Montana Medicaid and Healthy Montana Kids *Plus*

Member Guide

Effective 01/01/2020

Welcome

Medicaid's Mission

To assure that necessary medical care is available to all eligible Montanans within available funding resources.

You Matter

It's great to be a member of the Montana Medicaid or Healthy Montana Kids *Plus* (Medicaid for children) program. It means you can get help with most health concerns. Getting or keeping you healthy is important to us. Medicaid has a number of staff and programs to meet your healthcare needs.

This Guide is for people who are eligible for Montana Medicaid/Healthy Montana Kids *Plus* and receive the Standard Medicaid benefit. This guide will help to explain coverage, benefits, and rights and responsibilities.

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1. About Montana Medicaid

Montana Medicaid and Healthy Montana Kids *Plus*

Montana Medicaid is healthcare coverage for some low-income Montanans. Medicaid is run by the Montana Department of Public Health and Human Services (DPHHS).

Healthy Montana Kids *Plus* (HMK *Plus*) is **Medicaid** health coverage for low-income children in Montana and is also run by DPHHS.

The State of Montana pays about one-third of the cost of Medicaid and HMK *Plus* and the federal government pays the rest.

Medicaid and HMK *Plus* do not pay money to you. Instead, payments for healthcare services are sent directly to your healthcare providers.

For Medicaid and HMK *Plus* to pay for healthcare:

- services must be medically necessary;
- services must be provided by a healthcare provider who is a Montana Medicaid or HMK *Plus* provider; and
- services must be Medicaid or HMK *Plus* covered services.

Did You get a Medicaid or HMK *Plus* Card?

Here is what a Montana Access to Health card for adults looks like

Here is what a Healthy Montana Kids *Plus* card looks like

Adults with Medicaid will get a plastic “Montana Access to Health” card in the mail. Kids with HMK *Plus* will get a plastic “Healthy Montana Kids *Plus*” card in the mail. Each person will get his or her own card. Keep your card in a safe place. **Always take your card with you to your appointments and show it when you check in.**

If the information on your card is not right, tell the Office of Public Assistance (OPA) right away. If you haven’t received your health coverage card or you lose your card before you need medical care, contact the **Montana Public Assistance Helpline at 1-888-706-1535.**

Keep your card, even if your Medicaid or HMK *Plus* ends. If you get Medicaid or HMK *Plus* again in the future, you will use the same card.

The front of your card has your name, your member number, and your birth date. The member number is a unique identifier that is not your Social Security Number.

The back of your card has information about using the card and the **Medicaid/HMK *Plus* Member Help Line phone number, 1-800-362- 8312**. The back of the card also has information for your provider.

If you Move, Get Married, have a Baby or have Other Changes

Tell the Office of Public Assistance within 10 days if you have changes in your household. Some examples:

- change your mailing address;
- change your telephone number;
- marry or divorce;
- move to a nursing home;
- become pregnant;
- have a baby;
- change jobs;
- get other insurance; or
- have changes in your assets or income.

A case manager will tell you if you're still eligible for Medicaid or HMK *Plus*.

Nurse First Advice Line

Nurse First is a **free telephone nurse advice** line you can call when you are sick, hurt, or have health questions. Call the **Nurse First Advice Line at 1-800-330-7847** and talk with a registered nurse **24-hours a day, 7 days a week.** Nurse First is for members with Medicaid, or HMK *Plus* health coverage.

Before you go to your provider or the emergency room, call Nurse First. You may be able to treat the problem at home. Nurses licensed in the State of Montana at Nurse First can guide you to the right care, at the right place.

➢ Nurse First Advice Line can help you with Problems Like:

- fever;
- earache and headache;
- flu and sore throat;
- skin rash;
- vomiting or upset stomach;
- colds and coughing; and
- back pain.

If you have just found out you have diabetes, heart disease, high cholesterol, or any other health issue, the Nurse First Advice Line may give you information and help answer your questions.

➢ Don't call Nurse First when:

- You have a health concern you are sure is life threatening. In this case, **call 911** or go directly to the emergency room;
- It's time for your child's next well-child checkup or immunizations. Call your provider's office directly to schedule an appointment;
- You've seen your provider for a specific health problem and a follow-up appointment is needed. Call the office directly to schedule the appointment;
- You've seen your provider for a specific health problem, and they refer you to a specialist. Call the specialist's office directly to set up an appointment; or
- You, or your child, need regular services such as transfusions or dialysis. Make the series of appointments directly with your provider's office.

Remember, if you are not sure you should go to the emergency room, call the **Nurse First Advice Line at 1-800-330-7847.** The call is free. Registered nurses are available 24 hours a day, 7 days a week to help you.

What if I'm on the HELP Medicaid Plan, also known as Medicaid Expansion?

➢ HELP/Medicaid Expansion Program

The Montana Health and Economic Livelihood Partnership (HELP) Program, also known as Medicaid Expansion, provides health coverage to adults ages 19-64 with incomes up to 138% of the federal poverty level (FPL); who are Montana residents, not eligible for Medicare, and not incarcerated.

➢ Medicaid Card

HELP/Medicaid Expansion Program members will receive a Montana Access to Health card.

➢ Benefits

You are eligible to receive Standard Medicaid Benefits. See *Covered and Non-Covered* Services of this guide.

➢ Providers

You can get health services from any doctor, clinic, or other health care provider who accepts Montana Medicaid.

➢ Premiums

Note: The dollar amounts highlighted below are effective 01/01/2020 but are expected to change on 04/01/2020.

As a member of the HELP/Medicaid Expansion Program you pay a monthly premium. Your premium helps cover the cost of your health insurance. The HELP/Medicaid Expansion Program premium will total two percent (2%) of your yearly income billed monthly. Submit your payment with the payment stub included in your monthly bill. Premiums are due on the 1st of each month.

For members at or below one hundred percent (100%) of the Federal Poverty Level (FPL), which equals approximately $1,041 per month for an individual, or $2,146 per month for a family of four, failure to pay premiums will not result in dis-enrollment. Unpaid premiums for all members become a debt to the State and will be collected against future tax refunds. You can call DPHHS at 1-866-471-9621 to ask about your premium status.

➢ Premium Rights and Obligations

Note: The dollar amounts highlighted below are effective 01/01/2020 but are expected to change on 04/01/2020.

Even if you cannot pay your premium, you may still be able to keep HELP/Medicaid Expansion Program coverage. You will remain in the HELP/Medicaid Expansion Program if:

A. Your income is under 100% of the FPL, which is approximately $1,041 a month for an individual, or $2,146 a month for a family of four; or

B. If your income is above 100% of the FPL, you may lose your coverage if you fail to pay your premiums. You are still responsible for the payment of your premiums. This unpaid premium balance will be transferred to the State of Montana for collection from your state income tax refund.

Even if you cannot pay your premiums, you may be able to keep HELP/Medicaid Expansion Program coverage if you meet two or more of these circumstances, including:

- You have been discharged from the United States military services within the previous 12 months;
- You are enrolled for credit in a Montana university, Tribal college, or any other accredited college in Montana that offers at least a two- year degree;
- You see a primary care provider who is part of a qualified primary care case management program;
- You are in a substance use treatment program; or
- You are in a DPHHS approved wellness program.

If Montana DPHHS determines that you meet two or more of these conditions, you will continue to have access to the health care services covered by the HELP/Medicaid Expansion Program. You will still be responsible for payment of your premiums.

If two of the items above describe you, go to **apply here**, call 1-888-706-1535, or visit any local Office of Public Assistance. If you are disenrolled because you have unpaid (delinquent) premiums, you may reenroll in the HELP/Medicaid Expansion Program after:

A. You have paid your unpaid premium balance in full; **or**

B. You have received notice from the State of Montana that your unpaid premium balance has been assessed against your future state income tax. This

assessment occurs once per calendar quarter.

Members that would like to re-enroll may contact the Montana Public Assistance Help Line at 844-792-2460 or **apply here.**

72-Hour Presumptive Eligibility Program (for mental health crisis)

The 72-Hour Presumptive Eligibility program is funded through the Addictive and Mental Disorders Division. The purpose of this program is to provide mental health crisis services to individuals not currently enrolled in Medicaid. For more information on the 72-hour program, contact 1-406- 444-3964.

Presumptive Eligibility Program (PE)

Presumptive eligibility (PE) is short term coverage, for people who are not yet on Medicaid, and is available once every 12 months (or, once per pregnancy). It is designed to provide short-term healthcare coverage to persons with sudden, serious healthcare needs while Medicaid eligibility is explored. PE lasts from the date of determination until a determination of Medicaid program eligibility is made, or until the last day of the month following the month of determination, whichever is earlier.

