced or eliminated for some individuals based on final approval from CMS.

If you have any questions, please call the Montana Public Assistance Helpline at 1-888-706-1535.

Your Health Coverage Benefits

Information on Your Health Coverage

BlueCross BlueShield of Montana will send you an insurance card and a participant guide within 4 weeks after your coverage begins. Please review the participant guide. It has important information about your benefits, including information regarding any premium you owe. Always take your insurance card to all medical and dental appointments. For information, contact BCBSMT at 1-877-233-7055 or www.bcbsmt.com.

Information on Your Health Coverage

If you feel you have a physical, mental or emotional health condition that causes limitations in activities

(like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home, please contact us at the Montana Public Assistance Helpline at 1-888-706-1535.

Wellness Program
The goal of this program is to improve the overall health of participants using innovative models of care, participant education, and other wellness services. Examples of services may include: health screenings, nutrition awareness, active lifestyle education, tobacco cessation, and disease management. For more information, please visit TPA website.

Additional Services Available to You

HELP-Link, a Montana Department of Labor and Industry workforce program
For more information about this program, please visit **www.jobs.mt.gov** or stop by your local Job Service Office. This high quality, free program will provide you with a customized employment plan, connect you with local employers, and open access to training resources to help you find employment or grow your own earning capacity.

To find out what services are covered or not covered, copayment amounts, and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services go to the member page at **http://dphhs.mt.gov/MontanaHealthcarePrograms.** Here you can see the member guide and find out how to get a copy sent to you, member newsletters, and phone numbers for the Member Helpline and Nurse First Advice Line.

Your Health Coverage Change Reporting Requirements
You are required to report changes related to your Health Coverage, further details listed below:

Important things to remember about Medicaid:
- Tell your health care provider (doctor, hospital, clinic, etc.) you have Medicaid. Ask if your provider accepts Medicaid. If they don't, you may be responsible for the bill.
- Take your Montana Access to Health card or Healthy Montana Kids Plus card to each medical visit. If you need a new card, call the Montana Public Assistance Helpline at 1-888-706-1535.
- Medicaid does not cover some services. Check with your provider to see if the service is covered.
- Some people may pay a small amount (co-payment or cost share) for some medical services. There is no co-payment if you are under 21, pregnant, or an enrolled Native American or Alaska Native.
- Call Medicaid Transportation at 1-800-292-7114 if you need help paying for travel to get to a doctor's appointment or other medical service.

If you have questions about Medicaid services, ask your medical provider, review the Medicaid member guide online at http://dphhs.mt.gov/MontanaHealthcarePrograms/Welcome/MemberServices, or call the Montana Medicaid Helpline at 1-800-362-8312 to have a copy mailed to you.

If you enroll in new health insurance coverage, your new carrier may require proof of past health insurance coverage, including Medicaid. Call the Montana Public Assistance Helpline at 1-888-706-1535 if you need proof of the dates you were covered by Medicaid.

If health insurance is available for your household, report it to the Montana Public Assistance Helpline at 1-888-706-1535.

Estate Recovery
An individual's estate may be required to repay medical bills that Medicaid paid for individuals aged 55 or older, or anyone who lived in a nursing home (regardless of age).

Legal basis for this action is:

Name: [redacted]	Case #: [redacted]	Phone: [redacted]
Address: [redacted]	City: [redacted]	Zip Code: [redacted]
Address, if different from above:		
Phone, if different from above:		

This letter is your notice that on 05/23/2016 the Department of Public Health and Human Services (DPHHS) has made a decision regarding the Health Coverage benefits in your case.

If you think the decision is wrong and want someone to review this action, you may request a hearing. You must appeal the decision and request a hearing by 08/21/2016.

TWO WAYS TO REQUEST A HEARING

1. If you disagree with our decision complete the following request (1a-d) and mail to: Office of Fair Hearings, PO Box 202953, Helena, MT 59620 or fax to: Office of Fair Hearings, 406-444-3980.

a. I disagree with DPHHS' decision and I appeal the decision about my:

☐ Supplemental Nutrition Assistance Program (**SNAP**) benefits
(Oral requests are allowed for **SNAP**. Call 1-888-706-1535.)

☐ Temporary Assistance for Needy Families (**TANF**) benefits.

☐ Health Coverage benefits

b. I appeal the decisi[redacted]
_____
_____
_____

c. If you receive SNAP or Health Coverage **benefits, the benefits may automatically continue, as allowable,** unless you tell us you do not want continued benefits. **TANF** cash assistance is different from other programs and **does not continue** unless you tell us you want continued benefits. You must repay the amount of continued benefits if the fair hearing decision is not in your favor.

I do **NOT** want benefits to continue for: ☐ SNAP ☐ TANF ☐ Health Coverage

I want benefits to continue for: ☐ TANF

d. _____ _____
Signature (Claimant or Authorized Representative) Date

OR

2. Call the Montana Public Assistance Helpline at 1-888-706-1535 and ask for help to request a hearing.

If you want an attorney but cannot afford one, the Montana Legal Services Association at 1-800-666-6899 may help you.

Montana HELP Demonstration

Operations Protocol

Appendix E

Premium Invoice

(4 pages)

P.O. Box 3387
Scranton, PA 18505

1

GREAT
FALLS, MT 59405

HELP Plan Participants - Premium Rights and Obligations

As a participant of the HELP Plan, you are required to pay a monthly premium. The monthly premium will total 2% of your yearly income billed monthly. BCBSMT will send you a monthly bill for your premium. Submit your payment with the payment stub included in your monthly bill. Premiums are due on the 1st of each month.

WHAT IF I CANNOT PAY MY PREMIUM?

Even if you cannot pay your premium, you may still be able to keep HELP Plan coverage. You will remain in the HELP Plan if:

A. If your income is under 100% of the federal poverty level (approximately $990 a month for an individual, or $2,025 a month for a family of four you will be able to remain in the HELP Plan.
B. If your income is above 100% of the federal poverty level, you may lose your coverage if you fail to pay your premiums. You are still responsible for the payment of your premiums. The unpaid premium balance will be transferred to the State of Montana forcollection from your state income tax refund.

WHAT IF I HAVE SPECIAL CIRCUMSTANCES AND CANNOT PAY MY PREMIUM?

Even if you cannot pay your premiums, you may be able to keep HELP Plan coverage under certain circumstances including:

- You have been discharged from the United States military service within the previous 12 months;
- You are enrolled for credit in any Montana University System unit, a tribal college, or any other accredited college within Montana offering at least an associate degree;
- You see a primary care provider who is part of a patient-centered medical home;
- You are in a substance use treatment program; or
- You are in a DPHHS approved health behavior activity program administered by DPHHS or BCBSMT.

The list of approved programs is located at HELPPlan.mt.gov or call 1-855-324-6259.

If Montana DPHHS determines that you meet two or more of these conditions, you will continue to have access to the health care services covered by the HELP Plan. You will still be responsible for payment of your premiums.

If two of the following describe you, call 888-706-1535:

<table>
<tr><td>▪ You have been discharged from the United States military service within the past 12 months; or</td><td rowspan="2">To let us know you were in college or in the military go to apply.mt.gov, or call 888-706-1535 or visit any local Office of Public Assistance.</td></tr>
<tr><td>▪ You are enrolled for credit in a Montana university, tribal college, or any other accredited college in Montana that offers at least a two-year degree; or</td></tr>
<tr><td>▪ You are in an approved HELP Healthy Behavior Plan wellness program; or

You are in a substance use treatment program; or

You see a primary care provider who is part of a patient-centered medical home. You can find out by asking your doctor’s office.</td><td>To find out more about the Healthy Behavior programs or to sign up please go to HELPPlan.mt.gov or call BCBSMT Participant Services at 1-877-233-7055.

You can find out by asking your doctor’s office. To let us know, go to apply.mt.gov, or call 888-706-1535 or visit any local Office of Public Assistance.</td></tr>
</table>

CAN I REENROLL IN THE HELP PLAN IF I HAVE UNPAID PREMIUMS?

Yes, you may reenroll after

A. You have paid your unpaid (delinquent) premium balance in full, or
B. You have received notice from the State of Montana that they have assessed your unpaid premium balance against your future state income tax. This assessment occurs once per calendar quarter.

Participants that would like to reenroll should contact the Montana Public Assistance Help Line at 844-792-2460 or apply.mt.gov.

PREMIUM NOTICE

MONTANA DPHHS
Healthy People. Healthy Communities.
Department of Public Health & Human Services

BlueCross BlueShield of Montana

The HELP Plan is administered by Blue Cross and Blue Shield of Montana, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

Montana HELP Plan
P.O. Box 3387
Scranton, PA 18505

Participant Services
Toll-free: 1-877-233-7055 (TTY can call: 711)
Monday through Friday 8:00 am - 8:00 pm MST

Participant Name:
Participant ID:
Notice Date: 9/23/2016
Payment Due Date: 8/27/2016

Statement ID: 000000170591

Activity Description as of August 2016	Amount
Montana HELP Plan Premium for Current Month as of August 2016	$47.00
1-30 Days Overdue Outstanding Balance	$47.00
31-60 Days Overdue Outstanding Balance	$47.00
61-90 Days Overdue Outstanding Balance	$47.00
Greater than 90 Days Overdue Outstanding Balance	$188.00
Total	$376.00

Please Note: Unpaid premiums could result in an end to your health care coverage. If you have unpaid premiums for more than 90 days, the unpaid balance will be communicated to the State of Montana for collection against your future state income tax refunds. In addition, unless you have individual circumstances that allow you to remain in the HELP Plan, your health care coverage will end. Please see the reverse side of this invoice for HELP Plan Participant - Premium Rights and Obligations.

