MODEL APPLICATION TEMPLATE FOR STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT STATE CHILDREN'S HEALTH INSURANCE PROGRAM

Preamble

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children's Health Insurance Program (SCHIP). Title XXI provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner. To be eligible for funds under this program, states must submit a state plan, which must be approved by the Secretary. A state may choose to amend its approved state plan in whole or in part at any time through the submittal of a plan amendment.

This model application template outlines the information that must be included in the state child health plan, and any subsequent amendments. It has been designed to reflect the requirements as they exist in current regulations, found at 42 CFR part 457. These requirements are necessary for state plans and amendments under Title XXI.

The Department of Health and Human Services will continue to work collaboratively with states and other interested parties to provide specific guidance in key areas like applicant and enrollee protections, collection of baseline data, and methods for preventing substitution of Federal funds for existing state and private funds. As such guidance becomes available, we will work to distribute it in a timely fashion to provide assistance as states submit their state plans and amendments.

MODEL APPLICATION TEMPLATE FOR STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT STATE CHILDREN'S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory:___ _____ MONTANA_____
(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, **(42 CFR, 457.40(b))**

_____
(Signature of Governor, or designee, of State/Territory, Date Signed)

submits the following State Child Health Plan for the State Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved State Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following state officials are responsible for program administration and financial oversight **(42 CFR 457.40(c))**:

Name: Mary Dalton	Position/Title: State Medicaid and CHIP Director
Name: Jaqueline Forba	Position/Title: HMK Program Manager
Name: Katherine Buckley-Patton	Position/Title: HMK Section Supervisor

Section 1. General Description and Purpose of the State Child Health Plans and State Child Health Plan Requirements (Section 2101)

1.1 The state will use funds provided under Title XXI primarily for (Check appropriate box) (42 CFR 457.70):

1.1.1 ☐ Obtaining coverage that meets the requirements for a separate child health program (Section 2103); OR

1.1.2. ☐ Providing expanded benefits under the State's Medicaid plan (Title XIX); OR

1.1.3. ☒ A combination of both of the above.

Montana has had a separate child health program since 1999. Effective October 1, 2009, income eligibility guidelines will increase from 175% of the federal poverty level (FPL) to 250% of the FPL. The name of the program will change from Montana Children's Health Insurance Plan (CHIP) to the Healthy Montana Kids (HMK) coverage group of the Healthy Montana Kids Plan.

Effective October 1, 2009, DPHHS is implementing a CHIP-funded Medicaid Expansion Program for children 6-18 years of age whose family's income is at or below 133% of the FPL. Children enrolled in the CHIP-funded Medicaid Expansion Program must meet all Medicaid eligibility requirements. They will receive the Medicaid package of benefits and access to the Medicaid network of providers. Provider reimbursement will be at the Medicaid provider rates. The CHIP-funded Medicaid Expansion Program will be part of the Healthy Montana Kids *Plus* coverage group of the Healthy Montana Kids Plan.

1.2 ☒ Please provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. (42 CFR 457.40(d))

Expenditures for child health assistance will not be claimed as certified on the CMS-21 expenditure report prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS.

1.3 ☒ Please provide an assurance that the state complies with all applicable

civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. (42CFR 457.130)

Montana complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35.

1.4 Please provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this plan or plan amendment (42 CFR 457.65):

Effective date: October 1, 2009

Implementation date: October 1, 2009

Section 2. General Background and Description of State Approach to Child Health Coverage and Coordination (Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))

2.1. Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). (42 CFR 457.80(a))

The 2003 Montana Household Survey was conducted as a stratified random digit dial telephone survey. The data were collected by the Survey Research Center at the University of Montana – Missoula, Bureau of Business and Economic Research. The survey collected information on the health insurance status of each person in the household and some demographic information about the primary wage earner in the household. Seventeen percent (17%) or approximately 41,723 children between ages 0 through 18 were uninsured at all income levels and approximately 35,900 uninsured children lived in households at or below 200% FPL.

2.2. Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: (Section 2102)(a)(2) (42CFR 457.80(b))

2.2.1. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs (i.e., Medicaid and state-only child health insurance):

Montana has several efforts in place to identify and enroll all uncovered children who are eligible to participate in public health insurance

programs.

Montana developed and maintains a statewide network of over 700 community partners, including health care providers, community advocacy groups, and other related agencies to increase awareness of the program, distribute applications, and offer enrollment assistance to families. In 2008, DPHHS distributed over 13,000 brochures and applications through this network.

In each of the past two years, DPHHS has conducted a comprehensive back-to-school campaign in the fall. Approximately 35,000 postcards with the theme " Healthy Children Learn Better" were distributed to nearly 200 schools in 2008.

In early 2006 DPHHS conducted a statewide media campaign, including television, radio, and print advertising. Department staff produced all of the campaign materials in-house. A similar campaign will be conducted in support of the implementation of the Healthy Montana Kids program in the summer of 2009.

DPHHS staffs a telephone help-line for calls from Montanans in response to outreach campaigns, marketing, etc. Our staff is knowledgeable about requirements and services available from public health programs and Medicaid-funded programs. The staff responds to public inquiries, coordinates with these programs, and makes referrals.

Montana's services and programs intended to assure health care access include:

1. Public health referral systems—Women, Infants and Children (WIC)

Nutrition programs and public health home visiting services include assessment of high-risk conditions such as developmental, nutritional, psycho-social, and income factors. Clients with health care needs are referred to eligibility workers in local settings who determine whether the client is eligible to be covered by Medicaid-funded or CHIP-funded programs. In the case of programs for high-risk pregnant women, home visiting services and others may also do an initial screen for Medicaid eligibility authorizing clients for presumptive eligibility. WIC is funded with United States Department of Agriculture funding and public health home visiting is funded with a combination of Title V and State general fund resources.

2. Federally Qualified Health Centers—Montana has fifteen federally qualified health centers, and twenty six Community Health Centers (CHCs) (fifteen centers and eleven satellites), five Urban Indian Clinics and one Migrant Health Clinic (with several satellite sites operated seasonally). Each facility has the resources to determine presumptive Medicaid eligibility, and distribute applications for Medicaid-funded and CHIP-funded programs . CHCs must also provide services regardless of the client' s ability to pay. Four of the Community Health Centers are co-located with public health departments and make referrals to assure access to health care. Community Health Centers use standard procedures to determine appropriate pay level for each client including providing a financial screen for each new patient or family, providing information on and explanation of services for which family members are eligible, assisting with completing applications and collecting required documentation, determining eligibility on-site or forwarding applications to the determining agency, communicating with family members about eligibility status, and assisting families when their

financial situation and eligibility changes.

3. Children's Special Health Services (CSHS)—CSHS provides coverage for a limited number of children who have special health care needs. This program sponsors multi-specialty clinics and provides reimbursement for health care services if Medicaid or other health care insurance does not cover the services. The application for the CSHS program includes income determination to screen for Medicaid eligibility. CSHS program activities are funded with Title V resources.

4. Family Planning programs are contract services that identify clients in need of primary care services. They specifically target low-income clients. These clinics identify funding sources available to pay for preventive health services, including Medicaid and other insurance, and refer clients appropriately to those resources. The state supports Family Planning clinics with Title X funding, and local contributions may include Title V and other resources.

5. Rural Health Clinics (RHC) and National Health Service Corp (NHSC) providers are a loose network of primary care services throughout the state that allows clients to pay on a sliding fee scale. Twenty-three (23) RHCs provide services on a sliding fee scale, and 18 NHSC providers, located in federally designated shortage areas, provide services on a sliding fee scale. RHCs may refuse service to clients, but NHSC must accept any client regardless of ability to pay.

6. Part C of the Individuals with Disabilities Education Act provides statewide early intervention services to meet the needs of Montana's infants and toddlers with diagnosed disabilities or with developmental

delays that warrant concern for a child' s future development. Children deemed eligible for Part C Services in Montana who appear Medicaid eligible are referred to the local county office for a Medicaid eligibility determination.

7. Montana' s Children' s Mental Health Services Plan (CMHSP) provides basic outpatient and other limited mental health services through a single statewide fee-for-service program. CMHSP is not an insurance plan, but a capped appropriation. The Department of Public Health and Human Services (DPHHS) staff perform eligibility determinations. Clients who appear Medicaid eligible in the screening process are referred to the appropriate county office.

8. Medicaid provides health coverage for low-income, elderly, blind and disabled Montanans who have limited resources. Infants born to Medicaid-enrolled women typically remain Medicaid eligible for twelve months. Family income for children ages zero(0) through eighteen cannot exceed 133% of poverty. DPHHS administers the Medicaid Program and county public assistance offices determine eligibility for Medicaid, Temporary Aid to Needy Families (TANF), and Supplemental Nutrition Assistance Program (SNAP).

9. Federally Qualified Health Centers, Health Care Clinics, Migrant Health Clinics, Tribal Health Clinics, and Indian Health Services facilities are presumptive Medicaid eligibility sites for pregnant women. Staff at these sites helps people apply for Medicaid by providing assistance in completing the application and then forwarding the application to county public assistance offices for eligibility determination.

Outreach to inform potential recipients about Medicaid is accomplished through the previously noted resources and by distributing Medicaid information to many health care advocacy groups and providers in Montana. Montana reaches thousands of children in the CHIP-funded outreach process, many of whom are Medicaid eligible.

2.2.2. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-private partnership:

Montana has no health insurance programs that involve a public-private partnership.