Hospitals and other designated facilities participating in Montana Medicaid can make presumptive eligibility determinations for the following groups:

- Children (HMK *Plus* and HMK (CHIP));
- Pregnant women (Ambulatory Prenatal Care);
- Parent/Caretaker Relative Medicaid;
- Former Foster Care Children (ages 18 up to 26); and
- Breast and Cervical Cancer.

If You have Other Questions or Concerns

➢ What if you get a bill?

If you sign an Advanced Beneficiary Notice (private pay agreement) before receiving services, providers may bill you for:

- non-covered services;
- experimental services;
- unapproved services;
- covered but medically unnecessary services,

- unapproved services that require referral from your Passport to Health provider;
- services performed in an inappropriate setting;
- services received when you are not eligible for Medicaid; and
- investigational services.

You are responsible to pay for the service if you signed an agreement before the service was provided. If you think a provider is billing both you and Medicaid or HMK *Plus* for the same service, or is charging Medicaid, HMK *Plus*, or you for services you did not receive, call the **Medicaid/HMK *Plus* Member Help Line at 1-800-362-8312.**

Medicaid and HMK *Plus* usually do not pay your provider the full amount the provider charges for services. Your provider has agreed to accept the lower payment amount. You do not pay the amount above what Medicaid or HMK *Plus* pays.

If you have questions about a bill from your provider, try to work with your provider's office to get an answer. If you still need help, call the **Medicaid/HMK *Plus* Member Help Line at 1-800-362- 8312.**

➢ Can you get help getting to your appointment?

Medicaid or HMK *Plus* may pay for you to get to your healthcare provider or other healthcare service, if the service is covered by Medicaid or HMK *Plus*, and if you have no other way to get there. See pages 41 & 42 for details about transportation coverage.

➢ Do you need an interpreter?

If English is not your first language, or you have trouble understanding English, please ask your case manager, Medicaid provider or HMK *Plus* provider for an interpreter who speaks or signs your language. The interpreter can explain Medicaid or HMK *Plus* to you. Interpreters are free and available, including sign language.

➢ Do you have trouble hearing?

If you are hard of hearing or have a speech disability, call the **Montana Telecommunications Access Program (MTAP) at 1-800-833-8503**. They will give you more information about louder volume telephones, captioned telephones, and hands-free devices.

If you are deaf or hard of hearing and want direct call relay service, the Montana Relay call service will relay your phone calls – just call **711 or 1-800-253-4091**. The Montana Relay customer service number is **1- 800-833-8503**.

➢ If you have not had Medicaid for months

To reapply for Medicaid, HMK *Plus*, or HMK (CHIP) complete an online Medicaid application at **apply here**, or complete a paper application and give it to any county Office of Public Assistance (OPA), either in person or by mail. To find the location of your local OPA call the **Montana Public Assistance Helpline at 1-888-706-1535**.

➢ If you have more questions, contact your Office of Public Assistance (OPA)

To find the location of your local OPA call the Montana Public Assistance Helpline at **1-888- 706-1535.**

2. Your Passport to Health

Passport to Health

Passport to Health (Passport) is a Medical Home Program.

What is a medical home?

A medical home is your choice of one provider and ideally one pharmacy who will coordinate most, or all your health care needs.

This means any time you are sick, hurt, need medicine or need to see your doctor for an exam, you see the same provider. You work together to understand your health status, any medications you may take, and your health history. This helps you and your provider make good decisions, so you get the best healthcare possible.

Most members who have Medicaid or HMK *Plus* must participate in the Passport program.

Your Passport Provider

You will choose a dedicated Montana Medicaid Passport provider such as a physician, nurse practitioner, physician assistant, community health center, tribal health, Indian Health Service (IHS), or a primary care clinic. Your Passport provider will take care of most of your medical needs, make referrals to other providers as necessary, and keep your medical records up to date and in one place. With some exceptions, all medical appointments must be provided or approved by your Passport provider.

What to Expect from Your Passport Provider

Your Passport provider has agreed to several requirements to help coordinate your care. Your Passport provider should:

- provide primary care, preventive care, health maintenance, treatment of illness and injury, and coordinate your access to specialty care by providing referrals;
- assist you with finding services;
- provide or arrange for well-child checkups; children's healthcare (EPSDT) services, lead screenings, immunizations; and
- offer interpreter services covered by Medicaid.

Who's <u>not</u> eligible for Passport?

All Medicaid members are in the Passport program with some exceptions. You are not eligible for Passport if you are:

- eligible for spend down (medically needy),
- living in a nursing home or other institutional setting;
- receiving Medicaid for less than three (3) months;
- eligible for Medicare;
- eligible for Medicaid adoption assistance or guardianship;
- receiving back dated Medicaid eligibility,
- receiving Medicaid home and community-based services (HCBS);
- eligible for a non-Medicaid plan like HMK (CHIP), MHSP, or Plan First;
- receiving Medicaid under a presumptive eligible program;
- living outside of the State of Montana;
- eligible for Pregnancy Medicaid; or
- eligible for the Breast and Cervical Cancer program.

Choosing Your Passport Provider

You choose your Passport provider. You can choose the same provider for everyone in your family, or each person can have a different provider according to their healthcare needs. For example, parents may choose a pediatrician for their child, and a family doctor or nurse practitioner for themselves. If you want to keep seeing your current provider, ask if they are a Passport provider. If they are, you may choose that provider.

➢ Need Help Choosing?

Call the **Medicaid/HMK *Plus* Member Help Line at 1-800-362-8312**, available Monday through Friday, 8 am to 5 pm. The staff can tell you about Passport providers near you.

You can also choose your Passport provider anytime online by going to: **choose your passport provider.**

If you do not choose a Passport provider, one will be chosen for you. It's best if you choose because you know what's right for you and your family. After you choose or are assigned a Passport provider, you will get a confirmation letter in the mail with the name of the provider chosen or assigned.

The letter will also tell you how to contact your provider during normal work hours and after normal work hours.

American Indians and Passport

If you are American Indian, you can choose an Indian Health Services (IHS) or any other Passport provider. If you choose a Passport provider who is not IHS, you can still go to an IHS for health services without a referral from your Passport provider. **Medicaid and HMK *Plus*** may not pay the bill if you do not get a referral from your Passport provider before seeing another provider. When in doubt, contact your Passport provider.

Changing Your Passport Provider

If you need to change your Passport provider, call the **Medicaid/HMK *Plus* Member Help Line at 1-800-362-8312**, available Monday through Friday, 8 am to 5 pm, or log onto **choose your passport provider.** If you change your provider, you will get a letter in the mail confirming the change.

The change usually happens at the beginning of the next month, depending on when the change is requested.

Passport Referrals

Your Passport provider will provide for most of your healthcare needs, but sometimes you may need to see a specialist or go to urgent care. Your Passport provider will be asked to give a referral to the specialist or urgent care. The specialist or urgent care must make sure they have a referral from your Passport provider before they see you.

You don't need a referral from your Passport provider for all services. See Covered and Non-Covered Services section beginning on page 17 for services that don't need Passport referrals.

Can you be Removed from Passport?

Most members with Medicaid or HMK *Plus* must choose a Passport provider. Sometimes choosing one provider may make it hard to get healthcare when you need it. In some situations, exceptions may be approved. The Passport program may place time limits on all exceptions. Reasons to be exempt from Passport include if you are:

- enrolled with a case management program through another payer;
- unable to find a primary care provider willing to provide case management;
- living in a county where there is a shortage of primary care providers; or
- participating in Passport would be a hardship.

At the discretion of DPHHS, eligible Medicaid members who are exempt from participating in the Passport program may choose to enroll in Passport.

If you would like to voluntarily enroll or request an exemption from the Passport to Health program, call the **Medicaid/HMK *Plus* Member Help Line at 1-800-362-8312**, available Monday through Friday,
8 am to 5 pm.

Getting Passport Medical Care

➢ Checkups, exams, sick, or hurt

Always go to your Passport provider for regular exams or when you are sick or hurt.

➢ Emergency room care

A medical emergency is when you are sick or hurt and you need medical care right away. Examples of emergencies are if you are bleeding a lot, or having trouble breathing.

You can get emergency treatment without a referral from your Passport provider. If emergency treatment has been done and you still need more care, like getting stitches removed, you should go to your Passport provider for that care.

- **What if you have an emergency?**
  You are eligible to receive Standard Medicaid Benefits. See *Covered and Non-Covered* Services of this guide.

