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State/Territory Name: Montana

State Plan Amendment (SPA) #: 18-0010

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 3, 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-18-0010. This amendment permanently terminates Montana's Third Party Administrator (TPA) Alternative Benefit Plan (ABP), in recognition of the termination of the State's contract with MT Blue Cross/Blue Shield. Those Medicaid HELP expansion members previously served through the TPA ABP have been transitioned into the State's Medicaid Aligned ABP, in accordance with MT 18-0009. Those individuals exempt from ABP enrollment will be enrolled into State's Medicaid program.

Please be informed that this State Plan Amendment was approved May 3, 2018, with an effective date of January 1, 2018. We are enclosing the summary page equivalent of the CMS 179.

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
Mary Eve Kulawik

Medicaid Alternative Benefit Plan: 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 18-0010

Proposed Effective Date

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

Federal Statute/Regulation Citation

Federal Budget Impact

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

Subject of Amendment

This state plan amendment pertains to the State's intent to permanently terminate the Adult Expansion Group – HELP Program Third Party Administrator (TPA) Alternative Benefit Plan (15-0027 ABP), effective January 1, 2018.

This termination request is consistent with the recent amendments to the 1115 HELP Plan Waiver, to remove the TPA.

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 24, 2016**

Submit Date:

Medicaid Alternative Benefit Plan: General Information

State/Territory name: **Montana**

Transmittal Number: **MT 18-0010**

General Information:

Submission Title:

short (under 100 characters) label used to identify this submission in the web application

MT 18-0010 Montana HELP Program TPA ABP permanent termination

Description:

This state plan amendment pertains to the State's intent to permanently terminate the Adult Expansion Group – HELP Program Third Party Administrator (TPA) Alternative Benefit Plan (15-0027 ABP), effective January 1, 2018.

☑ Public notice has been conducted prior to SPA submission pursuant to 42 CFR 440.386.

ABP Screening Statements to Indicate Required Forms

Select one of the following options for eligibility group coverage:

◉ **The population group for this Alternative Benefit Plan includes only** the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act. *If the state selects this option, the state must complete form ABP2a to indicate agreement to voluntary benefit package selection assurances for the adult group.*

○ **The population group for this Alternative Benefit Plan includes the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act, and also includes other groups.** *If the state selects this option, the state must complete forms ABP2a and ABP2b to indicate agreement to voluntary benefit package selection assurances for the adult group and voluntary enrollment assurances for other eligibility groups.*

○ **The population for this Alternative Benefit Plan does not include the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.** *If the state selects this option, the state must complete form ABP2b to indicate agreement to voluntary enrollment assurances for these eligibility groups.*

☐ Enrollment is mandatory for some or all participants. *If selected, the state must complete form ABP2c to indicate agreement to mandatory enrollment assurances.*

Specify the number of **benchmark** benefit packages that will be created or amended with this submission. *The state must submit one version of forms ABP3, ABP4, ABP5, and ABP8 for each benchmark benefit package.* 0

Specify the number of **benchmark-equivalent** benefit packages that will be created or amended with this submission. *The state must submit one version of forms ABP3, ABP4, ABP6, and ABP8 for each benchmark-equivalent benefit package.* 1