2.3. Describe the procedures the state uses to accomplish coordination of SCHIP with other public and private health insurance programs, sources of health benefits coverage for children, and relevant child health programs, such as title V, that provide health care services for low-income children to increase the number of children with creditable health coverage. (Previously 4.4.5.) (Section 2102)(a)(3) and 2102(c)(2) and 2102(b)(3)(E)) (42CFR 457.80(c))

Special outreach and coordination efforts are in place among HMK, Children' s Mental Health Services Plan and Children' s Special Health Services. If a child applies for one program and doesn' t qualify, or if the child may be served by more than one program, the child is appropriately referred. The state continues to streamline enrollment procedures and collaborative outreach efforts to further the plan' s goal to coordinate with other public and private programs. Families that do not qualify for HMK coverage receive information about other health care resources, which include Montana Youth Care, Community Health Clinics, Shriner' s Hospital, Angel Flight, and many other health care resources, as appropriate.

Montana' s outreach and enrollment efforts are designed to maximize the number of children served under the Medicaid-funded and CHIP-funded programs. (We have no health insurance programs that involve a public-private partnership.) The state coordinates enrollment efforts with:

- Local public health departments
- WIC
- School Nutrition and Health Programs
- Federally Qualified Health Care Centers which include Community, Urban Indian, and Migrant Health Centers
- Case Management Providers
- Family Planning and Planned Parenthood Centers
- Rural Health Clinics
- Children' s Special Health Service Plan
- County Eligibility Case Managers and TANF Case Managers
- Indian Health Services
- Tribal Health Services
- Early Intervention Services (Part C)
- Child Support Enforcement
- Child Protective Services
- Head Start and Early Head Start
- Other Programs as they are identified

These providers:

- Inform participants in their programs of the Healthy Montana Kids Plan
- Distribute brochures and applications for the Healthy Montana Kids Plan

Section 3. Methods of Delivery and Utilization Controls (Section 2102)(a)(4))

☐ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 4.

3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of financing and the methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. (Section 2102)(a)(4) (42CFR 457.490(a))

Montana' s population is approximately 957,861. Of this number, excluding Medicare Advantage Plan enrollees, there are approximately 43,693 HMO certificate holders receiving health care services through a Health Maintenance Organization (HMO). A low penetration rate for managed care required that Montana rely primarily on indemnity insurance plans for coverage . DPHHS offered to contract with indemnity plans willing to meet the contracting criteria. In this way, DPHHS hoped to offer clients a choice in the more populated areas of the state. Until September 2006, DPHHS contracted with one indemnity plan, Blue Cross Blue Shield of Montana, and no HMOs.

In an effort to decrease administrative expenses, DPHHS issued a Request for Proposal (RFP) for Third Party Administrative (TPA) Services in early 2006. DPHHS contracted with Blue Cross Blue Shield of Montana for TPA services effective October 1, 2006.

The third party administrative (TPA) contract addresses the following areas: cost sharing, enrollment, marketing, benefits, premiums, provider network, utilization management, quality of care, access to care, member rights, civil rights, and grievance procedures. Contract standards are based on a review of standards from the following sources: National Association of Insurance Commissioners (NAIC) Model Acts, National Committee for Quality Assurance

(NCQA) Accreditation Standards, and existing Medicaid contracts.

Montana may vary significantly from provider standards established in other states. Montana is a frontier state characterized in the east by sparsely populated plains and in the west by small clusters of populations separated by mountain ranges. Given the diversity in geography and population density, Montana is unable to use a single distance and/or travel time to gauge adequacy of a provider network. Instead, availability of primary care practitioners and specialists in the normal service delivery area is decided for each town or locale. This model which is used by HMK has proven successful in our Medicaid PASSPORT program (our primary care case management model) that has been in operation since 1993. We find in a frontier state such as Montana this case-by-case approach is more meaningful to clients who are accustomed to, and often choose to, live extended distances from services.

Essential Community Providers:

The TPA contractor is required to offer a provider network contract to Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), Title X Family Planning providers, Indian Health Service providers, Tribal Health providers, Urban Indian Centers, Migrant Health Centers and county public health departments. The contract must offer terms and conditions at least as favorable as those offered to other entities providing the same or similar services. This provision is only in effect, however, if the afore-named entities substantially meet the same access and credentialing criteria as other contract providers and only for geographic areas jointly served by the entities and the plan.

3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children. Describe the systems

designed to ensure that enrollees receiving health care services under the state plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved state plan. (Section 2102)(a)(4) (42CFR 457.490(b))

The TPA contractor performs primary utilization management functions. Contract standards require adequate staff and procedures to ensure services provided to enrollees are medically necessary and appropriate. At a minimum, the TPA Contractor must address the use of referrals, prior authorizations, and client educational services.

The TPA Contractor must comply with requirements of applicable Montana law and rules governing health care quality control.

The TPA contractor' s physician incentive plans shall include no specific payment directly or indirectly to a physician or physician group as an inducement to reduce or limit medically necessary benefits furnished to a child.

The TPA Contractor is required to have an external quality review process.

DPHHS must approve the complaint resolution process for addressing enrollees' complaints and appeals. Upon enrollment, and at least annually thereafter, the TPA Contractor must inform enrollees of the complaint resolution process. The TPA Contractor must submit quarterly reports to DPHHS summarizing any complaint handled during the previous quarter. DPHHS must review all contractor complaint decisions.

The TPA Contractor must submit Healthcare Management Reports on a quarterly basis and the following HEDIS measures on an annual basis: access

to primary care, childhood immunization status, adolescent immunization status, appropriate use of asthma medications, well-child visits (in the first 15 months and annually from age three to six) and adolescent well-care visits.

The TPA Contractor encourages the use of a primary care provider (PCP) to serve as a child' s medical home. The PCP should perform all routine non-emergency care for the child and make necessary arrangements for a child who needs referral to a specialist or hospital. A specialist could serve as a child' s primary care provider. The state Medicaid program has extensive experience in using a PCP system and offers technical assistance.

The TPA Contractor includes in its educational materials for enrollees and providers information about additional services available to children with special health care needs. Examples of these services are the Children' s Mental Health Services Plan, Children' s Special Health Services (Title V), public health case management services for pregnant women and children.

Section 4. Eligibility Standards and Methodology. *(Section 2102(b))*

☐ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 5.

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. (Section 2102)(b)(1)(A)) (42CFR 457.305(a) and 457.320(a))

4.1.1. ☐ Geographic area served by the Plan:

4.1.2. ☒ Age: The HMK coverage group (separate CHIP program) is available to children ages zero through eighteen. Coverage for a child will continue through the end of the month of the child' s 19th birthday.

4.1.3. ☒ Income: Children from families whose adjusted gross income is at or below 250% of the federal poverty level are eligible for the HMK coverage group (CHIP) effective October 1, 2009. Earned (wages, tips, salaries, etc.) and unearned (child support, unemployment, etc.) income is counted when determining adjusted gross income. Any income excluded by other federal statute is not counted.

The current Medicaid eligibility guidelines are up to 133% FPL for children less than 6 years of age and up to100% FPL for children between 6 and 18 years of age.

The proposed CHIP-funded Medicaid expansion program will provide HMK Plus coverage group benefits for children 6 -18 years of age with family incomes between 101% and 133% FPL. All eligible children in a family regardless of the age of the

children will have HMK Plus coverage if the family income is 133% FPL or less. This standard eligibility guideline makes it easier for families because the children are enrolled in the same coverage group, have the same benefits and provider network.

During FFY 2010 CHIP members who are 6-18 years of age and have family incomes at or below 133% FPL will transition to the CHIP Medicaid expansion program in the HMK Plus coverage group at the time of their annual renewal. Due to this staggered transition to the CHIP Medicaid expansion program, there will be a declining number of children with incomes below 133% FPL in the HMK coverage group (CHIP). Within 12 months all eligible children with family incomes at or below 133% FPL will be enrolled in HMK Plus and those with family incomes between 134% and 250% will be in the HMK coverage group.

DPHHS excludes $1,440 per year for each family member whose earned-income is counted. DPHHS also excludes $2,400 per year for each person for whom dependent care is paid. Montana DPHHS did not revise these two income disregards when the income change was made from to 175% -250% FPL.

For purposes of determining financial eligibility for the HMK coverage group, a family unit consists of:

1. The child for whom the family is applying
2. The natural or adoptive parents of the child
3. The spouse of the child' s natural or adoptive parent
4. The child' s siblings (natural, adoptive, half, or step) from ages zero through eighteen, with the following

exception: If a sibling between ages 19 through 22 is attending school, he or she may be counted in the family unit.

5. The child' s (i.e., emancipated minor) spouse

An unmarried emancipated minor who applies for the program is considered his or her own family.

Effective October 1, 2009, DPHHS requires income verification when a family applies for the HMK Plan. Families are required to provide documentation for all countable income.

4.1.4. ☐ Resources (including any standards relating to spend downs and disposition of resources):

4.1.5. ☒ Residency (so long as residency requirement is not based on length of time in state): U.S. Citizenship and Montana residency are required. A Montana resident is anyone who declares him-or-herself to live in the state, including migrant and other seasonal workers. The parent is required to certify on the application that the child is a U.S. citizen, or Qualified Alien and a Montana resident. Montana follows federal guidelines in determining whether a child is a U.S. citizen, or Qualified Alien.

DPHHS requires citizenship verification for the HMK Plus coverage group including the CHIP-funded Medicaid expansion program. DPHHS is implementing citizenship verification for the HMK coverage group effective October 2009. DPHHS allows enrollment in the HMK Plan (HMK and HMK Plus) with a reasonable opportunity to verify citizenship or residency status. If the HMK application states the child was born in Montana,

DPHHS will verify citizenship through Montana vital records. When the Social Security Administration's citizenship electronic verification system is available, DPHHS will apply for access. Until the SSA electronic database is available for citizenship verification, DPHHS will require original documents for verification of citizenship or residency status for children not born in Montana.

4.1.6. ☒ Disability Status (so long as any standard relating to disability status does not restrict eligibility): No child is denied eligibility based on disability status. If the child receives SSI and is eligible for Medicaid, the child is denied coverage because of Medicaid eligibility not for disability status.