If this is your first statement, please note that an outstanding balance may have resulted due to late enrollment in a prior month's coverage period. If you have any questions or concerns please contact customer service at 1-877-233-7055 (TTY can call: 711)

For your records: Date Paid: _____ Check#: _____ Amount: _____

Detach and Return with payment

Participant Name:

Please make your check or money order payable to the Montana HELP Plan and write your Participant ID number on it. Do not send cash. Do not staple this to your check or money order. Thank you.

Total amount due	$376.00
Date due	8/27/2016

Group ID MT000001	**Plan ID** MT000006
Participant ID	**Statement Number** 000000170591

Amount Enclosed: $ _____

The Montana HELP Plan
P.O. Box 650213
Dallas TX 75265-0213

00115890 2MT000001000000170591000037600 1

Montana HELP Demonstration

Operations Protocol

Appendix F and G

Explanation of Benefits

(4 pages)

Participant: <MEMBER_NAME>
<ADDRESS1>
<ADDRESS2>
<ADDRESS3>
<CITY>, <STATE> <ZIP>

ID: <MEMBER_ID>

BlueCross BlueShield of Montana

MONTANA DPHHS

HELP PLAN

<PRINT_DATE>

HELP Plan Explanation of Benefits

This is NOT a bill. This explains the amount you are responsible to pay. Your provider will bill you for this copay.

Servicing Provider: <PRPR_NAME>
NPI: <PRPR_NPI>

Claim Number: <CLCL_ID>
Plan: <PDDS_DESC>

Dates of Service	Total Charges	Participant Responsibility			Plan Disallow	Amount Paid	Remarks
		<100%FPL Copay	>100%FPL Copay	Non-Covered			
<CDML_FROM_DT> <CDML_TO_DT>	<CDML_CHG_AMT>	<CDML_COPAY_AMT>	<CDML_COINS_AMT>	<NON_COV_AMT>	<CDML_DISALLOW_AMT>	<CDML_PAID_AMT>	<CDML_DISALL_EXCD>

Description of Service: <BILL_CODE_DESC> (Billing Code <BILL_CODE>)

CLAIM PRIMARY PAYOR PAYMENT: <PRIM_PAY_PMT>

CLAIM PRIMARY PAYOR ADJUSTMENT: <PRIM_PAY_ADJ>

CLAIMS TOTALS:	<CDML_CHG_AMT_TOT>	<CDML_COPAY_AMT_TOT>	<CDML_COINS_AMT_TOT>	<NON_COV_AMT_TOT>	<CDML_DISALLOW_AMT_TOT>	<CDML_PAID_AMT_TOT>
GRAND TOTALS:	<CDML_CHG_AMT_GRAND_TOT>	<CDML_COPAY_AMT_GRAND_TOT>	<CDML_COINS_AMT_GRAND_TOT>	<NON_COV_AMT_GRAND_TOT>	<CDML_DISALLOW_AMT_GRAND_TOT>	<CDML_PAID_AMT_GRAND_TOT>

Participant: <MEMBER_NAME>
<ADDRESS1>
<ADDRESS2>
<ADDRESS3>
<CITY>, <STATE> <ZIP>

ID: <MEMBER_ID>

BlueCross BlueShield of Montana

MONTANA DPHHS Healthy People. Healthy Communities.

HELP PLAN

Reason Codes

<LIST_CDML_DISALL_EXCD> <LIST_EXCD_SHORT_TEXT>

If you do not agree with this decision please review the attachment.

For Participant Services Call
BCBSMT <1-877-233-7055>

Hours of Operation:
<8:00a.m.-8:00pm MST >

TTY for the hearing impaired
<711>

COMMITMENT AGAINST FRAUD:
If you feel you or the Plan has been billed for services you did not receive, please contact the confidential hotline at: <1-800-543-0867>

IMPORTANT INFORMATION
(Retain for your records)

If we have denied your claim for benefits, in whole or in part, for a requested treatment or service then this document serves as part of your notice of an adverse determination. **Contact us at the number on the back of your ID card if you need assistance understanding this notice or your adverse determination.**

Your Internal Appeal Rights

What if I don't agree with this decision? You have a right to appeal an adverse determination. However, you only have 90 days from the date you receive the notice of adverse determination to file an internal appeal.

Who may file an internal appeal? You or someone you name to act for you (your authorized representative) may file an appeal. You may designate an authorized representative by completing the necessary forms. For more information on how to do so, contact us at the number on the back of your ID card.

How do I file an internal appeal? For claim appeals, you may contact us at the number on the back of your ID card and request an internal appeal or send a written request.

Blue Cross Blue Shield of Montana
Attn; Appeals and Grievances Department
P.O. Box 27838
Albuquerque, NM 87125-9705
Telephone: 1-877-232-5520
Confidential Fax: 1-866-643-7069

What about eligibility-related denials and rescissions? Please refer to your HELP Plan Participant Guide and/or HELP Evidence of Coverage found at http://dphhs.mt.gov/helpplan or call Toll Free 1-877-232-5520 for additional specifics. You may also contact us at the number on the back of your ID card.

What if my situation is urgent? If your situation meets the definition of urgent under the law, your review will generally be conducted as soon as possible. An urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your doctor you experience pain that cannot be adequately controlled while you wait for a decision on your appeal. If you believe your situation is urgent, you may request an expedited appeal by following the instructions above for filing an internal appeal.

Can I provide additional information about my claim? Yes, you will be informed about how to supply additional information once you initiate your appeal. You will also have the option of presenting evidence and testimony. In addition, we will provide you with any new or additional evidence, rationale, documents, or information used or relied upon in your adverse determination so you have a reasonable opportunity to respond before a final decision is made.

Can I request copies of information relevant to my claim? Yes, you may request and receive copies relevant to your claim free of charge. For example, upon request, you may receive the diagnosis and treatment codes (and their corresponding meanings) associated with an adverse determination. In addition, if we rely on a rule or guideline (such as a provision excluding certain benefits within your policy booklet) in making an adverse determination, we will provide that rule or guideline to you free of charge upon request. You can request copies of this information by contacting us at the number on the back of your ID card.

What happens next? You may do the following:
For Medical and Surgical Denials-
If you do not agree with the First Level appeal determination, you may choose to make a Second Level Appeal with the Department of Public Health and Human Services.

You may fax your Second Level appeal request to 1-866-643-7069 within 90 days of receiving the First Level determination or mail it to the address below:

Office of Fair Hearings
Montana Department of Public Health and Human Services
P.O. Box 202953
Helena, MT 59620-2953

The Office of Fair Hearings will contact you to conduct an impartial administrative hearing and/or a Fair Hearing. The Hearing Officer will research statutes, rules, regulations, policies, and court cases to reach conclusions of law. After weighing evidence and evaluating testimony, they issue written decisions that are binding unless appealed to the state Board of Public Assistance, the Department Director, or a district court.

Other Resources to Help You
For questions about your rights, this notice, or for assistance, you can contact a consumer assistance program or ombudsman.

Office of the Commissioner of Securities and Insurance
840 Helena Ave
Helena, Montana 59601
www.csi.mt.gov
Telephone: (800) 332-6148

You may be eligible to receive your adverse determination and this notice in a language listed below. In addition, you may call us to receive assistance in these languages.

SPANISH (Español): Para asistencia en Español, por favor llame al numero ubicado en la parte posterior de su tarjeta de identificacion.

TAGALOG (Tagalog): Upang humingi ng tulong sa Tagalog, paki tawagan ang numero na nakasulat sa inyong kard.

CHINESE (中文): 如果需要中文幫助，請撥打您卡上的電話號碼。

NAVAJO (Dine): Dinék'ehji áka'a'doowoo ł biniiyé, t'áá shǫǫdi koji' hodiilnih béésh bee haane'i bi numbo bee nééh ho'dólzinigii binuyé nanitinigii bine'dęę' bikáá'

ATTACHMENT C

Preventive Services Protocol

I. Background

HELP Program participants enrolled through the TPA will be required to pay premiums and copayments. Cost sharing for all individuals under the demonstration will be consistent with Medicaid regulations, and copay and premium payments will be subject to an aggregate cap of 5 percent of household income.

As required by the Centers for Medicare and Medicaid Services (CMS), the following Preventive Services Protocol describes how the Montana Department of Public Health and Human Services (DPHHS or State) will implement copayment exemptions for identified preventive services.

II. Exempt Services

The State will ensure that individuals enrolled under the Third Party Administrator (TPA), Blue Cross Blue Shield of Montana, will not be charged for preventive health care services. This includes coverage for evidence-based services for adults that have a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF), immunizations that are recommended and determined to be for routine use by the Advisory Committee on Immunization Practices (ACIP), services recommended by the Health Resources and Services Administration's (HRSA's) Bright Futures Project, and the preventive services for women designated under the Affordable Care Act.

