DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

December 20, 2017

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

Dear Ms. Matthews:

The Centers for Medicare & Medicaid Services (CMS) is approving Montana's amendment to the demonstration project entitled, "Montana Health Economic Livelihood Partnership (HELP) Demonstration" (Project Number 11-W-00300/8). This amendment removes reference to the third party administrator (TPA) from the special terms and conditions (STC) to reflect changes to the state's delivery system, and also removes the current copay structure that credited beneficiaries' premiums toward their cost sharing obligations. Beneficiary out of pocket expenditures, including premiums, will not exceed 5 percent of household income. This demonstration, as amended, promotes the objectives of title XIX by serving the health and wellness needs of Montana's vulnerable and low-income individuals.

Montana's amendment to the copay structure is a modification that aligns with removal of the TPA. While some beneficiaries may incur a slight increase in cost-sharing as a result of this amendment, others might experience no increase. However, certain policies decrease the potential for increased cost-sharing for beneficiaries. For example, Montana generously exempts preventative health services and prescription drugs from copayments, including immunizations and medically necessary health screenings. CMS believes that these copay exemptions protect beneficiaries with high health care needs from unaffordable copays. Also, all out of pocket expenditures, including premiums, cannot exceed 5 percent of household income per quarter. The current federal evaluation will include an analysis of the state's experience with transitioning the TPA to the state's delivery system and beneficiary experience with the change in beneficiary co-pay structure.

Approval of this amendment is conditioned upon compliance with the enclosed STCs and is subject to our receiving your acknowledgement of the award and the acceptance of the STCs within 30 days of the date of this letter.

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

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-03-17
7500 Security Boulevard
Baltimore, MD 21244-1850
E-mail: Valisha.Andrus@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Andrus 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
E-mail: Richard.Allen@cms.hhs.gov

If you have questions regarding this approval, please contact Ms. Judith Cash, Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at (410) 786-9686.

Sincerely,

/s/

Brian Neale
Director
Centers for Medicaid and CHIP Services

cc: Richard Allen, Associate Regional Administrator, CMS Denver 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 promotes the objectives of title XIX by increasing overall coverage of low income individuals in the state.

CENTERS FOR MEDICARE & 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. 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:

I. Preface
II. Program Description and Objectives
III. General Program Requirements
IV. Populations Affected
V. Benefits
VI. Delivery System
VII. Premiums and Copayments
VIII. Continuous Eligibility
IX. General Reporting Requirements
X. General Financial Requirements
XI. Monitoring Budget Neutrality
XII. Evaluation
XIII. Health Information Technology
XIV. T-MSIS Requirements
XV. Schedule of Deliverables

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

II. PROGRAM DESCRIPTION AND OBJECTIVES

This section 1115(a) demonstration provides authority for the state to charge premiums and copayments to enrollees in the new adult group with income greater than 50 percent of the FPL.

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 with income greater than 50 percent of the FPL, premiums and copayments combined may not exceed 5 percent of family household income. 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 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 there may not be sufficient providers; 3) require continuity of coverage that is not available or could not be effectively delivered; 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 9 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 X; 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 as required in 42 Code of Federal Regulations (CFR) section 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also comply with the public notice procedures set forth in 42 CFR section 447.205 for changes in statewide methods and standards for setting payment rates.

    If the state has federally recognized tribes, the state must also comply with the tribal consultation requirements set forth in section 1902(a)(73) of the Act and implemented in regulation at 42 CFR section 431.408(b), and the tribal consultation requirements

contained in the state's approved Medicaid State Plan, when any program changes to the demonstration, either through amendment as set out in STC 7 or extension, are proposed by the state.

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.

17. **Common Rule Exemption.** The state shall ensure that the only involvement of human subjects in research activities which may be authorized and/or required by this demonstration for projects which are conducted by or subject to the approval of CMS, and which are designed to study, evaluate, or otherwise examine the Medicaid program – including procedures for obtaining Medicaid benefits or services; possible changes in or alternatives to those programs or procedures; or possible changes in methods or level of payment for benefits or services under those programs. CMS has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.101(b)(5).

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 have exceptional health care needs, as identified through the application process or by an individual notifying the State at any time, 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 State is unable to contract with sufficient providers);

d. Individuals who the state determines, in accordance with objective standards approved by CMS , require continuity of coverage that is not available;

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 receive benefits through the state plan ABP.

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. Medicaid State Plan. Eligible enrollees in the Montana HELP Program will receive services approved in the state's Alternative Benefit Plan (ABP) through the State's Fee-for-service system (FFS).

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.

    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.

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

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

f. 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. 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.

   b. 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 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 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 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.