4.1.7. ☒ Access to or coverage under other health coverage: A child is found ineligible when: 1) the child is covered under a group health plan or under health insurance coverage as defined in section 2791 of the Public Health Service Act; 2) the child is eligible for Medicaid; or 3) the child is eligible to receive health insurance benefits under Montana's state employee or Montana University System employee benefit plans.

4.1.8. ☒ Duration of eligibility: Eligibility is redetermined every 12 months. Once a child is determined eligible, he or she remains eligible unless the child moves from the state, moves in-state and DPHHS is unable to locate the family, family initiates an application and is found eligible for the HMK *Plus* coverage group, is eligible for the state employee or Montana University System employee benefit plans, is found to have other creditable health insurance coverage, turns 19, dies, becomes an inmate of

a public institution, or the applicant fails to reapply or reapplies and the child is determined ineligible.

Eligible children on the initial application will have the same 12 month continuous eligibility period. Children who enroll at a later date may receive less than 12 months of continuous eligibility during their first year of enrollment. DPHHS chose to add the new child to the existing eligibility period in order to synchronize the reapplication/renewal period for all children in the family. Without this policy, a family would be required to re-apply for coverage for various children in the family at multiple times throughout the year.

4.1.9. ☒ Other standards (identify and describe): A Social Security Number (SSN) is required for a child who applies for benefits. Services are not denied or delayed to an otherwise eligible child pending issuance of the child' s SSN. The program follows all HIPAA related confidentiality standards and restricts the use or disclosure of information concerning applicants and enrollees to purposes directly connected with administration of the plan.

4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102)(b)(1)(B)) (42CFR 457.320(b))

4.2.1. ☒ These standards do not discriminate on the basis of diagnosis.
4.2.2. ☒ Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.
4.2.3. ☒ These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3. Describe the methods of establishing eligibility and continuing enrollment. (Section 2102)(b)(2)) (42CFR 457.350)

DPHHS will implement a combined application for the HMK Plan. This application will be distributed statewide and is accessible on the Internet. Both the HMK Plan office and county Offices of Public Assistance will continue accepting and processing previous versions of the programs' applications.

DPHHS will accept and determine eligibility for all applications for children' s health coverage provided by the Healthy Montana Kids Plan. Applications may be submitted directly to the Healthy Montana Kids Plan office or any county Office of Public Assistance (OPA). DPHHS staff in each location will screen for potential eligibility for the HMK Plan. Staff at the OPA and HMK Plan offices will coordinate eligibility determination activities and enroll eligible children in the appropriate HMK Plan coverage group, HMK or HMK *Plus*.

DPHHS is developing and implementing a computerized eligibility determination system for DPHHS health and social service programs e.g. Medicaid, Supplemental Nutrition Assistance Program (SNAP), etc. The HMK Plan will be a module in this eligibility determination system. The system will improve the accuracy and coordination between the HMK Plan coverage groups and with other DPHHS programs.

DPHHS performs the following functions as part of the eligibility determination process:

- Log and scan applications and pertinent documents into the electronic file system;
- Process applications;
- Determine eligibility;
- Refer applicants to Children's Special Health Services, Children's Mental Health Services, Montana Community Health Centers, or private health plans, as appropriate (Referral to other programs will not stop the HMK Plan eligibility determination process.);
- Staff a toll-free information number families may call to receive information about children's health coverage and eligibility;
- Send annual renewal notices to enrollees;
- Provide support for application and outreach sites;
- Provide a complaint process for applicants;
- Facilitate a smooth transition between different DPHHS providers and private insurances;
- Provide eligibility data needed for annual reports; and
- Conduct Quality Assurance Audits.

Eligibility Determination:

Children ages zero to 19 in families whose countable income is at or below 250% of the federal poverty level are eligible if all other eligibility criteria are met.

DPHHS eligibility is determined within forty five calendar days of receipt of a completed application. Children are not presumptively eligible for the HMK

coverage group during this period. By the 45th calendar day, a letter is sent to the family notifying them of the children' s eligibility status or requesting more information to complete the application process.

The eligibility determination time period for the application begins the first of the month after DPHHS receives the application. DPHHS processes the application and will contact the family if additional information is required.

Enrollment in the Health Plan:

Eligible children are enrolled on the first day of the month after the Department receives the application. For example, an application is received on October 15th and children are determined eligible on November 10th. Enrollment is November 1st.

Redetermination of Eligibility:

Children are continuously eligible unless the child' s status changes (see Section 4.1.8). Applicants must complete and submit a renewal application every twelve months. The renewal application is pre-printed with some information and is sent to the applicant for review and update. If the completed renewal application is not returned, the coverage terminates. Applicants may reapply for coverage at a later date. Children will not, however, be given preference for coverage and may be placed on the waiting list, if one exists. Enrollment is subject to available funding.

The following is a schedule of renewal mailings sent to families.

- About nine and one-half months after children are determined eligible, a postcard notifies the family a renewal packet will soon be mailed.
- Renewal packets are mailed to families 10 months after children are determined eligible.

- Reminder cards are mailed 11 months after children are determined eligible if the renewal packet was not completed and returned (30 days before enrollment is scheduled to end).

4.3.1 Describe the state's policies governing enrollment caps and waiting lists (if any). (Section 2106(b)(7)) (42CFR 457.305(b))

☐ Check here if this section does not apply to your state.

Montana currently has no waiting list, but our enrollment is limited by federal and state funds that have been appropriated to the program. If Montana should need to establish a waiting list in the future, the following procedure will be implemented. When the maximum number of children is enrolled, the enrollment is capped and a waiting list is established. The waiting list is for children determined eligible but for whom space is not available. Children are placed on the waiting list in the order in which they are determined eligible. Applicants are notified in writing if their children are eligible and placed on the waiting list. Applicants are also informed that they can contact DPHHS to inquire about their child' s position on the waiting list. Spaces become available at the end of each month when enrollment ends for currently enrolled children who:

1. turned age 19;
2. became eligible for HMK Plus coverage;
3. became eligible for state employee or Montana University System employee health insurance plans;
4. obtained coverage under another insurance;
5. moved out of state;
6. failed to reapply;
7. reapplied but were determined ineligible;
8. moved within the state and DPHHS is unable to locate the family; or
9. died.

When space becomes available, children are removed from the waiting list and enrolled until all spaces are filled. Applicants are notified in writing when their children are taken off the waiting list and are enrolled. Children on the waiting list are enrolled based on when they are determined eligible.

If space is available for at least one child, families with more than one eligible child on the waiting list will have all children enrolled at the same time. The children will all have the same enrollment date.

A child determined eligible who has a sibling already enrolled will not be placed on the waiting list. The newly eligible child is enrolled the first of the month after the Healthy Montana Kids Plan is notified. The renewal date for the newly eligible child will be the same as currently enrolled sibling.

Note: There is no waiting list for the HMK Plus coverage group, including the CHIP Medicaid expansion program.

4.4. Describe the procedures that assure that:

4.4.1. Through the screening procedures used at intake and follow-up eligibility determination, including any periodic redetermination, that only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including a state health benefits plan) are furnished child health assistance under the state child health plan. (Section 2102)(b)(3)(A)) (42CFR 457.350(a)(1) and 457.80(c)(3))

The application asks if a child applying for health coverage was covered by health insurance within the past three months. If the answer is yes and the coverage did not end due to one of the allowable exceptions, the child is not eligible for coverage.

Montana' s high number of families living below 250% FPL and high rate of uninsured children, coupled with Montana' s economy, are indicators that Montana' s low-income children are uninsured because their parents are unable to afford dependent health insurance. More than 50% of Montana' s employers are small employers (less than 50 employees) and most are unable to provide health insurance benefits for their employees. Health insurance plans in Montana give no indication children are moving from private insurance to publicly funded insurance.

The application asks the applicant to report any health insurance coverage and access to the state or Montana University System employee health benefit plans. If the family reports creditable coverage or access to the state or Montana University System employee health benefit plans, as defined in section 2791 of the Public Health Service Act, the child is found ineligible. DPHHS instituted an electronic data match of state and Montana University System employee health benefit plans enrollment files. The TPA Contractor, Blue Cross Blue Shield of Montana (BCBSMT) is the largest health insurance carrier in Montana and is required contractually to notify DPHHS whenever they have reason to believe an enrollee has other coverage. DPHHS staff investigate and if the child has other creditable insurance coverage, coverage will end.

4.4.2. The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan under Title XIX. (Section 2102)(b)(3)(B)) (42CFR 457.350(a)(2))

DPHHS staff screen applicants for HMK *Plus* eligibility.

4.4.3. The State is taking steps to assist in the enrollment in SCHIP of children determined ineligible for Medicaid. (Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR 431.636(b)(4))

If department staff determine a child is ineligible for HMK *Plus,* the staff will evaluate the application for HMK eligibility.

4.4.4 The insurance provided under the state child health plan does not substitute for coverage under group health plans. Check the appropriate box. (Section 2102)(b)(3)(C)) (42CFR 457.805) (42 CFR 457.810(a)-(c))

4.4.4.1. ☒ Coverage provided to children in families at or below 200% FPL: describe the methods of monitoring substitution.

Families must indicate on the HMK application if the children had insurance during the past three months prior to application.

A child is ineligible if he or she has been covered under a creditable health plan during the minimum three month " insurance delay period" prior to applying. The three month period is waived if,

1) The parent or guardian providing the insurance:

a. dies;

b. is terminated or laid off;

c. can no longer work because of a disability;

d. has a lapse in insurance coverage because he or she obtains new employment;

e. had insurance coverage that ended because the step-parent, who provided the coverage, and the parent divorced;

f. had coverage through the Insure Montana Program;

g. had coverage through the Medicaid Health Insurance Premium Payment Program;

h. paid more than 50% of the insurance premium; or

i. has insurance coverage that is not accessible (e.g. coverage is through an HMO in another state).

4.4.4.2. ☒ Coverage provided to children in families over 200% and up to 250% FPL: describe how substitution is monitored and identify specific strategies to limit substitution if levels become unacceptable.
See response to 4.4.4.1.

