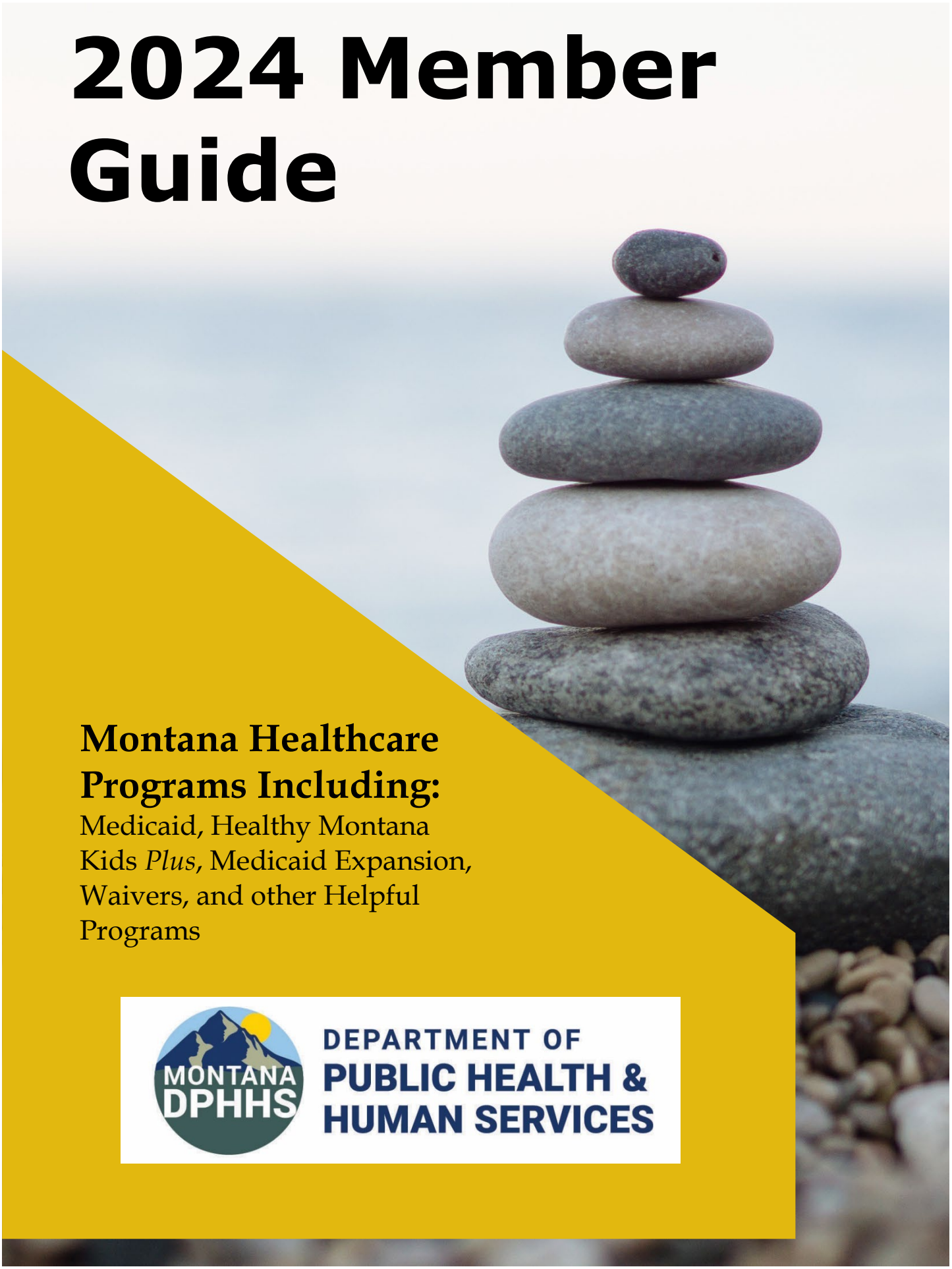
2024 Member Guide



Montana Healthcare Programs Including:

Medicaid, Healthy Montana Kids *Plus*, Medicaid Expansion, Waivers, and other Helpful Programs

MONTANA DPHHS

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

Published Date: January 1, 2024

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 a Montana Healthcare Program. This includes Medicaid, Healthy Montana Kids *Plus* (Medicaid for children), Medicaid Expansion (also known as HELP), one of our Waivers, or other helpful programs. It means you can get help with most health concerns. Getting and keeping you healthy is important to us.

This guide is mostly for people who are eligible for a Montana Healthcare Program or anyone receiving the Standard Medicaid Benefit. This guide also provides information on our other programs for people who may not receive the Standard Medicaid benefit.

In this guide, there is an explanation of your coverage and benefits. It will also let you know what your rights and responsibilities are as a member. In addition, the guide will provide contact information and resources for other helpful programs.

Contents

About Montana Medicaid and Healthy Montana Kids *Plus*

Montana Medicaid

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

Healthy Montana Kids *Plus* (HMK *Plus*)

Montana HMK *Plus* is Medicaid coverage for low-income children in Montana and is also ran 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.

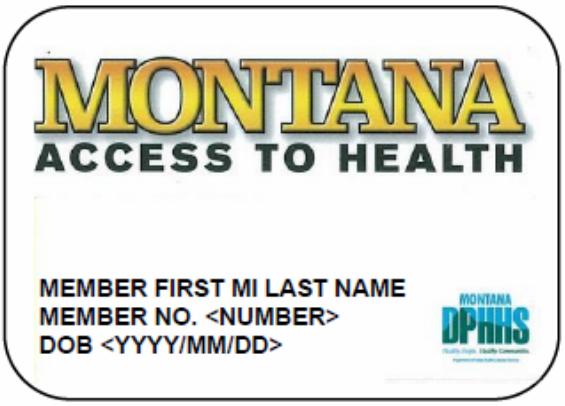
Medicaid and HMK *Plus* do not pay money to you. Instead, payments for healthcare services are sent directly to your healthcare providers.

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

- Services must be medically needed;
- 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.

Medicaid and HMK *Plus* Cards

Adults with Medicaid and children with HMK *Plus* will get a plastic card in the mail. This card will read "Montana Access to Health" and will be your Medicaid insurance card. 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 have not received your Medicaid card or lose your card, call **1-888-706-1535.** This phone number is for the **Montana Public Assistance Helpline.** This includes losing your card before you need medical care.