- **When should you go to the emergency room?**
  Go to the emergency room only when you have a medical or behavioral health emergency. See the definition of an emergency on page 36.

- **Urgent care**
  Urgent care clinics do not provide the same services as a Passport provider and some do not accept Medicaid. If you go to an urgent care clinic when your Passport provider is not in the office, make sure the urgent care takes Medicaid.

- **Not sure where to go?**
  If you are not sure if you have an emergency or need to get care right away, you should **call Nurse First at 1-800-330-7847.** There is more information about Nurse First on pages 6 & 7.

Concerns with Your Passport Provider

If you have concerns with your Passport provider, here are some things you can do:

- Talk to your provider, explain what the problem is and try to work it out;
- Choose a new Passport provider;
- Call the Member Help Line at **1-800-362-8312**. Tell the person who answers that you are having a problem with your Passport provider; or
- You have the right to file a complaint. To do this, call the **Medicaid/HMK *Plus* Member Help Line at 1-800-362-8312,** available Monday through Friday, 8 am to 5 pm.

If You Do Not Have Passport

You can get healthcare from any provider who is a Medicaid or HMK *Plus* provider.

Be sure to ask if the provider is a Medicaid or HMK *Plus* provider before you make an appointment. Here are some common kinds of providers you might see to receive healthcare:

- Physicians (doctors), such as internists; pediatricians, obstetricians, gynecologists;
- Mid-level practitioners, such as physician assistants, nurse midwives and nurse practitioners;
- IHS, tribal health, community health center, or a clinic;
- Ambulatory surgical center;
- FQHCs (Federally Qualified Health Centers);
- RHCs (Rural Health Clinics); or
- County or city-county health departments.

To find providers or places to get healthcare that are Medicaid or HMK *Plus* providers, go to **Member Services** and click on the "Medicaid Provider Search" link on the left-hand side of the page. Once there, you can search by provider type, provider specialty, name, zip code or even county.

3. Your Rights and Responsibilities

Your Rights as a Member with Medicaid or HMK *Plus*

A person who is eligible for Medicaid or HMK *Plus* has the right to be treated fairly and with courtesy and respect.

- You have the right to have your privacy protected and to be treated with dignity by providers and their staff;
- You have the right to get medical care no matter your race, color, nationality, sex, religion, age, creed, disability, marital status, or political belief;
- You have the right to know if the medical services you need are paid for by Medicaid or
- HMK *Plus*;
- You have the right to discuss all information on available treatment options and possible results with your provider before accepting or refusing treatment;
- You have the right to use the services of an interpreter, if necessary, at no cost to you;
- You have the right to make a complaint about the Medicaid or HMK *Plus* program; and
- You have the right to receive a reply to your complaint;

- You have the right to choose your provider; and
- You have the right to receive information and instructional materials; and the right to request additional information and materials.

Your Responsibilities as a Medicaid or HMK *Plus* Member

You and your healthcare provider are a team. Your job is to help your healthcare provider give you the best healthcare. Here's what you can do:

- Know if you are eligible and understand what benefits are available to you;
- Treat your healthcare providers with respect, just as you like to be treated;
- Call the Nurse First Advice Line – first.
  - Nurses are there every day, 24 hours a day to help you decide if you should see your provider, go to the emergency room or take care of the problem at home. Call 1-800-330-7847;
- Use an ambulance or go to an emergency room only if you have a medical emergency;
- Follow Montana Medicaid's policies and procedures;
- Receive most of your care through your primary care provider;
- Keep your appointments and call your provider in advance if you cannot make it to your appointment;
- Carry your Montana Medicaid or HMK *Plus* ID card with you and show it at every appointment;
- Contact the Office of Public Assistance (OPA) about any changes in your case;
- Ask all providers if they are Medicaid or HMK *Plus* providers before you make an appointment;
- Help your provider get your previous medical records;
- Tell your provider about signs of trouble, such as pain, allergies, or changes you've noticed;
- Get complete directions about drugs, treatments, or tests. Write down directions or ask your provider to write them down;
- Make a list of questions before your appointment. Ask about risks, choices, and costs before getting treatments or prescriptions. If you don't understand what you need to do to get better, ask more questions;
- Take time to decide about treatment. Think about your choices and discuss them with your provider. For some treatments, your provider will need prior authorization or Passport referral before the treatment is received;
- Go to the same pharmacy to get all your prescriptions. The pharmacist will tell you if different drugs taken together will give you problems or if a drug has side effects. The pharmacist can also answer questions about your prescription drugs;
- Don't sign anything you don't understand;
- Use Medicaid and HMK *Plus* wisely – only when you are sick or for exams and regular checkups to help prevent sickness; and
- If Medicaid or HMK *Plus* paid or may pay for medical care for injuries caused by another person, you must give DPHHS the names and addresses of the person or insurance company responsible. **Call DPHHS at 1-800-694-3084**.

4. Special Covered and Non-Covered Services

This section tells you if a service is covered by Medicaid or HMK *Plus*. For more details on non-covered services, turn to pages 30 & 31. There may be other services that Medicaid and HMK *Plus* will pay for that are not listed. Ask your provider if you're not sure if something is covered, has limits, or requires prior authorization by Medicaid or HMK *Plus*, or call the **Medicaid/HMK *Plus* Member Help Line at 1-800-362-8312.**

All Medicaid and HMK *Plus* services must be medically necessary.

All Medicaid and HMK *Plus* services must be provided by a Montana Medicaid provider.

Passport Referral

Some Medicaid and HMK *Plus* covered services may not be procedures your Passport provider performs. Your Passport provider should direct you to the appropriate healthcare provider and must give that appropriate provider a referral. This will allow Medicaid or HMK *Plus* to pay for those needed services.

Prior Authorization

Some Medicaid and HMK *Plus* services require authorization before Medicaid or HMK *Plus* will pay for the services. For transportation services call **1-800-292-7114**. For other services, talk to your Passport provider or other provider of service. You may also call the **Medicaid/HMK *Plus* Member Help Line at 1-800-362-8312.**

Montana Medicaid and HMK Plus makes every effort to have a complete set of medical policies in place. However, due to the fast pace of medical changes and new medical procedures, Medicaid and HMK Plus may not have a policy to address every service. In those cases, Medicaid and HMK Plus may review other information including current medical literature and other medical resources and consult with healthcare providers.

The description of Medicaid and HMK Plus covered and non-covered services presented in this document is a guide and not a contract to provide medical care. Administrative Rules of Montana, Title 37, Chapters 81 through 88 and 90, govern access and payment of services.

5. Benefit Chart for Standard Medicaid Services

Covered Services

Hospital, Clinic, and Physician Related Services

Benefit	Description	Limits/Exclusions	Passport Referral Needed?	Prior Authorization Needed?
Ambulatory Surgery Center (ASC)	Surgical procedures performed at a licensed outpatient/same day surgery facility	Covered surgical procedures are listed on the ASC Fee Schedule	Yes, for some services	Yes, for some services
Children's Healthcare / Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	Aids families in early identification and treatment of medical, dental, vision, mental health and developmental screenings or problems for children. For more information see explanation of services in this section, or visit Well Child Programs	Limited to children ages 20 and under	Yes, for some services	Yes, for some services
Federally Qualified Health Center / Community Health Center	Health centers that offer sliding fee scales based off income and provide comprehensive services (dental, behavioral health, chemical dependency, pharmaceutical, peer support and primary care)	N/A	Yes, for some services	Yes, for some services
Hospital - Inpatient	Services for members formally admitted as inpatient and the expected hospital stay is more than 24 hours	N/A	Yes, unless pregnancy related	Yes, for some services
Hospital - Outpatient	Hospital stays that are expected to last less than 24 hours	N/A	Yes, for some services	Yes, for some services
Indian Health Services / Tribal Health Centers	Federal healthcare advocate for American Indians and Alaska Natives.	Limited to members of federally recognized Indian tribes and their descendants.	No	Yes, for some services

Hospital, Clinic, and Physician Related Services - continued

Benefit	Description	Benefit	Passport Referral Needed?	Prior Authorization Needed?
Mid-Level Practitioners	Services provided by: ✓ Physician Assistants and Advanced Practice Registered Nurses (Nurse Anesthetists, Nurse Practitioners; ✓ Clinical Nurse Specialists; and ✓ Certified Nurse Midwives) See explanation of services in this section.	Non-Certified mid-wife services are not covered	Yes, for some services	Yes, for some services
Physician / Specialists	Services provided by physicians for treatment of illness, injury, primary care, preventive care, and health maintenance. See explanation of services in this section.	N/A	Yes, for some services	Yes, for some services
Podiatry	Routine podiatric care when a medical condition (such as diabetes) affecting the legs or feet requires treatment. See explanation of services in this section.	N/A	Yes, for some services	Yes, for some services
Public Health Clinic	Physician and mid-level practitioner services provided by a DPHHS designated Public Health Clinic.	N/A	Yes, for some services	Yes, for some services
Rural Health Clinics	Health clinics in rural areas that offer outpatient services (such as primary care and behavioral health).	N/A	Yes, for some services	Yes, for some services