4.4.4.3. ☐ Coverage provided to children in families above 250% FPL: describe how substitution is monitored and identify specific strategies in place to prevent substitution.

4.4.4.4. ☐ If the state provides coverage under a premium assistance program, describe:

The minimum period without coverage under a group health plan, including any allowable exceptions to the waiting period. Not applicable

The minimum employer contribution. Not applicable

The cost-effectiveness determination. Not applicable

4.4.5 Child health assistance is provided to targeted low-income children in the state who are American Indian and Alaska Native. (Section 2102)(b)(3)(D)) (42 CFR 457.125(a))

DPHHS works directly with tribes, the Indian Health Service, Tribal Health Services, and Urban Indian Centers to inform Native Americans in Montana about the HMK

Plan. The TPA Contractor is required to offer a provider contract to Urban Indian Centers, Indian Health Service and Tribal Health Service providers who meet certification qualifications. See Sections 3.1 and 9.9 for more information.

If any child determined eligible is identified as Native American or an Alaska Native, there is no cost-sharing for that family. The identification card each child receives from the TPA Contractor indicates that no co-payment is required when that child receives services.

Section 5. Outreach (Section 2102(c))

Describe the procedures used by the state to accomplish:

Outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program: (Section 2102(c)(1)) (42CFR 457.90)

A media campaign to reach families with children potentially eligible for health coverage will be conducted in FFY 2009 and 2010. Media message commercials will be broadcast on radio and television and news releases published in daily and weekly newspapers, specialty publications and professional association newsletters. Additionally, many DPHHS providers display applications in their waiting rooms.

Assumptions about the target population are based on the experience of the Medicaid Program, social services programs, health care agencies and providers. For an audience consisting of families with a variety of financial needs, DPHHS must appeal both to those who have regular interaction with human service agencies, and to working low-income families who traditionally avoid government programs. Outreach efforts emphasize this is a low-cost health coverage plan that is a collaborative effort between families and the state and federal governments to ensure children receive health care.

Direct Appeal to Eligible Families through Press Releases, Public Service Announcements, Brochures, Posters, and Videos:

DPHHS airs radio and television public service announcements about health care coverage programs for children. A toll-free number to call for more information is featured in the public service announcements, printed materials, and press releases. Occasional news releases are sent to the media about the

increased insurance coverage available to children. Radio stations, TV and cable stations, Montana daily and weekly newspapers, and specialty publications and newsletters for professional associations in children's health care, parenting, day care, and education receive the press releases and news items.

Outreach methods, other than written materials, are employed whenever possible. All outreach materials prominently feature DPHHS toll-free telephone number. Callers to the toll-free number speak to a customer service representative or leave their name and address to receive an application. Brochures and posters are prominently displayed in locations frequented by low-income families with children.

Outreach through Schools:
DPHHS collaborates with Healthy Mothers Healthy Babies (Covering Kids grantee) and the Office of Public Instruction to conduct back-to-school enrollment campaigns in school districts statewide. Information is sent to schools to help conduct outreach. School nurses and counselors are an important part of school-based outreach. Articles and information in school newspapers is another way to reach families. DPHHS works with the Free-and-Reduced School Lunch Programs to distribute information to families.

Outreach through Collaboration with Local Agencies, Grassroots Organizations, and Providers:
Outreach training sessions on eligibility are provided to a variety of staff including: county public health departments, county social services, WIC coordinators, county public assistance offices, family resource centers, churches, the program for Children with Special Health Care Needs, community-centered boards of grassroots organizations, Child Care Resource

and Referral agencies, tribal health and social services staff, and Head Start.

Outreach is conducted through DPHHS home visits and case management programs. Home visitors give HMK Plan information and answer questions from pregnant women, parents and families.

DPHHS works with Native American leaders, both urban and reservation, to develop specific outreach activities for this population.

Outreach through Collaboration with Statewide Maternal Child Health Organizations:

DPHHS staff operate the Maternal Child Health (MCH) toll-free help line which dispenses information about MCH programs, HMK and other health coverage programs and resources.

The Montana Council for Maternal and Child Health does a series of community forums every other year where family health care issues are discussed. They prominently feature children's health coverage program information in these forums.

Applications are available to families at FQHCs, community health and public health centers, IHS tribal sites, county Offices of Public Assistance, WIC offices, health care providers' offices, numerous community locations, and on the Internet at www.HMK.mt.gov. While many of these sites have personnel or advocates available to assist families in completing the application, the eligibility determination is not actually performed at these sites.

The Healthy Montana Kids Plan staff work closely with the Family and Community Health Bureau, which administers Montana's MCH Title V Block

Grant to ensure maximum coordination between programs.

Outreach through HMK Plan Enrollment Partners

The department will also conduct outreach through the following qualified entities: licensed health care providers, school districts, community-based organizations, government agencies and Indian Health Services. The department will consider requests to act as an Enrollment Partner from other entities and approve requests on a case by case basis.

A qualified entity becomes an Enrollment Partner by contacting the department and indicating an interest in becoming an enrollment partner. The department will provide an Enrollment Partner with HMK and HMK Plus materials and applications. Enrollment Partners must complete department sponsored training and provide application assistance to Healthy Montana Kids Plan applicants. The department will maintain a list of the names, addresses, and telephone numbers of its enrollment partners and publish the list on its web site.

Section 6. Coverage Requirements for Children's Health Insurance (Section 2103)

☐ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 7.

6.1. The state elects to provide the following forms of coverage to children: (Check all that apply.) (42CFR 457.410(a))

6.1.1. ☐ Benchmark coverage; (Section 2103(a)(1) and 42 CFR 457.420)

6.1.1.1. ☐ FEHBP-equivalent coverage; (Section 2103(b)(1)) (If checked, attach copy of the plan.)

6.1.1.2. ☐ State employee coverage; (Section 2103(b)(2)) (If checked, identify the plan and attach a copy of the benefits description.)

6.1.1.3. ☐ HMO with largest insured commercial enrollment (Section 2103(b)(3)) (If checked, identify the plan and attach a copy of the benefits description.)

6.1.2. ☒ Benchmark-equivalent coverage; (Section 2103(a)(2) and 42 CFR 457.430) Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431. See instructions.

DPHHS continues to offer benchmark-equivalent coverage of Montana state employee health insurance. The actuarial report and supporting documentation were submitted with the state plan amendment dated August 1, 2000, and remain unchanged

6.1.3. ☐ Existing Comprehensive State-Based Coverage; (Section 2103(a)(3) and 42 CFR 457.440) [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If existing comprehensive state-based

coverage is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for existing comprehensive state-based coverage.

6.1.4. ☐ Secretary-Approved Coverage. (Section 2103(a)(4)) (42 CFR 457.450)

- 6.1.4.1. ☐ Coverage the same as Medicaid State plan
- 6.1.4.2. ☐ Comprehensive coverage for children under a Medicaid Section 1115 demonstration project
- 6.1.4.3. ☐ Coverage that either includes the full EPSDT benefit or that the state has extended to the entire Medicaid population
- 6.1.4.4. ☐ Coverage that includes benchmark coverage plus additional coverage
- 6.1.4.5. ☐ Coverage that is the same as defined by existing comprehensive state-based coverage
- 6.1.4.6. ☐ Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Please provide a sample of how the comparison will be done)
- 6.1.4.7. ☐ Other (Describe)

6.2. The state elects to provide the following forms of coverage to children: (Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) **(Section 2110(a)) (42CFR 457.490)**

For the separate CHIP program the following statements apply to all services covered in this section (6.2):

1. There are no pre-existing condition limitations.
2. Experimental procedures, custodial care, personal comfort, hygiene, or convenience items that are not primarily medical in nature, whirlpools, organ and tissue transplants, TMJ treatment, treatment for obesity, acupuncture, biofeedback, neurofeedback, chiropractic services, elective abortions, in vitro fertilization, gamete or zygote intrafallopian

transfer, artificial insemination, reversal of voluntary sterilization, transsexual surgery, fertility enhancing treatment beyond diagnosis, cosmetic surgery, radial keratotomy, private duty nursing, treatment for which another coverage such as workers compensation is responsible, routine foot care, services for members confined in criminal justice institutions, and any treatment not medically necessary are not covered benefits. These exclusions are in addition to any exclusion noted in the individual coverage descriptions.

3. A $1 million lifetime maximum payment for medical benefits per member applies. Eyeglasses, dental and community based psychiatric services (CBPRS) do not count toward the lifetime maximum payment.

   The lifetime maximum is calculated based on total state and federal funds expended.

   The Third Party Administrative (TPA) contractor monitors high cost claims and contacts a family if it appears a child may reach the maximum lifetime maximum payment. The TPA contractor and DPHHS staff work with the family to pursue other coverage options such as HMK Plus, the state " high risk pool" , etc. The program will deny payment for services once the lifetime maximum payment is met. Note: Only one child has reached the lifetime maximum since the inception of the program in 1999.

For the CHIP-funded Medicaid Expansion Program covered services are specified in the Montana Medicaid State Plan.

6.2.1. ☒ Inpatient services (Section 2110(a)(1)): Semi-private room; intensive and coronary care units; general nursing; drugs; oxygen; blood transfusions; laboratory; imaging services;

physical, speech, occupational, heat, and inhalation therapy; operating, recovery, birthing and delivery rooms; routine and intensive nursery care for newborns; and other medically necessary services and supplies for treatment of injury or illness are covered.

Coverage of postpartum care for at least forty-eight hours for vaginal delivery and ninety-six hours for cesarean section is guaranteed.

Services for mental and chemical dependency disorders are outlined in Sections 6.2.10 and 6.2.18.

Organ and tissue transplants are not covered.

