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State/Territory Name: Montana

State Plan Amendment (SPA) #: MT-14-0041

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 10, 2015

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

Re: SPA MT-14-0041

Dear Ms. Dalton:

We have reviewed the proposed State Plan Amendment (SPA) submitted under transmittal number MT-14-0041. This amendment implements a limited Patient Centered Medical Home Program.

Please be informed that this State Plan Amendment was approved March 9, 2015 with an effective date of December 1, 2014. We are enclosing the summary page and the amended plan page(s).

If you have any questions regarding this SPA please contact Cindy Smith at 303-844-7041.

Sincerely,

/s/

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

Cc: Richard Opper, Department Director
Duane Preshinger
Jo Thompson
Mary Eve Kulawik

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: 14-0041 ~~15-0001~~	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 12/01/2014	

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

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

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

6. FEDERAL STATUTE/REGULATION CITATION: 1932(a)	7. FEDERAL BUDGET IMPACT: a. FFY 2015 (10 months) ($133,033) b. FFY 2016 (12 months) ($159,639) c. FFY 2017 (2 months) ($26,606)
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 3.1-F	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: N/A

10. SUBJECT OF AMENDMENT:
Implement the new Patient-Centered Medical Home Program, effective 12/1/14. Savings are indicated.

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
X OTHER, AS SPECIFIED:
Single Agency Director Review

12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]	16. RETURN TO: Montana Dept of Public Health and Human Services Mary E. Dalton Attn: Mary Eve Kulawik PO Box 4210 Helena MT 59604
13. TYPED NAME: Mary E. Dalton	
14. TITLE: State Medicaid Director	
15. DATE SUBMITTED: 12-8-14 re-submitted 12-11-14	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 12/11/14	18. DATE APPROVED: 3/9/15
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: 12/01/14	20. SIGNATURE OF REGIONAL OFFICIAL: /s/
21. TYPED NAME: Richard C. Allen	22. TITLE: ARA, DMCHO

23. REMARKS:

FORM HCFA-179 (07-92)

Citation	Condition or Requirement

1932(a)(1)(A)

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

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

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

Where the state's assurance is requested in this document for compliance with a particular requirement of 42 CFR 438 et seq., the state shall place check mark to affirm such compliance.

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

B. Managed Care Delivery System.1932(a)(1)(B)(ii)
The State will contract with the entity(ies) below and reimburse them as noted under each entity type.

1. ☐MCO
   a. ☐Capitation

2. ☒PCCM (individual practitioners)
   a. ☒ Case management fee
   b. ☐ Bonus/incentive payments
   c. ☒ Other (please explain below)

PCMH providers will be reimbursed a per member per month capitation fee in addition to Medicaid fee-for-service reimbursement, through one of three per member per month payments for each enrolled MTMPCMH Member:

a. a preventive and participation per MTMPCMH Member per month fee for members with no chronic conditions; or
b. a single chronic disease management per MTMPCMH Member per month fee for members with hypertension, asthma, or depression; or
c. a chronic disease management per MTMPCMH Member per month fee for members with diabetes, ischemic vascular disease (IVD), or multiple chronic diseases from b.

Citation	Condition or Requirement

3. ☐PCCM (entity based)
   a. ☒ Case management fee
   b. ☐ Bonus/incentive payments
   c. ☒ Other (please explain below)

PCMH providers will be reimbursed a per member per month capitation fee in addition to Medicaid fee-for-service reimbursement, through one of three per member per month payments for each enrolled MTMPCMH Member:

a. a preventive and participation per MTMPCMH Member per month fee for members with no chronic conditions; or
b. a single chronic disease management per MTMPCMH Member per month fee for members with hypertension, asthma, or depression; or
c. a chronic disease management per MTMPCMH Member per month fee for members with diabetes, IVD, or multiple chronic diseases from b.

For states that elect to pay a PCCM a bonus/incentive payment as indicated in B.2.b. or B.3.b, place a check mark to affirm the state has met ***all*** of the following conditions (which are representative of the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)).

☐a. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered.
☐b. Incentives will be based upon a fixed period of time.
☐c. Incentives will not be renewed automatically.
☐d. Incentives will be made available to both public and private PCCMs.
☐e. Incentives will not be conditioned on intergovernmental transfer agreements.
☐f. Incentives will be based upon specific activities and targets.