Preventive health care services including primary, secondary, and tertiary preventive services will be identified by diagnosis codes and/or procedure codes. Pharmacy claims will be identified through drug classes. DPHHS will maintain the list of exempt preventive services and drug classes and review and update the list at least annually. The Department will notify the claims processing vendors (TPA, Pharmacy and MMIS) of any updates to the list within ten (10) days.

The full list of preventive services exempt from copayment, including drugs, is attached (Appendix 1). Services related to family planning, individuals under the age of 21, emergency services, and pregnancies are currently exempt from copayments in accordance with federal regulations; these services are not included in the preventive lists. The Department already exempts tobacco cessation drug classes from copayments for all individuals; therefore, this service is not included in the preventive lists.
The State will utilize the following process to ensure enrollees are not charged for preventive services:

1. Providers will not charge copayments to enrollees at the point of service.

2. Providers will submit claims in compliance with International Classification of Diseases (ICD) coding guidelines.
3. The claims payment vendors will process claims, taking into consideration the aggregate cap of 5 percent of household income to ensure enrollees are not billed above the 5 percent cap.
4. The claims payment vendors will send remittance advice to the provider with copayment information.
5. Providers will bill enrollees for applicable copayments.

III. Provider Education and Training

The State will ensure that the TPA has written provider education materials regarding service exemptions and will work with the TPA to develop and disseminate information to providers.

IV. Enrollee Education

The State will ensure that that the TPA has written policies regarding service exemptions and will work with the TPA to develop and disseminate information to enrollees, including through the enrollee handbook. Enrollees will be notified of the service exemption policy and be provided with a list of exempted services within ten days of enrollment. The policy and list of exempted services will also be posted on the State and TPA's websites and be available in hard copy upon an enrollee's request. The information provided to beneficiaries will comply with the Information and Communication Requirements detailed in the 1915(b)(4) Waiver STCs (Section 11).

In its Quarterly Reports to CMS, the State will describe actions the State and TPA have taken to inform enrollees about exempt preventive services.

V. Enrollee Grievances and Appeals

The State and TPA will follow enrollee grievance and appeals processes described in the 1915(b)(4) and 1115 Waiver STCs and consistent with federal law. In its Quarterly Reports to CMS, the State will describe actions complaints, grievances, and appeals filed during the quarter regarding service exemptions and copays as well as any actions being taken to address significant issues evidenced by patterns of complaints or appeals.

Attachment C
Preventive Services Protocol
Appendix 1: Preventive Services Procedure Codes

Preventive Guideline	Procedure Code	Description
AAA screening	76700	Abdominal Ultrasound, complete
	76705	Abdominal Ultrasound, limited
	76770	Retroperitoneal Ultrasound, complete
	76775	Retroperitoneal Ultrasound, limited
	G0389	Ultrasound for AAA screening
Alcohol abuse	99408	Audit/DAST 15-30 min
	99409	Audit/DAST over 30 min
	G0442	Annual Alcohol screen 15 min
	G0443	Brief Alcohol misuse counseling
BRCA risk assessment/counseling	81211	BRCA 1&2Sequence
	81212	BRCA 1 & 2 testing
	81213	BRCA 1& 2 testing
	81214	BRCA 1 testing
	81215	BRCA 1 testing
	81216	BRCA 2 testing
	81217	BRCA 2 testing
Breast cancer screening	G0202	Screening mammogram digital
	77052	Comp Screen Mammogram add-on
	77057	Mammogram screening
Cervical cancer screening	G0101	Ca screen pelvic breast exam
	G0123	screen cerv/vag thin layer
	G0124	screen c/v thin layer by md
	G0141	screen c/v cyto autosys and md
	G0143	SCR c/v Cyto, thin layer Rescr
	G0144	SCR c/v Cyto, thin layer Rescr
	G0145	SCR c/v Cyto, thin layer Rescr
	G0147	SCR c/v Cyto automated sys
	G0148	scr c/v cyto autosys rescr
	Q0091	Obtaining screen pap smear
	P3000	Screen pap by tech with MD supv
	P3001	Screen pap smear by physician
	88141	Cytopath C/V interpret
	88142	Cytopath C/V thinlayer
	88143	Cytopath C/V Thinlayer Redo

Preventive Guideline	Procedure Code	Description
	88147	Cytopath C/V Automated
Cervical cancer screening (cont.)	88148	Cytopath C/V Auto Rescreen
	88150	Cytopath C/V Manual
	88152	Cytopath C/V Auto Redo
	88153	Cytopath C/V Redo
	88154	Cytopath C/V Select
	88155	Cytopath C/V Index
	88164	Cytopath TBS C/V Manual
	88165	Cytopath TBS C/V Redo
	88166	Cytopath TBS C/V Auto Redo
	88167	Cytopath TBS C/V Select
	88174	Cytopath C/V Auto in fluid
	88175	Cytopath C/V Auto fluid redo
Chlamydia screening	86631	Chlamydia antibody
	86632	Chlamydia IGM antibody
	87110	Chlamydia culture
	87270	Chlamydia trachomatis AG IF
	87320	Chlamydia Trach AG EIAC
	87490	Chlamydia Trach DNA Dir Probe
	87491	Chlamydia Trach DNA AMP Probe
	87492	Chlamydia Trach DNA Quant
	87801	Detect AGNT Mult DNA AMP
	87810	Chlamydia Trach Assay w/optic
Cholesterol screening	80061	Lipid Panel
	82465	Assay blood serum cholesterol
	83718	Assay of lipoprotein
	83719	Assay of blood lipoprotein
	83721	Assay of blood lipoprotein
	84478	Assay of lipoprotein
Colorectal cancer screening	G0104	Ca screen flexi sigmoidscope
	G0105	Colon cancer screen hi risk ind
	G0106	Colon Ca Screen; Barium Enema
	G0120	Colon Ca Screen; Barium Enema
	G0121	Colon Ca Screen Not high risk ind
	G0122	Colon Ca Screen; Barium Enema
	G0328	Fecal Blood Screen Immunoassay
	45330	Diagnostic Sigmoidoscopy
	45331	Sigmoidoscopy and biopsy
	45333	Sigmoidoscopy & polypectomy

Preventive Guideline	Procedure Code	Description
	45338	Sigmoidoscopy with tumor removal
Colorectal cancer screening (cont.)	45346	Sigmoidoscopy with ablation
	44388	Colonoscopy with ablation
	44389	Colonoscopy with stent placement
	44392	colonoscopy with polypectomy
	44394	colonoscopy with snare
	45378	Diagnostic colonoscopy
	45380	Colonoscopy and Biopsy
	45381	Colonoscopy submucous NJX
	45384	Colonoscopy with lesion removal
	45385	Colonoscopy with lesion removal
	45388	Colonoscopy with ablation
	82270	Occult blood feces
	82274	Assay test for blood fecal
	88304	Tissue exam by pathologist
	88305	Tissue exam by pathologist
	00810	Anesthesia low intestine scope
	74263	CT Colonography screening
Depression screening	99420	HRA test
	G0444	Depression screen annual
Diabetes screening	82947	Assay Glucose Blood Quant
	82948	Reagent strip/blood glucose
	82950	Glucose test
	82951	Glucose tolerance test
	82952	GTT-added samples
	83036	Glycosylated hemoglobin assay
Gonorrhea screen	87590	N Gonorrhoeae DNA Dir probe
	87591	N Gonorrhoeae DNA AMP probe
	87592	N Gonorrhoeae DNA Quant
	87801	Detect AGNT Mult DNA AMP
	87850	N Gonorrhoeae Assay with Optic
Healthy diet and physical activity counseling to prevent cardiovascular disease	97802	Medical Nutrition Therapy Ind Init
	97803	Medical Nutrition Therapy Ind Subsq
	97804	Medical Nutrition Group
	G0446	Intensive Behave Ther Cardio Dx
	G0447	Behavior counsel obesity 15 min
	G0473	Group Behave Couns 2-10

Preventive Guideline	Procedure Code	Description
	G0270	Medical Nutrition Tx for Change Dx
	G0271	Group MNT 2 or more 30 min
Hepatitis B screening	87340	Hep B Surface AG EIA
	87341	Hep B Surface AG EIA
Hepatitis C screening	86803	Hep C AB Test
	86804	Hep C AB Test Confirm
	G0472	Hep C Screen High Risk/Other
HIV screen	86689	HTLV/HIV Confirm J antibody
	86701	HIV-1 Antibody
	86702	HIV-2 Antibody
	86703	HIV-1/HIV-1 Antibody
	G0432	EIA HIV-1/HIV-2 Screen
	G0433	ELISA HIV-1/HIV-2 Screen
	G0435	Oral HIV-1/HIV-1 Screen
HPV screening	87624	HPV High Risk Types
	87625	HPV Types 16& 18 Only
Lung cancer screening with CT	G0296	Counseling visit to discuss lung cancer screening using low dose CT scan
	G0297	Low Dose Lung CT Scan
Osteoporosis screening in women	76977	US Bone Density Measure
	77078	CT Bone Density Axial
	77080	DXA Bone Density Axial
	77081	DXA Bone Density Peripheral
	G0130	Single Energy X-Ray Study
STD counseling	99401	Preventive counseling Ind
	99402	Preventive counseling Ind
	99403	Preventive counseling Ind
	99404	Preventive counseling Ind
	G0445	High intensive Behavioral CNSL STD 30 min
Tobacco use counseling and interventions	99401	Preventive counseling Ind
	99402	Preventive counseling Ind
	99403	Preventive counseling Ind
	99404	Preventive counseling Ind
	99406	Behavior Change Smoking 3-10 min
	99407	Behavior change smoking 10+ min
	G0436	Tobacco use counselling 3-10 min

