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State/Territory Name: Montana

State Plan Amendment (SPA) #: MT-17-0040

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Denver Regional Office
1961 Stout Street, Room 08-148
Denver, CO 80294

REGION VIII - DENVER

March 29, 2018

Marie Matthews, Medicaid & CHIP Director
Montana Department of Public Health & Human Services
P.O. Box 4210
Helena, MT 59604

Dear Ms. Matthews:

We have approved the State Plan Amendment (SPA) submitted under transmittal number MT-17-0040. The amendment revises the federal cost-sharing provisions for Montana's Medicaid program and removes reference to the terminated Third Party Administrator (TPA).

Please be informed that this State Plan Amendment was approved on March 29, 2018, with an effective date of January 1, 2018. We are enclosing the summary page and the amended plan page(s).

In addition, we are enclosing a companion letter to MT 17-0040 to address an issue that requires additional action by the State. We look forward to working with Montana to ensure proper implementation of all cost-sharing requirements.

If you have any questions regarding this SPA please contact Barbara Prehmus at (303) 844-7472.

Sincerely,

[redacted]

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

cc: Sheila Hogan, Department Director
Mary Eve Kulawik

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Denver Regional Office
1961 Stout Street, Room 08-148
Denver, CO 80294

REGION VIII - DENVER

March 29, 2018

Marie Matthews, Medicaid & CHIP Director
Montana Department of Public Health & Human Services
P.O. Box 4210
Helena, MT 59604

Dear Ms. Matthews:

We are sending this letter in companion to the approval of state plan amendment (SPA) #17-0040 which was submitted on December 29, 2017. As part of our review, the Centers for Medicare & Medicaid Services (CMS) and the State discussed the state's implementation of the cost sharing exemption of American Indian/Alaska Natives. This letter serves to memorialize the Montana's planned strategy to apply this exemption in a manner which is compliant with federal rules.

As part of our review of SPA #17-0040, Montana described their implementation of the American Indian and Alaska Natives (AI/AN) exemption from premiums and/or cost sharing, which is not consistent with federal rules. Federal rules require that AI/ANs who are eligible to receive or have received an item or service furnished by an Indian health care provider or through referral under contract health services are exempt from premiums; and AI/ANs 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 are exempt from cost sharing. States can elect from a variety of options in the state plan to implement these exemptions such as accepting self-attestation that an AI/AN individual has received a service or is eligible to receive a service from an Indian health care provider or requesting an applicant/beneficiary supply a letter from the Indian health care provider. Indian health care provider means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization. The State informed us that it is not implementing any of the available options outlined in the state plan.

As part of the approval of SPA#17-0040, the State has revised the applicable attestation on the G3 state plan page to indicate that the State will implement the exemption of the AI/ANs in a manner that is consistent with federal rules. Specifically, the State has agreed to flag a beneficiary/applicant as exempt in their eligibility system, CHIMES, when an individual has responded affirmatively to both the question on whether the applicant/beneficiary is an AI/AN and whether the individual has received, is receiving or is eligible to receive a service from an Indian health care provider or contract provider when applying for Medicaid eligibility. The State has agreed to make these system changes to be fully compliant by July 1, 2019.

If you have any questions regarding this companion letter to the approval of MT 17-0040, please contact Barbara Prehmus at (303) 844-7472.

Sincerely,

[redacted]

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

cc: Sheila Hogan, Department Director
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 17-0040

Proposed Effective Date

01/01/2018 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

N/A

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2018	$ 0.00
Second Year	2019	$ 0.00

Subject of Amendment

As mandated in section 14 (1) of Montana Senate Bill 261, the Department must terminate its contract with the Third Party Administrator (TPA), Blue Cross Blue Shield of Montana, of the Health and Economic Livelihood Partnership (HELP) Plan.

Montana will submit a cost share SPA to remove all references to the HELP Plan TPA and remove the HELP Plan TPA cost share table. There will be no changes to the current cost share model.

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:	**Mar 21, 2018**
Submit Date:	**Dec 29, 2017**

Medicaid Premiums and Cost Sharing

State Name: Montana

OMB Control Number: 0938-1148

Transmittal Number: MT - 17 - 0040

Expiration date: 10/31/2014

Cost Sharing Requirements — G1

1916
1916A
42 CFR 447.50 through 447.57 (excluding 447.55)

The state charges cost sharing (deductibles, co-insurance or co-payments) to individuals covered under Medicaid. Yes

☑ The state assures that it administers cost sharing in accordance with sections 1916 and 1916A of the Social Security Act and 42 CFR 447.50 through 447.57.

