Table of Contents

State/Territory Name: Montana

State Plan Amendment (SPA) #: 18-0004

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

CENTERS FOR MEDICARE & MEDICAID SERVICES

REGION VIII - DENVER

May 22, 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 reviewed the proposed State Plan Amendment (SPA) submitted under transmittal number MT-18-0004. This amendment adds foster children to the Montana Medicaid Comprehensive Primary Care Plus (CPC+) Program as a voluntary population and removes the HELP Third Party Administrator references.

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

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
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: 18-0004	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 01/01/2018	

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: 1932(a)	7. FEDERAL BUDGET IMPACT: a. FFY 2017 (9 months): $466,932.60 b. FFY 2018 (12 months): $622,576.80 c. FFY 2019 (3 months): $155,644.20
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 3.1-F, Section 2: Montana Medicaid CPC+ Program Pages 1-15 of 15	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 3.1-F, Section 2: Montana Medicaid CPC+ Program Pages 1-15 of 15

10. SUBJECT OF AMENDMENT:

Add the foster children population to the Montana Medicaid Comprehensive Primary Care Plus (CPC+) Program and removing HELP Third Party Administrator references.

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 Review

12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]	16. RETURN TO: Montana Department of Public Health and Human Services Mary E. Dalton Attn: Mary Eve Kulawik PO Box 4210 Helena MT 59620
13. TYPED NAME: Mary E. Dalton	
14. TITLE: State Medicaid Director	
15. DATE SUBMITTED: 3-22-18	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: March 22, 2018	18. DATE APPROVED: May 22, 2018
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: January 1, 2018	20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]
21. TYPED NAME: Richard C. Allen	22. TITLE: ARA, DMCHO

23. REMARKS:

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

B. Managed Care Delivery System.
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)
   a. ☒ Case management fee
   b. ☒ Bonus/incentive payments
   c. ☒ Other (please explain below)

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

Citation	Condition or Requirement

For the purposes of the Comprehensive Primary Care Plus (CPC+) Initiative, Montana Medicaid will only contract with primary care practices that are selected by CMS to participate in CPC+. CPC+ practices will receive a per member per month (PMPM) care management fee. The payment structure will align with Medicare and, when possible, with the other CMS selected CPC+ payers.

a. *Practices in Track 1 for CPC+ will receive four tiers of PMPM payments, depending on patient risk and level of care management required.*
b. *Practices in Track 2 will receive five tiers of PMPM payments; the top tier is for the most complex patients.*

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.

Montana Medicaid will pay performance-based incentive payments to CPC+ practices annually, based on the practice's ability to meet the agreed upon performance benchmarks. This payment will be a quality bonus paid out retrospectively. CPC+ practices that meet quality and utilization thresholds will be rewarded with CPC+ Medicaid per member per year (PMPY) payments. These bonus incentive payments will be based on utilization measures and quality measure performance benchmarks.

Citation	Condition or Requirement

CPC+ Practices in Track 2 will also receive Medicaid performance-based payments for utilization and quality, but at a slightly higher rate due to the more complex and robust care management capabilities required of the practice. The incentive payment differs based on the Track the practice is assigned to by CMS.

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.)*

The Department held tribal consultation on June 7, 2017, with the State's seven federally recognized Tribes, the Little Shell, Billings Area Indian Health Service, and Urban Indian Health Centers; and tribal consultation letters were mailed on December 27, 2017. Public notice was published on December 23, 2017, in the State's three major newspapers.

Medicaid CPC+ Development and Implementation Process
Montana Medicaid will work with a multi-stakeholder group in development and implementation of CPC+ and a payer table to streamline efforts in value-based payment and alleviate burden on providers.

Citation	Condition or Requirement

1. ***Payer Table****: Montana Medicaid will work regularly with other payers in an effort to align attribution methodologies, enhanced payments, performance-based incentives, alternative to fee-for-service payments, data sharing, and quality and patient experience measures.*

2. ***Montana CPC+ Workgroup****: The purpose of the multi-stakeholder workgroup for the Montana CPC+ Program is to ensure strategic alignment, critical review, and coordination of the community's individual and collaborative efforts to achieve measurable improvement in:*
   - *population health,*
   - *the health care experience, and*
   - *the cost of care received by patients attributed to the practices selected for CPC+.*

   Specifically, the CPC+ Workgroup will seek to:
   - *form consensus on common goals and desired outcomes for the CPC+ program;*
   - *define and operationalize goals and outcomes to enable effective execution for all partners;*
   - *work to identify necessary resources to support the adoption of sustainable, successful regional innovations;*
   - *serve as a unified voice to CMS to advocate, update, and share information and concerns on behalf of the Montana CPC+ Program;*
   - *promote CPC+ by educating the community and being a champion of the effort; and*
   - *align, where possible, with state initiatives, including the Montana PCMH Program.*