Preventive Guideline	Procedure Code	Description
	G0437	Tobacco use counselling 10+ min
Syphilis screening	86592	Syphilis test Non-TREP Qual
	86593	Syphilis test Non-TREP Quant
Preventive/Wellness exams	99385	Preventive Visit New age 18-39
	99386	Preventive Visit New age 40-64
	99387	Preventive Visit New age 65+
	99395	Preventive Visit Established age 18-39
	99396	Preventive Visit Established age 40-64
	99397	Preventive Visit Established age 65+
	99401	Preventive counseling Ind
	99402	Preventive counseling Ind
	99403	Preventive counseling Ind
	99404	Preventive counseling Ind
	99411	Preventative counseling group
	99412	Preventative counseling group
	G0402	Initial Preventative Exam
	G0445	High intensive Behavioral CNSL STD 30 min
Vaccines	90471	Immunization Admin
	90472	Immunization Admin Each Add
	90473	Immunization Admin Oral/Nasal
	90474	Immunization Admin Oral/Nasal
	G0008	Admin Influenza Virus
	G0009	Admin Pneumococcal Vaccine
	G0010	Admin Hep B Vaccine
	90581	Anthrax Vaccine SC or IM
	90585	BCG Vaccine Percut
	90586	BCG Vaccine Intravesical
	90620	Meningococcal recombinant protein and outer membrane vesicle vaccine, Serogroup B, 2 dose schedule, for intramuscular use
	90621	Meningococcal recombinant lipoprotein vaccine, serogroup B, 3 dose schedule, for intramuscular use
	90630	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use
	90632	Hep A Vaccine Adult IM

Preventive Guideline	Procedure Code	Description
	90636	Hep A/Hep B Vacc Adult IM
	90632	Hepatitis A vaccine (Hep A), adult dosage, for intramuscular use
	90636	Hepatitis A and hepatitis B vaccine (Hep A-Hep B), adult dosage, for intramuscular use
Vaccines(cont.)	90647	Haemophilus influenzae b vaccine (Hib), PRP-OMP conjugate, 3 dose schedule, for intramuscular use
	90648	Haemophilus influenzae b vaccine (Hib), PRP-T conjugate, 4 dose schedule, for intramuscular use
	90649	Human Papilloma virus vaccine, types 6, 11, 16, 18, quadrivalent (HPV4), 3 dose schedule, for intramuscular use
	90650	Human Papilloma virus vaccine, types 16, 18, bivalent (HPV2), 3 dose schedule, for intramuscular use
	90651	Human Papillomavirus vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavalent (HPV), 3 dose schedule, for intramuscular use
	90654	Influenza virus vaccine, trivalent (IIV3), split virus, preservative-free, for intradermal use
	90656	Influenza virus vaccine, trivalent (IIV3), split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use
	90658	Influenza virus vaccine, trivalent (IIV3), split virus, when administered to individuals 3 years of age and older, for intramuscular use
	90660	Influenza virus vaccine, trivalent, live (LAIV3), for intranasal use
	90661	Influenza virus vaccine (ccIIV3), derived from cell cultures, subunit, preservative and antibiotic free, for intramuscular use

Preventive Guideline	Procedure Code	Description
	90662	Influenza virus vaccine (IIV), split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use
	90669	Pneumococcal conjugate vaccine, 7 valent (PCV7), for intramuscular use
	90670	Pneumococcal conjugate vaccine, 13 valent (PCV13) IM
	90672	Influenza virus vaccine, quadrivalent, live (LAIV4), for intranasal use
Vaccines (cont.)	90673	Influenza virus vaccine, trivalent (RIV3), derived from recombinant DNA (RIV3), hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use
	90675	Rabies Vaccine IM
	90676	Rabies Vaccine ID
	90680	Rotavirus vaccine, pentavalent (RV5), 3 dose schedule, live, for oral use
	90681	Rotavirus vaccine, human, attenuated (RV1), 2 dose schedule, live, for oral use
	90686	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, when administered to individuals 3 years of age and older, for intramuscular use
	90688	Influenza virus vaccine, quadrivalent (IIV4), split virus, when administered to individuals 3 years of age and older, for intramuscular use
	90690	Typhoid vaccine oral
	90691	Typhoid vaccine IM
	90692	Typhoid vaccine H-P SC/ID
	90698	Diphtheria, tetanus toxoids, acellular pertussis vaccine, haemophilus influenzae Type b, and inactivated poliovirus vaccine (DTaP – IPV/Hib), for intramuscular use
	90703	Tetanus toxoid adsorbed, for intramuscular use

Preventive Guideline	Procedure Code	Description
	90704	Mumps virus vaccine, live, for subcutaneous use
	90705	Measles virus vaccine, live, for subcutaneous use
	90706	Rubella virus vaccine, live, for subcutaneous use
	90707	Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous use
	90708	Measles and rubella virus vaccine, live, for subcutaneous use
	90710	Measles, mumps, rubella, and varicella vaccine (MMRV), live, for subcutaneous use
	90713	Poliovirus vaccine, inactivated (IPV), for subcutaneous or intramuscular use
Vaccines (cont.)	90714	Tetanus and diphtheria toxoids adsorbed (Td), preservative free, when administered to individuals 7 years or older, for intramuscular use
	90715	Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), when administered to individuals 7 years or older, for intramuscular use
	90716	Varicella virus vaccine (VAR), live, for subcutaneous use
	90717	Yellow fever vaccine, live, SQ
	90719	Diphtheria toxoid, for intramuscular use
	90720	Diphtheria, tetanus toxoids, and whole cell pertussis vaccine and Haemophilus influenzae b vaccine (DTwP-Hib), for intramuscular use
	90721	Diphtheria, tetanus toxoids, and acellular pertussis vaccine and Haemophilus influenza b vaccine (DTaP/Hib), for intramuscular use
	90723	DTAP-HEP B- IPV vaccine IM

Preventive Guideline	Procedure Code	Description
	90732	Pneumococcal polysaccharide vaccine, 23-valent (PPSV23), adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use
	90733	Meningococcal polysaccharide vaccine , serogroups A, C, Y, W-135, quadrivalent (MPSV4) for subcutaneous use
	90734	Meningococcal conjugate vaccine, serogroups A, C, Y and W-135, quadrivalent (MenACWY), for intramuscular use
	90735	Encephalitis vaccine SC
	90736	Zoster (shingles) vaccine (HZV), live, for subcutaneous injection
	90740	Hepatitis B vaccine (HepB), dialysis or immunosuppressed patient dosage, 3 dose schedule, for intramuscular use
	90746	Hepatitis B vaccine (HepB), adult dosage, 3 dose schedule, for intramuscular use
Vaccines(cont.)	90747	Hepatitis B vaccine (HepB), dialysis or immunosuppressed patient dosage, 4 dose schedule, for intramuscular use
	90748	Hepatitis B and Haemophilus influenza b vaccine (Hib-HepB), for intramuscular us
	Q2034	Influenza virus vaccine, split virus, for intramuscular use (Agriflu)
	Q2035	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (AFLURIA)
	Q2036	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (FLULAVAL)

Preventive Guideline	Procedure Code	Description
	Q2037	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (FLUVIRIN)
	Q2038	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Fluzone)
	Q2039	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (not otherwise specified)
Dental preventive	D0120	Periodic oral eval
	D0140	Limit oral eval problem focus
	D0150	Comprehensive oral eval
	D0210	Intraoral complete film series
	D0220	Intraoral preapical first
	D0230	Intraoral periapical ea add
	D0240	Intraoral occlusal film
	D0250	Extraoral first film
	D0260	Extraoral ea additional film
	D0270	Dental bitewing single film
	D0272	Dental bitewing two films
	D0273	Bitewings three films
	D0274	Dental bitewing four films
	D0277	Vert bitewing seven to eight
	D0330	Dental panoramic film
	D0340	Dental cephalometric film
	D0350	Oral/facial photo images
	D0367	Cone beam CT interp both jaw
Dental preventive (cont.)	D0486	Accession of brush biopsy
	D0601	Caries risk assessment with a finding of high
	D0602	Caries risk assessment with a finding of moderate
	D0603	Caries risk assessment with a finding of low
	D1110	Dental prophylaxis adult
	D1206	Topical fluoride varnish
	D1208	Topical app of fluoride
	D1310	Nutrition counseling-control caries

Preventive Guideline	Procedure Code	Description
	D1320	Tobacco counseling
	D1330	Oral hygiene instruction
	D1351	Dental sealant per tooth
	D1352	Prev resin rest, perm tooth
	D1353	Sealant repair per tooth
	D1510	Space maintainer fixed unilat
	D1515	Fixed bilat space maintainer
	D1550	Replace space maintainer
	D1555	Remove fix space maintainer

Attachment C
Preventative Services Protocol
Appendix 1: Copay Exempt Drug Class Codes

