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State/Territory Name: Montana

State Plan Amendment (SPA) #: 22-0004

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid and CHIP Operations Group

December 20, 2022

Michael Randol
Montana Medicaid and Health Services Executive Director/State Medicaid Director
Montana Department of Public Health & Human Services
P.O. Box 4210
Helena, MT 59604

Re: Montana State Plan Amendment (SPA) 22-0004

Dear Director Randol:

The Centers for Medicare & Medicaid Services (CMS) completed review of Montana's State Plan Amendment (SPA) Transmittal Number 22-0004 submitted on March 31, 2022. The purpose of this SPA is for Montana to assume the responsibility of enrolling practices, other than Federally Qualified Health Centers or Rural Health Clinics, into the Comprehensive Primary Care Plus (CPC+) program; establish enrollment qualifications for Tracks 1 and 2; and describe a methodology under State Plan Section 4.19-B to pay performance-based incentives to CPC+ providers based on utilization measures and quality measure benchmarks.

We reviewed of this amendment according to statutory requirements of Title XIX of the Social Security Act and implementing Federal regulations. This letter is to inform you that Montana Medicaid SPA Transmittal Number 22-0004 is approved effective March 2, 2022.

If you have any questions regarding this amendment, please contact Sarah Abbott at 410-786-8286 or via email at Sarah.Abbott@cms.hhs.gov.

Sincerely,

[redacted]

Bill Brooks
Director
Division of Managed Care Operations

cc: Mary Eve Kulawik
Lynn DelVecchio
Todd McMillion
Josh Smith
Renee Frandson

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 22-0004

2. STATE: MT

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: 03/02/2022

5. FEDERAL STATUTE/REGULATION CITATION: 1932(a) and 1905(t)

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2022 $ 0
b. FFY 2023 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-F, Section 2: Montana Medicaid CPC+ Program Pages 1-18 of 18
4.19-B Reimbursement ~~Page 1 of 1 (NEW)~~ Pages 1 - 3 of 3 (NEW)

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attchment 3.1-F, Section 2: Montana Medicaid CPC+ Program Pages 1-14 of 14

9. SUBJECT OF AMENDMENT
Montana Medicaid will assume the responsibility of enrolling practices, other than Federally Qualified Health Centers or Rural Health Clinics, into the CPC+ program and establish enrollment qualifications for Track 1 and Track 2.

10. GOVERNOR'S REVIEW *(Check One)*
(●) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
( ) OTHER, AS SPECIFIED:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Michael Randol

13. TITLE
Medicaid and Health Services Executive Director/State Medicaid

14. DATE SUBMITTED
3-31-2022 ~~9-23-2022~~

15. RETURN TO
Montana Department of Public Health and Human Services
Michael Randol
Attn: Mary Eve Kulawik
PO Box 4210
Helena, MT 59620

FOR CMS USE ONLY

16. DATE RECEIVED 3/31/2022

17. DATE APPROVED 12/20/2022

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
3/2/2022

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Bill Brooks

21. TITLE OF APPROVING OFFICIAL
Director, Division of Managed Care Operations

22. REMARKS

12/15/22: State granted CMS permission to revise 4.19-B page numbers in box 7 (from "1 of 1" to "1 - 3 of 3"), and to revise box 9 "Date Submitted" to the original SPA submission date, 3/31/2022, rather than the RAI response date of 9/23/2022.

MT

Citation	Condition or Requirement

1932(a)(1)(A)

A. Section 1932(a)(1)(A) of the Social Security Act.

The State of Montana enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (managed care organization [MCOs], primary care case managers [PCCMs], and/or PCCM entities) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on state wideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230).

This authority may ***not*** be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries described in 42 CFR 438.50(d).

Where the state's assurance is requested in this document for compliance with a particular requirement of 42 CFR 438 et seq., the state shall place a check mark to affirm that it will be in compliance no later than the applicable compliance date. All applicable assurances should be checked, even when the compliance date is in the future. **Please see Appendix A of this document for compliance dates for various sections of 42 CFR 438.**

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.2
42 CFR 438.6
42 CFR 438.50(b)(1)-(2)

B. Managed Care Delivery System.

The State will contract with the entity(ies) below and reimburse them as noted under each entity type.

1. ☐ MCO
   a. ☐ Capitation
   b. ☐ The state assures that all applicable requirements of 42 CFR 438.6, regarding special contract provisions related to payment, will be met.

2. X PCCM (individual practitioners)
   a. ☒ Case management fee
   b. X Other (please explain below) CPC+ PCCMs may receive incentive payments as described in Attachment 4.19-B, page 1 as authorized in the SSA 1905(t).