6.2.2. ☒ Outpatient services (Section 2110(a)(2)) All services described in 6.2.1 which are provided on an outpatient basis in a hospital (including but not limited to observation beds and partial hospitalization services) or ambulatory surgical center; chemotherapy; emergency room services for surgery, accident or medical emergency; and other services for diagnostic or outpatient treatment of a medical condition, accident, or illness are covered.

Services for mental and chemical dependency disorders are outlined in Sections 6.2.11 and 6.2.19.

6.2.3. ☒ Physician services (Section 2110(a)(3)): Office, clinic, home, outpatient surgical center and hospital treatment for a medical

condition, accident, or illness by a physician, naturopathic physician or advance-practice registered nurse are covered.

Well-child, well-baby, and immunization services as recommended by the American Academy of Pediatrics are covered.

Routine physicals for sports, employment, or required by a government authority are covered.

Anesthesia services rendered by a physician anesthesiologist (other than the attending physician or assistant) or by a nurse anesthetist are covered provided that surgical and/or hospital benefits are also covered. Hypnosis, local anesthesia (unless it is included as part of a global procedure charge), and consultations prior to surgery are not covered.

6.2.4. ☒ Surgical services (Section 2110(a)(4)): Covered as described in 6.2.1, 6.2.2, and 6.2.3. In addition, professional services rendered by a physician, surgeon, or doctor of dental surgery for treatment of a fractured jaw or other accidental injury to sound natural teeth and gums are covered.

Organ and tissue transplants are not covered.

6.2.5. ☒ Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5)): Covered as described for other services described in this Section (6.2).

6.2.6. ☒ Prescription drugs (Section 2110(a)(6)): Coverage includes drugs prescribed by a practitioner acting within the scope of his or her practice. Chemotherapy drugs approved for use in humans by the U.S. Food and Drug Administration, vaccines, and drugs needed after an organ or tissue transplant are covered.

Birth control contraceptives are not covered.

The contractor must use the Medicaid formulary if it chooses to employ a formulary and must notify enrollees and providers which prescription drugs are covered.

Prescribed diabetic equipment and supplies including insulin, syringes, injection aids, devices for self-monitoring of glucose levels (including those for the visually impaired), test strips, visual reading and urine test strips, one insulin pump for the warranty period, accessories to insulin pumps, glucagons emergency kits, and one prescriptive oral agent for controlling blood sugar levels for each class of drug approved by the United States Food and Drug Administration are covered as a prescription drug.

Prescription prenatal vitamins, and medical foods for the treatment of inborn errors of metabolism that involve amino acid, carbohydrate, and fat metabolism, and for which medically standard methods of diagnosis, treatment, and monitoring exist, are covered.

Food supplements and vitamins (with the exception of prenatal vitamins), whether or not requiring a written prescription, are not covered.

6.2.7. ☐ Over-the-counter medications (Section 2110(a)(7))

6.2.8. ☒ Laboratory and radiological services (Section 2110(a)(8)):

Coverage includes imaging and laboratory services for diagnostic or therapeutic purposes due to accident, illness, or medical condition that are not described elsewhere in this section (6.2).

X-ray, radium, and radioactive isotope therapy are covered.

6.2.9. ☒ Prenatal care and prepregnancy family services and supplies (Section 2110(a)(9)): Prenatal care is covered as described for other medical conditions in this Section (6.2). Pre-pregnancy family planning services are covered. Birth control contraceptives are not covered.

Medical or surgical treatment to reverse surgically induced infertility; fertility enhancing procedures beyond diagnosis; and sex change operations are not covered.

6.2.10. ☒ Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10)):

Twenty-one days of inpatient mental health benefits per benefit year are covered. Partial hospitalization services may be

exchanged for inpatient days at a rate of two partial treatment days for one inpatient day. A partial hospitalization program operated by a hospital must comply with the standards for a partial hospitalization program published by the American Association for Partial Hospitalization.

Enrollees with the following disorders are not subject to a limit on covered inpatient mental health benefits provided: schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, and autism.

Enrollees receive the following mental health benefits: prescription drugs, outpatient and inpatient services as outlined in this section and 6.2.11.

Mental health coverage remains equivalent to the actuarial analysis included in the original state plan and approved on September 11, 1998.

6.2.11. ☒ Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11):

Professional outpatient services up to a maximum of twenty visits per year will be paid through the plan. Partial hospitalization services are paid as described in section 6.2.10.

Enrollees with the following disorders are not subject to a limit on covered outpatient mental health benefits: schizophrenia,

schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, and autism.

Mental health coverage remains equivalent to the actuarial analysis included in the original state plan that approved on September 11, 1998.

Enrollees who have a serious emotional disturbance (SED) as determined by a department or department-contracted licensed mental health professional may receive extended mental health services beyond coverage provided under the basic plan. Extended services include:

1) 30 days per benefit year of therapeutic group home services (including room and board).
2) 30 days per benefit year of therapeutic family services (moderate level including in the child' s home).
3) 120 hours per benefit year for day treatment;
4) 120 hours per benefit year for Community Based Psychiatric Rehabilitation and Support (CBPRS);
5) 30 visits per benefit year of individual or family therapy (for child, child with parent, or parent without the child) after the basic plan benefits have been exhausted; and
6) 144 hours per benefit year of respite care.

6.2.12. ☒ Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))

Eyeglasses are provided by a bulk-purchasing contractor and reimbursed directly by the State of Montana, Department of Public Health and Human Services. Eyeglasses are not paid by the TPA Contractor.

Audiological Services—Hearing exams, including newborn hearing screens in a hospital or outpatient setting, are covered. Coverage includes assessment and diagnosis. Hearing aids are covered.

6.2.13. ☐ Disposable medical supplies (Section 2110(a)(13))
6.2.14. ☐ Home and community-based health care services (See instructions) (Section 2110(a)(14))
6.2.15. ☐ Nursing care services (See instructions) (Section 2110(a)(15))
6.2.16. ☒ Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16):

6.2.17. ☒ Dental services (Section 2110(a)(17)):

Each enrollee may receive up to $412 in dental services each benefit year (October 1 through September 30). The dental services are reimbursed at 85% of billed charges, therefore, the maximum payment for the basic dental plan is $350 per benefit year.

Dental services are not included in the medical benefits provided by the plan. DPHHS pays dental services, on a fee-for-service basis. The State of Montana contracts directly with dentists. All services are included except: maxillofacial surgeries and prosthetics, dental implants, surgical procedures, treatment of

fractures, and orthodontia. There are no copayments for dental services.

Effective October 1, 2007, enrollees with significant dental needs beyond those covered in the basic dental plan may receive additional services through the Extended Dental Plan (EDP).

If a dental provider determines a child has significant dental needs which exceed the basic dental plan maximum payment, the provider may submit a prior authorization request for Extended Dental Plan (EDP) coverage. The provider's request must include the projected treatment plan and costs. DPHHS staff will review the provider's request and notify the provider and the family if the child is eligible for EDP coverage.

The type of services covered by EDP is the same type of services covered under the basic plan. For example, since restorations ("fillings") are covered by the basic plan, additional restorations may be approved under the EDP. However, orthodontic services which are not covered under the basic dental plan would not be approved.

Each enrollee who is determined eligible for extended benefits may receive up to $1,176.47 in dental services in the benefit year (October 1 through September 30). Since these services are reimbursed at 85% of billed charges, the maximum payment for EDP services is $1,000 per child per benefit year.

Therefore, if a child has both basic and EDP benefits the child

may receive up to $1,588.47 (basic=$412, EDP=$1,176.47) in services in a benefit year. The maximum payment is $1,350 (basic=$350, EDP=$1,000).

If a dental provider indicates a child needs services above the maximum amounts listed above, prior authorization requests for the Extended Dental Program will be evaluated on a first come-first serve basis.

6.2.18. ☒ Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18)):

The combined benefit for inpatient and outpatient treatment for alcoholism and drug addiction, excluding costs for medical detoxification, is subject to a maximum benefit of $6,000 in a 12-month period. The lifetime inpatient maximum benefit is $12,000. If the lifetime inpatient maximum is met, the annual outpatient benefit is reduced to $2,000. Costs for medical detoxification treatment are paid the same as any other illness and are not subject to the lifetime limits.

6.2.19. ☒ Outpatient substance abuse treatment services (Section 2110(a)(19)):

The combined benefit for inpatient and outpatient treatment for alcoholism and drug addiction, excluding costs for medical detoxification, is subject to a maximum benefit of $6,000 in a 12-month period. The lifetime impatient maximum benefit is $12,000. If the lifetime inpatient maximum is met, the annual outpatient benefit is reduced to $2,000. Costs for medical detoxification treatment are paid the same as any other illness

and are not subject to the lifetime limits.

6.2.20. ☐ Case management services (Section 2110(a)(20))
6.2.21. ☐ Care coordination services (Section 2110(a)(21))
6.2.22. ☒ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))
DPHHS requires prior authorization for occupational, speech and physical therapy services.

6.2.23. ☐ Hospice care (Section 2110(a)(23))

6.2.24. ☒ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) (Section 2110(a)(24)):

Vision Services and Medical Eye Care—Services for the medical treatment of diseases or injury to the eye by a licensed physician or optometrist working within the scope of his or her license are covered. Vision exams and eyeglass dispensing fees are covered.

6.2.25. ☐ Premiums for private health care insurance coverage (Section 2110(a)(25))

6.2.26. ☐ Medical transportation (Section 2110(a)(26))
6.2.27. ☐ Enabling services (such as transportation, translation, and outreach services (See instructions) (Section 2110(a)(27))
6.2.28. ☒ Any other health care services or items specified by the Secretary and not included under this section (Section 2110(a)(28))
Nurse Advice Line access to health information and advice twenty-four hours a day seven days a week is a covered benefit.