7. **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 attains the age specified in 1902(a)(10)(A)(i)(VIII) of the Act.
    ii. The individual is no longer a Montana resident.
    iii. The individual requests voluntary termination of eligibility.
    iv. The individual dies.
    v. The agency determines that eligibility was erroneously granted at the most recent determination, redetermination or renewal of eligibility because of agency error or fraud, abuse, or perjury attributed to the beneficiary or the beneficiary's representative.
    vi. 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 provider site visits, reports, or requests for corrective actions plans; 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 IV, 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 DY s. 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 III STC 9), 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 primary care for chronic disease management services (if chronic disease present)
    5. Percent of unique individuals accessing preventive services
    6. Percent of preventive care visits, total and average per person
    7. Percent of specialty care visits, total and average per person
    8. 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 115(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 State ABP, 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 7	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

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

Operations Protocol

I. Purpose

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

II. Overview

HELP Program members will be required to pay premiums and co-payments. Responsibility for paying premiums and co-payments will encourage HELP Program members 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 members are not subject to premiums: members 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 there may not be contracts with sufficient providers; (3) require continuity of coverage that is not available; 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 members with incomes at or below 50% of the federal poverty level (FPL). New adults who fall into one of these categories 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 members 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. 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

HELP Program members with income greater than 50% of the FPL will be charged premiums equal to 2% of their household income. The State will notify members 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 eligibility determination notice. .

2. Payment

The State will administer and collect member premiums, providing multiple options for members to remit payments. Members can pay their premiums by check and money order.
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 member's household income.

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

Members 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 member and must occur no later than the end of each calendar quarter in which a person has collectible debt.

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

Members 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 members will receive monthly premium invoices via mail documenting their owed premiums; members 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. Members 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.

Members 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 member may re-enroll in April). Assessment occurs when the Department of Revenue sends a notice of debt to the member 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 Program, 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 Program. In the month the individual successfully opts back in, eligibility is effective the first day of that same month.

4. Assessment

When a member 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 member 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 members.

Example A: Members with Incomes above 50% up to and including 100% FPL
A member with no dependents has an annual income of $8,830, around 75% FPL. The member's annual premium contribution is approximately $176 or $14 per month. Upon enrollment in the Help Program, the member is notified of their monthly premium and options for payment, as well as a monthly invoice. If the member 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 member will not be dis-enrolled for failure to pay the monthly premium.
Example B: Members with Incomes above 100% up to and including 133% FPL
A member has an annual income of $25,000, around 125% FPL. The member's annual premium contribution is $500 or approximately $41 per month. Upon enrollment in the HELP Program, the member is notified of their monthly premium and options for payment, as well as a monthly invoice. Members 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 member 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 member enrolls on May 4th (before the billing cutoff) and is billed for their May and June premium on May 12th.** • **If the member 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 member not pay, the grace period will cover July, August, and September. The member will be disenrolled in October with coverage lasting through October 31st. November 1st will be the first day of non-coverage, assuming the member did not pay the first premium amount in full or any other premium amounts.** **Example B2:** • **A member enrolls on May 15th (after the billing cutoff around the 10th of the month) and is billed on June 12th for May, June and July premium payments.** • **If the member 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 member not pay, the grace period will last the months of August, September, and October, and the member 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 member did not pay the first premium amount in full or any other premium amounts.

Premium payments are always credited toward a member's oldest debt. If the member 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 member will be dis-enrolled from the HELP Program. In addition, the member's outstanding premium balance will be transferred to the Department of Revenue for assessment and collection from their state income tax refund. The member may re-enroll in the HELP Program once they have remitted payment for unpaid premiums or after the Department of Revenue has assessed their debt. The Department of Revenue will assess members' debt on a quarterly basis.

IV. Co-payments

1. Overview

Members 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. 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 members at the point of service.
- Providers will submit claims to claims payment vendors (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 5% aggregate household cap to ensure members are not inappropriately billed for co-payments.

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

- The claims payment vendors will send remittance advice to the provider with co-payment information.
- Providers will bill members for applicable co-payments after receiving remittance advice from the claims payment vendors.
- If the member has reached the 5% aggregate household cap, the provider will not bill the member for the service.
- The State will include direction in the provider manual outlining the requirement to monitor uncollected co-pay amounts for HELP Program members. The State will send an annual survey to providers requesting a summary of uncollected co-payments from HELP Program members and their efforts to collect the co-payments.
- The enterprise data exchange should prevent overcharging of members as well as the process described above in which members are not charged at the point of service. However, if a member is overcharged, the State will re-process the claim, notify the provider, and, if the provider has collected payment, the provider will reimburse the member. If the member's incurred co-payments exceed the 5% aggregate cap, the State will also send the member a notice stating the member 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 member's condition is non-emergent;
2. Provides the member with the name and location of an alternative non-emergency services provider;
3. Inform the individual 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.