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.

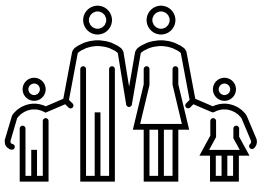
The front of your card has your name, your member number, and your birth date. The member number is a special number and is not your Social Security Number.

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

Changes in Income or Family

Tell the Office of Public Assistance within 10 days if you have changes in your home. You can call the Public Assistance Help Line or change your information online at https://apply.mt.gov. A case manager will tell you if you are still able to get Medicaid or HMK *Plus*. Some examples of changes to report include:

- Mailing address change;
- Phone number change;
- Marriage or Divorce status change;
- Moving to a nursing home;
- Getting pregnant;
- Having a baby;
- Job change;
- Having any change to insurance;
- Any changes in assets or income.



12-Month Postpartum Continuous Eligibility

The Montana Department of Health and Human Services (DPHHS) has expanded postpartum coverage. This started on July 1, 2023. It provides support for women after childbirth. Before this change, coverage for new mothers lasted for 60 days. Now, women can keep their Medicaid benefits for a full 12 months after giving birth. This includes women on Montana's Medicaid, HMK *Plus*, and HMK (CHIP).

If a member becomes pregnant or experiences any changes related to pregnancy, they need to inform the Office of Public Assistance (OPA). OPA needs to know about your pregnancy or postpartum status so they can make sure that your coverage is extended. If OPA isn't informed, they won't be able to adjust or prolong your coverage.

Medicaid Expansion

Medicaid expansion is also known as the Montana Health and Economic Livelihood Partnership (HELP) Program. It provides health care coverage to adults ages 19-64 with incomes up to 138% of the federal poverty level (FPL). To qualify, you must be a Montana resident. You must also not be able to get Medicare and cannot be in jail or prison at that time.

Those on Medicaid Expansion will also receive a "Montana Access to Health" card in the mail. Medicaid Expansion members can get Standard Medicaid Benefits. Please see *Covered and Non-Covered Services* of this guide.

Medicaid Expansion members can get health services from any provider. This includes doctors, clinics, or other health care providers. The provider must accept Montana Medicaid for the services to be covered. Some services may require prior authorization. Some other services may need a referral from your primary care provider.

Your Rights and Responsibilities

Rights

A person who has Medicaid or HMK *Plus* has the right to be treated fairly and with kindness and respect.

- You have the right to have your privacy protected. You also have the right to be treated with respect 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, treatment options, and outcomes that could happen. This includes discussing with your provider before saying "yes or "no" to treatment;
- You have the right to use the services of an interpreter, if needed. This service is free for the member;
- You have the right to be free from any form of restraint or seclusion. This could be used as a means of coercion, discipline, convenience, or retaliation;
- You have the right to request and receive a copy of your medical records. You also have the right to request that they be changed;
- You have the right to make a complaint about the Medicaid or HMK *Plus* program. You also 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. You also have the right to request additional information and materials.

Responsibilities

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

- Know if you are eligible for Medicaid and know what benefits are available to you;
- Treat your healthcare providers with respect;
- Provide your Medicaid card and any other insurance cards to your provider at each appointment;
- Complete and return all information requests from DPHHS and other insurances. This including trauma questionnaires and annual coordination of benefits requests. These are to be completed within the assigned time frame;
- 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 appointments and call your provider before if you cannot make it to your appointment;
- Carry your Montana Medicaid or HMK *Plus* ID card with you. Show your card 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;
- Ask all providers if they are in-network providers for any insurance companies you have an active policy with. Do this before you make an appointment;
- Help your provider get your prior medical records;
- Tell your provider about signs of trouble. This includes pain, allergies, or changes you may have 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 a Passport referral. This will be needed before that treatment is received;

- Go to the same pharmacy to get all your prescriptions. The pharmacist will tell you if certain drugs taken together will give you problems. They can also tell you if a drug has side effects. The pharmacist can answer questions about your prescription drugs;
- Don't sign things you do not understand;
- Use Medicaid and HMK *Plus* wisely. Use them only when you are sick or for exams and regular checkups to help prevent sickness;
- Assign rights from a third party to the Medicaid program. This is for medical support and payment of medical care.
- If Medicaid or HMK *Plus* paid or may pay for medical care for trauma caused by another person, you must give DPHHS details. This includes the names and addresses of your legal agent. It also includes the person or insurance company that is liable. This must be provided within 30 days of the incident that caused the trauma. It must also be provided before you agree to any payment with the liable party. **Call DPHHS Third Party Liabilities Program at 1-800-694-3084, option 7.**

Tort Recovery

A Medicaid member may need medical items or services because of trauma caused by a third party. This could include the action, lack of action, or neglect of a third party. Examples include trauma from a motor vehicle, injury caused by a damaged product (product liability), or injury from a job. Other examples include medical malpractice and other types of mishaps. All of these are referred to as casualty/tort cases. When this happens, the member or member's legal guardian may make a claim for payment. The claim for payment would be for medical and other losses incurred because of the injury. Claims in these cases may or may not be settled in court.

Federal law makes Montana DPHHS recover payment from deals outside of court or court judgments (awards). This is because a third party is responsible for the cost of medical care provided to the member. DPHHS is required to take back, if possible, the full amount spent on a member's medical care from the trauma.

DPHHS may open a claim with a responsible third party on behalf of a Medicaid member, if one has not already been opened. As part of being a Medicaid member, or the member's legal guardian, you must cooperate with DPHHS efforts to recover Medicaid's costs for medical care related to the trauma. If these rules are not followed, it could result in loss of Medicaid for the member, or the legal guardian. Medicaid eligibility for minors is not affected by failure to follow the rules of DPHHS recovery efforts.

Lien Recovery

To secure recovery of Medicaid payments made, the Montana Department of Public Health and Human Services (DPHHS) State Medicaid Agency may place a lien on real property owned by a Medicaid recipient on a waiver or living in a nursing home or institution. Real property types include but are not limited to, residence, recreational property, farms and ranches, businesses, land with or without improvements, and life estates. The amount of the lien cannot exceed the amount Medicaid paid on behalf of the recipient.