6.3 The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan: (42CFR 457.480)

6.3.1. ☒ The state shall not permit the imposition of any pre-existing

medical condition exclusion for covered services (Section 2102(b)(1)(B)(ii)); OR

6.3.2. ☐ The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.4.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA (Section 2103(f)). Please describe: Previously 8.6

6.4. Additional Purchase Options. If the state wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate option. To be approved, the state must address the following: (Section 2105(c)(2) and (3)) (42 CFR 457.1005 and 457.1010)

6.4.1. ☐ Cost Effective Coverage. Payment may be made to a state in excess of the 10% limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the state to administer the plan, if it demonstrates the following (42CFR 457.1005(a)):

6.4.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; Describe the coverage provided by the alternative delivery system. The state may cross reference section 6.2.1 - 6.2.28. (Section 2105(c)(2)(B)(i)) (42CFR 457.1005(b))

6.4.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above; Describe the cost of such coverage on an average per child basis. (Section 2105(c)(2)(B)(ii)) (42CFR 457.1005(b))

6.4.1.3. The coverage must be provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(c)(5)(F) or 1923 of the Social Security Act. Describe the community-based delivery system. (Section 2105(c)(2)(B)(iii)) (42CFR 457.1005(a))

6.4.2. ☐ Purchase of Family Coverage. Describe the plan to purchase family coverage. Payment may be made to a state for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: (Section 2105(c)(3)) (42CFR 457.1010)

6.4.2.1. Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and (Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.) (Section 2105(c)(3)(A)) (42CFR 457.1010(a))

6.4.2.2. The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. (Section 2105(c)(3)(B)) (42CFR 457.1010(b))

6.4.2.3. The state assures that the coverage for the family otherwise meets title XXI requirements. (42CFR 457.1010(c))

Section 7. Quality and Appropriateness of Care

☐ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 8.

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. (2102(a)(7)(A)) (42CFR 457.495(a))

Will the state utilize any of the following tools to assure quality?
(Check all that apply and describe the activities for any categories utilized.)

7.1.1. ☐ Quality standards
7.1.2. ☒ Performance measurement
7.1.3. ☒ Information strategies
7.1.4. ☐ Quality improvement strategies

DPHHS uses HEDIS performance measurements to evaluate care effectiveness for enrollees.

HMK *Plus* and HMK management staff are interested in assuring both programs adhere to continuity and comparability between the measures used. HMK *Plus* currently uses HEDIS measures for its Primary Care Case Management Program (PASSPORT).

.

The contract with the TPA Contractor requires them to collect and report HEDIS data and utilization reports. The following is a list of required measures and required reports:

HEDIS

- Childhood immunization status
- Adolescent immunization status
- Children' s access to primary care providers
- Well-child visits in the first fifteen months of life

- Well-child visits in the third, fourth, fifth, and sixth year of life
- Adolescent well care visits
- Use of appropriate medications for children with asthma

Utilization Reports

- X Healthcare Experience Profile
- X Plan Experience Report
- X Claims Lag Report
- X Summary Experience Report
- X Summary Savings Report
- X Summary Savings by Service Type
- X Statistical Analysis
- X Variance Analysis
- X Claims by Enrollment Demographics
- X Third Party Drug Claims by Therapeutic Group
- X Catastrophic Illness Analysis
- X Claims Distribution Analysis
- X Quality of Care – Indicators
- X Quality of Care - Complexity
- X Medical Claims Cost Analysis
- X Inpatient Utilization for Top 25 Hospitals
- X Inpatient Utilization for Top 25 Physicians
- X Inpatient Utilization by Principal Disease Category
- X Utilization for Top 20 Inpatient Surgeries by Frequency
- X Top 20 Inpatient Surgeries by Cost
- X Outpatient Utilization by Service Type
- X Impatient Utilization by Major Diagnostic Category
- X Outpatient Utilization by major Diagnostic Category
- X Utilization for Top 15 Outpatient Surgeries

DPHHS uses these performance measures, HEDIS, utilization and complaint data to evaluate the TPA Contractor' s performance.

Consumer education tools ensure enrollees have adequate information regarding eligibility and enrollment. DPHHS staff approves the member handbook to assure that benefit, provider network, and complaint procedures are communicated effectively. Other consumer education materials are developed as part of DPHHS' s quality assurance program and based on performance measures' results.

Newsletters are sent to families with enrolled children or children on the waiting list. The newsletters are sent when policy changes may impact families to provide information about benefits and encourage the use of preventive health services.

7.2. Describe the methods used, including monitoring, to assure: (2102(a)(7)(B)) (42CFR 457.495)

7.2.1 Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. (Section 2102(a)(7)) (42CFR 457.495(a))

DPHHS staff monitor the following HEDIS reports to evaluate and assure access to preventative care:

- Childhood immunization status
- Adolescent immunization status
- Children' s access to primary care providers
- Well-baby visits in the first fifteen months of life
- Well-child visits in the third, fourth, fifth, and sixth year of life

- Adolescent well care visits
- Use of appropriate medications for children with asthma
- Mental Health Utilization – Percentage of children receiving inpatient, intermediate care and ambulatory services
- Chemical Dependency Utilization – Percentage of children receiving inpatient, intermediate and ambulatory services
- Ambulatory care – Emergency department visits
- Appropriate treatment of children with upper respiratory infection
- Appropriate testing for children with pharyngitis

7.2.2 Access to covered services, including emergency services as defined in 42 CFR 457.10. (Section 2102(a)(7)) 42CFR 457.495(b))

Access Assurance for Care Delivered through Insurers and the CHIP Provider Network:

Access to services is measured by evaluating and monitoring the adequacy of provider networks and by analyzing the results of complaint data and performance measures. Provider network analysis looks at the number and types of physicians, hospitals and allied health providers of health care for children, their locations, and their hours. The TPA contractor is required to produce a provider network access plan. DPHHS staff evaluates this network as described in Section 3.1. DPHHS staff also annually evaluates access-related performance measures such as access-related complaints and access to primary care physicians (HEDIS).

The TPA contractor submits information each month about the number, type and geographic distribution of network providers. This information is posted on the program's website.

Emergency Services Access:

The contract with the TPA Contractor specifies prior authorization for emergency medical conditions is not required. An emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- placing the health of the child (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
- serious impairment to bodily functions, or
- serious dysfunction of any bodily organ or part.

Access to emergency services is monitored by analysis of complaint data and utilization data.

7.2.3 Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. (Section 2102(a)(7)) (42CFR 457.495(c))

The DPHHS contract with the TPA contractor requires medically appropriate second opinions, which may include major diagnoses or courses of treatment, as a covered benefit. The TPA Contractor is also required to have a system to assure prompt referrals for medically necessary, specialty, secondary, and tertiary care.

7.2.4 Decisions related to the prior authorization of health services are completed in accordance with state law or, in accordance with the

medical needs of the patient, within 14 days after the receipt of a request for services. (Section 2102(a)(7)) (42CFR 457.495(d))

Decisions related to the prior authorization of health services are completed in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. The TPA Contractor aims for a turnaround time of five (5) days.

Section 8. Cost Sharing and Payment *(Section 2103(e))*

☐ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 9.

8.1. Is cost-sharing imposed on any of the children covered under the plan? (42CFR 457.505)

8.1.1. ☒ YES
8.1.2. ☐ NO, skip to question 8.8.

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge and the service for which the charge is imposed or time period for the charge, as appropriate. (Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(c))

8.2.1. Premiums: NONE

8.2.2. Deductibles: NONE

8.2.3. Coinsurance; NONE

Copayments:

A) No co-payment is assessed for families with household incomes equal to or less than 100% o the federal poverty level.

B) No copayment is assessed for families with at least one enrollee who is a Native American or Native Alaskan.

C) Copayments do not exceed the maximum allowable cost-sharing charges in accordance with 42 CFR Part 457.555.

D) Copayments for inpatient hospital services are in accordance with 42 CFR 457.555 (b)

E) For families with household incomes above 100% of the federal poverty level, the following co-payments will apply:

Benefit	Co-payment
Inpatient hospital services (includes hospitalization for physical, mental and substance abuse reasons)	$25 per visit
Emergency room visit	$5 per visit
Outpatient hospital visit (includes outpatient treatment for physical, mental, and substance abuse reasons. Excludes outpatient visits for X-ray or laboratory services only)	$5 per visit
Physician, naturopathic physician, mid-level practitioner, advanced-practice registered nurse, optometrist, audiologist, mental health professional, or substance abuse counselor services (excludes dental, pathology, radiology, or anesthesiology services)	$3 per visit
Outpatient prescription drugs—generic	$3 per prescription
Outpatient prescription drugs—brand-name	$5 per prescription
Mail Order prescription drugs-generic (3 mo. supply)	$6 per prescription
Mail Order prescription drugs-brand name (3 mo. supply)	$10 per prescription
No co-payment applies to well-baby or well-child care, including age-appropriate immunizations.	
Co-payments are capped at $215 per family per benefit year (October 1 – September 30) for families with incomes up to 250% FPL. When the $215 maximum copayment has been met, the TPA contractor issues new member cards indicating no copayment in required for the remainder of the benefit year.	

8.2.4. Other: NONE

8.3. Describe how the public will be notified, including the public schedule, of this cost sharing (including the cumulative maximum) and changes to these

amounts and any differences based on income. (Section 2103(e)((1)(B)) (42CFR 457.505(b))

A description of cost sharing (including the cumulative maximum) is contained in the outreach and educational materials which are distributed to the general public. This information is contained in the Member Handbook which is updated and distributed to all members annually. The copayment requirement, if applicable, is indicated on the ID cards families receive from the TPA Contractor. If a member' s copayment requirement changes, the TPA contractor issues a new ID card which reflects the change.

DPHHS informs enrollees, applicants, providers and the general public of changes to cost sharing by revisions to the above-mentioned documents and revision of the Administrative Rules of Montana (ARMs).

Prior public notice of proposed co-payment changes are provided in a form and manner provided under applicable State law. Public notice is published prior to the requested effective date of the change.