General Provisions

☑ The cost sharing amounts established by the state for services are always less than the amount the agency pays for the service.

■ No provider may deny services to an eligible individual on account of the individual's inability to pay cost sharing, except as elected by the state in accordance with 42 CFR 447.52(e)(1).

■ The process used by the state to inform providers whether cost sharing for a specific item or service may be imposed on a beneficiary and whether the provider may require the beneficiary to pay the cost sharing charge, as a condition for receiving the item or service, is (check all that apply):

☐ The state includes an indicator in the Medicaid Management Information System (MMIS)

☐ The state includes an indicator in the Eligibility and Enrollment System

☐ The state includes an indicator in the Eligibility Verification System

☐ The state includes an indicator on the Medicaid card, which the beneficiary presents to the provider

☒ Other process

Description:

The State of Montana uses provider Medicaid Manuals to show the maximum allowable co-pay amount for services. These can be found on the Montana Medicaid website, medicaidprovider.mt.gov for each provider type. Montana Medicaid providers are not allowed to charge co-pays at point of service until the claim has gone through the adjudication process and been assessed against the individual's 5% household cap. The remittance advice sent to the provider after claims adjudication will indicate whether a co-pay is charged for the service and the amount due from the member. The State believes this is the only accurate way to keep beneficiaries from being charged above the 5 percent household cap.

The MMIS Verification System will provide information via an online portal and telephone hotline.

When beneficiaries are enrolled in Montana Medicaid they receive a member handbook explaining co-pay information including amounts.

■ Contracts with managed care organizations (MCOs) provide that any cost-sharing charges the MCO imposes on Medicaid enrollees are in accordance with the cost sharing specified in the state plan and the requirements set forth in 42 CFR 447.50 through 447.57.

Cost Sharing for Non-Emergency Services Provided in a Hospital Emergency Department

The state imposes cost sharing for non-emergency services provided in a hospital emergency department. Yes

☑ The state ensures that before providing non-emergency services and imposing cost sharing for such services, that the hospitals providing care:

- ■ Conduct an appropriate medical screening under 42 CFR 489.24, subpart G to determine that the individual does not need emergency services;
- ■ Inform the individual of the amount of his or her cost sharing obligation for non-emergency services provided in the emergency department;
- ■ Provide the individual with the name and location of an available and accessible alternative non-emergency services provider;
- ■ Determine that the alternative provider can provide services to the individual in a timely manner with the imposition of a lesser cost sharing amount or no cost sharing if the individual is otherwise exempt from cost sharing; and
- ■ Provide a referral to coordinate scheduling for treatment by the alternative provider.

☑ The state assures that it has a process in place to identify hospital emergency department services as non-emergency for purposes of imposing cost sharing. This process does not limit a hospital's obligations for screening and stabilizing treatment of an emergency medical condition under section 1867 of the Act; or modify any obligations under either state or federal standards relating to the application of a prudent-layperson standard for payment or coverage of emergency medical services by any managed care organization.

The process for identifying emergency department services as non-emergency for purposes of imposing cost sharing is:

Hospitals are required to comply with federal requirements to screen for and provide services to individuals who require emergency care. The State presumes all visits to the emergency department are not subject to cost sharing, unless the provider provides a written attestation to the State that the provider meets the State's requirements for imposing cost-sharing for non-emergency department services. Specifically, the State will require that a hospital may determine a visit to the emergency department to be a non-emergency and subject the member to a co-payment only if the hospital has a process in place to: (1) screen for and assess whether the visit is a non-emergeny, as required under federal law; (2) provide the individual with the name and location of an alternative non-emergency service provider; (3) determine that the alternative provider can provide services at a lower cost sharing amount; and, (4) provide a referral to schedule treatment by the alternative provider. In the event a visit is determined to be a non-emergency, the hospital may bill the patient once the claim is adjudicated. The State will instruct hospitals of these requirements, establish a hospital attestation process, and inform beneficiaries that they may only be charged a co-payment for non-emergency use of the ER if these conditions are met.

Cost Sharing for Drugs

The state charges cost sharing for drugs. Yes

The state has established differential cost sharing for preferred and non-preferred drugs. Yes

- ■ The state identifies which drugs are considered to be non-preferred.
- ☑ The state assures that it has a timely process in place to limit cost sharing to the amount imposed for a preferred drug in the case of a non-preferred drug within a therapeutically equivalent or similar class of drugs, if the individual's prescribing provider determines that a preferred drug for treatment of the same condition either will be less effective for the individual, will have adverse effects for the individual, or both. In such cases, reimbursement to the pharmacy is based on the appropriate cost sharing amount.