Citation	Condition or Requirement

CFR 438.50(b)(4)

C. Public Process.

Describe the public process including tribal consultation, if applicable, utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. *(Example: public meeting, advisory groups.)*

Montana Medicaid's Patient-Centered Medical Home Program (MTMPCMH) development and implementation process: The Department has been involved with a PCMH multi-payer stakeholder group, the Montana Patient-Centered Medical Home (PCMH) Stakeholder Council, established in Montana in 2009 by the Commissioner of Securities & Insurance. The purpose of the group is to develop a multi-payer initiative driven by an improvement plan focused on five core elements: 1. Developing key partnerships; 2. Defining and recognizing medical homes; 3. Improving purchasing and reimbursement policies; 4. Supporting practice change; and 5. Measuring progress.

The Council is comprised of primary care providers, specialty providers, public and private payers, consumers, advocates, and representatives of provider and advocate associations. Meetings are also attended by State Legislators, legislative staff, and members of the general public. This Council was codified during the 2013 Legislative Session and continues to serve as the advisory council for Medicaid's PCMH initiative. Medicaid relies on the PCMH Stakeholder Council for assistance in defining and refining Medicaid's PCMH initiative and adopting quality measures for evaluation.

The MTMPCMH was developed using the structure of Medicaid's PCCM program, Passport to Health. Medicaid members enrolled with a Passport to Health provider selected to be a MTMPCMH provider will automatically be part of that provider's PCMH caseload. Any Medicaid member may change to another Passport provider or MTMPCMH provider at any time (according to procedures established under the 1915(b) waiver).

Medicaid conducted Tribal consultation on August 15, 2014, in accordance with CMS requirements.

D. State Assurances and Compliance with the Statute and Regulations.

If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.

1932(a)(1)(A)(i)(I)
1903(m)
42 CFR 438.50(c)(1)

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

Citation	Condition or Requirement
1932(a)(1)(A)(i)(I) 1905(t) 42 CFR 438.50(c)(2) 1902(a)(23)(A)	2. ☒The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.
1932(a)(1)(A) 42 CFR 438.50(c)(3)	3. ☐The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring Beneficiaries to receive their benefits through managed care entities will be met.
1932(a)(1)(A) 42 CFR 431.51 1905(a)(4)(C)	4. ☒The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.
1932(a)(1)(A)	5. ☒The state assures that it appropriately identifies individuals in the mandatory exempt groups identified in 1932(a)(1)(A)(i).
1932(a)(1)(A) 42 CFR 438 1903(m)	6. ☒The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs and PCCMs will be met.
1932(a)(1)(A) 42 CFR 438.6(c) 42 CFR 438.50(c)(6)	7. ☐The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met.
42 CFR 438.50(c)(6) CFR 447.362	8. ☒The state assures that all applicable requirements of 42 CFR 447.362 for 42 payments under any non-risk contracts will be met.
45 CFR 92.36	9. ☒The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.
1932(a)(1)(A) 1932(a)(2)	E. Populations and Geographic Area 1. **Included Populations.** Please check which eligibility populations are included, if they are enrolled on a mandatory (M) or voluntary (V) basis, and the geographic scope of enrollment. Under the geography column, please indicate whether the nature of the population's enrollment is on a statewide basis, or if on less than a statewide basis, please list the applicable counties/regions.

Citation | Condition or Requirement

Population	M	Geographic Area	V	Geographic Area	Excluded
Section 1931 Children & Related Populations – 1905(a)(i)		To be determined	✔		
Section 1931 Adults & Related Populations1905(a)(ii)		To be determined	✔		
Low-Income Adult Group					NA
Former Foster Care Children under age 21					✔
Former Foster Care Children age 21-25					✔
Section 1925 Transitional Medicaid age 21 and older		To be determined	✔		
SSI and SSI related Blind Adults, age 18 or older* - 1905(a)(iv)		To be determined	✔		
Poverty Level Pregnant Women – 1905(a)(viii)		To be determined	✔		
SSI and SSI related Blind Children, generally under age 18 – 1905(a)(iv)		To be determined	✔		
SSI and SSI related Disabled children under age 18		To be determined	✔		