8.4. The state assures that it has made the following findings with respect to the cost sharing in its plan: (Section 2103(e))

8.4.1. ☒ Cost-sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B)) (42CFR 457.530)

8.4.2. ☒ No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2)) (42CFR 457.520)

8.4.3 ☒ No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. (Section 2103(e)(1)(A)) (42CFR 457.515(f))

8.5. Describe how the state will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the state for overpayment by an enrollee: (Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))

Enrollees in the HMK coverage group have co-payments if their family income is greater than 100% of FPL. The insurance card each child receives from the TPA Contractor indicates whether or not a child has a co-payment when services are used. The TPA Contractor tracks the co-payments charged to the family. When the $215 annual family maximum is reached, the TPA Contractor sends the family a letter indicating that the maximum co-payment has been met and a co-payment is not required for the remainder of the benefit year. The TPA contractor issues new ID cards which indicates no copayment is required for the remainder of the benefit year. Enrollment materials notify families how to recoup any excess co-payments they have paid. Families charged more than $215 in co-payments must submit co-payment receipts to DPHHS in order to be reimbursed for copayments they paid above the maximum. DPHHS reimburses the family for any co-payment paid above the $215 maximum payment.

Enrollees in the HMK *Plus* coverage group do not have a co-payment requirement.

8.6. Describe the procedures the state will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. (Section 2103(b)(3)(D)) (42CFR 457.535)

The DPHHS contract with the TPA Contractor requires that families with Native American or Alaska Native children have no co-payment for services.

ID cards for these children state that co-payments are not required.

No enrollees in the HMK *Plus* coverage group, regardless of race, have a co-payment requirement.

8.7. Please provide a description of the consequences for an enrollee or applicant who does not pay a charge. (42CFR 457.570 and 457.505(c))

8.7.1 Please provide an assurance that the following disenrollment protections are being applied:

☐ State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. (42CFR 457.570(a))

Not Applicable - Enrollees are not disenrolled for non-payment for cost sharing charges.

☐ The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non-payment of cost-sharing charges. (42CFR 457.570(b))

Not Applicable **-** Enrollees are not disenrolled for non-payment for cost sharing charges.

☐ In the instance mentioned above, that the state will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. (42CFR 457.570(b))

Not Applicable - Enrollees are not disenrolled for non-payment for cost sharing charges.

☒ The state provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42CFR 457.570(c))

Enrollees are not disenrolled for non-payment for cost sharing charges.

A Fair Hearing is granted to any enrollee or guardian when an adverse action results in disenrollment. (refer to Section 12.1 for additional detail.)

8.8. The state assures that it has made the following findings with respect to the payment aspects of its plan: (Section 2103(e))

8.8.1. ☒ No Federal funds will be used toward state matching requirements. (Section 2105(c)(4)) (42CFR 457.220)

8.8.2. ☒ No cost-sharing (including premiums, deductibles, copays, coinsurance and all other types) will be used toward state matching requirements. (Section 2105(c)(5) (42CFR 457.224) (Previously 8.4.5)

8.8.3. ☒ No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title.
(Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))

8.8.4. ☒ Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1)) (42CFR 457.622(b)(5))

8.8.5. ☒ No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105)(c)(7)(B)) (42CFR 457.475)

8.8.6. ☒ No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). (Section 2105)(c)(7)(A)) (42CFR 457.475)

Section 9. Strategic Objectives and Performance Goals and Plan Administration (Section 2107)

9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: (Section 2107(a)(2)) (42CFR 457.710(b))

DPHHS' s strategic objectives are to:

1. Improve the health status of children with a focus on preventive and early primary care treatment.
2. Increase the number of children who are enrolled in the Healthy Montana Kids Plan.
3. Prevent " crowd out" of employer coverage.
4. Coordinate and consolidate with other health care programs providing services to children to create a seamless health care delivery system for low-income children.

9.2. Specify one or more performance goals for each strategic objective identified: (Section 2107(a)(3)) (42CFR 457.710(c))

1. Improve health status of children with a focus on preventive and early primary care treatment.

   Performance goal: 96% of children 12-24 months of age will receive preventive or primary care treatment each year
2. Increase the number of children who are enrolled in the Healthy Montana Kids Plan.

   Performance goal: Enroll 29,000 additional children in the Healthy Montana Kids Plan.
3. Prevent " crowd-out" of employer coverage.

   Performance Goal: Maintain the proportion of children $\leq$ 250% of federal poverty who are covered under an employer-based plan taking

into account decrease due to health care costs or a downturn in the economy.

4. Coordinate and consolidate with other health care programs providing services to children to create a seamless health care delivery system for low-income children.

   Performance Goal: Co-ordinate with the Title V Children's Special Health Services program and the Children's Mental Health Services Plan to ensure 95% of eligible children who need care beyond what is offered under HMK coverage group are referred to these programs.

9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the state's performance, taking into account suggested performance indicators as specified below or other indicators the state develops:
(Section 2107(a)(4)(A),(B)) (42CFR 457.710(d))

Objective One: Improve health status of children with a focus on preventive and early primary treatment: The TPA Contractor is required to collect and report HEDIS data and utilization data. The Department of Public Health and Human Services will use this data to measure success of the plan in establishing baseline data and reaching the performance goals regarding immunization and well-child care.

DPHHS conducts an Enrollee Satisfaction Survey . Surveys are mailed to randomly selected current enrollees. The purpose of the survey is to assess enrollees' satisfaction with the program. The survey measures enrollees' perception of services received from providers and program staff. In addition, it measures the use and effectiveness of program materials.

Objective Two: Decrease the proportion of children in Montana who are

uninsured and reduce financial barriers to affordable health care coverage: Performance goals under this objective are measured based on the decrease in the number of uninsured children in families with incomes ≤250% of the federal poverty level compared with the number uninsured before the state plan's effective date. First, baseline numbers of uninsured children will be calculated from a three-year average of the 2005, 2006, and 2007 March supplement to the Current Population Survey produced by the Bureau of the Census. New estimates of uninsured children will be calculated as more current data become available and will be used to compare trends from year to year.

Objective Three: Prevent "crowd-out" of employer coverage: Performance goals under this objective will be measured based on the proportion of children at or below 250% of federal poverty who are covered under an employer based plan taking into account decreases due to increases in health care costs or a downturn in the economy. The proportion of children covered under the employer-based plan will be evaluated, and analysis will be conducted to test for evidence of "crowd-out". The baseline for comparison will be obtained from a 3 year average of the 2005, 2006, and 2007 March Current Population Survey.

In addition, the eligibility determination process includes questions relating to parents' access to and coverage by health insurance. This allows the state to track the number of children who have access to employer-based coverage and to ensure that children enrolling in the program are not dropping their employment-based coverage.

Objective Four: Coordinate and consolidate with other health care programs providing services to children to create a seamless health care delivery system for low-income children: Performance goals under this objective are

based on the enrollment of children receiving care through the Children's Mental Health Services Plan, HMK *Plus*, Health Insurance for Montana University System Dependent Care Premium Waiver Program, and Insure Montana. DPHHS staff provides information about Community Health Centers, Urban Indian Clinics, Migrant Health Clinics, National Health Service Corps sites and Montana Youth Care. DPHHS staff make referrals to Children's Special Health Services, Children's Mental Health Services Plan and other health care programs for children.

The Healthy Montana Kids Plan (HMK) will create a seamless health care delivery system for CHIP-funded and Medicaid-funded services provided by the Healthy Montana Kids Plan. The new computerized eligibility determination system for DPHHS health and social service programs will assist the department to meet this objective.

Objective Five: Increase the enrollment of currently eligible, but not participating, children in HMK *Plus*: Extensive outreach efforts including Community Enrollment Partners will be implemented to increase enrollment of currently eligible, but un-enrolled children.

Check the applicable suggested performance measurements listed below that the state plans to use: (Section 2107(a)(4))

9.3.1. ☒ The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.
9.3.2. ☒ The reduction in the percentage of uninsured children.
9.3.3. ☐ The increase in the percentage of children with a usual source of care.
9.3.4. ☐ The extent to which outcome measures show progress on one or more of the health problems identified by the state.
9.3.5. ☐ HEDIS Measurement Set relevant to children and adolescents younger than 19.

9.3.6. ☐ Other child appropriate measurement set. List or describe the set used.

9.3.7. ☒ If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:

- 9.3.7.1. ☒ Immunizations
- 9.3.7.2. ☒ Well childcare
- 9.3.7.3. ☒ Adolescent well visits
- 9.3.7.4. ☐ Satisfaction with care
- 9.3.7.5. ☐ Mental health
- 9.3.7.6. ☐ Dental care
- 9.3.7.7. ☒ Other, please list: Children' s access to primary care providers

9.3.8. ☐ Performance measures for special targeted populations.

9.4. ☒ The state assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. (Section 2107(b)(1)) (42CFR 457.720)

9.5. ☒ The state assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the state's plan for these annual assessments and reports. (Section 2107(b)(2)) (42CFR 457.750)

DPHHS completes the annual assessments and evaluations required in Section 2108(a). The Annual Report includes an assessment of the operation of the program and its progress toward meeting its strategic objectives and performance goals.

DPHHS completes and submits quarterly statistical reports through the SCHIP Statistical Enrollment Data System (SEDS). These statistics of unduplicated ever-enrolled children is reported by gender, race and ethnicity.

9.6. ☒ The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. (Section 2107(b)(3)) (42CFR 457.720)

9.7. ☒ The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. (42CFR 457.710(e))

9.8. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: (Section 2107(e)) (42CFR 457.135)

- 9.8.1. ☒ Section 1902(a)(4)(C) (relating to conflict of interest standards)
- 9.8.2. ☒ Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)
- 9.8.3. ☒ Section 1903(w) (relating to limitations on provider donations and taxes)
- 9.8.4. ☒ Section 1132 (relating to periods within which claims must be filed)

9.9. Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. (Section 2107(c)) (42CFR 457.120(a) and (b))

Since implementation, DPHHS advisory councils have provided important advice, comments, and recommendations.