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.

3. Co-payment Examples

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

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

The member is married without children (household size of two) with a household income of 75% FPL. During the member's first quarter in the HELP Demonstration, the member 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 member 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 member owes a $28 in copayments.

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

The member is a single male with an annual income of $11,888, or 101% FPL. The member 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. The member 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
Maximum quarterly co-payments owed by member: $148
Cost sharing waived (amount above 5% cost share max allowed by CMS): $12

The member 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 member will owe his maximum quarterly co-payment of $148.

When the member pays their premium, the payment is applied to the cap during the quarter for which the premium is due. In this example, if the member 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

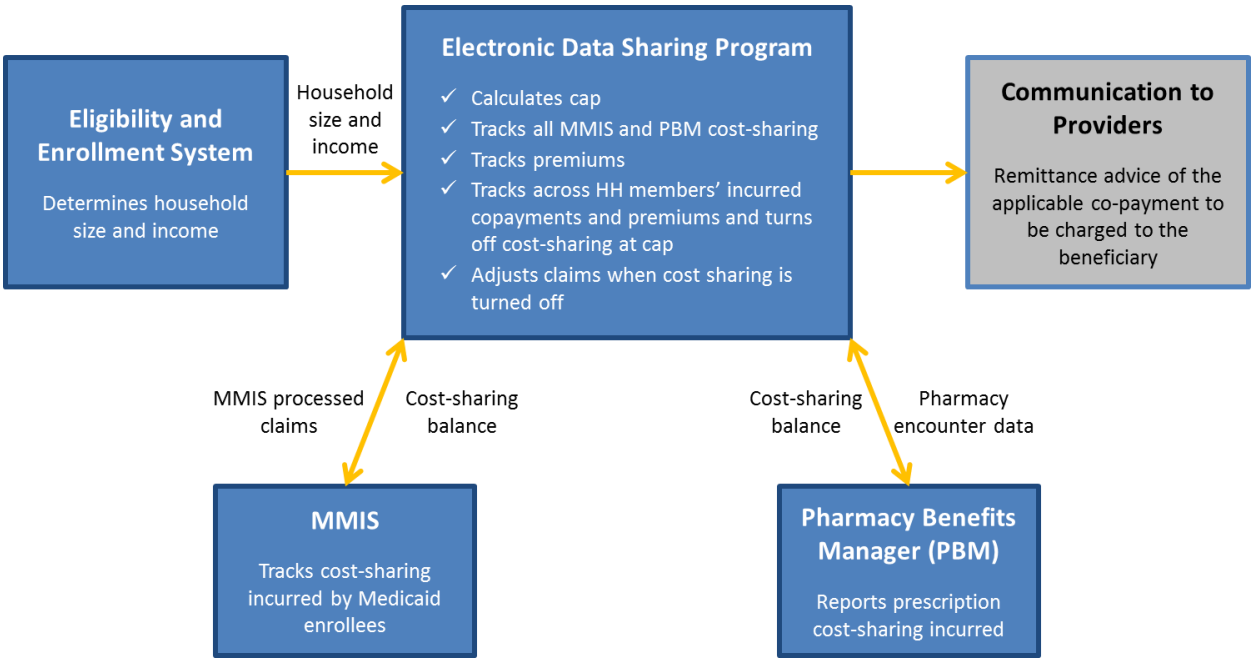
On a quarterly basis, the State, working with its claims payment vendor (Conduent) and through the enterprise data exchange detailed in Figure 1, will calculate the total incurred premiums and co-payments by each member to ensure that members' total out-of-pocket payments do not exceed the aggregate 5% household cap. The State will track premiums and co-payments of all household members, against the aggregate cap through data sharing across MMIS and the Pharmacy Benefit Manager (PBM).

After each claim is received, a member 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 member 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. Members will have access to a Member Help Line to assess whether they have reached their 5% aggregate household cap.

If the State, through its electronic data sharing among the MMIS and PBM, identifies a member 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 member reaches their 5% aggregate limit.

Figure 1. **Electronic Data Sharing Exchange**



If a member 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 member 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 member will be notified of the change in premium, if applicable.

If a member disagrees with a decision on the aggregate limit or termination of enrollment for failure to pay premiums, the member has the right to a fair hearing; a member may request a fair hearing on the aggregate limit or premium amounts after their initial eligibility determination. To request a fair hearing the member 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 Member Guide and each Explanation of Benefits.

