

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 09-008	2. STATE Montana
FOR: HEALTH CARE FINANCING ADMINISTRATION		3. PROGRAM IDENTIFICATION: Title XIX of the Social Security Act (Medicaid)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE April 1, 2009	
5. TYPE OF PLAN MATERIAL (Check One): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION:		7. FEDERAL BUDGET IMPACT: a. FFY \$0 b. FFY \$0	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 2.2-A Page 10a		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 2.2-A Page 10a	
10. SUBJECT OF AMENDMENT: Passport to Health auto reenrollment after losing eligibility. Changing auto reenroll time frame from three months to two months.			
11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL:		16. RETURN TO: Montana Dept. of Public Health and Human Services Mary E. Dalton Acting State Medicaid Director Attn: Jo Thompson PO Box 4210 Helena, MT 59604	
13. TYPED NAME: Mary E. Dalton			
14. TITLE: Acting State Medicaid Director			
15. DATE SUBMITTED: 4/27/09			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 4/27/09		18. DATE APPROVED: 7/24/09	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 4/1/09		20. SIGNATURE OF REGIONAL OFFICIAL:	
21. TYPED NAME: Richard C. Allen		22. TITLE: Associate Regional Administrator	
23. REMARKS:			

State/Territory: Montana

Agency*	Citation(s)	Groups Covered
1932(a)(4) of Act	B.	<u>Optional Groups Other Than the Medically Needy</u> (Continued) The Medicaid Agency may elect to restrict the disenrollment of Medicaid enrollees of MCOs, PIHPs, PAHPs, and PCCMs in accordance with the regulations at 42 CFR 438.56. This requirement applies unless a recipient can demonstrate good cause for disenrolling or if he/she moves out of the entity's service area or becomes ineligible. <u>X</u> Disenrollment rights are restricted for a period of <u>6</u> months (not to exceed 12 months). During the first three months of each enrollment period the recipient may disenroll without cause. The State will provide notification, at least once per year, to recipients enrolled with such organization of their right to and restrictions of terminating such enrollment. <u> </u> No restrictions upon disenrollment rights.
1903(m)(2)(H), 1902(a)(52) of the Act P.L. 101-508 42 CFR 438.56g		In the case of individuals who have become ineligible for Medicaid for the brief period described in section 1903(m)(2)(H) and who were enrolled with an MCO, PIHP, PAHP, or PCCM when they became ineligible, the Medicaid agency may elect to reenroll those individuals in the same entity if that entity still has a contract. <u>X</u> The agency elects to reenroll the above individuals who are ineligible in a month but in the succeeding two months become eligible, into the same entity in which they were- enrolled at the time eligibility was lost. <u> </u> The agency elects not to reenroll above individuals into the same entity in which they were previously enrolled.

*Agency that determines eligibility for coverage.

TN No. 09-008

Effective Dates 04/01/09

Supersedes TN no. 92-15

Approval Date # 7/24/09