Treatment Category	Drug Class	Description	Chronic Condition Treated
Behavioral Health/Substance Abuse	C0D	ANTI ALCOHOLIC PREPARATIONS	Alcohol Dependence
	H2F	ANTI-ANXIETY DRUGS	Anxiety, Panic Attack
	H2G	ANTI-PSYCHOTICS,PHENOTHIAZINES	Schizophrenia
	H2H	MONOAMINE OXIDASE(MAO) INHIBITORS	Depression
	H2M	BIPOLAR DISORDER DRUGS	Depression
	H2S	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	Depression
	H2U	TRICYCLIC ANTIDEPRESSANTS & REL. NON-SEL. RU-INHIB	Depression
	H2W	TRICYCLIC ANTIDEPRESSANT/PHENOTHIAZINE COMBINATNS	Depression
	H2X	TRICYCLIC ANTIDEPRESSANT/BENZODIAZEPINE COMBINATNS	Depression
	H3T	NARCOTIC ANTAGONISTS	Opioid Dependence
	H4B	ANTICONVULSANTS	Depression
	H7B	ALPHA-2 RECEPTOR ANTAGONIST ANTIDEPRESSANTS	Depression
	H7C	SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIS)	Depression
	H7D	NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIS)	Depression
	H7E	SEROTONIN-2 ANTAGONIST/REUPTAKE INHIBITORS (SARIS)	Depression
	H7J	MAOIS - NON-SELECTIVE & IRREVERSIBLE	Depression
	H7O	ANTIPSYCHOTICS,DOPAMINE ANTAGONISTS,BUTYROPHENONES	Schizophrenia
	H7N	SMOKING DETERRENTS, OTHER	Tobacco Use Disorder
	H7P	ANTIPSYCHOTICS,DOPAMINE ANTAGONISTS, THIOXANTHENES	Schizophrenia

Treatment Category	Drug Class	Description	Chronic Condition Treated
	H7S	ANTIPSYCHOTICS,DOPAMINE	Schizophrenia
	H7T	ANTIPSYCHOTICS,ATYPICAL,DOPAMINE,& SEROTONIN ANTAG	Schizophrenia and Depression
	H7U	ANTIPSYCHOTICS, DOPAMINE & SEROTONIN ANTAGONISTS	Schizophrenia
	H7X	ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED	Schizophrenia and Depression
	H7Z	SSRI & ANTIPSYCH,ATYP,DOPAMINE&SEROTONIN ANTAG CMB	Depression
	H8P	SSRI & 5HT1A PARTIAL AGONIST ANTIDEPRESSANT	Depression
	H8T	SSRI & SEROTONIN RECEPTOR MODULATOR ANTIDEPRESSANT	Depression
	J3A	SMOKING DETERRENT AGENTS (GANGLIONIC STIM,OTHERS)	Tobacco Use Disorder
	J3C	SMOKING DETERRENT-NICOTINIC RECEPT.PARTIAL AGONIST	Tobacco Use Disorder
Chronic Cardiovascular Disease	A1A	DIGITALIS GLYCOSIDES	Heart Failure
	A1C	INOTROPIC DRUGS	Heart Failure
	A2C	ANTIANGINAL & ANTI-ISCHEMIC AGENTS,NON-HEMODYNAMIC	Ischemic Heart Disease
	A4A	ANTIHYPERTENSIVES, VASODILATORS	Hypertension
	A4B	ANTIHYPERTENSIVES, SYMPATHOLYTIC	Hypertension
	A4C	ANTIHYPERTENSIVES, GANGLIONIC BLOCKERS	Hypertension
	A4D	ANTIHYPERTENSIVES, ACE INHIBITORS	Hypertension, Ischemic Heart Disease and Heart Failure
	A4F	ANTIHYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST	Hypertension, Ischemic Heart Disease and Heart Failure
	A4H	ANGIOTENSIN RECEPTOR ANTGNST & CALC.CHANNEL BLOCKR	Hypertension, Ischemic Heart Disease and Heart Failure
	A4I	ANGIOTENSIN RECEPTOR ANTAG./THIAZIDE DIURETIC COMB	Hypertension, Ischemic Heart

Treatment Category	Drug Class	Description	Chronic Condition Treated
			Disease and Heart Failure
	A4J	ACE INHIBITOR/THIAZIDE & THIAZIDE-LIKE DIURETIC	Hypertension, Ischemic Heart Disease and Heart Failure
	A4K	ACE INHIBITOR/CALCIUM CHANNEL BLOCKER COMBINATION	Hypertension
	A4T	RENIN INHIBITOR, DIRECT	Hypertension
	A4U	RENIN INHIBITOR,DIRECT AND THIAZIDE DIURETIC COMB	Hypertension
	A4V	ANGIOTEN.RECEPTR ANTAG./CAL.CHANL BLKR/THIAZIDE CB	Hypertension
	A4W	RENIN INHIBITOR, DIRECT & ANGIOTENSIN RECEPT ANTAG.	Hypertension
	A4X	RENIN INHIBITOR, DIRECT & CALCIUM CHANNEL BLOCKER	Hypertension
	A4Y	ANTIHYPERTENSIVES, MISCELLANEOUS	Hypertension
	A4Z	RENIN INHIB, DIRECT& CALC.CHANNEL BLKR & THIAZIDE	Hypertension
Chronic Cardiovascular Disease (cont.)	A7B	VASODILATORS,CORONARY	Ischemic Heart Disease and Heart Failure, Angina
	A7H	VASOACTIVE NATRIURETIC PEPTIDES	Hypertension and Heart Failure
	A7J	VASODILATORS, COMBINATION	Heart Failure
	A9A	CALCIUM CHANNEL BLOCKING AGENTS	Hypertension, Ischemic Heart Disease and Heart Failure
	C6N	NIACIN PREPARATIONS	Hyperlipidemia
	D7L	BILE SALT SEQUESTRANTS	Hyperlipidemia
	J7A	ALPHA/BETA-ADRENERGIC BLOCKING AGENTS	Hypertension and Heart Failure
	J7B	ALPHA-ADRENERGIC BLOCKING AGENTS	Hypertension
	J7C	BETA-ADRENERGIC BLOCKING AGENTS	Heart Failure and Ischemic Heart Disease

Treatment Category	Drug Class	Description	Chronic Condition Treated
	J7E	ALPHA-ADRENERGIC BLOCKING AGENT/THIAZIDE COMB	Hypertension
	J7H	BETA-ADRENERGIC BLOCKING AGENTS/THIAZIDE & RELATED	Hypertension
	M4D	ANTIHYPERLIPIDEMIC - HMG COA REDUCTASE INHIBITORS	Hyperlipidemia and Ischemic Heart Disease
	M4E	LIPOTROPICS	Ischemic Heart Disease
	M4I	ANTIHYPERLIP - HMG-COA&CALCIUM CHANNEL BLOCKER CB	Hyperlipidemia, Hypertension, Ischemic Heart Disease
	M4L	ANTIHYPERLIPIDEMIC-HMG COA REDUCTASE INHIB.&NIACIN	Hyperlipidemia and Ischemic Heart Disease
	M4M	ANTIHYPERLIP.HMG COA REDUCT INHIB&CHOLEST.AB.INHIB	Hyperlipidemia and Ischemic Heart Disease
	M9D	ANTIFIBRINOLYTIC AGENTS	Ischemic Heart Disease
	M9E	THROMBIN INHIBITORS,SEL.,DIRECT,&REV.-HIRUDIN TYPE	DVT and Ischemic Heart Disease
	M9F	THROMBOLYTIC ENZYMES	DVT and Stroke/Transient Ischemic Attack
	M9K	HEPARIN AND RELATED PREPARATIONS	DVT and Ischemic Heart Disease
	M9L	ANTICOAGULANTS,COUMARIN TYPE	DVT and Ischemic Heart Disease
	M9P	PLATELET AGGREGATION INHIBITORS	Ischemic Heart Disease and Stroke/Transient Ischemic Attack
Chronic Cardiovascular Disease (cont.)	M9T	THROMBIN INHIBITORS,SELECTIVE,DIRECT, & REVERSIBLE	DVT and Ischemic Heart Disease

Treatment Category	Drug Class	Description	Chronic Condition Treated
	M9V	DIRECT FACTOR XA INHIBITORS	DVT, PE, Atrial Fibrillation
	R1E	CARBONIC ANHYDRASE INHIBITORS	Hypertension and Heart Failure
	R1F	THIAZIDE AND RELATED DIURETICS	Hypertension and Heart Failure
	R1H	POTASSIUM SPARING DIURETICS	Hypertension and Heart Failure
	R1L	POTASSIUM SPARING DIURETICS IN COMBINATION	Hypertension and Heart Failure
	R1M	LOOP DIURETICS	Hypertension and Heart Failure
	H3D	ANALGESIC/ANTIPYRETICS, SALICYLATES	Prevention for MI
	A2A	ANTIARRHYTHMICS	Cardiac Arrhythmia
Chronic Pulmonary Disease	A1B	XANTHINES	Asthma and COPD
	A1D	GENERAL BRONCHODILATOR AGENTS	Asthma and COPD
	B6M	GLUCOCORTICOIDS, ORALLY INHALED	Asthma and COPD
	J5A	ADRENERGIC AGENTS,CATECHOLAMINES	Asthma and COPD
	J5D	BETA-ADRENERGIC AGENTS	Asthma and COPD
	J5G	BETA-ADRENERGIC AND GLUCOCORTICOID COMBINATIONS	Asthma and COPD
	J5J	BETA-ADRENERGIC AND ANTICHOLINERGIC COMBINATIONS	COPD
	Z2F	MAST CELL STABILIZERS	Asthma
	Z2X	PHOSPHODIESTERASE-4 (PDE4) INHIBITORS	COPD
	Z4B	LEUKOTRIENE RECEPTOR ANTAGONISTS	Asthma
	Z4E	5-LIPOXYGENASE INHIBITORS	COPD