Citation	Condition or Requirement

SSI and SSI related Disabled adults age 18 and older – 1905(a)(v)		To be determined	✔		
SSI and SSI Related Aged Populations age 65 or older- 1905(a)(iii)		To be determined	✔		
SSI Related Groups Exempt from Mandatory Managed Care under 1932(a)(2)(B)					NA
Recipients Eligible for Medicare					✔
American Indian/Alaskan Natives		To be determined	✔		
Children under 19 who are eligible for SSI		To be determined	✔		
Children under 19 who are eligible under Section 1902(e)(3)					NA
Children under 19 in foster care or other in-home placement					✔
Children under 19 receiving services funded under section 501(a)(1)(D) of title V and in accordance with 42 CFR 438.50(d)(v)		To be determined	✔		
Other					NA

2. **Excluded Groups.** Within the populations identified above as Mandatory or Voluntary, there may be certain groups of individuals who are excluded from the managed care program. Please indicate if any of the following groups are excluded from participating in the program:

   All Montana Medicaid members enrolled in Passport to Health under the State's 1915(b) waiver authority are eligible to voluntarily participate in the statewide MTMPCMH. Geographic areas for the Medicaid PCMH initiative will only be limited by the number and location of MTMPCMH providers willing to enroll.
   Excluded: Medicare dual eligible, members residing in a nursing facility or ICF/IID, members eligible less than 3 months, members enrolled in HCBS waiver or HCBS state plan, members with retroactive eligibility, medically needy members with a spend down, subsidized adoption members, members who are unable to find a PCP who is willing to provide case management, eligible for Plan First, eligible for Foster Care, receiving Medicaid under Presumptive Eligibility, and members residing in a PRTF.

Citation	Condition or Requirement

Exempt: Members with TPL that offers a case management program, out of state foster care, members residing in an out of state treatment center, members who do not have 30 days' notice of their provider leaving, members PCP refuses to see them or provide referrals, members in the NICU, member requests a medical hardship, members admitted to a treatment center, correcting errors of members enrollment.

1932(a)(4) F. Enrollment Process.

1. Definitions.

   a. Auto Assignment- assignment of a beneficiary to a health plan when the beneficiary has not had an opportunity to select their health plan.

   b. Default Assignment- assignment of a beneficiary to a health plan when the beneficiary has had an opportunity to select their health plan.

2. Please describe how the state effectuates the enrollment process. Select an enrollment methodology from the following options and describe the elements listed beneath it:

   a. ☐ The applicant is permitted to select a health plan at the time of application.

      i. How the state fulfills its obligations to provide information as specified in 42 CFR 438.10(e).

      ii. What action the state takes if the applicant does not indicate a plan selection on the application.

      iii. If action includes making a default assignment, describe the algorithm used and how it meets all of the requirements of 42 CFR 438.50(f).

      iv. The state's process for notifying the beneficiary of the default assignment. (Example: *state generated correspondence.*)

   b. ☒ The beneficiary has an active choice period following the eligibility determination.

      i. How the beneficiary is notified of their initial choice period, including its duration.
      The Medicaid member is notified of the initial choice period, including its duration, by letter and by a telephone call from Medicaid's Passport to Health Enrollment Broker.

Citation	Condition or Requirement

ii. How the state fulfills its obligations to provide information as specified in 42 CFR 438.10(e).
The State fulfills its obligations to provide information for potential enrollees through Passport to Health Enrollment Broker telephone calls, the Welcome to Passport mailing.

iii. Describe the algorithm used for default assignment and describe the algorithm used and how it meets all of the requirements of 42 CFR 438.50(f).

The PCMH Program will use the Passport to Health algorithm. Passport to Health auto-assigns members to a provider if they have not chosen one, sixty days or more after the first outreach attempt. The auto assignment is intended to choose the best suited PCP for a member. The system assigns by the following criteria, in this order:

1. Previous Passport enrollment,
2. Most current claims history,
3. Case (family) Passport assignment(s),
4. Native Americans will be assigned to IHS if one is within fifty miles of their home, and
5. Geographic area (within a fifty mile radius).

iii. The state's process for notifying the beneficiary of the default assignment.
The Medicaid member is notified of the MTMPCMH default assignment by letter from the MTMPCMH and confirmation letter from the State's Enrollment Broker.