Senior and Long-Term Care Services

Benefit	Description	Limits/Exclusions	Passport Referral Needed?	Prior Authorization Needed?
Home Health	Home health services provided by a licensed and certified agency. See explanation of services in this section.	There must be a medical need for home health services to be delivered in the member's residence which is anywhere that normal life activities occur. A physician must certify that a member is eligible for home health services and establish a plan of care which is reviewed every 60 days. Home health services are limited to 180 visits per year. DPHHS may exceed the limitation on existing covered services if its medical staff determines that the proposed extended services are medically necessary. All home health services must be prior authorized by DPHHS or its designee. Home health aide services are only provided when personal care attendant services are unavailable through the personal assistance program. Home health services do not include audiology, or respite services. Therapy services must be provided by a licensed therapist.	No	Yes, contact Mountain Pacific Quality Health at: 1-800-219-7035

Senior and Long-Term Care Services - continued

Benefit	Description	Limits/Exclusions	Passport Referral Needed?	Prior Authorization Needed?
Personal Assistance	Hands-on assistance with activities of daily living	There must be a medical or functional need for hands on assistance with an activity of daily living to qualify for services. Limit 80 hours per two-week period. Activities of daily living must be delivered in the home.	No	Yes, contact Mountain Pacific Quality Health at: 1-800-268-1145
Community First Choice	Hands-on assistance with activities of daily living	Member must meet institutional level of care to be eligible for service. In addition, there must be a medical or functional need for hands on assistance with activity of daily living to qualify for services. Limit 84 hours per two-week period. Activities of daily living must be delivered in the home.	No	Yes, contact Mountain Pacific Quality Health at: 1-800-268-1145

Behavioral Health Related Services

Benefit	Description	Limits/Exclusions	Passport Referral Needed?	Prior Authorization Needed?
Children's Mental Health	Mental health services provided by: ✓ Licensed Professional Counselors (LCPC); ✓ Licensed Clinical Social Workers (LCSW); ✓ Psychiatrists; and ✓ Psychologists Mental Health Center Services include: ✓ Day treatment; outpatient psychotherapy; ✓ Community based psychiatric community rehabilitation and support; ✓ Comprehensive school and community treatment; ✓ Targeted case management; and ✓ Home support services Therapeutic Group Homes, including extraordinary needs aids. Therapeutic Foster Care Psychiatric Residential Treatment Facility Hospital and Partial Hospitalization Services Explanation of services can be found at the following website: Children's Mental Health	See link to Children's Mental Health Bureau website: Children's Mental Health	No	Yes, for some services

Behavioral Health Related Services - continued

Benefit	Description	Limits/Exclusions	Passport Referral Needed?	Prior Authorization Needed?
Adult Mental Health	Mental Health services provided by: ✓ Licensed Professional Counselors (LCPC); ✓ Licensed Clinical Social Workers (LCSW); ✓ Psychiatrists; and ✓ Psychologists Mental Health Center Services include: ✓ Intensive Community-Based Rehabilitation; ✓ Program of Assertive Community Treatment; ✓ Crisis Stabilization ✓ Day Treatment ✓ Dialectical Behavior Therapy ✓ Mental Health Outpatient Therapy ✓ Community Based Psychiatric Rehabilitation Support; and ✓ Mental Health Targeted Case Management Hospital and Partial Hospitalization Services Adult Group Home & Adult Foster Care Services Illness Management & Recovery Services Explanation of services can be found at the following website: Adult Mental Health	N/A	No	Yes, for some services

Behavioral Health Related Services - continued

Benefit	Description	Limits/Exclusions	Passport Referral Needed?	Prior Authorization Needed?
Substance Use Disorder Treatment	Substance Use Disorder services provided by: ✓ Licensed Professional Counselors (LCPC), Licensed Professional Social Workers (LCSW), or other Mental Health Professional with SUD in their scope Substance Use Disorder Treatment services include: screening and assessment, treatment, recovery support, and clinically managed low intensity residential services for substance use disorders through outpatient, residential treatment, and non-hospital inpatient treatment. Chemical Dependency Center (state-approved program) services include: medically monitored intensive inpatient clinically managed high-intensity residential; clinically managed low-intensity residential; partial hospitalization; intensive outpatient therapy; outpatient therapy; biopsychosocial assessment; screening, brief intervention, and referral to treatment; drug testing; and targeted case management. Explanation of services can be found at the following website: Substance Use Disorder Services.	No limit to medically necessary outpatient psychotherapy sessions	No	Yes, for some services

Transportation Services

Benefit	Description	Limits/Exclusions	Passport Referral Needed?	Prior Authorization Needed?
Ambulance for Emergency Services	Emergency ground or air transport See the definition of emergency services in this section. If you are not sure if you should go to the emergency room, call the Nurse First Advice Line at 1-800-330-7847, call 911, or call the local emergency number for services.	If the transport is denied as not medically necessary, you will be responsible for the bill.	No	No
Specialized Non-Emergency Transportation (NEMT)	Schedule non-emergency use of ambulance, wheelchair-lift equipped vans, taxicabs, and buses. See explanation of services in this section.	Limited to transportation of persons with disabilities for the purpose of obtaining non-emergency medical services covered by the Medicaid program.	No	Yes, call 1-800-292-7114 before travel takes place
Transportation	Reimbursement for personal vehicle mileage or bus ticket to travel to a healthcare provider or other Medicaid covered healthcare service. See explanation of services in this section.	Coverage for transportation and per-diem pay is available only for transportation and per-diem pay; to the site of a medical services provider closest to where the member is located.	No	Yes, call 1-800-292-7114 before travel takes place

Dental Services

Benefit	Description	Limits/Exclusions	Passport Referral Needed?	Prior Authorization Needed?
Dental	Dental services (exams, cleanings, X-rays, fillings, crowns, dentures, orthodontia). See explanation of services in this section.	Adults ages 21 and over are limited to $1,125 of dental treatment benefits annually (July-June). Anesthesia, dentures diagnostic and preventative services do not count towards the annual dental limit. Adults determined categorically eligible for Aged, Blind, and Disabled Medicaid are not subject to the annual dental treatment limit, however, service limits may apply.	No	Yes, for some services
Dentures	Dentures are covered if medically necessary. See explanation of services in this section.	Partial dentures may be replaced every 5 years. Full dentures may be replaced every 10 years.	No	No

Vision Related Services

Benefit	Description	Limits/Exclusions	Passport Referral Needed?	Prior Authorization Needed?
Optometric / Opticians	Eye exams or diagnosis and treatment of eye diseases.	One eye exam every 365 days for members age 20 and under. One eye exam every 730 days for members age 21 and over.	No	No
Eyeglasses	Corrective lenses and/or frames to aid and improve vision.	One pair of glasses every 365 days for members age 20 and under. One pair of glasses every 730 days for members age 21 and over. Frames must be Medicaid approved frames. Medicaid will not pay for most add-ons such as photo-grey or transition lenses, progressive or no line bifocal lenses, tints other than rose 1 or 2, polycarbonate or shatter resistant material in lenses, scratch-resistant coating and ultra-violet coating. Contact lenses are covered only when medically necessary and not for cosmetic reasons.	No	Some features may require authorization

Miscellaneous Services

Benefit	Description	Limits/Exclusions	Passport Referral Needed?	Prior Authorization Needed?
Audiology/ Hearing Aids	Hearing aids, evaluations, and basic hearing assessments for members with hearing disorders.	Hearing aids must be ordered by a medical provider.	No	Yes, for some services
Chiropractic	Chiropractic care is covered for children through age 20.	None	Yes	No
Diabetes Prevention Program (DPP) (A national program)	Trained lifestyle coaches facilitate 16 weekly & biweekly sessions followed by 6 monthly sessions.	Offered to adults only who are at risk for developing type 2 diabetes. Authorized providers must be approved by the Division of Public Health & Safety,	No	No
Dialysis Clinic	Outpatient dialysis services provided to members who have been diagnosed with end-stage renal (kidney) disease	Must be diagnosed by a provider as suffering from chronic end stage renal (kidney) disease	No	No
Durable Medical Equipment (DME)	Equipment or supplies to treat a health problem or a physical condition	Equipment or supplies must be ordered by a medical provider	No	Yes, for some equipment. Call 1-800-362-8312
Habilitative Care	Habilitative services when you require help to maintain, learn, or improve skills and functioning for daily living, or to prevent deterioration. Services may be provided in a variety of inpatient and/or outpatient settings.	Services include, but are not limited to physical therapy, occupational therapy, speech therapy, and behavioral health professional treatment. Applied behavior analysis for adults is excluded. Services are reimbursable if a licensed therapist is needed. Services must be prescribed by a healthcare provider.	Yes, for some services	Yes, for some services