3. ☐ PCCM entity
   a. ☐ Case management fee
   b. ☐ Shared savings, incentive payments, and/or financial rewards (see 42 CFR 438.310(c)(2))
   c. ☐ Other (please explain below)

MT

Citation	Condition or Requirement

For the purposes of the Comprehensive Primary Care Plus (CPC+) Initiative, Montana Medicaid will only contract with primary care case managers other than Federally Qualified Health Centers and Rural Health Clinics that are physicians, physician group practices, physician assistants, or nurse practitioners and meet at least one of the following criteria:

a) Certification as a Patient Centered Medical Home by the National Committee for Quality Assurance (NCQA);
b) Designation as a Primary Care Medical Home by the Joint Commission;
c) Certification for Patient Centered Medical Home by the Accreditation Association for Ambulatory Health Care;
d) Certification for Patient-Centered Medical Home by URAC; or
e) Previous CMS selection of practice into CPC+.

In addition to the above criteria, practices selected for Track 2, must meet the following qualification criteria:

a) Provide integrated behavioral health services to include assessments of a member's psychosocial needs using evidence-based tools and provide referrals to resources and supports to meet the identified needs;
b) Conduct care team meetings weekly to review patient-level data and internal monitoring;
c) Provide at least two types of alternative access to healthcare including e-visits, phone visits, group visits, and alternative location visits: and
d) Provider at least one alternative contact modality, such as, emails, text reminders, or letters.

CPC+ practices will receive a per member per month (PMPM) care management fee in addition to fee-for-service payments.

a) Practices in Track 1 for CPC+ will receive four tiers of PMPM payments, depending on patient risk and level of care management required.
b) Practices in Track 2 will receive five tiers of PMPM payments; the top tier is for the most complex patients.

If PCCM entity is selected, please indicate which of the following function(s) the entity will provide (as in 42 CFR 438.2), in addition to PCCM services:

☐ Provision of intensive telephonic case management
☐ Provision of face-to-face case management
☐ Operation of a nurse triage advice line
☐ Development of enrollee care plans.
☐ Execution of contracts with fee-for-service (FFS) providers in the FFS program
☐ Oversight responsibilities for the activities of FFS providers in the FFS program
☐ Provision of payments to FFS providers on behalf of the State.
☐ Provision of enrollee outreach and education activities.

☐ Operation of a customer service call center.
☐ Review of provider claims, utilization and/or practice patterns to conduct provider profiling and/or practice improvement.
☐ Implementation of quality improvement activities including administering enrollee satisfaction surveys or collecting data necessary for performance measurement of providers.
☐ Coordination with behavioral health systems/providers.
☐ Coordination with long-term services and supports systems/providers.
☐ Other (please describe): _____

42 CFR 438.50(b)(4)

C. Public Process.

Describe the public process including tribal consultation, if applicable, utilized for both the design of the managed care program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan managed care program has been implemented. *(Example: public meeting, advisory groups.)*
If the program will include long term services and supports (LTSS), please indicate how the views of stakeholders have been, and will continue to be, solicited and addressed during the design, implementation, and oversight of the program, including plans for a member advisory committee (42 CFR 438.70 and 438.110)

Tribal consultation letters were mailed on 3/2/2022. Public notice was posted on the Department webpage on 3/1/2022. Additionally, Montana collaborates with provider advocacy groups such as the Montana Hospital Association, the Montana Primary Care Association, and the Montana Healthcare Foundation. Biannual updates are given to the Montana Legislature. Additionally, CPC+ will be discussed in ongoing Tribal Consultation meetings, as an Indian Health Service is a participating CPC+ clinic.

D. State Assurances and Compliance with the Statute and Regulations.
If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.

1932(a)(1)(A)(i)(I)
1903(m)

1. ☐ The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.

MT

Citation	Condition or Requirement
42 CFR 438.50(c)(1)	
1932(a)(1)(A)(i)(I) 1905(t) 42 CFR 438.50(c)(2) 1902(a)(23)(A)	2. ☒ The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts (including for PCCM entities) will be met.
1932(a)(1)(A) 42 CFR 438.50(c)(3)	3. ☐ The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring beneficiaries to receive their benefits through managed care entities will be met.
1932(a)(1)(A) 42 CFR 431.51 1905(a)(4)(C) 42 CFR 438.10(g)(2)(vii)	4. ☒ The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.
1932(a)(1)(A)	5. ☒ The state assures that it appropriately identifies individuals in the mandatory exempt groups identified in 1932(a)(1)(A)(i).
1932(a)(1)(A) 42 CFR 438 1903(m)	6. ☒ The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs, PCCMs, and PCCM entities will be met.
1932(a)(1)(A) 42 CFR 438.4 42 CFR 438.5 42 CFR 438.7 42 CFR 438.8 42 CFR 438.74 42 CFR 438.50(c)(6)	7. ☐ The state assures that all applicable requirements of 42 CFR 438.4, 438.5, 438.7, 438.8, and 438.74 for payments under any risk contracts will be met. N/A
1932(a)(1)(A) 42 CFR 447.362 42 CFR 438.50(c)(6)	8. ☒ The state assures that all applicable requirements of 42 CFR 447.362 for payments under any non-risk contracts will be met.
45 CFR 75.326	9. ☒ The state assures that all applicable requirements of 45 CFR 75.326 for procurement of contracts will be met.
42 CFR 438.66	10. Assurances regarding state monitoring requirements:

