DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

1. TRANSMITTAL NUMBER: **11-018**

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 **07/01/2011**

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

1905(a)26 and 1934

7. FEDERAL BUDGET IMPACT:
a. FFY 2011 $ (187,774)
b. FFY 2012 $ (431,477)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Enclosure 3, Citation 3.1(a)(1); Enclosure 4, Citation 3.1(a)(2)
Enclosure 5, Attachment 3.1-A; Enclosure 6, Attachment 3.1-B
Enclosure 7, Supplement 3 to Attachment 3.1-A Pages 1-7

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Enclosure 3, Citation 3.1(a)(1); Enclosure 4, Citation 3.1(a)(2)
Enclosure 5, Attachment 3.1-A; Enclosure 6, Attachment 3.1-B
Enclosure 7, Supplement 3 to Attachment 3.1-A Pages 1 - 8

10. SUBJECT OF AMENDMENT:

Termination of PACE program and removal of PACE from Medicaid optional eligibility coverage groups.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Single Agency Director

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: **Mary E. Dalton**

14. TITLE: **Medicaid Director**

15. DATE SUBMITTED: 6/30/11

16. RETURN TO:
Montana Dept. of Public Health and Human Services
Mary E. Dalton
Medicaid Director
Attn: Jo Thompson
PO Box 4210
Helena, MT 59604

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 6/30/11

18. DATE APPROVED: 7/25/11

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 7/1/11

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Richard C. Allen

22. TITLE: ARA

23. REMARKS:

FORM HCFA-179 (07-92)

Enclosure 3

State of Montana
PACE State Plan Amendment Pre-Print

Citation 3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)

1905(a)(26) and 1934

___ Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 3 to Attachment 3.1-A.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy. (Note: Other programs to be offered to Categorically Needy beneficiaries would specify all limitations on the amount, duration and scope of those services. As PACE provides services to the frail elderly population without such limitation, this is not applicable for this program. In addition, other programs to be offered to Categorically Needy beneficiaries would also list the additional coverage -that is in excess of established service limits- for pregnancy-related services for conditions that may complicate the pregnancy. As PACE is for the frail elderly population, this also is not applicable for this program.)

Enclosure 4

State of ____Montana_____
PACE State Plan Amendment Pre-Print

Citation 3.1(a)(2) Amount, Duration, and Scope of Services: Medically Needy (Continued)
1905(a)(26) and 1934

____ Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 3 to Attachment 3.1-A.

ATTACHMENT 3.1-B identifies services provided to each covered group of the medically needy. (Note: Other programs to be offered to Medically Needy beneficiaries would specify all limitations on the amount, duration and scope of those services. As PACE provides services to the frail elderly population without such limitation, this is not applicable for this program. In addition, other programs to be offered to Medically Needy beneficiaries would also list the additional coverage - that is in excess of established service limits- for pregnancy-related services for conditions that may complicate the pregnancy. As PACE is for the frail elderly population, this also is not applicable for this program.)

State of Montana
PACE State Plan Amendment Pre-Print

Amount, Duration and Scope of Medical and Remedial Care Services Provided To the Categorically Needy

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1-A.

_____ Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

__X__ No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

State of Montana
PACE State Plan Amendment Pre-Print

Amount, Duration and Scope of Medical and Remedial Care Services Provided To the Medically Needy

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1-A.

_____ Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

__X__ No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

State of Montana
PACE State Plan Amendment Pre-Print

Name and address of State Administering Agency, if different from the State Medicaid Agency.
Single State Agency

I. Eligibility

The State determines eligibility for PACE enrollees under rules applying to community groups.

A. The State determines eligibility for PACE enrollees under rules applying to institutional groups as provided for in section 1902(a)(10)(A)(ii)(VI) of the Act (42 CFR 435.217 in regulations). The State has elected to cover under its State plan the eligibility groups specified under these provisions in the statute and regulations. The applicable groups are:

(If this option is selected, please identify, by statutory and/or regulatory reference, the institutional eligibility group or groups under which the State determines eligibility for PACE enrollees. Please note that these groups must be covered under the State's Medicaid plan.)

B. _____ The State determines eligibility for PACE enrollees under rules applying to institutional groups, but chooses not to apply post-eligibility treatment of income rules to those individuals. (If this option is selected, skip to II - Compliance and State Monitoring of the PACE Program.

C. ____ The State determines eligibility for PACE enrollees under rules applying to institutional groups, and applies post-eligibility treatment of income rules to those individuals as specified below. Note that the post-eligibility treatment of income rules specified below are the same as those that apply to the State's approved HCBS waiver(s).

Regular Post Eligibility

1. ____ SSI State. The State is using the post-eligibility rules at 42 CFR 435.726. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

(a). Sec. 435.726--States which do not use more restrictive eligibility requirements than SSI.