If a lien is imposed and the recipient is discharged from the facility or institution and returns home, DPHHS may release the lien based on a written request from the recipient. DPHHS will not impose a lien on real property that is the recipient's home, and the home is lawfully resided in by the recipient's spouse, a child of the recipient who has been determined permanently and totally disabled by the Social Security Administration, is blind, or under 21 years of age. Additionally, heirs may retain the property by paying the lesser of the amount the State Medicaid Agency is entitled to recover, or the fair market value of the property.

DPHHS may enforce the lien after the Medicaid recipient's death, or upon the sale, transfer or exchange of the right, title and interest in the real property. In accordance with Social Security Act 1917 § (b)(1)(3)(B), no lien will be imposed on Tribal trust property and improvements to tribal trust property (buildings or other attachments).

Estate Recovery

Montana DPHHS must get Medicaid payments made for the following members after their death. This is required by federal law.

- Members living in nursing homes;

- Members living in institutions such as the Montana State Hospital and Intensive Behavior Center; and
- Members aged 55 and older at the time they receive services paid by Medicaid.

The State Medicaid Agency may reclaim assets by filing a claim against the deceased member's estate. This would be for the amount Medicaid paid on the member's behalf. Recovery may be made from any property the Medicaid member had an interest in prior to the member's death. This includes both real property (real estate; land with or without upgrades) and personal property including but not limited to:

- Property that is part of the member's probate estate;
- Property that is not part of the member's probate estate;
- Property that was solely owned by the member;
- Property that the member owned jointly with another or others as a joint tenant or tenant-in-common; and
- Property transferred by Beneficiary Deed or Quit Claim Deed.

Medicaid Expansion members are not subject to this unless you are a member that had long-term care such as a nursing home and home and community-based services that were paid by Medicaid. This is required per federal law.

DPHHS will not take from Tribal trust property. This includes real property and upgrades. They will also not take from income derived from trust resources or Tribal trust property.

Questions or Concerns

What If I Get a Bill?

It is not common for Medicaid and HMK *Plus* to 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. Contact the provider to verify they know you have Medicaid coverage. Ask the provider to bill Medicaid for the service.

In most cases, providers should not send you a bill. This is unless you signed an Advanced Beneficiary Notice (private pay agreement) **before** getting services. With a signed private pay agreement, providers may bill you for:

- Services that are not covered under Medicaid;
- Experimental services;
- Services that are not approved;
- Covered but not medically necessary services,
- Not approved services that require a referral from your Passport provider;
- Services performed in a setting that is not appropriate;
- Services received when you are not eligible for Medicaid; and
- Investigational services.

You are required to pay for the service if you signed an agreement before the service was provided. Call the **Medicaid/HMK *Plus* Member Help Line at 1-800-362-8312** if you think any of these are happening:

- If you think a provider is sending you a bill and should not be;
- If you think a provider is billing both you and Medicaid or HMK *Plus* for the same service; or
- If you think a provider is billing you, Medicaid, or HMK *Plus* for services you did not receive.

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 **1-800-362- 8312.** This phone number is for the **Medicaid/HMK *Plus* Member Help Line.**

Can You Get a Report of Medical Claims Paid by Medicaid?

You have the right to request a report of medical service claims paid by Medicaid. You can request this on your behalf or the behalf of a person you have custody or legal guardianship of. A claims report will only be provided to the member, a member's parent, legal guardian, or another authorized person if there is a valid DPHHS release of information on file.

To request a claims report, mail a signed letter that includes the information below. You can also complete and mail a DPHHS Form No. HPS-405, to the Montana Department of Public Health and Human Services. The address to mail it to is P.O. Box 202953. The DPHHS Form No. HPS-405 can be found online at https://dphhs.mt.gov/assets/hipaa/RequestForPHI.pdf.
Please include the following:

- First and last name of person making the request,
- Relationship to member,
- First and last name of member,
- Member's Social Security Number (SSN),
- Member's Medicaid ID number,
- Member's date of birth (DOB),
- Date span of claims,
- Specific provider name (if applicable), and
- Address where records should be mailed.

Claims reports will be mailed within 30 days from when the request is received by DPHHS.

Can You Get Help Getting to Your Appointment?

Medicaid or HMK *Plus* may provide travel help for you to get to and from medical appointments. See pages 54 and 55 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 Medicaid or HMK *Plus* provider. You may also ask your case manager 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).** They can be reached at **1-800-833-8503**. They will give you more information about telephones with louder volume, telephones with captions, and hands-free devices.

The Montana Relay service can help if you want direct call relay service. This can help if you are deaf of hard of hearing. The number to call is **711.** You can also call them at **1-800-253-4091**. The Montana Relay customer service number is **1-800-833-8503**.

Other Helpful Programs for People without Medicaid

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

The 72-Hour Presumptive Eligibility program is paid for by the Behavioral Health and Developmental Disabilities Division. This program aims to provide mental health crisis services to people not currently enrolled in Medicaid. For more information, call **1-406-444-3964**.

Presumptive Eligibility Program (PE)

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

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

- Children (HMK *Plus* and Healthy Montana Kids (HMK) also known as Children's Health Insurance Program (CHIP));
- Pregnant women (Ambulatory Prenatal Care);
- Parent/Caretaker Relative Medicaid;
- HELP/Medicaid Expansion;
- Former Foster Care Children (ages 18 up to 26); and
- Breast and Cervical Cancer.

Additional Questions?

If you have more questions, contact your Office of Public Assistance (OPA). To find out where your local OPA is, call the **Montana Public Assistance Helpline**. They can be reached at **1-888-706-1535.**

Passport to Health

Passport to Heath (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, Medicaid Expansion (HELP), or HMK *Plus* must participate in the Passport program.

Your Passport Provider

You will choose an assigned Montana Medicaid Passport provider. This can include a provider such as a physician, nurse practitioner, physician assistant, or community health center. This could also include a provider such as tribal health, Indian Health Service (IHS), or a primary care clinic. Your Passport provider will take care of most of your medical needs. They will also make referrals to other providers as necessary. The provider will keep your medical records up to date and in one place. All medical appointments must be provided or approved by your Passport provider. There may be some exceptions to this. Please ask your Passport provider for more information.

What to Expect from Your Passport Provider

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

- Provide primary and preventative care;
- Provide health maintenance;
- Provide treatment of illness and injury;
- 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, and immunizations; and
- Offer interpreter services covered by Medicaid.