MT

Citation	Condition or Requirement

☐ The state assures that all applicable requirements of 42 CFR 438.66(a), (b), and (c), regarding a monitoring system and using data to improve the performance of its managed care program, will be met.

☐ The state assures that all applicable requirements of 42 CFR 438.66(d), regarding readiness assessment, will be met.

☐ The state assures that all applicable requirements of 42 CFR 438.66(e), regarding reporting to CMS about the managed care program, will be met.

1932(a)(1)(A)
1932(a)(2)

E. Populations and Geographic Area.

1. **Included Populations.** Please check which eligibility groups are included, if they are enrolled on a **Mandatory (M)** or **Voluntary (V)** basis (as defined in 42 CFR 438.54(b)) or **Excluded (E),** and the geographic scope of enrollment. Under the **Geographic Area** column, please indicate whether the nature of the population's enrollment is on a statewide basis, or if on less than a statewide basis, please list the applicable counties/regions. Also, if type of enrollment varies by geographic area (for example, mandatory in some areas and voluntary in other areas), please note specifics in the **Geographic Area** column. Under the **Notes** column, please note any additional relevant details about the population or enrollment.

A. Mandatory Eligibility Groups (Eligibility Groups to which a state must provide Medicaid coverage)

1. Family/Adult

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
1. Parents and Other Caretaker Relatives	§435.110		✔			
2. Pregnant Women	§435.116			✔		
3. Children Under Age 19 (Inclusive of Deemed Newborns under §435.117)	§435.118		✔			
4. Former Foster Care Youth (up to age 26)	§435.150		✔			
5. Adult Group (Non-pregnant individuals age 19-64 not eligible for Medicare with income no more than 133% FPL)	§435.119		✔			
6. Transitional Medical Assistance (Includes adults and children, if not eligible under §435.116, §435.118, or §435.119)	1902(a)(52), 1902(e)(1), 1925, and 1931(c)(2) of SSA		✔			
7. Extended Medicaid Due to Spousal Support Collections	§435.115		✔			

MT

Citation | Condition or Requirement

2. Aged/Blind/Disabled Individuals

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
8. Individuals Receiving SSI age 19 and over only (See E.2. below regarding age <19)	§435.120		✔			
9. Aged and Disabled Individuals in 209(b) States	§435.121					N/A
10. Individuals Who Would be Eligible for SSI/SSP but for OASDI COLA Increase since April, 1977	§435.135		✔			
11. Disabled Widows and Widowers Ineligible for SSI due to an increase of OASDI	§435.137		✔			
12. Disabled Widows and Widowers Ineligible for SSI due to Early Receipt of Social Security	§435.138		✔			
13. Working Disabled under 1619(b)	1619(b), 1902(a)(10)(A)(i)(II), and 1905(q) of SSA		✔			
14. Disabled Adult Children	1634(c) of SSA		✔			

B. Optional Eligibility Groups

1. Family/Adult

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
1. Optional Parents and Other Caretaker Relatives	§435.220		✔			
2. Optional Targeted Low-Income Children	§435.229		✔			
3. Independent Foster Care Adolescents Under Age 21	§435.226					N/A
4. Individuals Under Age 65 with Income Over 133%	§435.218					N/A
5. Optional Reasonable Classifications of Children Under Age 21	§435.222		✔			
6. Individuals Electing COBRA Continuation Coverage	1902(a)(10)(F) of SSA		✔			