Beneficiary and Public Notice Requirements

☑ Consistent with 42 CFR 447.57, the state makes available a public schedule describing current cost sharing requirements in a manner that ensures that affected applicants, beneficiaries and providers are likely to have access to the notice. Prior to submitting a SPA which establishes or substantially modifies existing cost sharing amounts or policies, the state provides the public with advance notice of the SPA, specifying the amount of cost sharing and who is subject to the charges, and provides reasonable opportunity for stakeholder comment. Documentation demonstrating that the notice requirements have been met are submitted with the SPA. The state also provides opportunity for additional public notice if cost sharing is substantially modified during the SPA approval process.

Other Relevant Information

Montana has notified the public and provided opportunities for public input on cost sharing requirements through its website as well as the 1115 Waiver public notice process. Montana has taken the following public notice actions; respective dates are noted next to each action.

1. Published Montana Administrative Register 37-730 (October 29, 2015)
2. Published public notice in newspapers in three of Montana's largest communities (November 22, 2015)
3. Posted public notice on the DPHHS website (November 19, 2015)
4. Sent an informational memo to the Montana Health Coalition (State's medical advisory committee) members, ad hoc members, and interested parties and posted the memo to the DPHHS website (November 18, 2015)
5. Hosted a public meeting and webinar to collect input on the Basic Medicaid Waiver (December 2, 2015)
6. Presented and discussed the transition and Basic Medicaid Waiver in public meetings/forums that included the opportunity for public comment, including: (1) HELP Act legislative public hearings in both the Montana Senate and House of Representatives (March and April 2015); (2) In-person tribal consultations with the State's tribal governments, tribal health programs, Urban Indian Centers, and the Indian Health Service in Helena, Montana (August 2015); (3) National Alliance for Mental Illness statewide conference in Billings, Montana (October 2015); (4) Meeting of Mental Health Center Directors in Helena, Montana (November 2015); (5) Legislative Interim Children, Families, Health, and Human Services Committee in Billings, Montana (November 2015); and Weekly meetings between the Governor's Office and stakeholders (ongoing).

V.20140415

Medicaid Premiums and Cost Sharing

State Name: Montana

OMB Control Number: 0938-1148

Transmittal Number: MT - 17 - 0040

Expiration date: 10/31/2014

Cost Sharing Amounts - Targeting G2c

1916
1916A
42 CFR 447.52 through 54

The state targets cost sharing to a specific group or groups of individuals. Yes

Population Name (optional):

Eligibility Group(s) Included: Adults aged 19-64 in Montana who have incomes between 51% FPL and 138% FPL

Incomes Greater than 0% FPL TO Incomes Less than or Equal to 138% FPL

	Service	Amount	Dollars or Percentage	Unit	Explanation	
+	Inpatient Hospital	10.00	%	Entire Stay	Members 101% - 138% FPL. 10% of the payment the State makes for the service.	X
+	Inpatient Hospital	75.00	$	Entire Stay	Members 0- 100% FPL.	X
+	Durable Medical Equipment	10.00	%	Item	Members 101% - 138% FPL. 10% of the payment the State makes for the service.	X
+	Durable Medical Equipment	4.00	$	Item	Members 0 - 100% FPL.	X
+	Lab/Radiology	10.00	%	Procedure	Members 101% - 138% FPL. 10% of the payment the State makes for the service.	X
+	Lab/Radiology	4.00	$	Procedure	Members 0 - 100% FPL.	X
+	Primary Care Physician	10.00	%	Visit	Members 101% - 138% FPL. 10% of the payment the State makes for the service. Services that are considered preventive services and therefore exempt from copayments are outlined in the 1115 Waiver and Preventive Services Protocol.	X
+	Primary Care Physician	4.00	$	Visit	Members 0 - 100% FPL. Services that are considered preventive services and therefore exempt from copayments are outlined in the 1115 Waiver and Preventive Services Protocol.	X
+	Outpatient Hospital	10.00	%	Visit	Members 101% - 138% FPL. 10% of the payment the State makes for the service.	X
+	Outpatient Hospital	4.00	$	Visit	Members 0 - 100% FPL.	X
+	Specialist	10.00	%	Visit	Members 101% - 138% FPL. 10% of the payment the State makes for the service.	X
+	Specialist	4.00	$	Visit	Members 0 - 100% FPL.	X