Miscellaneous Services - continued

Benefit	Description	Limits/Exclusions	Passport Referral Needed?	Prior Authorization Needed?
Home Infusion Therapy	Comprehensive treatment program of pharmaceutical products and clinical support services provided to members who are living in their home, a nursing facility, or any setting other than a hospital. See explanation of services in this section.	Medications which can be appropriately administered orally, through intramuscular or subcutaneous injection, or through inhalation, are NOT covered. Also, drug products that are not FDA-approved or whose use in the non-hospital setting present an unreasonable health risk are not covered.	No	Yes, for most services
Independent Diagnostic Testing Facility (IDTF)	Diagnostic testing services provided under supervision of a physician independent of a hospital	Lab is not covered under IDTF. The provider must enroll as an independent lab to bill lab procedures.	No	No
Independent Lab and X-Ray	Tests and imaging provided by an independent (non-hospital) lab or imaging facility	N/A	Yes, for some services	No
Nutrition	Nutritionist or dietician services	Limited to children ages 20 and under. Services must be ordered by a healthcare provider.	Yes, for some services	No
Pharmacy	Prescribed medications (prescription or over the counter) See explanation of services in this section.	Generic drugs are required when possible. Drugs prescribed for the following are not covered: ✓ To promote fertility; ✓ For erectile dysfunction; ✓ For weight reduction; and ✓ For cosmetic purposes or hair growth	No	Yes, for some medications

Miscellaneous Services - continued

Benefit	Description	Limits/Exclusions	Passport Referral Needed?	Prior Authorization Needed?
Private Duty Nursing	Skilled nursing services for children with severe medical problems who are not in a hospital.	Limited to children ages 20 and under. Services must be ordered by a healthcare provider. Services do not include taking care of a child to give the regular caretaker a break (respite care).	Yes	Yes
Rehabilitative Care	Services when you need help to keep, get back or improve skills and functioning for daily living that have been lost or impaired. Services may be provided in a variety of inpatient and/or outpatient settings.	Services include, but are not limited to physical therapy, occupational therapy, speech therapy, and behavioral health professional treatment. Applied behavior analysis for adults is excluded. Services are reimbursable if a licensed therapist is needed. Services must be prescribed by a healthcare provider.	Yes, for some services	Yes, for some services

Non-covered Services

The following are examples of medical and non-medical services that are not covered by Standard Medicaid:

- Adult Chiropractic;
- Acupuncture;
- Naturopathic;
- Dietician, for those over the age of 21;
- Surgical technicians who are not physicians or mid-level practitioners;
- Adult Nutritional;
- Massage Therapy;
- Dietary supplements;
- Homemaker;
- Remodeling of home, plumbing, car repair, and/or modification of an automobile;
- Childbirth services not provided in a licensed healthcare facility or nationally accredited birthing center, unless as an emergency service;

- Infertility or sterilization reversals;
- Experimental, unproven, investigational, and services in an inappropriate setting;
- Invasive medical procedures for weight reduction (gastric bypass, gastric banding, or bariatric surgery); and
- Unauthorized circumcisions.

This is not a complete list.

6. More Information about Standard Medicaid

This section includes examples of Standard Medicaid. If you are on Medicaid, including the HELP/Medicaid Expansion Program, or HMK *Plus* you receive the Standard Medicaid benefit. Not all services are listed, and not all details about each service are shown.

Ask your Passport provider or primary care provider for more information. You can also call the **Medicaid/HMK *Plus* Member Help Line at 1-800-362-8312** for more information.

All covered treatments and services must be medically necessary and provided by an enrolled Medicaid provider.

Alcohol and Other Drug Treatment (Substance Use Disorder)

There are several different kinds of alcohol and drug treatment services. Services must be ordered by a licensed healthcare professional trained in substance use disorder treatment services and provided by a substance use disorder program (SUD) approved by Medicaid. Treatment must be medically necessary.

- Medically monitored inpatient (non-hospital);
- Clinically managed residential;
- Partial Hospitalization (Day Treatment);
- Intensive outpatient;
- Screening and assessment;
- Individual, group, and family counseling;
- Targeted case management (adult and youth);
- Drug testing; and
- Peer Support

Some services require prior authorization.

Autism Services

Services available include: occupational therapy, physical therapy, speech therapy and other Medicaid services as referred by a primary care practitioner.

Breast Pumps

Members who are at least 28 weeks pregnant or breastfeeding can receive one breast pump per pregnancy. To order a double electric breast pump, you must complete a two-part process:

1) The mother must see her healthcare provider, who will fax Medicaid a prescription for the pump; and
2) the mother must go to **Healthy Babies, Happy Moms** and complete the order form online.

Birth Control

Birth control pills, condoms, shots, and most other types of birth control and family planning supplies are covered. Birth control must be prescribed by a healthcare provider.

Case Management (Targeted)

The cost of targeted case management may be covered. You may be able to receive targeted case management if you fall into one of the following groups:

- High-risk pregnant women up to sixty days after childbirth and babies of high-risk pregnant women up to one year of age;
- Members 18 years and older with severe disabling mental illness;
- Members 16 years and older with developmental disabilities or who reside in a children's developmental disabilities group home;
- Children and youth ages 17 and under, or to the age of 20 if the youth is still in secondary school with serious emotional disturbance;
- Children and youth between the ages of birth and 18 with special healthcare needs;
- Children age 20 and under with substance use related disorders;
- Adults 21 years and older with substance use related disorders; and
- Children and youth under age 18 with serious emotional disturbance in an out-of- state psychiatric treatment facility.

Children's Healthcare (EPSDT)

If you take your child to a provider for a well-child check-up or because they are feeling sick, this is the "Early and Periodic Screening" part of EPSDT. Children need regular visits to a provider to make sure they are growing and are healthy. It's also important to catch problems early so they can be treated. You can read more about well-child checkups on pages 43 & 44.

If your child's provider finds something that needs to be treated or investigated further, this is the "Diagnosis and Treatment" part of EPSDT. If the treatment is ordered by a provider and is medically necessary, it is covered.

If you feel that your child is not receiving what they need, call the **Medicaid/HMK *Plus* Member Help Line at 1-800-362-8312**.

Chiropractic Services

Chiropractic services for children ages 20 and younger are covered. Adults with Medicare and Medicaid may receive copayment, coinsurance, and deductible reimbursement for limited chiropractic services.

Chiropractic services for children ages 20 and younger include:

- Spine adjustment;
- X-rays; and
- Evaluation and management.

Circumcision

Circumcision may be covered if medically necessary. Please contact your provider for more information.

Community First Choice (CFC)

The type of care authorized is developed with each member in a person-centered manner and is dependent upon specific needs and living situations. Services available through the CFC program include:

- Assistance with activities of daily living: bathing, dressing, grooming, toileting, eating, medication assistance, ambulation, and exercising;
- Limited assistance with instrumental activities of daily living: grocery shopping, housekeeping, laundry, community integration, yard hazard removal for providing safe access and entry to the home, and correspondence assistance;
- Personal emergency response system monitoring; and
- Medical escort.

Services may not be provided in a hospital, a hospital providing long term care, a nursing home, an assisted living facility, or group homes.

Dental Braces (Orthodontia)

Non-cosmetic braces may be covered for children ages 20 and under and must be prior authorized.

Dental Services

Most routine dental services are covered for members with Standard Medicaid and HMK *Plus* (children through age 20).

➢ Children 20 and under

- Can get dental exams and cleanings as often as necessary;
- Should visit a dentist by their first birthday, and then at least once every six months after the first tooth comes in;
- During a well-child checkup, providers should do an oral exam, including the application of fluoride varnish if needed;
- Bridges and tooth-colored crowns are available;
- Dentures are covered; and

- Children are not subject to the annual dental treatment limit.