MT

Citation | Condition or Requirement

2. Aged/Blind/Disabled Individuals

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
7. Aged, Blind or Disabled Individuals Eligible for but Not Receiving Cash	§435.210 and §435.230		✔			
8. Individuals eligible for Cash except for Institutionalized Status	§435.211		✔			
9. Individuals Receiving Home and Community-Based Waiver Services Under Institutional Rules	§435.217			✔		
10. Optional State Supplement Recipients - 1634 and SSI Criteria States – with 1616 Agreements	§435.232		✔			
11. Optional State Supplemental Recipients- 209(b) States and SSI criteria States without 1616 Agreements	§435.234					N/A
12. Institutionalized Individuals Eligible under a Special Income Level	§435.236					N/A
13. Individuals Participating in a PACE Program under Institutional Rules	1934 of the SSA					N/A
14. Individuals Receiving Hospice Care	1902(a)(10)(A)(ii)(VII) and 1905(o) of the SSA		✔			
15. Poverty Level Aged or Disabled	1902(a)(10)(A)(ii)(X) and 1902(m)(1) of the SSA					N/A
16. Work Incentive Group	1902(a)(10)(A)(ii)(XIII) of the SSA		✔			
17. Ticket to Work Basic Group	1902(a)(10)(A)(ii)(XV) of the SSA					N/A
18. Ticket to Work Medically Improved Group	1902(a)(10)(A)(ii)(XVI) of the SSA					N/A
19. Family Opportunity Act Children with Disabilities	1902(a)(10)(A)(ii)(XIX) of the SSA					N/A
20. Individuals Eligible for State Plan Home and Community-Based Services	§435.219					N/A

MT

Citation | Condition or Requirement

3. Partial Benefits

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
21. Family Planning Services	§435.214			✔		
22. Individuals with Tuberculosis	§435.215					N/A
23. Individuals Needing Treatment for Breast or Cervical Cancer (under age 65)	§435.213			✔		

C. Medically Needy

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
1. Medically Needy Pregnant Women	§435.301(b)(1)(i) and (iv)			✔		
2. Medically Needy Children under Age 18	§435.301(b)(1)(ii)			✔		
3. Medically Needy Children Aged 18 through 20	§435.308			✔		
4. Medically Needy Parents and Other Caretaker Relatives	§435.310					N/A
5. Medically Needy Aged	§435.320			✔		
6. Medically Needy Blind	§435.322			✔		
7. Medically Needy Disabled	§435.324			✔		
8. Medically Needy Aged, Blind and Disabled in 209(b) States	§435.330					N/A

2. **Voluntary Only or Excluded Populations.** Under this managed care authority, some populations cannot be subject to mandatory enrollment in an MCO, PCCM, or PCCM entity (per 42 CFR 438.50(d)). Some such populations are Eligibility Groups separate from those listed above in E.1., while others (such as American Indians/Alaskan Natives) can be part of multiple Eligibility Groups identified in E.1. above.

Please indicate if any of the following populations are excluded from the program, or have only voluntary enrollment (even if they are part of an eligibility group listed above in E.1. as having mandatory enrollment):

Population	Citation (Regulation [42 CFR] or SSA)	V	E	Geographic Area	Notes
Medicare Savings Program – Qualified Medicare Beneficiaries, Qualified Disabled Working Individuals, Specified Low Income Medicare Beneficiaries, and/or Qualifying Individuals	1902(a)(10)(E), 1905(p), 1905(s) of the SSA		✔		

MT

Citation Condition or Requirement

Population	Citation (Regulation [42 CFR] or SSA)	V	E	Geographic Area	Notes
"Dual Eligibles" not described under Medicare Savings Program - Medicaid beneficiaries enrolled in an eligibility group other than one of the Medicare Savings Program groups who are also eligible for Medicare			✔		
American Indian/Alaskan Native— Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes	§438.14	✔			
Children Receiving SSI who are Under Age 19 - Children under 19 years of age who are eligible for SSI under title XVI	§435.120	✔			
Qualified Disabled Children Under Age 19 - Certain children under 19 living at home, who are disabled and would be eligible if they were living in a medical institution.	§435.225 1902(e)(3) of the SSA				N/A
Title IV-E Children - Children receiving foster care, adoption assistance, or kinship guardianship assistance under title IV-E *	§435.145	✔			
Non-Title IV-E Adoption Assistance Under Age 21*	§435.227	✔			
Children with Special Health Care Needs - Receiving services through a family-centered, community-based, coordinated care system that receives grant funds under section 501(a)(1)(D) of Title V, and is defined by the State in terms of either program participation or special health care needs.			✔		

* = Note – Individuals in these two Eligibility Groups who are age 19 and 20 can have mandatory enrollment in managed care, while those under age 19 cannot have mandatory enrollment. Use the Notes column to indicate if you plan to mandatorily enroll 19 and 20 year olds in these Eligibility Groups.