   Members of the work group include:
   - *representatives from each of the participating payers; and*
   - *primary care practice representatives participating in the Montana CPC+ Program, including clinical and operations staff from independent practices and health systems, practices in both Track 1 and Track 2, and practices across Montana geographic regions.*

Citation	Condition or Requirement

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.
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 447.362 42 CFR 438.50(c)(6)	8.	☒The state assures that all applicable requirements of 42 CFR 447.362 for 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.

Citation | Condition or Requirement

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.

Population	**M**	**Geographic Area**	V	**Geographic Area** Statewide, but limited to practices selected by CMS for CPC+.	**Excluded**
Section 1931 Children & Related Populations – 1905(a)(i)			✔		
Section 1931 Adults & Related Populations1905(a)(ii)			✔		
Low-Income Adult Group			✔		
Former Foster Care Children under age 21			✔		
Former Foster Care Children age 21-25			✔		
Section 1925 Transitional Medicaid age 21 and older			✔		
SSI and SSI related Blind Adults, age 18 or older* - 1905(a)(iv)			✔		
Poverty Level Pregnant Women – 1905(a)(viii)			✔		
SSI and SSI related Blind Children, generally under age 18 – 1905(a)(iv)			✔		
SSI and SSI related Disabled children under age 18			✔		
SSI and SSI related Disabled adults age 18 and older – 1905(a)(v)			✔		
SSI and SSI Related Aged Populations age 65 or older- 1905(a)(iii)			✔		

Citation | Condition or Requirement

Population	**M**	**Geographic Area**	V	**Geographic Area** Statewide, but limited to practices selected by CMS for CPC+.	**Excluded**
SSI Related Groups Exempt from Mandatory Managed Care under 1932(a)(2)(B)			✔		
Recipients Eligible for Medicare					✔
American Indian/Alaskan Natives			✔		
Children under 19 who are eligible for SSI			✔		
Children under 19 who are eligible under Section 1902(e)(3)			✔		
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)			✔		
Other – Individuals at or below 138% FPL Age 19 through 64-1902 (a)(10)(A)(i)(VIII)			✔		

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:

☒Other Insurance--Medicaid beneficiaries who have other health insurance.

☒Reside in Nursing Facility or ICF/MR--Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

☐Enrolled in Another Managed Care Program--Medicaid beneficiaries who are enrolled in Medicaid's managed care program.

Citation	Condition or Requirement

☒Eligibility Less Than 3 Months--Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program.

☐ Participate in HCBS Waiver--Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).

☒ Retroactive Eligibility–Medicaid beneficiaries for the period of retroactive eligibility.

☒Other (Please define):

All Montana Medicaid members enrolled in Passport under the federal 1915(b) waiver authority are eligible to voluntarily participate in the statewide Medicaid CPC+.

Other Excluded Groups:

- *Medicare Dual Eligibles;*
- *Medically needy members with a spend down;*
- *Subsidized adoption members;*
- *Members who are unable to find a Primary Care Provider (PCP) who is willing to provide case management;*
- *Section 1115 Plan First family planning eligibles;*
- *Presumptive Medicaid eligibles; and*
- *Members residing in a Psychiatric Residential Treatment Facility (PRTF).*

Exempt Groups:

- *Members with Third Party Liability (TPL);*
- *Out of state foster care youth;*
- *Residents of an out of state treatment center;*
- *Members who do not have 30 days' notice of their provider leaving;*
- *Members whose PCP refuses to see them or provide referrals;*
- *Infants in the Neonatal Intensive Care Unit (NICU);*
- *Members requesting a medical hardship;*

Citation	Condition or Requirement

Exempt Groups Continued):

- *Inpatient admits to a treatment center, including but not limited to inpatient chemical dependency centers or inpatient mental health centers; and*
- *Members whose enrollment with a provider must be corrected.*

CPC+ attribution

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

CPC+ member eligibility

Medicaid will designate which members are eligible for the CPC+ program. Passport members who choose or are assigned, through the established algorithm, to a CPC+ provider will be included in the CPC+ program with their selected provider. Members can opt out of the CPC+ program and choose or be assigned a different provider.

Members enrolled in the Children's Health Insurance Plan (CHIP) are operated by a Third Party Administrator (TPA) and will be enrolled into their CPC+ program if the member meets the criteria set forth by the TPA's CPC+ program. Blue Cross Blue Shield of Montana (BCBSMT) is Montana Medicaid's TPA for CHIP members. CPC+ attribution for CHIP members will be determined by BCBSMT's method.

