Department Updates

Children, Families, Health, and Human Services Interim Committee

July 8, 2026

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

Agenda

- Federal Change and Department Actions
- Medicaid Process Demonstration
- Rural Health Transformation Program Update

Federal Changes and Department Actions

Jessie Counts, Human Services Executive Director
Rebecca de Camara, Medicaid and Health Services Executive Director

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

Montana's Commitment to July 1 Implementation of Medicaid Expansion Community Engagement Requirements

Montana state leadership, including the Governor and Legislature, have long signaled their commitment to implementing work requirements (i.e., Community Engagement (CE) requirements)

- In 2019, the Montana Legislature passed House Bill (HB) 658, which established state support for CE requirements.
- In 2025, Montana submitted an 1115 Demonstration waiver to Center for Medicare & Medicaid Services (CMS) to align the state's Medicaid Expansion program with House Resolution 1 (H.R. 1) requirements, including CE, and gain authority to implement them as soon as possible.
    - Based on feedback from CMS, DPHHS now intends to pursue CE requirements in H.R. 1 through a State Plan Amendment (SPA), not the 1115 Demonstration waiver.
- **Montana intends to leverage these efforts to effectively implement CE requirements as a national "early adopter" with a go-live date of July 1, 2026**.

Review of CMS Interim Final Rule with Comment Period (IFC)

- **On June 1, 2026, the Centers for Medicare and Medicaid Services (CMS) released their anticipated IFC, providing more detail on CE requirements and implementation.**
- **DPHHS thoroughly reviewed the IFC upon its release**:
  - DPHHS intends to implement CE on July 1, 2026. The information in the IFC does not require material changes or updates to Montana's decision to implement CE as a national early adopter.
  - Assumptions and decisions the Department made while preparing operationally for early CE implementation (in close coordination with CMS) were aligned with information in the IFC.
  - Since the IFC's release on June 1, 2026, the Department has moved quickly to update external communications on our website, client forms, and operational materials (e.g., business processes, trainings) to align with the level of detail and information provided in the IFC.

Key Information from the IFC (1/2)

Category	Summary of Information
Demonstrating Community Engagement	• An individual meets CE in a month through any of the following activities (including a combination of activities): 80+ hours of work (paid, in-kind, or unpaid), 80+ hours of community service, 80+ hours in a qualifying work program, at-least-half-time education enrollment, or monthly income equal to or greater than federal minimum wage × 80 hours ($580 at $7.25); seasonal workers use a six-month income average.
Specified Excluded Individuals and Mandatory Exceptions	• Specified excluded individuals are excluded from needing to meet CE entirely: CE is not a condition of their eligibility. These groups include: former foster youth under age 26, American Indians/Alaska Natives, parents/guardians/caretakers/family caregivers, totally disabled veterans, individuals who are medically frail, individuals compliant with SNAP/TANF work requirements, those in substance-use treatment, current inmates, and pregnant/postpartum individuals • Mandatory excepted individuals still need to meet CE as a condition of eligibility, but are deemed compliant for the months in which they meet an exception (under 19, on Medicare, in a mandatory eligibility group, a specified excluded individual, recently incarcerated in the last three months, or experiencing a short-term hardship)
Assessing Compliance	• States elect a lookback: 1–3 consecutive months immediately before application, and one or more (state-elected, non-consecutive permitted) months between renewals (*Montana has selected a one-month lookback for application and a three-month lookback for renewals*) • Compliance must be assessed at application and renewal

Key Information from the IFC (2/2)

Category	Summary of Information
Verifying Compliance	• States must attempt ex parte verification using reliable data before requesting documents • An exclusion always takes precedence over meeting CE through qualifying activities
Noncompliance Procedures	• When a state can not verify CE, it must send a noncompliance notice giving 30 calendar days to make a "satisfactory showing“ of compliance; coverage can't be terminated during that window, and the state must first check all other bases of eligibility
Outreach	• Notices should be sent to all adult-group and applicable 1115 enrollees (not just known applicable individuals), beginning 4–6 months before CE takes effect (*Montana began noticing in March 2026*)
Monitoring	• States must submit timely, complete, sufficient-quality data across five categories (enrollment, application/renewal processing, determination outcomes, populations subject to/compliant with CE, and other CMS-specified data), leveraging existing CMS reports when possible

Medically Frail Exclusion

- Medically frail, or a **medical condition or health needs that impact ability to work or do other community engagement (CE) activities**, is one of several exclusions available for individuals subject to CE requirements for Medicaid Expansion