Who is Not 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;
- Receiving back dated Medicaid eligibility,
- Receiving Medicaid home and community-based services (HCBS);
- Eligible for a non-standard Medicaid plan like MHSP or Plan First;
- Receiving Medicaid under a presumptive eligibility program;
- Living outside of the State of Montana;
- Eligible for Pregnancy Medicaid; or
- Eligible for the Breast and Cervical Cancer program.

HMK (CHIP) program members are also not eligible for Passport.

Choosing Your Passport Provider

You choose your Passport provider. You can choose the same provider for everyone in your family or each person can also have a different provider. You can choose this according to the healthcare needs of each person. For example, parents may choose a pediatrician for their child and a family doctor 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.** They can be reached at **1-800-362-8312**. They are available Monday through Friday from 8 am to 5 pm. The staff can tell you about Passport providers near you. You can also choose your Passport provider online by going to: https://mtaccesstohealth.portal.conduent.com/mt/general/enrollBroker.do.

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. This letter will include the name of the provider chosen or assigned to you. The letter will also tell you how to contact your provider during and after normal work hours.

American Indians and Passport

If you are American Indian, you can choose an Indian Health Services (IHS), Tribal Health Provider, Urban Indian Organization (I/T/U), or any other enrolled Passport provider. American Indian members may visit IHS/Tribal/Urban Organization providers without a Passport referral. **Medicaid and HMK *Plus*** may not pay the bill if you do not get a referral from your Passport provider before seeing another non-I/T/U provider. An I/T/U can also refer members to another provider even if they are not the member's Passport 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.** They can be reached at **1-800-362-8312**. They are available Monday through Friday from 8 am to 5 pm. You can also do this online at: https://mtaccesstohealth.portal.conduent.com/mt/general/enrollBroker.do**.** 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. This date is dependent on when the change is requested.

Passport Referrals

Your Passport provider will provide most of your healthcare needs. 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 must make sure they have a referral from your Passport provider before they see you. Urgent Care will also need a Passport referral. If your Passport provider is unavailable at the time you are seen at urgent care, they may provide the referral after.

You don't need a referral from your Passport provider for all services. See the Covered and Non-Covered Services section beginning on page 23. This will list services that don't need Passport referrals.

Which Members are Exempt from Taking Part in 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 cases, 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;
- Participating in the Health Insurance Premium Payment (HIPPS) program;
- 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.

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 medical emergencies include excessive bleeding or difficulties 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, you should go to your Passport provider for that care. This could include services like getting stitches removed.

- **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 44.

- **Urgent care**
  Urgent care clinics do not provide the same services as a Passport provider. Some urgent care providers do not accept Medicaid. If you go to an urgent care clinic, make sure the urgent care takes Medicaid. If you need to visit an urgent care when your Passport provider is unavailable, you can do so. Make sure your Passport provider provides a referral after the fact. The referral is still required for urgent care visits.

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.** They can be reached at **1-800-362-8312**. They are available Monday through Friday from 8 am to 5 pm.

Quality of care complaints should be directed to the **Department of Labor and Industry.** They can be reached at **(406) 444-2840**.

If You Do Not Have Passport

You can get healthcare services 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). This can include internists; pediatricians, obstetricians, and gynecologists;
- Mid-level practitioners. This can include 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 a provider or place to get healthcare that are Medicaid or HMK Plus approved, go to https://mtdphhs-provider.optum.com. Use the "Find a provider" button. There you can search by type, specialty, and even location.

Specialty Covered and Non-Covered Services

This section will tell you if a service is covered by Medicaid or HMK *Plus*. For more details on non-covered services, turn to page 37. 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. You can also call the **Medicaid/HMK *Plus* Member Help Line.** They can be reached 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 Referrals

Some Medicaid and HMK *Plus* covered services may not be done by your Passport provider. Your Passport provider should direct you to the appropriate healthcare provider as needed. They 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.** They can be reached at **1-800-362-8312.**

Montana Medicaid and HMK Plus makes every effort to have a full set of medical policies in place. Due to the fast pace of medical changes and new medical procedures, there may not be a policy yet. Medicaid and HMK Plus may not have a policy to address every service. When this happens, Medicaid and HMK Plus may review other information. This could include current medical literature and other medical resources. They may also consult with healthcare providers.

The description of Medicaid and HMK Plus covered and non-covered services presented in this document is a guide. It is 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.

Tribal Health Improvement Program

Montana Medicaid operates a Primary Care Case Management entity program known as the Tribal Health Improvement Program (T-HIP). T-HIP provides care management services for eligible Native American members who reside on a reservation. This is a voluntary program, and as a Montana Medicaid member, you have the right to opt-out any time you choose. The program was created to help you understand your health care. This includes helping coordinate services, advocating on your behalf, improving your understanding of disease management and increasing self-management skills. Members who are eligible are contacted by the T-HIP on their reservation through letters and phone calls. If you feel that this program would be of benefit to you and your health but have never received a call or letter regarding this program, you can contact the Health Resources Division at (406) 444-1292 to confirm eligibility and get connected with the local T-HIP.

Benefit Charts for Standard Medicaid Benefits

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 https://dphhs.mt.gov/MontanaHealthcarePrograms/WellChild	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, Clinic, and Physician Related Services Continued

Benefit	Description	Limits/Exclusions	Passport Referral Needed?	Prior Authorization Needed?
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 or Tribal healthcare services for American Indians and Alaska Natives.	Limited to members of federally recognized Indian tribes and their descendants.	No	Yes, for some services
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 sections.	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?
Community First Choice	Hands-on assistance with activities of daily living	The Member must meet the institutional level of care to be eligible for services. 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: **1-800-219-7035**
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. 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	No
Hospice	Hospice is a program of care and support for people who are terminally ill and have chosen not to pursue curative treatment.	The member's doctor and the hospice medical director must certify that the member is terminally ill and has six months or less to live if the illness runs its normal course. The member must sign a statement choosing hospice care instead of other covered benefits to treat terminal illness.	No	No