3. **(Optional) Other Exceptions.** The following populations (which can be part of various Eligibility Groups) can be subject to mandatory enrollment in managed care, but states may elect to make exceptions for these or other individuals. Please indicate if any of the following populations are excluded from the program, or have only voluntary enrollment (even if they are part of an eligibility group listed above in E.1. as having mandatory enrollment):

MT

Citation | Condition or Requirement

Population	V	E	Notes
Other Insurance--Medicaid beneficiaries who have other health insurance		✔	This population is excluded if their primary insurance is a managed care plan.
Reside in Nursing Facility or ICF/IID-- Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).		✔	
Enrolled in Another Managed Care Program--Medicaid beneficiaries who are enrolled in another Medicaid managed care program		✔	
Eligibility Less Than 3 Months--Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program		✔	
Participate in HCBS Waiver--Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).		✔	
Retroactive Eligibility–Medicaid beneficiaries for the period of retroactive eligibility.		✔	
Other (Please define):		✔	Members requesting a medical hardship; Foster care youth placed out of state; Infants in the NICU, members participating in the Breast and Cervical Cancer program, and residents of an out of state treatment center.

1932(a)(4)
42 CFR 438.54

F. Enrollment Process.

Based on whether mandatory and/or voluntary enrollment are applicable to your program (see E. Populations and Geographic Area and definitions in 42 CFR 438.54(b)), please complete the below:

1. For **voluntary** enrollment: (see 42 CFR 438.54(c))
   a. Please describe how the state fulfills its obligations to provide information as specified in 42 CFR 438.10(c)(4), 42 CFR 438.10(e) and 42 CFR 438.54(c)(3).

   State with voluntary enrollment must have an enrollment choice period or passive enrollment. Please indicate which will apply to the managed care program:
   All new Montana Medicaid members are sent a PCCM enrollment packet by the enrollment broker. Included is a letter instructing the member they have 45 days to select a primary care provider, or one will be chosen for them. Members are given information in the enrollment packet about factors to consider in choosing a provider. If the provider they select is a CPC+ program provider, the member is enrolled in CPC+. The members

Citation	Condition or Requirement
	may change PCCM providers at any time with a 30-day notice.
	If the enrollment broker chooses a provider for the member, the PCCM attribution method described in the 1915(b) Passport waiver is utilized. ☒
	If applicable, please check here to indicate that the state provides an **enrollment choice period**, as described in 42 CFR 438.54(c)(1)(i) and 42 CFR 438.54(c)(2)(i), during which individuals who are subject to voluntary enrollment may make an active choice to enroll in the managed care program, or will otherwise continue to receive covered services through the fee-for-service delivery system.
	i. Please indicate the length of the enrollment choice period: 45 days
	b. ☐ If applicable, please check here to indicate that the state uses a **passive enrollment** process, as described in 42 CFR 438.54(c)(1)(ii) and 438.54(c)(2)(ii), for individuals who are subject to voluntary enrollment.
	i. If so, please describe the algorithm used for passive enrollment and how the algorithm and the state's provision of information meets all of the requirements of 42 CFR 438.54(c)(4),(5),(6),(7), and (8).
	ii. Please indicate how long the enrollee will have to disenroll from the plan and return to the fee-for-service delivery system:
	2. For **mandatory** enrollment: (see 42 CFR 438.54(d))
	a. Please describe how the state fulfills its obligations to provide information as specified in 42 CFR 438.10(c)(4), 42 CFR 438.10(e) and 42 CFR 438.54(d)(3).
	b. ☐ If applicable, please check here to indicate that the state provides an **enrollment choice period**, as described in 42 CFR 438.54(d)(2)(i), during which individuals who are subject to mandatory enrollment may make an active choice to select a managed care plan, or will otherwise be enrolled in a plan selected by the State's default enrollment process.
	i. Please indicate the length of the enrollment choice period:
	c. ☐ If applicable, please check here to indicate that the state uses a **default** enrollment process, as described in 42 CFR 438.54(d)(5), for individuals who are subject to mandatory enrollment.
	i. If so, please describe the algorithm used for default enrollment and how it meets all of the requirements of 42 CFR 438.54(d)(4), (5), (7), and (8).
	d. ☐ If applicable, please check here to indicate that the state uses a **passive enrollment** process, as described in 42 CFR 438.54(d)(2), for individuals who are subject to mandatory enrollment.

MT

i. If so, please describe the algorithm used for passive enrollment and how it meets all of the requirements of 42 CFR 438.54(d)(4), (6), (7), and (8).