Medicaid Premiums and Cost Sharing

	Service	Amount	Dollars or Percentage	Unit	Explanation	
+	Mid-Level Practitioner	10.00	%	Visit	Members 101% - 138% FPL. 10% of the payment the State makes for the service.	X
+	Mid-Level Practitioner	4.00	$	Visit	Members 0 - 100% FPL.	X
+	Psychiatrist	10.00	%	Visit	Members 101% - 138% FPL. 10% of the payment the State makes for the service.	X
+	Psychiatrist	4.00	$	Visit	Members 0 - 100% FPL.	X
+	Behavioral Health Provider	10.00	%	Visit	Members 101% - 138% FPL. 10% of the payment the State makes for the service.	X
+	Behavioral Health Provider	4.00	$	Visit	Members 0 - 100% FPL.	X
+	Other Medical Professional	10.00	%	Visit	Members 101% - 138% FPL. 10% of the payment the State makes for the service.	X
+	Other Medical Professional	4.00	$	Visit	Members 0 - 100% FPL.	X
+	Denturists	10.00	%	Visit	Members 101% - 138% FPL. 10% of the payment the State makes for the service.	X
+	Denturists	4.00	$	Visit	Members 0 - 100% FPL.	X
+	Federally Qualified Health Center	10.00	%	Visit	Members 101% - 138% FPL. 10% of the payment the State makes for the service.	X
+	Federally Qualified Health Center	4.00	$	Visit	Members 0 - 100% FPL.	X
+	Rural Health Clinic	10.00	%	Visit	Members 101% - 138% FPL. 10% of the payment the State makes for the service.	X
+	Rural Health Clinic	4.00	$	Visit	Members 0 - 100% FPL.	X
+	Dialysis Clinic	10.00	%	Visit	Members 101% - 138% FPL. 10% of the payment the State makes for the service.	X
+	Dialysis Clinic	4.00	$	Visit	Members 0 - 100% FPL.	X
+	Ambulatory Surgical Center	10.00	%	Visit	Members 101% - 138% FPL. 10% of the payment the State makes for the service.	X
+	Ambulatory Surgical Center	4.00	$	Visit	Members 0 - 100% FPL.	X
+	Independent Diagnostic Testing Facility	10.00	%	Visit	Members 101% - 138% FPL. 10% of the payment the State makes for the service.	X
+	Independent Diagnostic Testing Facility	4.00	$	Visit	Members 0 - 100% FPL.	X
+	Podiatry	10.00	%	Visit	Members 101% - 138% FPL. 10% of the payment the State makes for the service.	X
+	Podiatry	4.00	$	Visit	Members 0 - 100% FPL.	X
+	Home Infusion Therapy (codes 99601 and 99602 are exempt)	10.00	%	Visit	Members 101% - 138% FPL. 10% of the payment the State makes for the service.	X
+	Home Infusion Therapy (codes 99601 and 99602 are exempt)	4.00	$	Visit	Members 0 - 100% FPL.	X
+	Non-Emergency Use of the ER	8.00	$	Visit	Individuals with income 51-138% of the FPL.	X

	Service	Amount	Dollars or Percentage	Unit	Explanation	
+	Pharmacy	4.00	$	Prescription	For preferred brands. Pharmacy drugs that are considered preventive services and therefore are exempt from copayments are outlined in the 1115 Waiver and Preventive Services Protocol.	X
+	Pharmacy	8.00	$	Prescription	For non-preferred. Pharmacy drugs that are considered preventive services and therefore are exempt from copayments are outlined in the 1115 Waiver and Preventive Services Protocol.	X

The state permits providers to require individuals to pay cost sharing as a condition for receiving items or services, subject to the conditions specified at 42 CFR 447.52(e)(1). This is only permitted for non-exempt individuals with family income above 100% FPL. **No**

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

If the state targets cost sharing for non-preferred drugs to specific groups of individuals (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 to specific individuals (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**

Remove Population

Add Population

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

Medicaid Premiums and Cost Sharing

State Name: Montana

OMB Control Number: 0938-1148

Transmittal Number: MT - 17 - 0040

Expiration date: 10/31/2014

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

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. If the applicant affirms an item or service has ever been received from an I/T/U this information is coded into the States eligibility system (CHIMES), and sent with the copay indicator of "No" to the fiscal intermediary (MMIS) for cost share exemption.

■ 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: [ ] %

[■] The state calculates family income for the purpose of the aggregate limit on the following basis:

- (•) 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 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 and PBM. The provider is notified through a remittance advice of the applicable co-payment and the provider will bill the beneficiary. 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.

[■] 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. Consumers may access information regarding the aggregate household limit through a benificiary hotline or online consumer portal.

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

PRA Disclosure Statement

V.20140415