CMS Definition of Medically Frail

The Interim Final Rule with Comment (IFC) released by the Centers for Medicare and Medicaid Services (CMS) on June 1, 2026 offered new insights into the definition of medically frail as it relates to an exclusion for CE requirements:

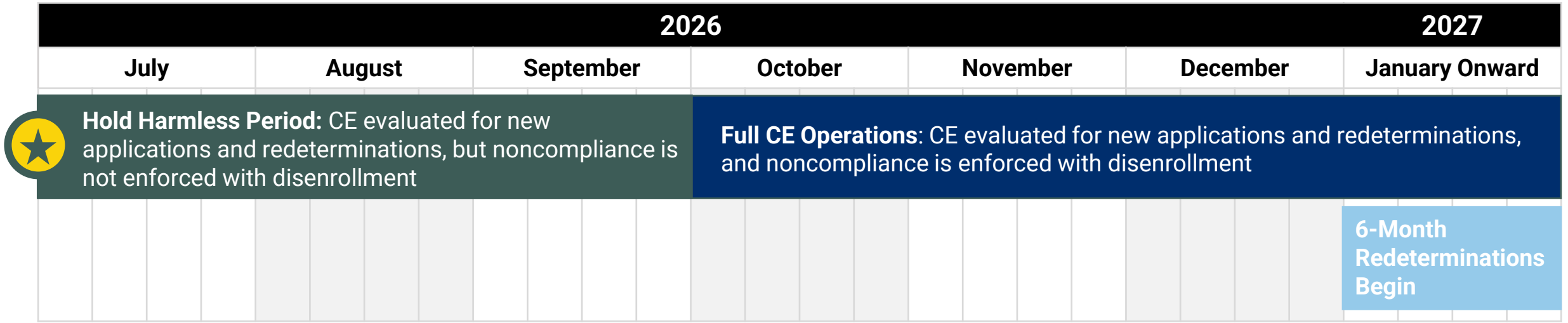
- **Five categories exist**: blind or disabled, substance use disorder (SUD), disabling mental disorder, physical, intellectual, or developmental disability that significantly impairs their ability to perform one or more activities of daily living (ADLs); and a serious or complex medical condition
- To meet an exclusion for medically frail, **an individual must have a specified condition AND demonstrate that the condition impacts their ability to work or complete other qualifying activities**
- CMS only formally defined the blind or disabled category (based on existing SSA definition), and **directed states to develop their own condition lists for the other four categories**

Montana's Approach to Medically Frail: Condition List

In close consultation with the Department's State Medical Officer, DPHHS has developed the following framework for conditions that meet the criteria outlined by CMS (outside of blind/disabled)

- Adult failure to thrive
- Age-related debility
- Alcohol use disorder
- Alcoholic hepatic disease / cirrhosis
- Amputation — acquired absence of limb (upper/lower extremity, various levels)
- Amyotrophic lateral sclerosis (ALS)
- Bed confinement; need for assistance; limited mobility
- Brain injury — traumatic intracranial injury (acute, initial encounter)
- Brain injury sequelae — personality/behavioral disorders due to known physiological condition
- Cancer
- Cerebral palsy (spastic, dyskinetic, ataxic, mixed, unspecified)
- Chronic Kidney Disease stage 5 or ESRD
- Chronic obstructive pulmonary disease (COPD)
- Cognitive impairment — mild neurocognitive disorder due to known physiological condition
- Creutzfeldt-Jakob disease
- Cystic fibrosis (pulmonary manifestations, meconium ileus, other complications)
- Delusional disorders
  Dementia (vascular, Alzheimer's, other)
- Dependence on ventilator, wheelchair, oxygen, other devices
- Down syndrome (trisomy 21 nonmosaicism, mosaicism, translocation)
- Emphysema
- Fragile X syndrome
- Gait and mobility issues
- Heart disease — ischemic heart disease (angina, MI, chronic ischemic, other)
- Heart failure; hypertensive heart/CKD
- Hemophilia (A, B, C) and other hereditary coagulation defects
- History of falling
- HIV/AIDS — human immunodeficiency virus disease
- Huntington's disease
- Major depressive disorder
- Multiple sclerosis
- Muscle atrophy, weakness, sarcopenia
- Muscular dystrophy (Duchenne, Becker, limb-girdle, facioscapulohumeral, other)
- Opioid use disorder
- Other non-mood psychotic disorders (brief psychotic, shared psychotic, other)
- Panic disorder
- Parkinson's disease
- Prader-Willi syndrome
- