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State/Territory Name: Montana

State Plan Amendment (SPA) #: MT-16-0020

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
1961 Stout Street, Room 08-148
Denver, CO 80294

Region VIII

July 19, 2016

Ms. Mary E. Dalton
State Medicaid and CHIP Director
PO Box 4210
Helena, MT 59601-4210

RE: SPA 16-0020

Dear Ms. Dalton:

We reviewed Montana's proposed State Plan Amendment (SPA) submitted under transmittal number MT -16-0020. This amendment implements federal cost-sharing provisions for Montana's Medicaid standard population to align with the expansion HELP population. Please be informed that this SPA was approved today with an effective date of June 1, 2016. We are enclosing the CMS 179 Form and the approved State Plan pages.

We note that in the SPA review process, we became aware of other issues that we will be addressing separately. We look forward to working with the state to ensure proper implementation of all requirements.

If you have any questions regarding this SPA, please contact Mary Marchioni at (303) 844-7094.

Sincerely,

[redacted]

Richard C. Allen
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

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

Medicaid Premiums and Cost Sharing: Summary Page (CMS 179)

State/Territory name: **Montana**

Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

MT 16-0020

Proposed Effective Date

06/01/2016 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2016	$0.00
Second Year	2017	$0.00

Subject of Amendment

Align Montana's Standard Medicaid Population with the expansion HELP Population. These changes address the following: a standard cost share amount for outpatient services, inpatient services and pharmacy services; and Medicaid cost sharing incurred will not exceed an aggregate limit of five percent of the family's quarterly income.

Governor's Office Review

- **Governor's office reported no comment**

Comments of Governor's office received

Describe:

No reply received within 45 days of submittal

Other, as specified

Describe:

Signature of State Agency Official

Submitted By:	**Mary Eve**
Last Revision Date:	**Jun 22, 2016**
Submit Date:	**Jun 22, 2016**

Date Received: 22 June, 2016
Date Approved: 19 July, 2016
Signature of Approving Official: [redacted]
Printed Name and Title: Richard C. Allen, Associate Regional Administrator
Division of Medicaid & Children's Health

Medicaid Premiums and Cost Sharing

State Name: Montana

OMB Control Number: 0938-1148

Transmittal Number: MT - 16 - 0020

Expiration date: 10/31/2014

Cost Sharing Amounts - Categorically Needy Individuals G2a

1916
1916A
42 CFR 447.52 through 54

The state charges cost sharing to all categorically needy (Mandatory Coverage and Options for Coverage) individuals. Yes

Services or Items with the Same Cost Sharing Amount for All Incomes

	Service or Item	Amount	Dollars or Percentage	Unit	Explanation	
+	Inpatient Hospital	75.00	$	Entire Stay		X
+	Ambulatory Surgical Center	4.00	$	Visit		X
+	Denturists	4.00	$	Visit		X
+	Durable Medical Equipment	4.00	$	Visit		X
+	Federally Qualified Health Center	4.00	$	Visit		X
+	Dialysis Clinics	4.00	$	Visit		X
+	Outpatient Hospital	4.00	$	Visit		X
+	Rural Health Clinic	4.00	$	Visit		X
+	Home Infusion Therapy (codes 99602 and 99601 are exempt)	4.00	$	Visit		X
+	Independent Diagnostic Testing Facilities	4.00	$	Visit		X
+	Mid-Level Practitioners	4.00	$	Visit		X
+	Physician	4.00	$	Visit		X
+	Podiatry	4.00	$	Visit		X
+	Psychiatrists	4.00	$	Visit		X
+	Dental	4.00	$	Visit		X
+	Home Health	4.00	$	Visit		X
+	Licensed Professional Counselors	4.00	$	Visit		X
+	Psychological Services	4.00	$	Visit		X

State: Montana
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Medicaid Premiums and Cost Sharing

	Service or Item	Amount	Dollars or Percentage	Unit	Explanation	
+	Social Worker	4.00	$	Visit		X
+	Speech Therapy	4.00	$	Visit		X
+	Audiology	4.00	$	Visit		X
+	Hearing Aids	4.00	$	Visit		X
+	Occupational Therapy	4.00	$	Visit		X
+	Opticians	4.00	$	Visit		X
+	Optometric	4.00	$	Visit		X
+	Physical Therapy	4.00	$	Visit		X
+	Public Health Clinics	4.00	$	Visit		X
+	Pharmacy	4.00	$	Prescription	For preferred brands.	X
+	Pharmacy	8.00	$	Prescription	For non-preferred.	X
+	Independent Lab and X-Ray Services	4.00	$	Visit		X
+	Mental Health Clinics	4.00	$	Visit		X
+	Chemical Dependency Services	4.00	$	Visit		X

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Services or Items with Cost Sharing Amounts that Vary by Income

Service or Item:

Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	
+				$	Visit		X

Add Service or Item

Cost Sharing for Non-preferred Drugs Charged to Otherwise Exempt Individuals

If the state charges cost sharing for non-preferred drugs (entered above), answer the following question:

The state charges cost sharing for non-preferred drugs to otherwise exempt individuals. No

Cost Sharing for Non-emergency Services Provided in the Hospital Emergency Department Charged to Otherwise Exempt Individuals

If the state charges cost sharing for non-emergency services provided in the hospital emergency department (entered above), answer the following question:

The state charges cost sharing for non-emergency services provided in the hospital emergency department to otherwise exempt individuals.	No

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20140415

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Cost Sharing Limitations

G3

42 CFR 447.56
1916
1916A

☑ The state administers cost sharing in accordance with the limitations described at 42 CFR 447.56, and 1916(a)(2) and (j) and 1916A(b) of the Social Security Act, as follows:

Exemptions

Groups of Individuals - Mandatory Exemptions

The state may not impose cost sharing upon the following groups of individuals:

- ■ Individuals ages 1 and older, and under age 18 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118).
- ■ Infants under age 1 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118), whose income does not exceed the higher of:
  - ■ 133% FPL; and
  - ■ If applicable, the percent FPL described in section 1902(l)(2)(A)(iv) of the Act, up to 185 percent.
- ■ Disabled or blind individuals under age 18 eligible for the following eligibility groups:
  - ■ SSI Beneficiaries (42 CFR 435.120).
  - ■ Blind and Disabled Individuals in 209(b) States (42 CFR 435.121).
  - ■ Individuals Receiving Mandatory State Supplements (42 CFR 435.130).
- ■ Children for whom child welfare services are made available under Part B of title IV of the Act on the basis of being a child in foster care and individuals receiving benefits under Part E of that title, without regard to age.
- ■ Disabled children eligible for Medicaid under the Family Opportunity Act (1902(a)(10)(A)(ii)(XIX) and 1902(cc) of the Act).
- ■ Pregnant women, during pregnancy and through the postpartum period which begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends, except for cost sharing for services specified in the state plan as not pregnancy-related.
- ■ Any individual whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs.
- ■ An individual receiving hospice care, as defined in section 1905(o) of the Act.
- ■ Indians who are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services.
- ■ Individuals who are receiving Medicaid because of the state's election to extend coverage to the Certain Individuals Needing Treatment for Breast or Cervical Cancer eligibility group (42 CFR 435.213).

Groups of Individuals - Optional Exemptions

The state may elect to exempt the following groups of individuals from cost sharing:

The state elects to exempt individuals under age 19, 20 or 21, or any reasonable category of individuals 18 years of age or over. Yes

Indicate below the age of the exemption:

- ○ Under age 19
- ○ Under age 20
- ◉ Under age 21
- ○ Other reasonable category

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The state elects to exempt individuals whose medical assistance for services furnished in a home and community-based setting is reduced by amounts reflecting available income other than required for personal needs. Yes

Services - Mandatory Exemptions

The state may not impose cost sharing for the following services:

- ■ Emergency services as defined at section 1932(b)(2) of the Act and 42 CFR 438.114(a).
- ■ Family planning services and supplies described in section 1905(a)(4)(C) of the Act, including contraceptives and pharmaceuticals for which the state claims or could claim federal match at the enhanced rate under section 1903(a)(5) of the Act for family planning services and supplies.
- ■ Preventive services, at a minimum the services specified at 42 CFR 457.520, provided to children under 18 years of age regardless of family income, which reflect the well-baby and well child care and immunizations in the Bright Futures guidelines issued by the American Academy of Pediatrics.
- ■ Pregnancy-related services, including those defined at 42 CFR 440.210(a)(2) and 440.250(p), and counseling and drugs for cessation of tobacco use. All services provided to pregnant women will be considered pregnancy-related, except those services specificially identified in the state plan as not being related to pregnancy.
- ■ Provider-preventable services as defined in 42 CFR 447.26(b).

Enforceability of Exemptions

The procedures for implementing and enforcing the exemptions from cost sharing contained in 42 CFR 447.56 are (check all that apply):

- ■ To identify that American Indians/Alaskan Natives (AI/AN) are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services in accordance with 42 CFR 447.56(a)(1)(x), the state uses the following procedures:
  - ☒ The state accepts self-attestation
  - ☐ The state runs periodic claims reviews
  - ☒ The state obtains an Active or Previous User Letter or other Indian Health Services (IHS) document
  - ☒ The Eligibility and Enrollment and MMIS systems flag exempt recipients

☐ Other procedure

Additional description of procedures used is provided below (optional):

The State accepts self-attestation in response to the question on the single streamlined application inquiring whether the applicant has ever received an item or a service from an I/T/U.

