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State/Territory Name: Montana

State Plan Amendment (SPA) #: MT-17-0011

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form/Summary Form (with 179-like data)
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
1961 Stout Street, Room 08-148
Denver, CO 80294



Region VIII

July 6, 2017

Marie Matthews, Medicaid & CHIP Director
Montana Department of Public Health & Human Services
P.O. Box 4210
Helena, MT 59604

Re: SPA MT-17-0011

Dear Ms. Matthews:

We have reviewed the proposed State Plan Amendment (SPA) submitted under transmittal number MT-17-0011. This amendment will no longer cover children who were in foster care and on Medicaid in any other state at the time they turned 18 or aged out of the foster care system.

Please be informed that this State Plan Amendment was approved July 6, 2017, with an effective date of July 1, 2017. We are enclosing the summary page and the amended plan page(s).

If you have any questions regarding this SPA please contact Barbara Prehmus at (303) 844-7472.

Sincerely,

A solid black rectangular box used to redact the signature of Richard C. Allen.

Richard C. Allen
Associate Regional Administrator
Division for Medicaid & Children's Health Operations

cc: Sheila Hogan, Department Director
Duane Preshinger
Jo Thompson
Mary Eve Kulawik

Medicaid State Plan Eligibility: Summary Page (CMS 179)

State/Territory name: Montana

Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY= the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

MT 17-0011

Proposed Effective Date

07/01/2017 (mm/dd/yyyy)

Federal Statute/Regulation Citation

42 CFR 435.150

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2017	\$0.00
Second Year	2018	\$0.00

Subject of Amendment

Effective July 1, 2017, Montana will no longer cover children who were in foster care and on Medicaid in any other state at the time they turned 18 or aged out of the foster care system.

Governor's Office Review

- ☒ Governor's office reported no comment
☐ Comments of Governor's office received

Describe:

- ☐ No reply received within 45 days of submittal
☐ Other, as specified

Describe:

Signature of State Agency Official

Submitted By: Mary Eve
Last Revision Date: May 25, 2017
Submit Date: May 25, 2017



Medicaid Eligibility

State Name: Montana

OMB Control Number: 0938-1148

Transmittal Number: MT - 17 - 0011

Eligibility Groups - Mandatory Coverage Former Foster Care Children

S33

42 CFR 435.150

1902(a)(10)(A)(i)(IX)

- ☒ **Former Foster Care Children** - Individuals under the age of 26, not otherwise mandatorily eligible, who were on Medicaid and in foster care when they turned 18 or aged out of foster care.

☒ The state attests that it operates this eligibility group under the following provisions:

☒ Individuals qualifying under this eligibility group must meet the following criteria:

☒ Are under age 26.

☒ Are not otherwise eligible for and enrolled for mandatory coverage under the state plan, except that eligibility under this group takes precedence over eligibility under the Adult Group.

☒ Were in foster care under the responsibility of the state or Tribe and were enrolled in Medicaid under the state's state plan or 1115 demonstration when they turned 18 or at the time of aging out of that state's or Tribe's foster care program.

The state elects to cover children who were in foster care and on Medicaid in any state at the time they turned 18 or aged out of the foster care system.

☐ Yes ☒ No

The state covers individuals under this group when determined presumptively eligible by a qualified entity. The state assures it also covers individuals under the Pregnant Women (42 CFR 435.116) and/or Infants and Children under Age 19 (42 CFR 435.118) eligibility groups when determined presumptively eligible.

☒ Yes ☐ No

☒ The presumptive period begins on the date the determination is made.

☒ The end date of the presumptive period is the earlier of:

The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or

The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

☒ Periods of presumptive eligibility are limited as follows:

☐ No more than one period within a calendar year.

☐ No more than one period within two calendar years.

☒ No more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.

☐ Other reasonable limitation:

MT-17-0011

Approval Date: 07/6/2017

Effective Date: 7/1/2017



Medicaid Eligibility

	Name of limitation	Description	
+			X

The state requires that a written application be signed by the applicant or representative.

☒ Yes ☐ No

☐ The state uses a single application form for Medicaid and presumptive eligibility, approved by CMS.

☒ The state uses a separate application form for presumptive eligibility, approved by CMS. A copy of the application form is included.

An attachment is submitted.

☒ The presumptive eligibility determination is based on the following factors:

☒ The individual must meet the categorical requirements of 42 CFR 435.150.

☒ State residency

☒ Citizenship, status as a national, or satisfactory immigration status

☒ The state uses qualified entities, as defined in section 1920A of the Act, to determine eligibility presumptively for this eligibility group.

List of Qualified Entities

S17

A qualified entity is an entity that is determined by the agency to be capable of making presumptive eligibility determinations based on an individual's household income and other requirements, and that meets at least one of the following requirements. Select one or more of the following types of entities used to determine presumptive eligibility for this eligibility group:

☐ Furnishes health care items or services covered under the state's approved Medicaid state plan and is eligible to receive payments under the plan

☐ Is authorized to determine a child's eligibility to participate in a Head Start program under the Head Start Act

☐ Is authorized to determine a child's eligibility to receive child care services for which financial assistance is provided under the Child Care and Development Block Grant Act of 1990

☐ Is authorized to determine a child's eligibility to receive assistance under the Special Supplemental Food Program for Women, Infants and Children (WIC) under section 17 of the Child Nutrition Act of 1966

☒ Is authorized to determine a child's eligibility under the Medicaid state plan or for child health assistance under the Children's Health Insurance Program (CHIP)

☐ Is an elementary or secondary school, as defined in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801)

☐ Is an elementary or secondary school operated or supported by the Bureau of Indian Affairs

☐ Is a state or Tribal child support enforcement agency under title IV-D of the Act

☐ Is an organization that provides emergency food and shelter under a grant under the Stewart B.



Medicaid Eligibility

- ☐ Is a state or Tribal office or entity involved in enrollment in the program under Medicaid, CHIP, or title IV-A of the Act

- ☐ Is an organization that determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under section 8 or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437) or under the Native American Housing Assistance and Self Determination Act of 1996 (25 U.S.C. 4101 et seq.)

- ☐ Is a health facility operated by the Indian Health Service, a Tribe, or Tribal organization, or an Urban Indian Organization

- ☒ Other entity the agency determines is capable of making presumptive eligibility determinations:

	Name of entity	Description	
+	Hospital	Any hospital in Montana that accepts Medicaid and/ or CHIP	X

- The state assures that it has communicated the requirements for qualified entities, at 1920A(b)(3) of the Act,
☒ and has provided adequate training to the entities and organizations involved. A copy of the training materials has been included.

An attachment is submitted.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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