Treatment Category	Drug Class	Description	Chronic Condition Treated
	W7 W	ALLERGENIC EXTRACTS	Allergy, Asthma
	J5F	ADRENERGICS	Anaphylaxis Therapy for Allergy Asthma
Diabetes	C4B	ANTIHYPERGLYCEMIC-GLUCOCORTICOID RECEPTOR BLOCKER	Diabetes Mellitus
	C4C	ANTIHYPERGLY,DPP-4 ENZYME INHIB &THIAZOLIDINEDIONE	Diabetes Mellitus
	C4D	ANTIHYPERGLYCEMC-SOD/GLUC COTRANSPORT2(SGLT2)INHIB	Diabetes Mellitus
	C4F	ANTIHYPERGLYCEMIC,DPP-4 INHIBITOR & BIGUANIDE COMB	Diabetes Mellitus
	C4G	INSULINS	Diabetes Mellitus
	C4H	ANTIHYPERGLYCEMIC, AMYLIN ANALOG-TYPE	Diabetes Mellitus
Diabetes (cont.)	C4I	ANTIHYPERGLY,INCRETIN MIMETIC(GLP-1 RECEP.AGONIST)	Diabetes Mellitus
	C4J	ANTIHYPERGLYCEMIC, DPP-4 INHIBITORS	Diabetes Mellitus
	C4K	ANTIHYPERGLYCEMIC, INSULIN-RELEASE STIMULANT TYPE	Diabetes Mellitus
	C4L	ANTIHYPERGLYCEMIC, BIGUANIDE TYPE	Diabetes Mellitus
	C4M	ANTIHYPERGLYCEMIC, ALPHA-GLUCOSIDASE INHIBITORS	Diabetes Mellitus
	C4N	ANTIHYPERGLYCEMIC,THIAZOLIDINEDIONE(PPARG AGONIST)	Diabetes Mellitus
	C4R	ANTIHYPERGLYCEMIC,THIAZOLIDINEDIONE & SULFONYLUREA	Diabetes Mellitus
	C4S	ANTIHYPERGLYCEMIC,INSULIN-REL STIM.& BIGUANIDE CMB	Diabetes Mellitus
	C4T	ANTIHYPERGLYCEMIC,THIAZOLIDINEDIONE & BIGUANIDE	Diabetes Mellitus
	C4V	ANTIHYPERGLYCEMIC - DOPAMINE RECEPTOR AGONISTS	Diabetes Mellitus
	C4E	ANTIHYPERGLYCEMC-SOD/GLUC COTRANSPORT2(SGLT2)INHIB	Diabetes Mellitus
	M4G	AGENTS TO TREAT HYPOGLYCEMIA (HYPERGLYCEMICS)	Diabetes Mellitus

Treatment Category	Drug Class	Description	Chronic Condition Treated
HIV	W5C	ANTIVIRALS, HIV-SPECIFIC, PROTEASE INHIBITORS	HIV
	W5I	ANTIVIRALS, HIV-SPECIFIC, NUCLEOTIDE ANALOG, RTI	HIV
	W5J	ANTIVIRALS, HIV-SPECIFIC, NUCLEOSIDE ANALOG, RTI	HIV
	W5K	ANTIVIRALS, HIV-SPECIFIC, NON-NUCLEOSIDE, RTI	HIV
	W5L	ANTIVIRALS, HIV-SPEC., NUCLEOSIDE ANALOG, RTI COMB	HIV
	W5M	ANTIVIRALS, HIV-SPECIFIC, PROTEASE INHIBITOR COMB	HIV
	W5N	ANTIVIRALS, HIV-SPECIFIC, FUSION INHIBITORS	HIV
	W5O	ANTIVIRALS, HIV-SPEC, NUCLEOSIDE-NUCLEOTIDE ANALOG	HIV
	W5P	ANTIVIRALS, HIV-SPEC, NON-PEPTIDIC PROTEASE INHIB	HIV
	W5Q	ARTV CMB NUCLEOSIDE,NUCLEOTIDE,&NON-NUCLEOSIDE RTI	HIV
	W5T	ANTIVIRALS, HIV-SPECIFIC, CCR5 CO-RECEPTOR ANTAG.	HIV
	W5U	ANTIVIRALS,HIV-1 INTEGRASE STRAND TRANSFER INHIBTR	HIV
	W5X	ARV CMB-NRTI,N(T)RTI, INTEGRASE INHIBITOR	HIV
	W5Z	ARV COMB-NRTIS & INTEGRASE INHIBITOR	HIV
Antiarthritics	S2A	COLCHICINE	AntiArthritics
	S2T	NSAIDS (COX NON-SPECIFIC INHIB)& PROSTAGLANDIN CMB	AntiArthritics
Antiarthritics (cont.)	S2B	NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE	AntiArthritics
	S2L	NSAIDS,CYCLOOXYGENASE-2(COX-2) SELECTIVE INHIBITOR	AntiArthritics
	Q5E	TOPICAL ANTI-INFLAMMATORY, NSAIDS	AntiArthritics
	R1R	URICOSURIC AGENTS	AntiArthritics, Anti Gout
Hepatitis	W5Y	HEP C VIRUS,NUCLEOTIDE ANALOG NS5B POLYMERASE INH	Hepatitis C
	W5G	HEPATITIS C TREATMENT AGENTS	Hepatitis C

Treatment Category	Drug Class	Description	Chronic Condition Treated
	W0B	HEP C VIRUS - NS5B POLYMERASE & NS5A INHIB. COMBO.	Hepatitis C
	W0D	HEPATITIS C VIRUS - NS5A, NS3/4A, NS5B INHIB CMB.	Hepatitis C
	W5F	HEPATITIS B TREATMENT AGENTS	Hepatitis B
	W5G	HEPATITIS C TREATMENT AGENTS	Hepatitis C
Cancer	V1A	ANTINEOPLASTIC - ALKYLATING AGENTS	Cancer
	V1J	ANTINEOPLASTIC - ANTIANDROGENIC AGENTS	Cancer
	V1B	ANTINEOPLASTIC - ANTIMETABOLITES	Cancer
	V3F	ANTINEOPLASTIC - AROMATASE INHIBITORS	Cancer
	V3L	ANTINEOPLASTIC - JANUS KINASE (JAK) INHIBITORS	Cancer
	V3C	ANTINEOPLASTIC - MTOR KINASE INHIBITORS	Cancer
	V1M	ANTINEOPLASTIC IMMUNOMODULATOR AGENTS	Cancer
	V1O	ANTINEOPLASTIC LHRH (GNRH) AGONIST, PITUITARY SUPPR.	Cancer
	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	Cancer
	V1F	ANTINEOPLASTICS,MISCELLANEOUS	Cancer
	Z2G	IMMUNOMODULATORS	Cancer
	V1T	SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS)	Cancer - prevention
	V1E	STEROID ANTINEOPLASTICS	Cancer
	Q5N	TOPICAL ANTINEOPLASTIC & PREMALIGNANT LESION AGNTS	Cancer
Other chronic conditions	W7K	ANTISERA	Immune Globulin, Chronic Immune Disorders
	D6F	NON NARCOTIC ANALGESIC	Ulcerative Colitis
	C7A	HYPERURICEMIA TX - XANTHINE OXIDASE INHIBITORS	Preventative for Gout
	D8A	PANCREATIC ENZYMES	Cystic Fibrosis
	P4L	BONE RESORPTION INHIBITORS	Prevent Osteoporosis

Treatment Category	Drug Class	Description	Chronic Condition Treated
	H2D	BARBITURATES	Epilepsy
	Q3E	CHRONIC INFLAM. COLON DX, 5-A-SALICYLAT,RECTAL TX	Chronic Ulcerative Colitis
Other chronic conditions (cont.)	C1A	ELECTROLYTE DEPLETERS	Chronic Kidney Disease
	H4B	ANTICONVULSANTS	Epilepsy, Bipolar
	Q6G	OPHTHALMIC PREPARATIONS	Glaucoma
	Z2E	IMMUNOSUPPRESSIVES	Kidney Transplant, immunosuppression
Vaccines	W7L	GRAM POSITIVE COCCI VACCINES	Vaccines
	W7M	GRAM (-) BACILLI (NON-ENTERIC) VACCINES	Vaccines
	W7Q	GRAM NEGATIVE COCCI VACCINES	Vaccines
	W7C	INFLUENZA VIRUS VACCINES	Vaccines
	W7Z	VACCINE/TOXOID PREPARATIONS,COMBINATIONS	Vaccines
	W7B	VIRAL/TUMORIGENIC VACCINES	Vaccines

Attachment C
Preventative Services Protocol
Appendix 1: Chronic Conditions Diagnosis Codes