VI. Member and Provider Engagement

1. Member Education and Outreach

a. State-led education and outreach

The state will disseminate information to members through consumer notices, Member Guide, and on the DPHHS HELP Program website. Members 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's website and will be available in hard copy upon a member's request.

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 member request, and the state will provide resources for accessibility (e.g. disability and language access). 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, members and providers have access to the information. The website will also include copies of member materials such as the Member Guide, and provide contact information for consumer support where members 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 member inquiries in a timely manner.

The State will be responsible for ensuring there is sufficient staffing and other administrative support to respond to member questions regarding premiums and co-payments, and will be obligated to educate members on these topics. State-led education will 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.

In its Quarterly Reports to CMS, the State will describe actions the State has taken to inform members about co-payment exempted services.

Upon HELP Program eligibility determination, HELP Program members will receive a notice from the DPHHS advising them of the following:

- HELP Program eligibility determination: The notice will include the basis of the member'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 member's guide and newsletters. If eligibility determinations were determined using modified adjusted gross income (MAGI), the state will include information to inform beneficiaries about receiving coverage through a non-MAGI bases.
- Appeals: The notice will include information regarding the Medicaid appeals process as required under federal law.

b. Copies of member-facing materials

i. Member Guide [Appendix A]

c. Copies of member **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 B]
ii. **Premium Invoice** [Appendix C]

2. Provider Education and Outreach

a. 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. 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 Program is consistent with program policies and procedures, and that information about the HELP Program is distributed through existing provider communication channels.

b. Copies of provider-facing materials

The State will make available educational materials as needed, including information specific to premiums and copayments.

VII. Grievances

The State will follow member grievance and appeals processes described in the 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.

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

ATTACHMENT C

Preventive Services Protocol

I. Background

HELP Program participants 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 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 (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 pregnancy 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 it has written provider education materials regarding service exemptions and will develop and disseminate information to providers.

IV. Enrollee Education

The State will ensure that it has written policies regarding service exemptions and will 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'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 has taken to inform enrollees about exempt preventive services.

V. Enrollee Grievances and Appeals

The State 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
	88147	Cytopath C/V Automated

Preventive Guideline	Procedure Code	Description
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
	45338	Sigmoidoscopy with tumor removal

Preventive Guideline	Procedure Code	Description
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
	G0270	Medical Nutrition Tx for Change Dx

Preventive Guideline	Procedure Code	Description
	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
	G0437	Tobacco use counselling 10+ min
Syphilis screening	86592	Syphilis test Non-TREP Qual

Preventive Guideline	Procedure Code	Description
	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
	90636	Hep A/Hep B Vacc Adult IM
	90632	Hepatitis A vaccine (Hep A), adult dosage, for intramuscular use

Preventive Guideline	Procedure Code	Description
	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
	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

Preventive Guideline	Procedure Code	Description
	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
	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

Preventive Guideline	Procedure Code	Description
	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
	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

Preventive Guideline	Procedure Code	Description
	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)
	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

Preventive Guideline	Procedure Code	Description
	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
	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
	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

Treatment Category	Drug Class	Description	Chronic Condition Treated
	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 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

Treatment Category	Drug Class	Description	Chronic Condition Treated
	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
	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

Treatment Category	Drug Class	Description	Chronic Condition Treated
	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
	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
	W7W	ALLERGENIC EXTRACTS	Allergy, Asthma
	J5F	ADRENERGICS	Anaphylaxis Therapy for Allergy Asthma

Treatment Category	Drug Class	Description	Chronic Condition Treated
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(PP ARG 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
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

Treatment Category	Drug Class	Description	Chronic Condition Treated
	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
	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

Treatment Category	Drug Class	Description	Chronic Condition Treated
	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
	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 debt2	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		Measures 9+10+11≈8	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			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 individuals3	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
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

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*		
Use of Preventive services4											
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 services5											
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 26+27+28+ 29+30 ≈ 25	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			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 program6	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

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*		
Complaints, grievances, and appeals											
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 of disenrollment >$0 and <$15	Number of beneficiaries disenrolled from the demonstration in the reporting month (measure 12) whose monthly premium at the time of disenrollment was greater than $0 but less than $15	x		x		x			Measures 40+41+42+ 43+44≈12 (for those with premiums)	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*		
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 of disenrollment ≥$75	Number of beneficiaries disenrolled from the demonstration in the reporting month (measure 12), whose monthly premium at the time of disenrollment was $75 or greater.	x		x		x				Phase 2 - End of Q2 2017
Total debt owed at disenrollment for failure to pay											

#	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*		
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.