■ To identify all other individuals exempt from cost sharing, the state uses the following procedures (check all that apply):

☒ The MMIS system flags recipients who are exempt

☐ The Eligibility and Enrollment System flags recipients who are exempt

☐ The Medicaid card indicates if beneficiary is exempt

☒ The Eligibility Verification System notifies providers when a beneficiary is exempt

☐ Other procedure

Additional description of procedures used is provided below (optional):

Cost share tracking against the 5% household cap will apply to both premiums and co-payments. When the participant pays their premium, the payment is applied to the aggregate household cap during the quarter for which the premium is due.
The preventive services protocol approved in the Health and Economic Livelihood Plan (HELP) Medicaid 1115 waiver applies to all cost sharing.

Payments to Providers

☑ The state reduces the payment it makes to a provider by the amount of a beneficiary's cost sharing obligation, regardless of whether the provider has collected the payment or waived the cost sharing, except as provided under 42 CFR 447.56(c).

Payments to Managed Care Organizations

The state contracts with one or more managed care organizations to deliver services under Medicaid. No

Aggregate Limits

☑ Medicaid premiums and cost sharing incurred by all individuals in the Medicaid household do not exceed an aggregate limit of 5 percent of the family's income applied on a quarterly or monthly basis.

■ The percentage of family income used for the aggregate limit is:

◉ 5%

○ 4%

○ 3%

○ 2%

○ 1%

○ Other: ____ %

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☑ The state calculates family income for the purpose of the aggregate limit on the followi

◉ Quarterly

○ Monthly

The state has a process to track each family's incurred premiums and cost sharing through a mechanism that does not rely on beneficiary documentation. **Yes**

☑ Describe the mechanism by which the state tracks each family's incurred premiums and cost sharing (check all that apply):

☒ As claims are submitted for dates of services within the family's current monthly or quarterly cap period, the state applies the incurred cost sharing for that service to the family's aggregate limit. Once the family reaches the aggregate limit, based on incurred cost sharing and any applicable premiums, the state notifies the family and providers that the family has reached their aggregate limit for the current monthly or quarterly cap period, and are no longer subject to premiums or cost sharing.

☐ Managed care organization(s) track each family's incurred cost sharing, as follows:

☒ Other process:

The State utilizes an electronic data sharing program that evaluates whether the individual is subject to premiums and co-payments or exempt, whether the service is exempt from a co-payment, and whether the individual has hit the 5% aggregate household cost sharing cap. On a daily basis, payer systems—
MMIS, TPA and Pharmacy Benefit Manager (PBM)—send the electronic data sharing program processed claims. On a daily basis, the electronic data sharing program will send updated cost sharing balances to the MMIS, TPA and PBM. The provider is notified through a remittance advice of the applicable co-payment and the provider will bill the beneficiary.

☑ Describe how the state informs beneficiaries and providers of the beneficiaries' aggregate family limit and notifies beneficiaries and providers when a beneficiary has incurred premiums and cost sharing up to the aggregate family limit and individual family members are no longer subject to premiums or cost sharing for the remainder of the family's current monthly or quarterly cap period:

The State will issue a written notice to a beneficiary when the beneficiary reaches their aggregate household cap. Once the maximum aggregate limit is reached the Electronic Data Exchange (EDX) system will notify the State and a letter will be issued that no further co-pay will be taken in that quarter. This functionality will be in place July 1st, 2016.

Consumers may access information regarding the aggregate household limit through the following avenues: (1) a TPA hotline for TPA enrollees; or (2) an MMIS hotline or online consumer portal for non-TPA enrollees.

The state has a documented appeals process for families that believe they have incurred premiums or cost sharing over the aggregate limit for the current monthly or quarterly cap period. **Yes**

Describe the appeals process used:

The member will use the standard fair hearing process if they disagree with a decision on the aggregate limit. To request a fair hearing the member may call the Office of Fair Hearings or submit a form with their complaint to the office. The fair hearing process is documented in ARM 37.5.307.

☑ Describe the process used to reimburse beneficiaries and/or providers if the family is identified as paying over the aggregate limit for the month/quarter:

The claim will be reprocessed to indicate no co-pay. The provider is responsible to reimburse the member for any co-pay

that was collected in error. When the State sends a notice to the beneficiary that they hit the 5% cap, the notice will also include information that they may have been overcharged by their provider and they should reach out to the provider to seek reimbursement.

☑ Describe the process for beneficiaries to request a reassessment of their family aggregate limit if they have a change in circumstances or if they are being terminated for failure to pay a premium:

Beneficiaries will contact the Office of Public Assistance (OPA) and follow the process outlined by OPA.

The state imposes additional aggregate limits, consistent with 42 CFR 447.56(f)(5). No

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