Disease Category	Diagnosis Code
Chronic Kidney Disease	D59.3, I72.2, K76.7
	M10.30-M10.39
	M32.14, M32.15
	N03.0-N03.9
	N04.0-N04.9
	N05.0-N05.9
	N06.0-N06.9
	N18.0-N18.9
	N25.0-N25.9
	N26.1-N26.9
	Q61.02, Q61.11, Q61.19, Q61.2, Q61.3, Q61.4, Q61.5, Q61.8, Q62.0
Chronic Obstructive Pulmonary Disease	J44.0-J44.9
Emphysema	J43.0-J43.9
	J98.2
Other Lung Disease	J60-J65
	J70.0, J70.3, J81.1
	J84.0-J84.10
	J84.8-J84.89
	J96.10-J96.92
Depression	F33.0, F33.1, F33.2, F33.3
	F33.40-F33.42
	F33.8, F33.9
Diabetes	E08-E13.9
Ischemic Heart Disease	I20.0-I20.9
	I21.0-I21.9
	I22.0-I22.9
	I24.0-I24.9
	I25.10-I25.119
	I25.2, I25.42, I25.5, I25.6
	I25.70-I25.709
	I25.810-I25.812
	I25.82, I25.83, I25.89, I25.9
Schizophrenia	F20.0, F20.1, F20.2, F20.3, F20.5
	F20.81-F20.89

Disease Category	Diagnosis Code
	F20.9, F21
Stroke with Lasting Affects	I69.00-I69.998
HIV	B20, Z21
Bipolar	F31.0
	F31.10-F31.13
	F31.2
	F31.30-F31.32
	F31.4, F31.5
	F31.60-F31.64
	F31.70-F31.78
	F31.81-F31.89
	F31.9
Heart Failure	I50.1, I50.22, I50.23, I50.32, I50.33, I50.42, I50.43, I50.9

ATTACHMENT D

Quarterly Progress Report Format

Table 1. Measures for Quarterly Reporting—Montana's HELP Demonstration

#	Measure	Definition	Overall Measure	Recommended Subgroups						Relationship among measures**	Montana Reporting Timeline (Phase 1 or Phase 2)
				<50% FPL	50-100% FPL w/ premium	50-100% FPL no premium	>100% FPL w/ premium	>100% FPL no premium	Dem*		
Enrollment											
1	Monthly count of total enrollment	Number of unduplicated individuals enrolled at any time during the month	x	x	x	x	x	x	x		Phase 1 - End of Q1 2017
2	Monthly count of new enrollees	Number of individuals who began a new enrollment spell this month who have not had Medicaid coverage within prior 3 months	x	x	x	x	x	x	x		Phase 2 - End of Q2 2017
3	Monthly count of re-enrollments	Number of individuals who began a new enrollment spell this month who have had Medicaid coverage within the prior 3 months	x	x	x	x	x	x	x		Phase 2 - End of Q2 2017
Premium payment											
4	Monthly count of beneficiaries who paid a premium during the month	Among enrolled individuals who owe premiums, number of beneficiaries who paid their premium for this month	x		x		x			Measures 4+5+6≈1 for those with income >50% FPL subject to premiums	Phase 1 - End of Q1 2017
5	Monthly count of beneficiaries in the grace period	Among enrolled individuals who owe premiums, number of beneficiaries who did not pay their premium for the month but are not three months past due	x		x		x				Phase 1 - End of Q1 2017

#	Measure	Definition	Overall Measure	Recommended Subgroups						Relationship among measures**	Montana Reporting Timeline (Phase 1 or Phase 2)
				<50% FPL	50-100% FPL w/ premium	50-100% FPL no premium	>100% FPL w/ premium	>100% FPL no premium	Dem*		
6	Monthly count of beneficiaries in long term arrears	Among enrolled individuals who owe premiums, number of beneficiaries who have not paid a premium in over three months. This includes individuals with income between 50-100% FPL who would have been disenrolled for non-payment of premiums if their income had been greater than 100% FPL			x						Phase 2 - End of Q2 2017
7	Monthly count of beneficiaries with collectible debt	Among enrolled individuals who owe premium payments, number of beneficiaries who have collectible debt[2]	x		x		x				Phase 2 - End of Q2 2017

[2] For beneficiaries between 50 and 100 percent FPL, the difference between measure 7 and the sum of measures 5 and 6 should be the number of individuals who have paid some premiums within the last three months but have not fully paid off their debt.

#	Measure	Definition	Overall Measure	Recommended Subgroups						Relationship among measures**	Montana Reporting Timeline (Phase 1 or Phase 2)
				<50% FPL	50-100% FPL w/ premium	50-100% FPL no premium	>100% FPL w/ premium	>100% FPL no premium	Dem*		
Mid-year change in circumstance in household composition or income											
8	Monthly count of beneficiaries who gave notice of mid-year change in circumstance in household or income information	Number of enrolled beneficiaries who notified the state of a mid-year change in circumstance and the change was effective during the reporting month	x	x	x	x	x	x			Phase 1 - End of Q1 2017
9	No premium change following mid-year update of household or income information	Number of beneficiaries who notified the state of a mid-year change in circumstance and experienced no change in their premium requirement during the reporting month	x	x	x	x	x	x		Measures 9+10+11≈ 8	Phase 2 - End of Q2 2017
10	Premium increase following mid-year update of household or income information	Number of beneficiaries who notified the state of a mid-year change in circumstance and experienced an increase in their premium requirement during the reporting month	x	x	x	x	x	x			Phase 2 - End of Q2 2017

#	Measure	Definition	Overall Measure	Recommended Subgroups						Relationship among measures**	Montana Reporting Timeline (Phase 1 or Phase 2)
				<50% FPL	50-100% FPL w/ premium	50-100% FPL no premium	>100% FPL w/ premium	>100% FPL no premium	Dem*		
11	Premium decrease following mid-year update of household or income information	Number of beneficiaries who notified the state of a mid-year change in circumstance and experienced a decrease in their premium requirement during the reporting month	x		x		x				Phase 2 - End of Q2 2017
Disenrollments outside annual renewal determinations											
12	Monthly count of total disenrollment	Number of beneficiaries disenrolled from the HELP program mid-year in the reporting month (exclude beneficiaries who disenrolled during their renewal month)	x	x	x	x	x	x	x	Measures 13+14+15 ≈12	Phase 1 - End of Q1 2017
13	Monthly count of disenrollment, failure to pay	Number of beneficiaries disenrolled mid-year in the reporting month (not their renewal month) for failure to pay premiums	x				x		x		Phase 1 - End of Q1 2017

#	Measure	Definition	Overall Measure	Recommended Subgroups						Relationship among measures**	Montana Reporting Timeline (Phase 1 or Phase 2)
				<50% FPL	50-100% FPL w/ premium	50-100% FPL no premium	>100% FPL w/ premium	>100% FPL no premium	Dem*		
14	Monthly count of disenrollment, continuous eligibility exceptions	Number of beneficiaries disenrolled mid-year in the reporting month (not their renewal month) due to specifically noted continuous eligibility exceptions for individuals[3]	x	x	x	x	x	x	x		End of Q1 2017
15	Monthly count of disenrollment, other	Number of beneficiaries disenrolled mid-year in the reporting month (not their renewal month) for any reason other than failure to pay premiums or a specific continuous eligibility exception	x	x	x	x	x	x	x		End of Q1 2017
Cost sharing limit											
16	Monthly count of beneficiaries who have exceeded 2% co-pay credit but not reached 5% limit	Count of enrolled individuals who have hit 2% co-pay credit since enrollment and must now make cost sharing payments, but who have not yet reached the 5% cost sharing limit	x		x		x				Phase 2 - End of Q2 2017

[3] Continuous eligibility exceptions include: not being located for a period of more than one month, after good faith efforts by the state to do so; no longer being a Montana resident; requesting termination of eligibility; death; failure to provide, or cooperate in obtaining, a Social Security Number, if otherwise required; providing an incorrect or fraudulent Social Security Number; being determined eligible for Medicaid in error; failure to provide the documentation of citizenship or immigration status required under federal law.

#	Measure	Definition	Overall Measure	Recommended Subgroups						Relationship among measures**	Montana Reporting Timeline (Phase 1 or Phase 2)
				<50% FPL	50-100% FPL w/ premium	50-100% FPL no premium	>100% FPL w/ premium	>100% FPL no premium	Dem*		
17	Monthly count of beneficiaries who have hit 5% cost sharing limit	Count of enrolled individuals who have hit 5% limit on cost sharing and premiums since enrollment, and no longer make cost sharing payments	x		x		x				Phase 2 - End of Q2 2017
Use of Preventive services[4]											
18	Monthly count of beneficiaries who have accessed incentivized preventive services, overall	Total number of beneficiaries enrolled at any point in the month that was six months prior to the reporting month who utilized any incentivized preventive services in the 12 months prior to that month	x	x	x	x	x	x	x		Phase 1 - End of Q1 2017
19	Per-member-per-month use of preventive services, by incentivized service	Total number of preventive services provided during the month six months prior to the reporting month, divided by the number of members enrolled during that month	x	x	x	x	x	x	x		Phase 1 - End of Q1 2017

[4] Montana will report measures 18 – 24 with a six month lag.