When DPHHS proposes changes to the Administrative Rules of Montana notice is given and a public hearing is scheduled to allow interested parties to comment and provide input.

In November, 2008, a citizens' initiative, Montana Initiative I-155, Healthy Montana Kids Plan Act was approved by 70% of all voters. The HMK Plan Act increases the income eligibility guideline for HMK (formerly known as CHIP) enrollees to 250% of the FPL. Included in HMK Plan Act is the elimination of the Medicaid asset test for children. The department also is implementing a CHIP-funded/Medicaid Expansion Program for children ages 6-18 years of age whose family incomes are at or below 133% of the FPL.

Other provisions in the Healthy Montana Kids Act include the following:

- Enrollment Partners
- Increase the " insurance delay period" from one month to three months
- Coordinate enrollment and application for CHIP-funded and Medicaid-funded benefits
- Presumptive eligibility
- Premium assistance
- Assistance to employers to implement Premium Only Health Benefit Plans (" Section 125 Plans")

Legislative Input:

- During the 2009 legislative session the legislature appropriated State Special Revenue funds as the state match for the HMK initiative described above.
- DPHHS provides quarterly program updates to legislative interim committees.

Meetings with Interested Parties:

DPHHS staff meets with other statewide association advisory boards and interested parties, including: Montana Hospital Association, Primary Care Association, Health Advisory Council, Public Health Association, Family Planning State Council, Montana Council for Maternal and Child Health, Montana Children's Alliance, Children's Committee of the Mental Health Association, Head Start, Public Health and School Nurses, Governor's Council on Children and Families, the Montana Association of Counties, Human Services Committee, Montana People's Action, Working for Equality and Economic Liberation, Montana Migrant Council, and the Native American Advisory Council. At the request of several organizations, a program update is provided at each meeting, allowing time for questions, comments, and problem solving.

9.9.1 Describe the process used by the state to ensure interaction with Indian Tribes and organizations in the state on the development and implementation of the procedures required in 42 CFR 457.125. (Section 2107(c)) (42CFR 457.120(c))

DPHHS works directly with tribes, the Indian Health Service, Tribal Health Services, Bureau of Indian Affairs, Urban Indian Clinics and the Governor's Native American Advisory Council to inform Native

Americans in Montana about the program. DPHHS staff provides annual updates and training at each of the seven Montana reservations and five Urban Indian Clinics. In addition, DPHHS staff participates in the annual CMS/IHS Medicare, Medicaid and CHIP training.

DPHHS staff presented a web-based seminar to Tribal Council Chairpersons, IHS and Tribal Health Directors, Urban Indian Clinic Directors and IHS administrators regarding the Healthy Montana Kids Plan.

9.9.2 For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), please describe how and when prior public notice was provided as required in §457.65(b) through (d).

Prior public notice of proposed changes is provided in a form and manner provided under applicable State law. Public notice will be published prior to the requested effective date of the change.

9.10. Provide a one year projected budget. A suggested financial form for the budget is attached. The budget must describe: (Section 2107(d)) (42CFR 457.140)

- Planned use of funds, including --
  - Projected amount to be spent on health services;
  - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
  - Assumptions on which the budget is based, including cost per child and expected enrollment.
- Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.

Please see attached FY2010 projected budget.

SCHIP Budget FFY 2010

	Federal Fiscal Year Costs
Enhanced FMAP rate	77.19% (estimated)
Benefit Costs	
Insurance payments	
Managed care	
Fee for Service (FFS)	91,184,319
Total Benefit Costs	91,184,319
(Offsetting beneficiary cost sharing payments)	0
Net Benefit Costs	91,184,319
Administration Costs	
Personnel	2,083,560
General administration	2,558,013

Contractors/Brokers (e.g., enrollment contractors)	-
Claims Processing	521,456
Outreach/marketing costs	577,567
Other - Indirect Cost	1,909,151
Total Administration Costs	7,649,747
10% Administrative Cost Ceiling	10,131,591
Federal Share (multiplied by FMAP @ 77.19%)	76,290,015
State Share - (22.81%)	22,544,050
TOTAL PROGRAM COSTS	98,834,065

Enrollment fee, deductible and enrollee premium are not required. Enrollee cost sharing is netted out of the total benefit costs.

Budget Assumptions

Benefits

Montana contracts with Blue Cross Blue Shield of Montana (BCBSMT) for third party administrative services (TPA) for medical and pharmacy benefits. The department provides eyeglasses, dental services and community based psychiatric (CBPRS) services on a fee for service basis.

The estimated monthly enrollment is 46,365 for FY 2010. The cost per

member per month include the separate CHIP program and the CHIP-Medicaid Expansion Program and the projected benefit cost is $164/month.

The income eligibility guidelines for the HMK coverage group (CHIP) change from 175% to 250% FPL effective October 1, 2009. The increase in the projected expenditures reflects claims costs associated with the increased enrollment of children in the HMK coverage group and the CHIP Medicaid expansion program.

Administration

Department staff is responsible for program management including assessment, policies and procedures development, department and community programs' coordination, budgeting, eligibility determination, enrollment, contract monitoring, outreach and oversight.

The program transitioned from purchasing a fully insured plan for each enrollee to self-insurance with a contract for third party administrative (TPA) services on October 1, 2006. The fully insured contract and the TPA contract both paid claims on a fee for service (FFS) basis. There was no change in benefits or cost-sharing.

Funding

Tobacco settlement funds, tobacco tax and State Special Revenue Funds are used as the non-Federal share of plan expenditures. The State Special Revenue Fund is composed of, but is not limited to fees collected by the Montana Insurance Commissioner from each insurer applying for or annually renewing a certificate of authority to conduct the business of insurance in Montana.

Montana' s State Legislature gave the Department of Public Health and Human Services authority to match federal dollars with private donations. Montana will, upon CMS approval, use private donations when available. Background information on donors will be submitted to CMS, as required, prior to the expenditure of donated funds. Montana ensures that donations used as matching funds adhere to requirements stated in 42 CFR Subpart B (433.51 – 433.74).

Section 10. Annual Reports and Evaluations (Section 2108)

10.1. Annual Reports. The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: (Section 2108(a)(1),(2)) (42CFR 457.750)

10.1.1. ☒ The progress made in reducing the number of uncovered low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

10.2. ☒ The state assures it will comply with future reporting requirements as they are developed. (42CFR 457.710(e))

10.3. ☒ The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

Section 11. Program Integrity (Section 2101(a))

☐ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue to Section 12.

11.1. ☒ The state assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Section 2101(a)) (42CFR 457.940(b))

11.2. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: (Section 2107(e)) (42CFR 457.935(b)) The items below were moved from section 9.8. (Previously items 9.8.6. - 9.8.9)

- 11.2.1. ☒ 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)
- 11.2.2. ☒ Section 1124 (relating to disclosure of ownership and related information)
- 11.2.3. ☒ Section 1126 (relating to disclosure of information about certain convicted individuals)
- 11.2.4. ☒ Section 1128A (relating to civil monetary penalties)
- 11.2.5. ☒ Section 1128B (relating to criminal penalties for certain additional charges)
- 11.2.6. ☒ Section 1128E (relating to the National health care fraud and abuse data collection program)

Section 12. Applicant and Enrollee Protections ***(Sections 2101(a))***

☐ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan.

12.1. Eligibility and Enrollment Matters

Please describe the review process for eligibility and enrollment matters that complies with 42 CFR 457.1120.

A Social Security Number is required for a child who applies for benefits. Enrollment is not be denied or delayed to an otherwise eligible child pending issuance of a child' s SSN. The program restricts the use of disclosure of information concerning applicants and enrollees to purposes directly connected with administration of the plan.

An applicant or enrollee has an opportunity for review of eligibility and enrollment matters. Such matters include the following: denial of eligibility, failure to make a timely determination of eligibility and termination of enrollment.

The review process for eligibility and enrollment matters is conducted by the DPHHS Office of Fair Hearings, Quality Assurance Division, in accordance with the program' s Fair Hearing Policy. Families of children who are applying for or are enrolled in the program are notified of their right to Fair Hearing.

A Fair Hearing is granted to the following individuals: 1) applicant, parent or guardian who requests a hearing because his or her application is denied, and 2) an enrollee, parent or guardian when an adverse action results in disenrollment. The hearing request must be submitted in writing within 90 days of the Department' s action notice.

A hearing request is defined as a clear expression by the applicant, or authorized representative that he or she wants the opportunity to present the case to a higher authority.

The Department is responsible to assure an applicant' s right to due process and hearing. Hearings are conducted by an impartial official of the Department who is not directly involved in the initial determination of the action in question.

The Hearing Officer' s decision is made within 90 days of the hearing' s conclusion. The decision becomes final unless the Department or the applicant appeals the decision within 15 days of the mailing of the Fair Hearing decision. No action is taken on the case until the 15-day limit for appeal passes. There is a hearing record compiled for each case and it is available to the applicant at a reasonable time for viewing and copying.

12.2. Health Services Matters

Please describe the review process for health services matters that comply with 42 CFR 457.1120.

An applicant or enrollee has an opportunity for a review of health services matters. The TPA contractor' s complaint resolution policy: An enrollee may call or write to the plan to ask questions, ask for a review of a decision or make a verbal complaint. The TPA Contractor will respond to telephone inquiries within 10 working days. The TPA Contractor will acknowledge a written complaint within 10 days of receipt and send a written response or decision on the complaint within 45 days of receipt. An enrollee may make a final appeal if an unfavorable decision is received from the TPA Contractor. Within 90 days of receiving a letter from the TPA Contractor about a decision,

the enrollee may submit a written complaint to Montana DPHHS Office of Fair Hearings. This information is outlined in the Member Handbook that is provided when children are enrolled.

12.3. Premium Assistance Programs

If providing coverage through a group health plan that does not meet the requirements of 42 CFR 457.1120, please describe how the state will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each redetermination of eligibility.