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State/Territory Name: Montana

State Plan Amendment (SPA) #: MT-11-011

This file contains the following documents in the order listed:

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

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
1600 Broadway, Suite 700
Denver, CO 80202-4967

Region VIII

March 22, 2011

Mary Dalton, Medicaid & Health Services Manager
Montana Department of Health & Human Services
1400 Broadway
PO Box 202951
Helena, MT 59620

Re: SPA MT-11-011

Dear Ms Dalton:

We have reviewed the proposed State Plan Amendment (SPA) submitted under transmittal number (TN) 11-011. The purpose of this SPA is to update the State's Medicaid for Workers with Disabilities Program cost sharing schedule.

Please be informed that this State Plan Amendment is approved effective January 1, 2011. We are enclosing the CMS-179 and the amended plan page(s).

If you have any questions regarding this SPA please contact Diana Maiden at 303-844-7114.

Sincerely,

/s/

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

Cc: Anna Whiting Sorrell
Duane Preshinger
Jo Thompson

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **11-011**

2. STATE: **Montana**

3. PROGRAM IDENTIFICATION: Title XIX of the Social Security Act (Medicaid)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
01/01/2011

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

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

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

6. FEDERAL STATUTE/REGULATION CITATION:
1902(a)(10)(A)(ii)(XIII), (XV), (XVI), and 1916(g) of the Act

7. FEDERAL BUDGET IMPACT:
a. FFY **2011** **$ 11,869**
b. FFY **2012** **$ 15,826**
c. FFY **2013** **$ 15,826**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 2.6-A, Page 12m

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 2.6-A, Page 12m

10. SUBJECT OF AMENDMENT: This amendment reduces the cost share fees for the Medicaid for Workers with Disabilities program (Ticket to Work and Work Incentives Improvement Act -TWWIIA) for three of the four income ranges. The State determined that three of the cost share fees, as originally stated, had the potential to exceed the limit of 7% of the participant's income stated in TWWIIA.

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

12. SIGNATU[redacted]

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

14. TITLE: **State Medicaid Director**

15. DATE SUBMITTED: 12/23/10

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 12/23/10

18. DATE APPROVED: 3/22/11

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 01/01/11

[redacted]EGIONAL OFFICIAL:

21. TYPED NAME: Richard C. Allen

22. TITLE: ARA, DMCHO

23. REMARKS:

State/Territory: Montana

Citation	Condition or Requirement

1902(a)(10)(A)(ii)(XIII) (XV), (XVI), and 1916(g) of the Act

Payment of Premiums or Other Cost Sharing Charges

For individuals eligible under the BBA eligibility group described in No. 23 on page 23d of ATTACHMENT 2.2-A:

_X_ The agency requires payment of premiums or other cost-sharing charges on a sliding scale based on income. The premiums or other cost-sharing charges, and how they are applied are described below:

Only the income of the employed worker with disabilities will be considered in determining the amount of premium. Cost shares will be the same as the standard copayments for other Medicaid programs.

Income Range (% of FPL for 1)	Monthly Premium
Up to 100% FPL*	$35
Over 100% - 150%	$67
Over 150% - 200%	$100
Over 200% - 250%	$135

*For the "Up to 100% FPL" group, if the $35 cost share fee exceeds 7% of the worker's income, the cost share fee will be set to zero.