1. Allowances for the needs of the:
(A.)Individual (check one)
1___ _ The following standard included under the State plan (check one):
(a) _____SSI
(b) _____ _Medically Needy while living in the community; if living in a nursing home facility the needs are $30 for an SSI recipient, $50 for others, unless receiving VA income, then those VA income recipients receive $90 needs allowance.
(c) _____The special income level for the institutionalized
(d) _____Percent of the Federal Poverty Level: %
(e) _____Other (specify):_____
2._____The following dollar amount: $___
Note: If this amount changes, this item will be revised.
3._____The following formula is used to determine the needs allowance:
_____
_____

Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

(B.) Spouse only (check one):
1.____ SSI Standard
2.____ Optional State Supplement Standard
3.____ Medically Needy Income Standard
4.____ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
5 .____The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.
6___ __ The amount is determined using the following formula:

7.____ Not applicable (N/A)

(C.) Family (check one):
1.____ AFDC need standard

2. Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3.____ The following dollar amount: $___
Note: If this amount changes, this item will be revised.
4.____ The following percentage of the following standard that is not greater than the standards above: % of_____ standard.
5.____ The amount is determined using the following formula:
6.____ Other
7.____ Not applicable (N/A)

(2). Medical and remedial care expenses in 42 CFR 435.726.

Regular Post Eligibility

2. ____ 209(b) State, a State that is using more restrictive eligibility requirements than SSI. The State is using the post-eligibility rules at 42 CFR 435.735. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

(a) **42 CFR 435.735**--States using more restrictive requirements than SSI.

1. Allowances for the needs of the:
(A.) Individual (check one)
1.___The following standard included under the State plan (check one):
(a) _____SSI
(b) _____Medically Needy
(c) _____The special income level for the institutionalized
(d) _____Percent of the Federal Poverty Level: %
(e) _____Other (specify):_____
2.___The following dollar amount: $
Note: If this amount changes, this item will be revised.
3___The following formula is used to determine the needs allowance:
_____
_____

Note: If the amount protected for PACE enrollees in item 1 is **equal to, or greater than** the maximum amount of income a PACE enrollee may have and be eligible under PACE, **enter N/A in items 2 and 3.**

(B.) Spouse only (check one):

1._____The following standard under 42 CFR 435.121:

_____

2._____The Medically needy income standard

_____

3.____The following dollar amount: $___

Note: If this amount changes, this item will be revised.

4.____The following percentage of the following standard that is not greater than the standards above: ____% of _____ standard.

5._____The amount is determined using the following formula:

_____

6._____Not applicable (N/A)

(C.) Family (check one):

1.____AFDC need standard

2 Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3. The following dollar amount: $_____

Note: If this amount changes, this item will be revised.

4. The following percentage of the following standard that is not greater than the standards above:_____% of_____ standard.

5. The amount is determined using the following formula:

_____

6.____ Other

7. ___ Not applicable (N/A)

(b) Medical and remedial care expenses specified in 42 CFR 435.735.

Spousal Post Eligibility

3. ____State uses the post-eligibility rules of Section 1924 of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of PACE services if it determines the individual's eligibility under section 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(a.) Allowances for the needs of the:

1. Individual (check one)

(A)_ __The following standard included under the State plan (check one):

1. _____SSI

2. _____ Medically Needy while living in the community; if living in a nursing home facility the needs are $30 for an SSI recipient, $50 for others, unless receiving VA income, then those VA income recipients receive $90 needs allowance.

3. _____The special income level for the institutionalized

4. _____Percent of the Federal Poverty Level: _____%

5. _____Other (specify):_____

(B)._____The following dollar amount: $_____

Note: If this amount changes, this item will be revised.

(C)_____The following formula is used to determine the needs allowance:

_____

_____

If this amount is different than the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community:

_____

_____

_____

_____

_____

II. Rates and Payments

A. The State assures CMS that the capitated rates will be equal to or less than the cost to the agency of providing those same fee-for-service State plan approved services on a fee-for-service basis, to an equivalent non-enrolled population group based upon the following methodology. Please attach a description of the negotiated rate setting methodology and how the State will ensure that rates are less than the cost in fee-for-service.

1. Rates are set at a percent of fee-for-service costs
2. Experience-based (contractors/State's cost experience or encounter date)(please describe)
3. Adjusted Community Rate (please describe)
4. Other (please describe)

B. The State Medicaid Agency assures that the rates were set in a reasonable and predictable manner. Please list the name, organizational affiliation of any actuary used, and attestation/description for the initial capitation rates.

C. The State will submit all capitated rates to the CMS Regional Office for prior approval.

III. Enrollment and Disenrollment

The State assures that there is a process in place to provide for dissemination of enrollment and disenrollment data between the State and the State Administering Agency. The State assures that it has developed and will implement procedures for the enrollment and disenrollment of participants in the State's management information system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants in that month.

Attachment: Rates and Payments