➢ Adults with Standard Medicaid Benefits

- Adults ages 21 and older are limited to $1,125 of dental treatment benefits annually (July-June);
  - Covered anesthesia services, dentures, diagnostic and preventative services do not count towards the annual dental limit.
  - Adults determined categorically eligible for Aged, Blind, and Disabled Medicaid are not subject to the annual dental treatment limit, however, service limits may apply.
- Can have dental exams and cleanings every six months; and
- Can have basic treatment services, such as fillings and extractions, up to the $1,125 annual limit.
- Can get two porcelain crowns per calendar year; and
- Dentures (see next section).

Adult members are responsible to pay for non-covered dental services and any dental treatment services received above the annual $1,125 limit.

➢ Dentures for Adults

- Dentures are covered for adults;
- Partial dentures may be replaced if the dentures are 5-years old or older;
- Full dentures may be replaced if the dentures are 10-years old or older; and
- One lost pair of dentures in a person's lifetime is covered.

Diabetes Prevention Program (DPP)

The National Diabetes Prevention Program is an evidenced-based public health program that supports healthy lifestyle changes for adults who are at risk for developing type 2 diabetes. Trained lifestyle coaches deliver the program through several organizations across the state. This is a covered service through Montana Medicaid if provided by a Montana Medicaid provider who is authorized through the Montana Public Health & Safety Division. For more information go to this website: **Diabetes Prevention Program.**

Dialysis

Dialysis is a medical process to temporarily purify the blood for persons in kidney failure. Services covered at dialysis clinics include outpatient dialysis and training for self-dialysis.

Drugs (Prescriptions)

To find out if a drug you need is covered or to find out if a drug needs prior authorization, talk to your pharmacist or your healthcare provider. Medicaid usually pays for a 34-day supply. You may get a 90-day supply of some drugs taken all the time, such as drugs for heart disease, blood pressure, diabetes, thyroid conditions, women's health, and birth control. Your pharmacist can tell you if you can get a 90-day supply.

Drugs (Over-the-counter)

The following over-the-counter drugs are covered if they are prescribed for you by your

healthcare provider:

- Antacids;
- Aspirin;
- Diphenhydramine;
- Doxylamine;
- Folic Acid;
- H2 antagonist GI products;
- Head lice treatments;
- Insulin;
- Ketotifen ophthalmic solution;
- Laxatives;
- Levonorgestrel;
- Non-sedating antihistamines;
- Nicotine patches, gum and lozenges;
- Oxybutynin transdermal;
- Proton pump inhibitors;
- Pyridoxine; and
- Steroid Nasal Spray.

Nursing homes pay for over-the-counter laxatives, antacids, and aspirin for their residents.

Durable Medical Equipment (DME)

Some medical equipment otherwise known as Durable Medical Equipment (DME) are covered. Some services require prior authorization. For more information about equipment coverage or prior authorization requirements, please talk to your medical provider, your DME supplier, or call the **Medicaid Help Line at 1-800-362-8312**.

Emergency Services

Emergency services are covered. An emergency means the symptoms, or a medical or behavioral health condition are severe enough that a person with an average knowledge of health and medicine would expect there might be danger to the health or cause serious harm to any body part of the person or unborn child if the person is not treated right away.

Family Planning Services

Most family planning services are covered, including, but not limited to:

- Physical exams, with breast exams;
- Pap tests (to test for pre-cancerous conditions);
- Pregnancy tests;
- Birth control;
- Testing and treatment for sexually transmitted infections;
- Vaccines, including Human papillomavirus (HPV); and
- Sterilization information and counseling.

Sterilization is covered for members who are mentally competent and 21 years old or older at the time the consent form is signed. The consent form must be signed by the member at least 30 days before the scheduled sterilization.

Infertility services and paternity (to identify fatherhood) tests are not covered.

Foot Care (Podiatry)

Covered services include:

- Cutting or removing corns or calluses;
- Trimming nails;
- Applying skin creams;
- Measuring and fitting foot or ankle devices;
- Lab services and supplies; and
- Orthopedic shoes are covered if:
  - you are age 20 or under; or
  - you have a brace, or a device attached to your shoe.

Hearing Aids

Hearing Aids, repairs and some related items are covered. To see if you qualify for hearing aids, your physician must refer you to an audiologist who is a Medicaid provider. The audiologist will perform tests and request a prior authorization.

Group Medical Visits

A provider may see many patients at the same time for follow-up or routine care. This is a group visit, which may be covered by Medicaid. Your provider can let you know if he or she offers covered group visits.

Home and Community-Based Waiver Services (HCBS)

Members who may be eligible for HCBS waivers are:

- Members with a physical disability(s);
- Members who are elderly;
- Members with a brain injury;
- Members with a severe or disabling mental illness (SDMI); and
- Members with developmental disabilities.

Services are different in each HCBS waiver and are determined by your needs. Here is a partial list of HCBS services:

- Case management;
- Personal assistance for supervision and socialization;
- Modifications to home or vehicle;
- Supported living and assisted living;
- Clinical and therapy services;
- Substance use disorder treatment;
- Communication and social interaction skill building;
- Homemaking;
- Private nursing;
- Adult day care;
- Adult group and foster home;
- Community-based psychiatric rehabilitation and support;
- Specially trained attendant care;
- Service animals;
- Home delivered meals;
- Respite care;
- Illness management and recovery;
- Health and wellness;
- Pain and symptom management;
- Peer support services; and
- Other services defined under a waiver.

For more information about these HCBS waiver programs, call:

- Big Sky Waiver (Elderly and Physically Disabled waiver) **1-406-444-4077**;
- SDMI waiver **1-406-444-3964**; and
- Developmentally disabled waiver **1-406-444-2995**.

Home Health Services

Home Health services are intermittent, part-time nursing and restorative therapy services provided in the home to eligible people who require these services. The goal of the Home Health Services Program is to avoid unnecessary hospital or nursing facility stays by providing skilled nursing or therapy services in the home. Covered services include:

- Intermittent, part-time care in your home from a skilled nurse;
- Home health aide care – services for a short, definite period of time to assist in the activities of daily living and care of the household to keep you in your home. This is only available when personal assistance services are not available;
- Physical therapy, occupational therapy or speech therapy by a licensed therapist; and
- Medical equipment, appliances and medical supplies.

Home Health Services require prior authorization.

Home Infusion Therapy

Some drug treatments must be given in your veins (intravenously). For some members, these treatments may be given in their homes. Infusion therapy in your home is covered, along with the cost of the person who comes to your home to give you the drug treatments. Services must be prior authorized.

Hospice

Hospice manages all care related to a terminal illness. Grief counseling is also available for the family. Hospice is provided by a licensed and certified agency.

Hospital Services

Services you get in a hospital, whether you stay in the hospital overnight or not, are covered.

Some examples of services you might get in a hospital are:

- Emergency room services;
- Medical services for which your provider admits you to the hospital;
- Physical therapy;
- Lab services;
- X-rays;
- Cardiac (heart) rehabilitation; and
- Pulmonary (breathing) rehabilitation.

Many hospital services must be prior authorized before you go to the hospital. For more information about hospital services, call the **Medicaid/HMK *Plus* Member Help Line at 1-800-362-8312**.

Interpreter Services

Interpreter services will be provided if you are not a comfortable English speaker. Interpreter services are covered if you get a covered service. Your provider or case manager can help arrange for a qualified interpreter to provide services. You may request a friend or family member to be your interpreter. There is no cost to you for using interpreter services.

Lead Screening

Blood lead testing is covered by Medicaid and HMK *Plus*. The symptoms of lead poisoning can be difficult or impossible to recognize, making blood lead testing the only way to confirm exposure.

HMK *Plus* children should be tested for lead poisoning at 12 and 24 months of age. Children up to age 6 who have not been checked for lead poisoning before, should also be tested. All HMK *Plus* children at other ages should be screened for risk of lead poisoning.

Mental Health Services for Adults

Medicaid covers these mental health services for all adults:

- Crisis and emergency services;
- Individual, group, and family counseling;
- Inpatient and outpatient therapy;
- Medication management; and
- Psychological testing.

Medicaid also covers these services for adults with a Severe or Disabling Mental Illness (SDMI):

- Adult group and foster home;
- Community-based psychiatric rehabilitation and support;
- Illness management and recovery;
- Dialectical behavior therapy (including coping skills);
- Assertive community treatment;
- Crisis intervention facility;
- Targeted case management;
- Partial hospitalization;
- Day treatment half day; and
- Intensive community-based rehabilitation.

Some services require prior authorization.