Senior and Long-Term Care Services Continued

Benefit	Description	Limits/Exclusions	Passport Referral Needed?	Prior Authorization Needed?
Money Follows the Person	Assistance moving from a nursing home back into the community.	Eligible participants include those who have resided in an institutional setting (nursing home, hospital, etc.) for at least 60 days and whose care has been paid for by Medicaid for at least **one** of those 60 days. Participants must also be eligible for one of the Montana Waiver Partner programs (i.e., Big Sky Waiver, Severe Disabling Mental Illness Waiver (SDMI), or Developmental Disability Waiver).	No	Yes, contact Mountain Pacific Quality Health at: **1-800-219-7035**
Nursing Home	Provides room, board, daily attendant and nursing services, ancillary items, and some specialty care in nursing homes.	Admission requires level of care screening.	No	Yes, contact Mountain Pacific Quality Health at: **1-800-219-7035**
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 of 80 hours per two-week period. Activities of daily living must be delivered in the home.	No	Yes, contact Mountain Pacific Quality Health at: **1-800-219-7035**

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); ✓ Licensed Marriage and Family Therapists (LMFT) ✓ 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; ✓ Home Support Services; ✓ Therapeutic Foster Care; and ✓ Mental Health Intensive Outpatient Therapy Therapeutic Group Home, including Extraordinary Needs Aides Psychiatric Residential Treatment Facility Acute Inpatient Services Partial Hospital Services Therapeutic Home Visit if in a Psychiatric Residential Treatment Facility or Therapeutic Group Home Explanation of services can be found at the following website: https://dphhs.mt.gov/BHDD/cmb/childrensmentalhealthservices	See link to Children's Mental Health Bureau website: https://dphhs.mt.gov/BHDD/cmb/	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); ✓ Licensed Marriage and Family Therapists (LMFT); ✓ 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; ✓ Peer Support; ✓ 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: https://dphhs.mt.gov/amdd/mentalhealthservices/index	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 (SUD) Treatment	Substance Use Disorder (SUD) services provided by: ✓ Licensed Professional Counselors (LCPC), Licensed Clinical Social Workers (LCSW), or other Mental Health Professional with SUD in their scope. Substance Use Disorder Treatment services include: screening and assessment, medication assisted 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: peer support; 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: https://dphhs.mt.gov/amdd/substanceabuse/index)	There is no limit to medically necessary outpatient psychotherapy sessions	No	Yes, for some services

Behavioral Health Related Services - continued				
Benefit	**Description**	**Limits/Exclusions**	**Passport Referral Needed?**	**Prior Authorization Needed?**
Applied Behavior Analysis (ABA) Services	Applied Behavior Analysis (ABA) is a type of therapy that can improve social, communication, and learning skills through positive reinforcement. ABA services are provided by a licensed Board-Certified Behavior Analyst (BCBA). If a member is referred for ABA services, a parent or guardian may search for a BCBA on the provider search portal found here: https://mtdphhs-provider.optum.com/tpa-ap-web/?navDeepDive=MT_publicHomeDefaultContentMenuportal . ✓ Provider Type: Board Certified Behavior Analyst, then click "Search" button at bottom of page. More information is available on the Developmental Disabilities Program web page: https://dphhs.mt.gov/dsd/developmentaldisabilities/ABAS/index	Members must meet at least one of the following criteria: ✓ Diagnosis of Autism Spectrum Disorder (ASD) and no older than 20 years of age; ✓ Diagnosis of Serious Emotional Disturbance (SED), no older than 17 years of age or no older than 20 years of age if enrolled in an accredited secondary school, and meet certain functional impairment criteria; or ✓ Determined eligible for State-administered developmental disabilities services, no older than 20 years of age, and meet certain functional impairment criteria.	No	Yes, after initial 180 days or 1260 units (whichever occurs first) are expended.

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 the transport is denied as not medically necessary, you will be responsible for the bill.	No	No
Specialized Non-Emergency Transportation (NEMT)	Scheduled 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?
MT Asthma Home Visiting Program (MAP)	6 contacts over 1 year with an RN or RRT trained in asthma education, care coordination, and home environment assessments. In-person home visiting is available in over 20 counties and virtual home visiting is offered statewide.	Individuals must have an emergency department visit, hospitalization, or unscheduled medical office visit for asthma or an Asthma Control Test score of less than 20 in the last year. *Montanans with an asthma diagnosis who do not meet these requirements are still eligible for MAP with a direct referral from their healthcare provider.	No	No
Audiology/ Hearing Aids	Hearing aids, evaluations, and basic hearing assessments for members with hearing disorders.	Hearing aids must be ordered by a medical provider. Over the counter hearing aids are non-covered as well as some miscellaneous supplies.	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 18 years and older who are at risk for developing type 2 diabetes. Authorized providers must be approved by the Division of Public Health & Safety,	No	No
Diabetes Self-Management Education and Support (DSMES)	Certified diabetes care and education specialists deliver ongoing diabetes education and self-management sessions to people with diabetes. Offered to individuals who have a documented diagnosis of type 1, type 2 or gestational diabetes, and a written referral from the treating physician or qualified non-physician practitioner.	*A new referral is required for follow-up visits after one year. Individual DSMES must be provided by an accredited/recognized program with up to 6 units (3 hours/day) Group DSMES must be provided by an accredited/recognized program with up to 12 units (6 hours/day) *No monthly/annual limit *No age limit	Yes	No

Miscellaneous Services - continued

Benefit	Description	Limits/Exclusions	Passport Referral Needed?	Prior Authorization Needed?
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
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

Miscellaneous Services - continued

Benefit	Description	Limits/Exclusions	Passport Referral Needed?	Prior Authorization Needed?
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
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. These are 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. This is unless it is as an emergency service or an approved midwife attended home birth;
- 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.

More Information about Standard Medicaid

This section includes examples of Standard Medicaid benefits. If you are on Medicaid, Medicaid Expansion (HELP), or HMK *Plus,* you receive the Standard Medicaid benefit. Not all services are listed. 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.** They can be reached at **1-800-362-8312** for more information.

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

Applied Behavioral Analysis (ABA) Services

ABA is a type of therapy that uses positive reinforcement. It aims to improve social, communication, and learning skills. This therapy is provided by a licensed Board-Certified Behavior Analyst (BCBA). ABA services include:

- Assessment;
- Treatment plan development;
- Service delivery by a Registered Behavior Technician and supervision by a BCBA.