c. ☐ The beneficiary is auto-assigned to a health plan immediately upon being determined eligible.

i. How the state fulfills its obligations to provide information as specified in 42 CFR 438.10(e).
Montana Medicaid enrolls members with a MTMPCMH if the chosen or assigned provider in Medicaid's PCMH Program.

ii. The state's process for notifying the beneficiary of the auto-assignment. (*Example: state generated correspondence.*)
The Medicaid member is notified of the MTMPCMH default assignment by letter from the MTMPCMH and confirmation letter from the State's Enrollment Broker.

iii. Describe the algorithm used for auto-assignment and describe the algorithm used and how it meets all of the requirements of 42 CFR 438.50(f).

Citation	Condition or Requirement

The PCMH Program will use the Passport to Health algorithm. Passport to Health auto-assigns members to a provider if they have not chosen one, sixty days or more after the first outreach attempt. The auto assignment is intended to choose the best suited PCP for a member. The system assigns by the following criteria, in this order:

1. Previous Passport enrollment,
2. Most current claims history,
3. Case (family) Passport assignment(s),
4. Native Americans will be assigned to IHS if one is within fifty miles of their home, and
5. Geographic area (within a fifty mile radius).

1932(a)(4)
42 CFR 438.50

3. State assurances on the enrollment process.

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

a. ☒The state assures it has an enrollment system that allows Beneficiaries who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program.

b. ☒The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid Beneficiaries enrolled in either an MCO or PCCM model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3).

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

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

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

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

1932(a)(4)
42 CFR 438.56

G. Disenrollment.

1. The state will☐/will not☒ limit disenrollment for managed care.
Montana Medicaid will not prevent a member from dis-enrolling from a MTMPCMH provider and choosing a different MTMPCMH or Passport to Health provider.

Citation	Condition or Requirement

2. The disenrollment limitation will apply for Choose an item. months (up to 12 months). NA

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

4. Describe the state's process for notifying the Medicaid Beneficiaries of their right to disenroll without cause during the first 90 days of their enrollment. *(Examples: state generated correspondence, HMO enrollment packets etc.)*
Montana Medicaid provides educational materials to each member enrolled with a PCMH. The materials explain the process for members to disenroll from a provider. Member education is provided through several venues including letters, emails and/or texts if applicable, and telephone calls. Member education is also undertaken during office visits to the patient's medical home.

5. Describe any additional circumstances of "cause" for disenrollment (if any).
No specific "cause" is needed on the part of a Medicaid member to disenroll from a MTMPCMH provider.

H. Information Requirements for Beneficiaries

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

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

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

I. List all benefits for which the MCO is responsible.
N/A

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

J. ☐The state assures that each managed care organization has established an internal grievance procedure for enrollees.

1932(a)(5)(D)(b)(5)
42 CFR 438.206

K. Describe how the state has assured adequate capacity and services.

For Montana's PCMH initiative, The Department will begin the program with a limited number of PCMH providers. Medicaid members whose Passport provider is not a MTMPCMH have access to their Passport provider and the ability to change to another Passport provider once a month as desired.

42 CFR 438.207

Citation	Condition or Requirement
1932(a)(5)(D)(c)(1)(A) 42 CFR 438.240	L. ☒The state assures that a quality assessment and improvement strategy has been developed and implemented.
1932(a)(5)(D)(c)(2)(A) 42 CFR 438.350	M. ☐The state assures that an external independent review conducted by a qualified independent entity will be performed yearly.
1932 (a)(1)(A)(ii)	N. Selective Contracting Under a 1932 State Plan Option To respond to items #1 and #2, place a check mark. The third item requires a brief narrative. 1. The state will☒/will not☐ intentionally limit the number of entities it contracts under a 1932 state plan option. 2. ☒The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services. 3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. *(Example: a limited number of providers and/or enrollees.)* Montana Medicaid begins the MTMPCMH Program with a limited number of providers. The State will rate provider MTMPCMH applicants based on NCQA recognition, Passport to Health status, numbers and types of providers in the PCMH practice, PCMH model, and qualification by Montana's Commissioner of Securities and Insurance (CSI). Once the pilot can send and receive data, qualified (NCQA recognized and approved by CSI) providers will be added upon request to the Department. 4. ☐The selective contracting provision in not applicable to this state plan.