Mental Health Services for Children

HMK *Plus* covers these mental health services for children:

- Individual, group, and family counseling;
- Outpatient mental health assessments;
- Acute inpatient hospital services;
- Partial hospitalization services;
- Individual and family counseling;
- Targeted case management;
- Day treatment services;
- Psychological testing;
- Community-based psychiatric rehabilitation and support;
- Comprehensive school and community treatment;
- Therapeutic youth group home;
- Extraordinary needs aid if in a group home;
- Home support services;

- Therapeutic family and foster care; and
- Psychiatric residential treatment facility.

Most services must be prior authorized.

Nursing Homes

Covered services include a shared room (or a private room if your provider says it's medically necessary), laundry service, travel for medical appointments, meals, minor medical or surgical supplies, nursing services, social services, and activity programs. The nursing home will provide you with a list of other services you will receive, and the nursing home will know which services need prior authorization.

OB (Obstetric) Services

Routine care during pregnancy, including individual and group prenatal visits and checkups for the mother after she gives birth are covered.

A baby's delivery must be in a licensed hospital or birthing center to be covered. For group prenatal visits, please check with your healthcare provider for additional information. Not all healthcare providers offer this service.

Out-of-State Services

You may need to get medical services outside of Montana.

- If you have an accident, crisis or something that cannot wait until you're back in Montana, seek help at a hospital. The out-of-state hospital must become a Montana Medicaid or HMK *Plus* provider to get paid.
- A hospital provider, 100 miles or less outside the Montana border is considered an in-state provider and Medicaid or HMK *Plus* will pay for services if the provider is enrolled in Montana Medicaid or HMK *Plus*;
- All out-of-state hospital inpatient services need prior authorization before you get services unless you have an emergency; and
- Services received outside the United States, including Canada or Mexico, are not covered.

Respiratory (Breathing) Therapy

Respiratory therapy is covered for children ages 20 and under and includes treatment by a licensed respiratory therapist. Services are ordered by your child's healthcare provider. If your child has Passport, the Passport provider must approve the service.

Therapy Management for Drugs

Montana Medicaid covers shared drug therapy management services provided by a Clinical Pharmacist. Please see your healthcare provider for additional information as not all healthcare providers offer this service.

School-Based Service

Children can get some HMK *Plus* services at school. These services are called school-based services. If your child has Passport, their Passport provider may need to approve some services. Examples of services your child may get at school are:

- Speech therapy;
- Occupational therapy;
- Physical therapy;
- Private duty nursing;
- Help with daily living activities;
- Specialized transportation;
- Mental health; and.
- Orientation and mobility services for blind or low vision.

Tobacco and Smoking

Tobacco cessation products and counseling are covered by Medicaid. Talk to your healthcare provider or call the **Medicaid/HMK *Plus* Member Help Line at 1-800-362-8312** for more information.

The Montana Tobacco Quit Line is a free service for all Montanans. The Quit Line helps Montanans quit cigarettes, chew, cigars and e-cigarettes. The Quit Line offers free counseling and free Nicotine Replacement Therapy (patches, gum or lozenges). The Quit Line has special programs for American Indians and pregnant women. Call the Montana Tobacco Quit Line at 1-800-QUIT-NOW or 1-800-784-8699.

Transplants

Most transplants are covered. All transplant services, except for corneal transplants, require prior authorization.

Transportation

Medicaid may provide travel assistance benefits to help you get to and from medical appointments.

The following are the rules used to decide if travel funds will be given:

- You must use the least costly way to travel that still meets your needs;

- All transportation must be approved before you go, and if your appointment is changed, you must get your transportation approved again. The number to call for approval is **1-800-292-7114;**
- Medicaid will reimburse for travel to your Passport provider or to the closest, approved provider of other medical services;
- Travel funds can be provided for out-of-town or out-of-state services if the service is not available near you. Advance payment will be on a case-by- case basis; and
- You must be eligible for Medicaid or HMK *Plus* on the date of the medical appointment.

If you used a personal vehicle for emergency travel you must call **1-800-292-7114** within 30 days of the emergency to be considered for payment.

There are different rules for different kinds of transportation, such as taxicabs, buses, wheelchair accessible vans, and non-emergency ambulances. Sometimes friends or family members can get paid for using their cars to take you to Medicaid covered appointments.

Be sure to call the Medicaid Transportation Center at **1-800-292-7114** before you arrange travel. You will be paid after you travel if you have followed the above steps. The transportation center will contact your provider's office to make sure you went to your appointment before paying.

Vision and Eyeglass Services

Medicaid adults and Healthy Montana Kids *Plus* children are eligible for eye exams and eyeglasses. See specifics of benefits for adults and children below.

- Optometric Eye exams for members age 20 and under are covered once every 365 days. For members age 21 and over, exams are covered once every 730 days.
- If a member's vision changes, and meets the established amount of changes, another exam will be needed. Members with a history of diabetes are eligible for exams once per year regardless of age.
- Eyeglasses benefits are once every 365 days for members age 20 and under and once every 730 days for members age 21 and over.
- When an adult has a change in prescription and it meets the amount of change, then the **eyeglass lenses only** will be replaced if the prescription changed before two years from the last prescription given by an Optometrist or Ophthalmologist.
- Children age 20 and under that lose, break or have stolen, the eyeglasses provided by Medicaid; may be eligible for a one-time replacement of the existing prescription within twelve months after the initial pair of glasses were issued. If additional features were

previously paid for by the member, the member will again be responsible for paying for those features, if they are desired.

- The Medicaid benefit does not include replacement of lost, stolen, or damaged eyeglasses for adult members age 21 and over. Adult members will need to pay out of pocket for replacement eyeglasses at a cost determined by the provider in these situations.
- Eyeglasses are provided to Medicaid members through a sole source vendor and dispensed by an enrolled optometric provider. Members need to verify with their Optometrist that they participate with this eyeglass contracted supplier. If not, the member can locate an Optician or optometric provider that does participate with the eyeglass vendor to order their glasses.
- See the **Covered Services: Standard Medicaid Benefit Chart** (page 27) for Eyeglass specific covered and non-covered items. Members will be responsible to pay the provider ordering the eyeglasses, not the eyeglass contractor, for non-covered items, if ordered.
- Contact lenses are covered only when medically necessary and not for cosmetic reasons.

Well-Child Checkups

All members ages 20 and under should have regular well-child services or visits. When you make an appointment for a well-child visit, be sure to say that it is a well-child visit so enough time will be scheduled with your doctor.

Your child, age 20 and under, should receive the following during a well-child visit:

- Head-to-toe unclothed physical exam;
- Eye check;
- Oral check by provider, including application of fluoride varnish if needed;
- Hearing check;
- Nutrition check-up;
- Growth and development check-up;
- Blood and urine tests, if needed;
- Immunizations, if needed;
- Speech and language checkup; and
- Lead screening at ages 1 and 2, or up to 6 years if not previously tested.

During the well-child visit, you will also receive health education. If problems or concerns are found during the well-child visit, your child may be referred to another provider for more exams and treatment.

Your child should visit a dentist by their first birthday and at least once every six months after the first tooth comes in.

You can request that your child get a well-child screening during any visit for an illness or injury.

➢ Immunizations

It's important for a child to visit a provider, Community Health Center, or Public Health Clinic to get the right immunizations. Getting immunizations not only protects the child, but also anyone the child meets.

A child's provider will know which immunizations the child should get and when he or she should get them. Immunizations protect against many diseases including:

- Hepatitis A and B;
- Diphtheria;
- Tetanus;
- Pertussis (whooping cough);
- Polio;
- Pneumococcal disease;
- MMR (measles-mumps-rubella);
- Varicella (chicken pox);
- Influenza (flu);
- Hib (Haemophilus Influenzae Type B);
- HPV (Human papillomavirus);
- Meningococcal (Meningitis) disease; and
- Rotavirus.

If a child misses an immunization, follow up with the primary care physician as soon as possible. Keep an immunization record filled out by the healthcare provider. You will need this record when a child starts day care, school, and college.

Medicaid has adopted the American Academy of Pediatrics Bright Futures Periodicity Schedule. The full national schedule can be found at **Bright Futures**.

7. More Helpful Programs

Assistance for Members with Medicare

If you have Medicare and Medicaid, most of your healthcare costs are paid by Medicare. Medicaid may help with costs that Medicare doesn't pay.