ABA services generally occur face-to-face. They can occur in the home, community, or office setting. The services may also be delivered individually or to two or more people at the same time. Training and support may also be provided to parents, guardians, or caregivers. To learn more about ABA services, please visit: https://dphhs.mt.gov/BHDD/DisabilityServices/developmentaldisabilities/ABAS/index.

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. They must also be provided by a substance use disorder program (SUD) approved by Medicaid. Treatment must be medically necessary. These include:

- 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.

Montana Asthma Home Visiting Program

The Montana Asthma Home Visiting Program (MAP) provides free asthma education. This can be provided to anyone with asthma that is not controlled. Examples of topics that are covered include:

- What asthma is;
- How to control your asthma; and
- How to avoid asthma triggers.

This was developed based on medical guidelines. It is also based on research from the Centers of Disease Control and Prevention (CDC).The program includes 6 interactions. These are with a trained healthcare provider over the course of one year. During these, participants receive:

- Personalized asthma education;
- Home environmental assessment to identify possible asthma triggers; and
- Incentives including a spacer for medication administration, a HEPA air purifier, and replacement HEPA filters.

This service is free to all eligible Montanans and is not covered by Medicaid. For more information and to register for the program, go to this website: **https://dphhs.mt.gov/publichealth/asthma/asthmahomevisiting**.

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. The provider will fax Medicaid a prescription for the pump; and
2) The mother must go to https://www.healthybabieshappymoms.com/montana and complete the order form online.

Case Management (Targeted)

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

- 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 (SDMI);
- Individuals with developmental disabilities enrolled in the 0208 1915(c) Waiver or eligible individuals aged 16 and over;
- Children and youth ages 17 and under, or up 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 aged 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 a psychiatric residential treatment facility or therapeutic group home.

Children's Healthcare (EPSDT)

EPSDT stands for Early and Periodic Screening, Diagnosis and Treatment. 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 56 and 57.

If your child's provider finds something that needs to be treated or looked into 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.** They can be reached at **1-800-362-8312**.

Chiropractic Services

Chiropractic services for children ages 20 and younger are covered. Adult chiropractic services are not a covered benefit of Medicaid. Adults with Medicare and Medicaid may receive copayment, coinsurance, and deductible reimbursement for 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)

This type of care is chosen with each member in a person-centered manner. It 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. These 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

Children 20 and under:

- Can get dental exams and cleanings as often as needed;
- Should visit a dentist by their first birthday. They should also visit at least once every six months after the first tooth comes in;
- During a well-child checkup, providers should do an oral exam. This should include 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 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;
- Can have basic treatment services, such as fillings and extractions, up to the $1,125 limit per year;
- Can get two porcelain crowns per calendar year; and
- Dentures (see next section).

Adult members have a $1,125 dental spending limit every year. Adult members are responsible to pay for non-covered dental services and any dental treatment services above this limit.

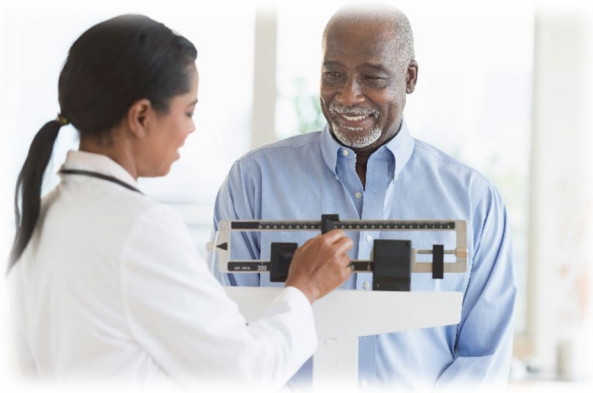
Dentures for Adults

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 a public health program based on evidence. It supports healthy lifestyle changes for adults who are at risk of 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. That provider must be authorized through the Montana Public Health & Safety Division. For more information go to this website: **https://diabetes-prevention-mtdphhs.hub.arcgis.com/**



Diabetes Self-Management Education and Support (DSMES)

Diabetes and Self-Management Education and Support (DSMES) is a way to continually learn about diabetes and how to manage it yourself. It also includes activities that assist a person in changing and keeping the behaviors learned. This is needed to manage his or her condition on an ongoing basis. DSMES is provided by Certified Diabetes Care and Education Specialist (CDCES). CDCES are trained to support individuals who have been diagnosed with type 1, type 2 or gestational diabetes. This is a covered service through Montana Medicaid if provided by a Montana Medicaid provider. For more information go to this website: https://diabetes-self-management-education-services-mtdphhs.hub.arcgis.com/.

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 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. This could include 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)

Some over-the-counter drugs are covered if they are prescribed for you by your healthcare provider. A list of these drugs can be found on the pharmacy provider web page at https://medicaidprovider.mt.gov/19 under the "Over-the-Counter" tab.

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 condition (medical or behavioral), are severe enough that a person with an average knowledge of health and medicine would expect there might be danger. This includes the belief there will be danger to the health or 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. They also must be 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. Paternity (to identify fatherhood) tests are not covered.

Fertility Preservation Services

Medicaid members who are aged-eligible and diagnosed with cancer are now able to receive fertility preservation services. The member must be between the ages of 12 and 35. They are required to have been diagnosed by a physician with a form of cancer. They also must be receiving treatment that may cause a substantial risk of sterility or infertility (including surgery, radiation, or chemotherapy). These services are limited to the collection of eggs and sperm. Each qualifying member is limited to one benefit per lifetime. Please contact your provider for more information.

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(s).

Group Medical Visits

A provider may see many members 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.

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.

Some items may be non-covered by Montana Healthcare Programs and include the following:

- Over the counter hearing aids;
- Wax filters;
- Domes;
- Wax picks; and
- Ear plugs.

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 that may be available in one or more of the HCBS waivers:

- 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;
- Community-based psychiatric rehabilitation and support;
- Homemaking;
- Private nursing;
- Adult day care;
- Adult group and foster home;
- 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/or Physically Disabled Waiver) **1-406-444-4077**;
- SDMI Waiver **1-406-444-3964**; and
- Developmentally Disabled Waiver **1-406-444-2995**.

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. The cost of the person who comes to your home to give you the drug treatment is also covered. Services must be prior authorized.

Home Health Services

Home Health services are intermittent, part-time nursing, and restorative therapy services. They are 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. This is done 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.

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.