Montana Medicaid may periodically enhance the attribution process in an effort to improve the performance of the program and align better with other willing payers in the state. Montana Medicaid will provide each participating practice with a report containing all members attributed to their practice in the designated time frame. Montana Medicaid will collaborate with Medicare and other payers in the state through the multi-payer collaborative to best align attribution methodologies when possible.

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 healthplan.

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

Citation	Condition or Requirement

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 CPC+ provider at the time of application.

      i. How the state fulfills its obligations to provide information as specified in 42 CFR 438.10(e).
      Montana Medicaid members are required to select a primary care provider within a 45-day choice period. Members receive a reminder letter, an outreach call and are given 45 days to select a provider.

      ii. What action the state takes if the applicant does not indicate a plan selection on the application.
      If the member does not choose a primary care provider within 45 days then they are auto-assigned to one. Members are not auto-assigned to a provider unless they have not chosen a provider themselves.

      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).
      The Medicaid system will automatically assign members after their 45-day choice period to a provider appropriate to the member's age, sex, and location based on the following criteria (in order):
      a. Previous provider enrollment;
      b. Claims information;
      c. Family provider enrollment;
      d. Native American members who have declared a tribal enrollment who live in a county where there is an IHS provider; and
      e. Randomly, to a provider in the member's geographic area who is accepting new members.

      iv. The state's process for notifying the beneficiary of the default assignment. (Example: *state generated correspondence.*)
      Members who have not chosen and are assigned to a provider are notified at least ten days in advance of the effective assignment to allow members to notify Montana Medicaid if they would like to select a different provider. Members may change their provider up to once per month, but the change is not effective until the following month, depending on the date the choice is made. Members are notified of the primary care provider they've been assigned in a mailed letter.

Citation	Condition or Requirement

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 telephone call from Medicaid's Enrollment Broker.

If the Passport provider a member chooses or is auto-assigned to is a CPC+ provider, the member is automatically part of the provider's CPC+ caseload.

ii. How the state fulfills its obligations to provide information as specified in 42 CFR 438.10(e).
The State fulfills its obligation to provide information for potential enrollees through Enrollment Broker telephone calls, web tutorials, and welcome to Passport mailings.

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 Medicaid system will automatically assign members after their 45 day choice period to a provider appropriate to the member's age, sex, and location based on the following criteria (in order):
a. Previous provider enrollment;
b. Claims information;
c. Family provider enrollment;
d. Native American members who have declared a tribal enrollment who live in a county where there is an IHS provider; and
e. Randomly, to a provider in the member's geographic area who is accepting new members.

iv. The state's process for notifying the beneficiary of the default assignment.
Medicaid members are notified of the provider default assignment by letter from the 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).

ii. The state's process for notifying the beneficiary of the auto-assignment. (*Example: state generated correspondence.*)

Citation	Condition or Requirement

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).

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 M C O 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.

e. ☐ 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.

f. ☒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.

Citation	Condition or Requirement
1932(a)(4) 42 CFR 438.56	G. Disenrollment
	1. The state will☐/will not ☒limit disenrollment for managed care.
	2. The disenrollment limitation will apply for months (up to 12 months).
	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 contracted CPC+ providers must give education materials to each Medicaid member attributed to their practice. The materials must explain the process for members to dis-enroll from the program, change their provider, and the CPC+ services available to them. Member education is provided through program materials, written communication, and telephone calls.*
	5. Describe any additional circumstances of "cause" for disenrollment (if any). *No specific "cause" is needed on part of the Medicaid member to dis-enroll from a CPC+ 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. *Providers will not notice members on Medicaid internal appeals and grievances processes regarding prior authorization or denied claims, they are only required to provide information specific to the CPC+ program.*
1932(a)(5)(D)(b) 1903(m) 1905(t)(3)	I. List all benefits for which the MCO is responsible. *Montana Medicaid CPC+ providers are required to reach out to their attributed members to explain to them what services are offered through their CPC+ model and how to dis-enroll or change providers.*
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. *The State reviews the Network Adequacy report monthly to ensure members have access to covered services through an adequate provider network. To date, there have been no issues concerning access to primary care providers in the state.*

Citation		Condition or Requirement
42 CFR 438.207		
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 is only allowed by CMS to offer the CPC+ program to the practices that were selected by CMS as CPC+ practices as having met the required criteria and signed CMS participation agreements.* 4. ☐The selective contracting provision in not applicable to this state plan.