1932(a)(4)
42 CFR 438.54

3. State assurances on the enrollment process.

Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

42 CFR 438.52

a. ☒ The state assures that, per the choice requirements in 42 CFR 438.52:

i. Medicaid beneficiaries with mandatory enrollment in an MCO will have a choice of at least two MCOs unless the area is considered rural as defined in 42 CFR 438.52(b)(3);
ii. Medicaid beneficiaries with mandatory enrollment in a primary care case management system will have a choice of at least two primary care case managers employed by or contracted with the State;
iii. Medicaid beneficiaries with mandatory enrollment in a PCCM entity may be limited to a single PCCM entity and will have a choice of at least two PCCMs employed by or contracted with the PCCM entity.

42 CFR 438.52

b. ☐ The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs in accordance with 42 CFR 438.52(b). Please list the impacted rural counties:

☒ This provision is not applicable to this 1932 State Plan Amendment.

42 CFR 438.56(g)

c. ☒ The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.

☐ This provision is not applicable to this 1932 State Plan Amendment.

42 CFR 438.71

d. ☒ The state assures that all applicable requirements of 42 CFR 438.71 regarding developing and implementing a beneficiary support system that provides support to beneficiaries both prior to and after MCO, PCCM, or PCCM entity enrollment will be met.

MT

Citation	Condition or Requirement

1932(a)(4)
42 CFR 438.56

G. Disenrollment.

1. The state will☐/ will not☒ limit disenrollment for managed care.

2. The disenrollment limitation will apply for_____(up to 12 months).

3. ☒The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56.

4. Describe the state's process for notifying the Medicaid beneficiaries of their right to disenroll without cause during the 90 days following the date of their initial enrollment into the MCO, PCCM, or PCCM entity.

Montana Medicaid contracted CPC+ providers must give education materials to each Medicaid member attributed to their practice. The materials must explain the process for members to dis-enroll from the program, change their provider, and the CPC+ services available to them. Member education is provided through program materials, written communication, and telephone calls.

5. Describe any additional circumstances of "cause" for disenrollment (if any).

No specific "cause" is needed on part of the Medicaid member to dis-enroll from a CPC+ provider. Members are notified of disenrollment rights in the Montana Medicaid Member Guide and on the Department website.

H. Information Requirements for Beneficiaries.

1932(a)(5)(c)
42 CFR 438.50
42 CFR 438.10

☒The state assures that its state plan program is in compliance with 42 CFR 438.10 for information requirements specific to MCOs, PCCMs, and PCCM entity programs operated under section 1932(a)(1)(A)(i) state plan amendments.

1932(a)(5)(D)(b)
1903(m)
1905(t)(3)

I. List all benefits for which the MCO is responsible.

Not applicable.

Complete the chart below to indicate every State Plan-Approved services that will be delivered by the MCO, and where each of those services is described in the state's Medicaid State Plan. For "other practitioner services", list each provider type separately. For rehabilitative services, habilitative services, EPSDT services and 1915(i), (j) and (k) services list each program separately by its own list of services. Add additional rows as necessary.

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In the first column of the chart below, enter the name of each State Plan-Approved service delivered by the MCO. In the second – fourth column of the chart, enter a State Plan citation providing the Attachment number, Page number, and Item number, respectively.

State Plan-Approved Service Delivered by the MCO	Medicaid State Plan Citation		
	Attachment #	Page #	Item #
Ex. Physical Therapy	*3.1-A*	*4*	*11.a*

1932(a)(5)(D)(b)(4)
42 CFR 438.228

J. ☐ The state assures that each MCO has established an internal grievance and appeal system for enrollees.

MT

Citation	Condition or Requirement
1932(a)(5)(D)(b)(5) 42 CFR 438.62 42 CFR 438.68 42 CFR 438.206 42 CFR 438.207 42 CFR 438.208	K. Services, including capacity, network adequacy, coordination, and continuity. ☒ The state assures that all applicable requirements of 42 CFR 438.62, regarding continued service to enrollees, will be met. ☐ The state assures that all applicable requirements of 42 CFR 438.68, regarding network adequacy standards, will be met. ☐ The state assures that all applicable requirements of 42 CFR 438.206, regarding availability of services, will be met. ☐ The state assures that all applicable requirements of 42 CFR 438.207, regarding assurances of adequate capacity and services, will be met. ☐ The state assures that all applicable requirements of 42 CFR 438.208, regarding coordination and continuity of care, will be met.
1932(c)(1)(A) 42 CFR 438.330 42 CFR 438.340	L. ☐ The state assures that all applicable requirements of 42 CFR 438.330 and 438.340, regarding a quality assessment and performance improvement program and State quality strategy, will be met.
1932(c)(2)(A) 42 CFR 438.350 42 CFR 438.354 42 CFR 438.364	M. ☐ The state assures that all applicable requirements of 42 CFR 438.350, 438.354, and 438.364 regarding an annual external independent review conducted by a qualified independent entity, will be met.
1932 (a)(1)(A)(ii)	N. Selective Contracting Under a 1932 State Plan Option. To respond to items #1 and #2, place a check mark. The third item requires a brief narrative. 1. The state will ☐/will not ☒ intentionally limit the number of entities it contracts under a 1932 state plan option.