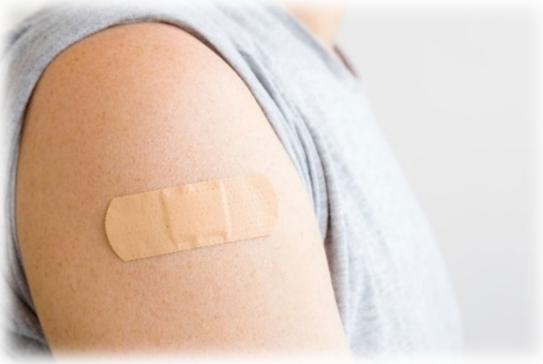
Many hospital services must be prior authorized before you go to the hospital. For more information about hospital services, call the **Medicaid/HMK *Plus* Member Help Line.** They can be reached at **1-800-362-8312**.

Immunizations

It's important for children 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.

The 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 the 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 here: https://www.aap.org/en/practice-management/bright-futures.

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 are not always noticed. This means blood lead testing is 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;
- Targeted case management;
- Day treatment services;
- Psychological testing;
- Community-based psychiatric rehabilitation and support;
- Comprehensive school and community treatment;
- Therapeutic group home;
- Extraordinary needs aide if in a group home;
- Home support services;
- Therapeutic family and foster care;
- Psychiatric residential treatment facility;
- Therapeutic Home Visit while in a Psychiatric Residential Treatment Facility or Therapeutic Group Home; and
- Mental Health Intensive Outpatient Therapy.

Some services require prior authorization.

Midwife Homebirths

Effective January 1, 2024, Montana Medicaid will allow eligible members to have home birthing options. To be eligible for a home birth, it must be determined there are low risk of adverse birth outcomes. Approved home births are to be attended by a certified nurse midwife or direct entry midwife as licensed under Montana law. Please contact your provider for more information.

Money Follows the Person

Montana's Money Follows the Person (MFP) is a grant funded project through the Centers for Medicare and Medicaid Services (CMS). This grant has been authorized through 2027. MFP assists seniors and members with disabilities. It helps them to move out of institutional settings and back into their communities.

Members who are eligible must have resided in an institutional setting (nursing home, hospital, etc.) for at least 60 days. They must also have had their care paid for by Medicaid for at least **one** of those 60 days. Members must also be eligible for one of the Montana Waiver Partner programs. This could include the Big Sky Waiver, Severe Disabling Mental Illness Waiver (SDMI), or Developmental Disability Waiver.

MFP assists members with their transition into the community. They do this by providing services that remove barriers. These can include but are not limited to:

- Payment of the rent and utility deposits, when necessary;
- Help with past due rent and utility bills/deposits;
- Purchase of household goods and services. This can include (limited) basic household furnishings, bedding, kitchenware, etc.; and
- Environmental and/or vehicle modifications.

Members must transition to an MFP qualified residential setting. Such housing options include:

- A home owned or leased by a member or their family;
- An apartment with an individual lease and secure access. It also must have a living, sleeping, bathing, and cooking area where a member or their family has control; and
- A community-based residential setting such as a group home. This can have a maximum of 4 unrelated people (excluding caregivers or personal attendants).

To make a referral or for more information, please contact Money Follows the Person:

- Email to MoneyFollowsThePerson@mt.gov
- Call (406) 439-6870
- Fax (406) 655-7646
- Submit a secure referral form via the Money Follows The Person website (https://dphhs.mt.gov/sltc/mfp).

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. The nursing home will know which services need prior authorization. Admission to a nursing home requires a level of care screening. Contact Mountain Pacific Quality Health at 1-800-219-7035.

OB (Obstetric) Services

Medicaid covers routine care during pregnancy. They also cover individual and group prenatal visits and checkups for the mother after she gives birth.

A baby's delivery must be in a licensed hospital or birthing center to be covered. They will also be covered if it is an approved midwife homebirth. 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. It 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.

School-Based Services

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.

Therapy Management for Drugs

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

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.** They can be reached 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 pregnant and post-partum women, American Indians (1-855-5AI-QUIT), and for youth under 18 (My Life My Quit, 1-855-891-9989). Call the Montana Tobacco Quit Line at **1-800-QUIT-NOW** or visit quitnowmontana.com**.**

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 service or appointment must be covered by Medicaid or HMK *Plus*. To be eligible, you must also have no other way of getting to the appointment.

There are different rules and reimbursement rates for different kinds of transportation. These transportation types can include commercial transportation (taxicabs and busses), specialized transportation (wheelchair accessible vans and non-emergency ambulances), and personal transportation (family, friend, or your own private car).

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

- You must be eligible for Medicaid or HMK *Plus* on the date of the medical appointment;
- 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**;
- You must use the least costly way to travel that still meets your needs;
- Travel to your Passport provider, to the closest approved provider, or for other medical services; and
- Travel funds can be provided for out-of-town or out-of-state services if the service is not available near you.

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.

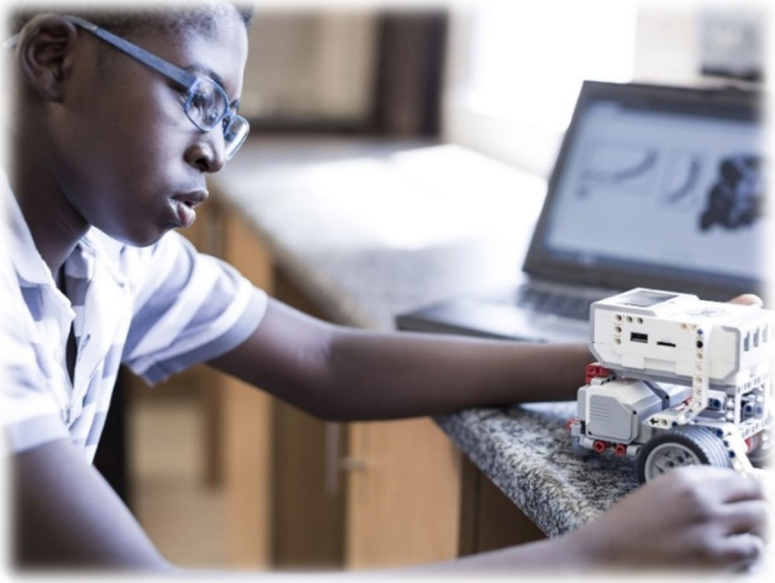
Be sure to call the Medicaid Transportation Center at **1-800-292-7114** before you arrange travel. Reimbursement is made after you travel if you have followed the above steps. The transportation center will contact your provider's office to make sure you went to your appointment before paying.