Members who have Medicare with incomes too high to get Medicaid may be able to get Medicare monthly premiums paid. There are three programs called Medicare Savings Programs

you may apply for at the Office of Public Assistance. For Medicaid members who qualify, Medicaid will pay:

- Qualified Medicare Beneficiary Program (QMB) may pay a portion of your Medicare
- Part A and B monthly premium, coinsurance, and deductibles;
- Specified Low-Income Medicare Beneficiary Program (SLMB) may pay a portion of your Medicare Part B monthly premium;
- Qualifying Individual Program (QI) may pay a portion of your Medicare Part B monthly premium; and
- Big Sky Rx may pay all or part of your Medicare drug plan monthly premium.
- Big Sky Rx is a state funded program run by DPHHS. Big Sky Rx is for people who have Medicare and don't qualify for Medicaid or the Medicare Savings Programs listed above.

For more information about Big Sky Rx, call **1-866-369-1233** or visit **Big Sky Rx Program**.

You can get more information about Medicare and related services from SHIP (State Health Insurance Assistance Program) at **1-800-555-3191.**

Plan First

If you lose, or are not eligible for Medicaid or HMK *Plus*, family planning services may be paid by Plan First. Plan First is a separate Medicaid program that covers family planning services for eligible women. Some of the services covered include office visits, contraceptive supplies, laboratory services, and testing and treatment of sexually transmitted diseases (STDs).

You may be eligible if you are:

- Montana resident;
- Female, age 19 through 44;
- Able to bear children and not presently pregnant;
- Annual household income up to and including 211% FPL; and
- Not enrolled in Medicaid.

To apply or for more information visit the Plan First Website at **Plan First.**

Health Insurance Premium Payment (HIPP) Program

The Health Insurance Premium Payment Program (HIPP) is a program that allows members to be enrolled in a group or individual health plan and have the premiums paid by Medicaid. The health plan must be deemed 'cost effective' by the HIPP program. Medicaid and HMK *Plus* members can carry multiple health coverages without any impact to their Medicaid eligibility. Members with Medicare or HMK coverage are not eligible for the HIPP program.

Here are some ways you may be eligible for HIPP:

- You have insurance either through your job or through an individual healthcare policy;
- Your job offers insurance, but you haven't signed up because it costs too much; or
- You had insurance through your job, but you are no longer working and can't pay the COBRA continuation coverage premiums.

For more information **about HIPP, call 1-800-694-3084** and press **1** when prompted.

Waiver for Additional Services and Populations

The Waiver for Additional Services and Populations (WASP) provides Standard Medicaid benefits for individuals who qualify for or are enrolled in the Mental Health Service Plan (MHSP) who are age 18 or older, have severe and disabling mental illness (SDMI), and are otherwise ineligible for Medicaid benefits.

To apply or for more information contact the Addictive & Mental Disorders Division at **1-406-444-9635,** email **Mary.Collins@mt.gov** or visit the WASP website at **WASP**.

Resources

Organization or Service	Website	Phone Number
Aging Services	Aging Services	1-800-551-3191
AIDS or Sexually Transmitted Diseases	STD/HIV Program	1-406-444-3565
Child Abuse and Neglect	Child and Family Services	1-866-820-5437
Child Support Customer Service	Child Support Enforcement	1-800-346-5437
Childhood Lead Poison Prevention Information	Lead Poisoning Prevention	1-406-444-0340
Children's Special Health Services	Children's Special Health Services	1-800-762-9891
Citizen's Advocate (Governor's Office)	Citizen's Advocate	1-406-444-3468
Elder Abuse Information (Adult Protective Services)	Adult Protective Services	1-844-277-9300
Healthy Montana Kids (CHIP)	Healthy Montana Kids (HMK)	1-877-543-7669
Legal Services	Montana Law Help	1-800-666-6899
Medicaid Fraud Line	Montana Fraud Line	1-800-201-6308
Medicaid/HMK *Plus* Member Help Line	Member Services	1-800-362-8312
Montana Citizen's Advocate	Citizen's Advocate	1-406-444-3468
Mental Health Services	Mental Health Services	1-888-866-0328
Montana Public Assistance Help Line (OPA)	Public Assistance Help Line	1-888-706-1535
Medicaid Transportation Center	Medicaid Transportation	1-800-292-7114
Medicare	Medicare	1-800-633-4227
Mental Health Ombudsman	Mental Health Ombudsman	1-888-444-9669
National Alliance on Mental Illness-Montana	NAMI Montana	1-406-443-7871
National Domestic Violence Hotline	Domestic Violence Hotline	1-800-799-7233
Poison Control	Poison Control	1-800-222-1222
Medicare Prescription Assistance Programs	Big Sky Rx Program	1-866-369-1233
Social Security	Social Security	1-800-772-1213
Substance Abuse Treatment	Substance Use Disorder Services	1-406-444-3964
Suicide Prevention	Suicide Prevention	1-800-273-8255 Or text "MT" to 741-741
Teen Dating Abuse Helpline	Teen Dating Abuse Helpline	1-866-331-9474
Tobacco Quit Line	Tobacco Quit Line	1-866-485-7848
WIC Nutrition Information	WIC	1-800-433-4298

8. Grievances and Appeals

If You Experience Discrimination

DPHHS may not exclude, deny benefits to, or otherwise discriminate against any person because of race, color, national origin, age, physical or mental disability, marital status, religion, creed, gender, sexual orientation, political belief, genetic information, veteran status, culture, social origin or condition, or ancestry.

Discrimination may not occur regarding admission, participation, or receipt of services or benefits of any programs, activities, or employment, whether carried out by DPHHS, through a contractor, or other entity.

To file a complaint for discrimination, forms are available by request at Medicaid/HMK *Plus* Member Help Line at 1-800-362-8312 or go to **Notice of Nondiscrimination** or contact:

Complaint Coordinator
Phone: 1-406-444-4211
V/TTY: 1-866-735-2968

You may file a complaint with the federal Office of Civil Rights. To do so contact:

Office of Civil Rights
US Department of Health and Human Services 1961 Stout Street, Room 1426
Denver, CO 80294
Phone: 1-303-844-2024
TDD: 1-303-844-3439

If You Disagree with a Decision by Medicaid or HMK *Plus*

You may act for yourself or for someone else, for one of the reasons listed below.

If you are denied Medicaid or HMK *Plus* eligibility:

There is a form you may use to request a fair hearing on the back of the notices that are sent out by the Office of Public Assistance. You may also call the Montana Public Assistance Helpline at **1- 888-706-1535** to find out why you were denied eligibility.

If Medicaid or HMK *Plus* won't pay the healthcare bill or you disagree with a decision:

If Medicaid or HMK *Plus* didn't pay for a service you think they should, or you disagree with any decision, you may call the **Medicaid/ HMK *Plus* Member Help Line at 1-800-362-8312**.

You can always request a fair hearing with the DPHHS Office of Fair Hearings if you disagree with a decision on eligibility, payment of your bill, or any other adverse action taken against you. A fair hearing is an impartial administrative hearing. For information on how to request a hearing or to file a request, contact:

Department of Public Health and Human Services
Office of Fair Hearings PO Box 202953
2401 Colonial Drive, Third Floor Helena, MT 59620
406-444-2470
Fax: 406-444-3980
E-mail: **hhsofh@mt.gov**

Let Us Know How Medicaid is Working for You

We want you to be happy with your Medicaid coverage. To let us know how we are doing call the **Medicaid/ HMK *Plus* Member Help Line at 1-800-362-8312**. We are here to help you with questions or problems. Talking about a problem or filing a complaint or an appeal will not affect your coverage or benefits.

Protected Health Information

The Notice of Protected Health Information is available upon request through the **Medicaid/ HMK *Plus* Member Help Line at 1-800-362-8312** or go to **DPHHS.**

DPHHS complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-406-444-1386 (TTY: 1-800-833-8503).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-406-444-1386 (TTY: 1-800-833-8503).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-406-444-1386 (TTY: 1-800-833-8503)。

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-406-444-1386（TTY: 1-800-833-8503）まで、お電話にてご連絡ください

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-406-444-1386 (TTY: 1-800-833-8503).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-406-444-1386 (TTY: 1-800-833-8503).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-406-444-1386 (TTY: 1-800-833-8503).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-406-444-1386 (TTY: 1-800-833-8503) 번으로 전화해 주십시오.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-406-444-1386 (رقم هاتف الصم والبكم: 1-800-833-8503).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-406-444-1386 (TTY: 1-800-833-8503).

MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring 1-406-444-1386 (TTY: 1-800-833-8503).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-406-444-1386 (TTY: 1-800-833-8503).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-406-444-1386 (телетайп: 1-800-833-8503).

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-406-444-1386 (TTY: 1-800-833-8503).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-406-444-1386 (TTY: 1-800-833-8503).

MONTANA

DPHHS

Healthy People. Healthy Communities.

Department of Public Health & Human Services