Citation	Condition or Requirement

2. ☐ The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.

3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. *(Example: a limited number of providers and/or enrollees.)*

4. ☒ The selective contracting provision in not applicable to this state plan.

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Citation	Condition or Requirement

Appendix A: Compliance Dates (from Supplementary Information in 81 FR 27497, published 5/6/2016)

States must comply with all provisions in effect as of the issuance of this preprint. Additionally, the following compliance dates apply:

Compliance Dates	Sections
For rating periods for Medicaid managed care contracts beginning before July 1, 2017, States will not be held out of compliance with the changes adopted in the following sections so long as they comply with the corresponding standard(s) codified in 42 CFR part 438 contained in 42 CFR parts 430 to 481, edition revised as of October 1, 2015. **States must comply with these requirements no later than the rating period for Medicaid managed care contracts starting on or after July 1, 2017.**	§§ 438.3(h), 438.3(m), 438.3(q) through (u), 438.4(b)(7), 438.4(b)(8), 438.5(b) through (f), 438.6(b)(3), 438.6(c) and (d), 438.7(b), 438.7(c)(1) and (2), 438.8, 438.9, 438.10, 438.14, 438.56(d)(2)(iv), 438.66(a) through (d), 438.70, 438.74, 438.110, 438.208, 438.210, 438.230, 438.242, 438.330, 438.332, 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424, 438.602(a), 438.602(c) through (h), 438.604, 438.606, 438.608(a), and 438.608(c) and (d)
For rating periods for Medicaid managed care contracts beginning before July 1, 2018, states will not be held out of compliance with the changes adopted in the following sections so long as they comply with the corresponding standard(s) codified in 42 CFR part 438 contained in the 42 CFR parts 430 to 481, edition revised as of October 1, 2015. **States must comply with these requirements no later than the rating period for Medicaid managed care contracts starting on or after July 1, 2018.**	§§ 438.4(b)(3), 438.4(b)(4), 438.7(c)(3), 438.62, 438.68, 438.71, 438.206, 438.207, 438.602(b), 438.608(b), and 438.818
States must be in compliance with the requirements at § 438.4(b)(9) no later than the rating period for Medicaid managed care contracts starting on or after July 1, 2019.	§ 438.4(b)(9)
States must be in compliance with the requirements at § 438.66(e) no later than the rating period for Medicaid managed care contracts starting on or after the date of the publication of CMS guidance.	§ 438.66(e)
States must be in compliance with § 438.334 no later than 3 years from the date of a final notice published in the Federal Register.	§ 438.334
Until July 1, 2018, states will not be held out of compliance with the changes adopted in the following sections so long as they comply with the corresponding standard(s) codified in 42	§§ 438.340, 438.350, 438.354, 438.356, 438.358, 438.360, 438.362, and 438.364

MT

Citation | Condition or Requirement

Compliance Dates	Sections
CFR part 438 contained in the 42 CFR parts 430 to 481, edition revised as of October 1, 2015.	
States must begin conducting the EQR-related activity described in § 438.358(b)(1)(iv) (relating to the mandatory EQR-related activity of validation of network adequacy) **no later than one year from the issuance of the associated EQR protocol.**	§ 438.358(b)(1)(iv)
States may begin conducting the EQR-related activity described in § 438.358(c)(6) (relating to the optional EQR-related activity of plan rating) **no earlier than the issuance of the associated EQR protocol.**	§ 438.358(c)(6)

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0933. The time required to complete this information collection is estimated to average 10 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850

CMS-10120 (exp. TBD – currently 4/30/17)

A. **CPC+ Performance-based Reimbursement**

Providers under this provision are being paid for their role as part of a PCCM arrangement to perform certain PCCM functions on behalf of a PCCM contracted practice, and these payments would otherwise go to the PCCM. CPC+ providers are eligible to receive an annual performance-based payment in addition to FFS and PCCM case management fees but only if the eligibility, utilization, and performance requirements are met. Montana Medicaid will pay annual performance-based incentive payments to CPC+ providers enrolled under the 1932(a) authority based on the provider's ability to meet the agreed upon performance benchmarks. This payment will be a quality bonus paid out retrospectively. CPC+ providers that meet quality and utilization thresholds will be rewarded with CPC+ Medicaid per member per year (PMPY) payments. These bonus incentive payments will be based on utilization measures and quality measure performance benchmarks.