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 whose Medicaid provided eyeglasses have been lost, broken or stolen, 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 33) 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. This will ensure there is enough time 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. They should also see the dentist 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.

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 these at the Office of Public Assistance. For Medicaid members eligible for these programs (listed below), Medicaid may pay:

- Qualified Medicare Beneficiary Program (QMB) - a portion of your Medicare Part A and B monthly premium, coinsurance, and deductibles;
- Specified Low-Income Medicare Beneficiary Program (SLMB) - a portion of your Medicare Part B monthly premium; and
- Qualifying Individual Program (QI) - a portion of your Medicare Part B monthly premium.

An additional program, Big Sky Rx, may pay all or part of your Medicare drug plan monthly premium. This 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. You can get more information about Medicare and related services from SHIP (State Health Insurance Assistance Program) at **1-800-551-3191.**

For more information about Big Sky Rx, call **1-866-369-1233** or visit https://dphhs.mt.gov/MontanaHealthcarePrograms/BigSky.

Health Insurance Premium Payment (HIPP) Program

The Health Insurance Premium Payment Program (HIPP) is a Medicaid program that may pay for group or individual health plan premiums. These 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 (CHIP) 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, university, or through an individual healthcare policy;
- Your job or university 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 **9** when prompted.

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 https://dphhs.mt.gov/MontanaHealthcarePrograms/PlanFirst**.**

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). They must be 18 or older, have severe and disabling mental illness (SDMI), and are otherwise ineligible for Medicaid benefits.

WASP also covers additional dental services above the $1,125 State Plan treatment cap. To receive this, you must be determined categorically eligible for Medicaid in the Aged, Blind, and Disabled (ABD) category.

To apply or for more information contact the Behavior Health and Developmental Disorders Division at **1-406-444-3055.** You can also email **icoy@mt.gov** or visit the WASP website at https://dphhs.mt.gov/MontanaHealthcarePrograms/Medicaid/Medicaid1115Waiver**.**

Grievances and Appeals

If You Experience Discrimination

DPHHS may not exclude, deny benefits to, or otherwise discriminate against any person. This includes discrimination based on:

- Race, color, national origin, culture, social origin or condition, or ancestry;
- Age;
- Physical or mental disability;
- Marital status, gender, sexual orientation, or genetic information;

- Political belief, creed, or religion; or
- Veteran status

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

To file a complaint for discrimination, forms are available by request at the Medicaid/HMK *Plus* Member Help Line at **1-800-362-8312**. You can also go online: https://dphhs.mt.gov/NondiscriminationPolicy 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 Administrative 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 Administrative Hearings
PO Box 202922
2401 Colonial Drive, Third Floor, Helena, MT 59620
406-444-2470
Fax: 406-444-6565
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.** They can be reached 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**. You can also go online: https://dphhs.mt.gov/.

Resources

Organization or Service	Website	Phone Number
Aging Services	https://dphhs.mt.gov/sltc/aging/	1-800-551-3191
AIDS or Sexually Transmitted Diseases	https://dphhs.mt.gov/publichealth/hivstd/	1-406-444-3565
Child Abuse and Neglect	https://dphhs.mt.gov/cfsd/	1-866-820-5437
Child Support Customer Service	https://dphhs.mt.gov/cssd/	1-800-346-5437
Childhood Lead Poison Prevention Information	https://dphhs.mt.gov/publichealth/cdepi/diseases/Lead	1-406-444-0340
Children's Special Health Services	https://dphhs.mt.gov/ecfsd/cshs/	1-800-762-9891
Citizen's Advocate (Governor's Office)	(no website available)	1-406-444-3468
Elder Abuse Information (Adult Protective Services)	https://dphhs.mt.gov/SLTC/aps/index	1-844-277-9300
Legal Services	https://www.montanalawhelp.org/	1-800-666-6899
DPHHS Language Assistance Services	Language Assistance Services (mt.gov)	1-800-368-1019
Medicaid Fraud Line	https://dphhs.mt.gov/MontanaHealthcarePrograms/fraudandabuse	1-800-201-6308
Medicaid/HMK *Plus* Member Help Line	(no website available)	1-800-362-8312
Medicaid Transportation Center	https://dphhs.mt.gov/MontanaHealthcarePrograms/Medicaid/Transportation	1-800-292-7114
Medicare	https://www.mymedicare.gov/	1-800-633-4227
Medicare Prescription Assistance Programs (Big Sky Rx)	https://dphhs.mt.gov/MontanaHealthcarePrograms/BigSky	1-866-369-1233
Mental Health Ombudsman	https://mhombudsman.mt.gov/	1-888-444-9669
Mental Health Services for Adults	https://dphhs.mt.gov/amdd/mentalhealth	1-888-866-0328
Mental Health Services for Children/Youth	https://dphhs.mt.gov/BHDD/cmb/	1-406-444-4545
Montana Public Assistance Help Line (OPA)	https://dphhs.mt.gov/hcsd/officeofpublicassistance	1-888-706-1535
National Alliance on Mental Illness-Montana	http://www.namimt.org/	1-406-443-7871
National Domestic Violence Hotline	https://www.thehotline.org/	1-800-799-7233
Poison Control	https://dphhs.mt.gov/publichealth/EMSTS/prevention/poison	1-800-222-1222
Social Security	https://www.ssa.gov/	1-800-772-1213
Substance Abuse Treatment	https://dphhs.mt.gov/amdd/substanceabuse	1-406-444-3964
Suicide Prevention	https://dphhs.mt.gov/suicideprevention/suicideresources	988 or 1-800-273-8255 or text "MT" to 741-741
Teen Dating Abuse Helpline	https://www.loveisrespect.org/	1-866-331-9474
Tobacco Quit Line	https://dphhs.mt.gov/publichealth/mtupp	1-866-485-7848
WIC Nutrition Information	https://dphhs.mt.gov/ecfsd/wic/	1-800-433-4298

DPHHS complies with applicable Federal civil rights laws and does not discriminate based on 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).

DEPARTMENT OF
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