#	Measure	Definition	Overall Measure	Recommended Subgroups						Relationship among measures**	Montana Reporting Timeline (Phase 1 or Phase 2)
				<50% FPL	50-100% FPL w/ premium	50-100% FPL no premium	>100% FPL w/ premium	>100% FPL no premium	Dem*		
Use of other services[5]											
20	Physician service utilization	PMPM utilization of physician visits for currently enrolled beneficiaries	x	x	x	x	x	x			Phase 1 - End of Q1 2017
21	Prescription drug use	PMPM prescription fills greater than 28 days for currently enrolled beneficiaries	x	x	x	x	x	x			Phase 1 - End of Q1 2017
22	Emergency department utilization, emergency	PMPM emergency department visits for emergent conditions among currently enrolled beneficiaries (i.e. those not subject to a copayment)	x	x	x	x	x	x			Phase 1 - End of Q1 2017
23	Emergency department utilization, non-emergency	PMPM emergency department visits for non-emergent conditions among currently enrolled beneficiaries (i.e. those subject to a copayment)	x	x	x	x	x	x			Phase 1 - End of Q1 2017
24	Inpatient admissions	PMPM inpatient admissions among currently enrolled beneficiaries	x	x	x	x	x	x			Phase 1 - End of Q1 2017
Renewal (*starting in 2017*)											
25	Monthly count of beneficiaries due for renewal	Number of beneficiaries due for renewal in the reporting month	x	x	x	x	x	x		Measures	Phase 1 - End of Q1 2017

[5] Montana will report measures 18 – 24 with a six month lag.

#	Measure	Definition	Overall Measure	Recommended Subgroups						Relationship among measures**	Montana Reporting Timeline (Phase 1 or Phase 2)
				<50% FPL	50-100% FPL w/ premium	50-100% FPL no premium	>100% FPL w/ premium	>100% FPL no premium	Dem*		
26	Number who did not renew	Number of beneficiaries due for renewal in the reporting month who are determined ineligible for the HELP program because they failed to complete or return renewal forms or other required documentation, or who were lost to follow up	x	x	x	x	x	x		26+27+28 +29+30 ≈ 25	Phase 1 - End of Q1 2017
27	Number who lost eligibility	Number of beneficiaries due for renewal in the reporting month who respond to renewal notices, but are determined ineligible for the HELP program[6]	x	x	x	x	x	x			Phase 2 - End of Q2 2017
28	No premium change	Number of beneficiaries due for renewal in the reporting month who remain eligible, with no change in premium requirement	x	x	x	x	x	x			Phase 2 - End of Q2 2017
29	Premium increase	Number of beneficiaries due for renewal in the reporting month who remain eligible, with an increase in required premium	x	x	x	x	x	x			Phase 2 - End of Q2 2017
30	Premium decrease	Number of beneficiaries due for renewal in the reporting month who remain eligible, with a decrease required premium	x		x		x				Phase 2 - End of Q2 2017
Complaints, grievances, and appeals											

[6] Measures 26 and 27 parallel the distinction between performance indicators 10c (Medicaid determination – eligibility cannot be established) and 10b (Medicaid determination – ineligibility established).

#	Measure	Definition	Overall Measure	Recommended Subgroups						Relationship among measures**	Montana Reporting Timeline (Phase 1 or Phase 2)
				<50% FPL	50-100% FPL w/ premium	50-100% FPL no premium	>100% FPL w/ premium	>100% FPL no premium	Dem*		
31	Complaints and grievances, Medicaid program	Total number of complaints and grievances filed in the reporting month regarding the HELP program	x								Phase 1 - End of Q1, 2017
32	Complaints and grievances, plan administrator	Total number of complaints and grievances filed in the reporting month regarding the plan administrator	x								Phase 1 - End of Q1, 2017
33	Complaints and grievances, provider	Total number of complaints and grievances filed in the reporting month regarding a provider	x								Phase 1 - End of Q1, 2017
34	Appeals, eligibility	Total number of appeals filed in the reporting month regarding eligibility	x								Phase 1 - End of Q1, 2017
35	Appeals, premiums	Total number of appeals filed in the reporting month regarding the size of premium payments	x								Phase 1 - End of Q1, 2017
36	Appeals, denial of benefits	Total number of appeals filed in the reporting month regarding denials of benefits	x								Phase 1 - End of Q1, 2017

#	Measure	Definition	Overall Measure	Recommended Subgroups						Relationship among measures**	Montana Reporting Timeline (Phase 1 or Phase 2)
				<50% FPL	50-100% FPL w/ premium	50-100% FPL no premium	>100% FPL w/ premium	>100% FPL no premium	Dem*		
Enrollment duration among disenrollees											
37	Enrollment duration 0-3 months	Number of beneficiaries disenrolled from the demonstration in the reporting month (measure 12) who had been enrolled in the demonstration for 3 or fewer months at the time of disenrollment	x	x	x	x	x	x		Measures 37+38+39 ≈12	Phase 2 - End of Q2 2017
38	Enrollment duration 4-6 months	Number of beneficiaries disenrolled from the demonstration in the reporting month (measure 12) who had been enrolled in the demonstration for between 4 and 6 months at the time of disenrollment	x	x	x	x	x	x			Phase 2 - End of Q2 2017
39	Enrollment duration >6 months	Number of beneficiaries disenrolled from the demonstration in the reporting month (measure 12) who had been enrolled in the demonstration for 6 or more months at the time of disenrollment	x	x	x	x	x	x			Phase 2 - End of Q2 2017
Monthly premiums owed at disenrollment											
40	Amount of monthly premium at time	Number of beneficiaries disenrolled from the demonstration in the reporting	x		x		x			Measures 40+41+42 +43+44≈1	Phase 2 - End of Q2 2017

#	Measure	Definition	Overall Measure	Recommended Subgroups						Relationship among measures**	Montana Reporting Timeline (Phase 1 or Phase 2)
				<50% FPL	50-100% FPL w/ premium	50-100% FPL no premium	>100% FPL w/ premium	>100% FPL no premium	Dem*		
	of disenrollment >$0 and <$15	month (measure 12) whose monthly premium at the time of disenrollment was greater than $0 but less than $15								2 (for those with premiums)	
41	Amount of monthly premium at time of disenrollment $15-<$30	Number of beneficiaries disenrolled from the demonstration in the reporting month (measure 12), whose monthly premium at the time of disenrollment was $15 or greater, but less than $30	x		x		x				Phase 2 - End of Q2 2017
42	Amount of monthly premium at time of disenrollment $30-<$50	Number of beneficiaries disenrolled from the demonstration in the reporting month (measure 12), whose monthly premium at the time of disenrollment was $30 or greater, but less than $50	x		x		x				Phase 2 - End of Q2 2017
43	Amount of monthly premium at time of disenrollment $50-<$75	Number of beneficiaries disenrolled from the demonstration in the reporting month (measure 12), whose monthly premium at the time of disenrollment was $50 or greater, but less than $75.	x		x		x				Phase 2 - End of Q2 2017
44	Amount of monthly premium at time	Number of beneficiaries disenrolled from the demonstration in the reporting month (measure 12), whose	x		x		x				Phase 2 - End of Q2 2017

#	Measure	Definition	Overall Measure	Recommended Subgroups						Relationship among measures**	Montana Reporting Timeline (Phase 1 or Phase 2)
				<50% FPL	50-100% FPL w/ premium	50-100% FPL no premium	>100% FPL w/ premium	>100% FPL no premium	Dem*		
	of disenrollment ≥$75	monthly premium at the time of disenrollment was $75 or greater.									
Total debt owed at disenrollment for failure to pay											
45	Amount of total debt owed at time of disenrollment for failure to pay: <$50	Number of beneficiaries disenrolled from the demonstration in the reporting month for failure to pay (measure 13), whose total debt owed at the time of disenrollment was less than $50.					x			Measures 45+46+47 +48 ≈13 (for those above 100% FPL with premiums)	Phase 2 - End of Q2 2017
46	Amount of total debt owed at time of disenrollment for failure to pay: ≥$50 but <$100	Number of beneficiaries disenrolled from the demonstration in the reporting month for failure to pay (measure 13), whose total debt owed at the time of disenrollment was greater than or equal to $50, but less than $100.					x				Phase 2 - End of Q2 2017

#	Measure	Definition	Overall Measure	Recommended Subgroups						Relationship among measures**	Montana Reporting Timeline (Phase 1 or Phase 2)
				<50% FPL	50-100% FPL w/ premium	50-100% FPL no premium	>100% FPL w/ premium	>100% FPL no premium	Dem*		
47	Amount of total debt owed at time of disenrollment for failure to pay: ≥$100 but <$150	Number of beneficiaries disenrolled from the demonstration in the reporting month for failure to pay (measure 13), whose total debt owed at the time of disenrollment was greater than or equal to $100, but less than $150.					x				Phase 2 - End of Q2 2017
48	Amount of total debt owed at time of disenrollment for failure to pay: ≥$150	Number of beneficiaries disenrolled from the demonstration in the reporting month for failure to pay (measure 13), whose total debt owed at the time of disenrollment was greater than $150.					x				Phase 2 - End of Q2 2017

* Indicates any demographic subgroups that CMS and the state wish to monitor. We recommend providing a breakdown of enrollment counts by age, and the state may also wish to provide a breakdown by race and/or sex. Note that this does not apply to the income groups which are not subject to premiums.

** This column contains expected relationships between measures that may be useful in data quality checks. For example, 4+5+6≈1 means that measures 4, 5, and 6 should sum to approximately equal measure 1.

ATTACHMENT E

Evaluation Design (Reserved)