Quality measures are calculated from data that includes Medicaid claims data, electronic health record import, and provider manual data enhancement. The claims data and electronic health record data is automatically populated in the quality measure software and can be enhanced by additional provider data entry and health information exchange data when it becomes available. The contract and measurement years are both calendar years. Utilization measures are derived exclusively from claims data. Providers have one calendar year from the end of the contract year to review and enhance data in the quality measure software. The final data is finalized by February of the following year. Montana issues incentive payments within 90 days of the data finalization.

B. Quality Measures

1) Controlling High Blood Pressure: Percentage of patients 18-85 with hypertension diagnosis and whose blood pressure was adequately controlled (<140/90mmHg) during measurement period;
2) Diabetes Management: Percentage of patients 18-75 years of age with diabetes diagnosis and hemoglobin A1c>9.0% (poor control) during measurement period. This is a negative measure;
3) Colorectal Cancer Screening: Percentage of adults 50-75 years who had appropriate screening for colorectal cancer;
4) Cervical Cancer Screening: Percentage of women 21-64 years of age who were screened for cervical cancer;
5) Breast Cancer Screening: Percentage of women 50-74 years of age who had a mammogram;
6) Body Mass Index Screening and Follow Up Plan: Percentage of patients aged 18 and older with a BMI either <18.5 or >+25 kg/m2. With a follow-up plan during the last 12 months;
7) HPV immunization Status: Percentage of patients ages 11-26, with 2 or 3 doses prior to age 27;
8) Childhood Immunization Status: Percentage of children 2 years of age that have all vaccinations listed in the CMS Child Core Set Technical Specifications;
9) Initiation and Engagement of Alcohol and Other Drug Dependence Treatment Percentage of patients 13 years of age and older with a new episode of alcohol or drug abuse or

alcohol dependence that initiated treatment or had two additional services within 30 days of the visit:

10) Tobacco Use Screening and Cessation Intervention: Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months and received a tobacco cessation intervention if identified as a tobacco user;
11) Screening for Depression and Follow up Plan: Percentage of patients aged 12 years and older screened for depression and if positive, a follow-up plan is documented on the date of the screen; and
12) Adult Major Depressive Disorder (MDD)screening and Suicide Risk Assessment: Percentage of patients aged 18 years and older with a diagnosis of MDD with a suicide risk assessment completed during the visit in which the diagnosis was identified.

C. Utilization Measures and Payments

1) Total Emergency Department (ED) visits for attributed patients;
2) Total Hospital Inpatient visits for attributed patients;
3) ED and Inpatient payments are extracted from Medicaid claims and are stratified by age and gender and compared to the US 2000 census data. If the clinic performs better than the 70th percentile of expected ED visits and hospitalization a flat fee per member is paid.
4) Providers that meet the utilization measure 70th percentile benchmark will receive $5 per attributed member for Track 1 clinics and $8 per attributed member for Track 2 clinics;
5) Providers can receive partial payments if the 60th, 50th and 40th percentiles are met. Track 1 and Track 2 clinics will receive $4 and $7, $3 and $6, and $2 and $5 respectively per attributed members for meeting the 60th, 50th, and 40th percentiles.

D. Quality Performance Payments

1) Eligibility: All CPC+ track 1 and track 2 providers will be eligible for an annual performance payment if the PCCM provider meets the requirements described below.
2) Methodology:
   a) CPC+ providers that achieve annual performance benchmarks determined by Montana Medicaid are eligible to receive performance payments.
   b) Quality and utilization measures and performance benchmarks are reviewed annually and set using Montana-specific population health data, data from NCQAs Quality Compass databased for the Medicaid (HMO) line of business, Health People 2030 goals, and CMS published Child and Adult Core Measures.
   c) Changes to quality benchmarks will be included in annual CPC+ provider contracts.
   d) The CPC+ PCCM has one year after the performance period ends to submit the required clinical data to Montana Medicaid.
   e) The incentive payment differs based on the Track to which the PCCM provider is assigned. Providers in track 2 will receive a slightly higher performance-based payment due to the more complex and robust care management capabilities required of the practice.
   f) Payments will be distributed to each PCCM based on the number of Medicaid members attributed to the PCCM. Members are only included in the calculation if they were attributed to the PCCM for a minimum of nine months of the performance period.

g) Numerators and denominators for each measure are determined by the attributed members that meet the inclusion criteria and meet the benchmark for the measure.
h) When providers meet the benchmark for a quality measure, they are paid a fee per member attributed to the clinic and meeting the inclusion criteria for that measure. The fees are $0.38 per measure for Track 1 Clinics and $0.60 for Track 2 Clinics. There are no partial payments if providers do not meet the benchmark.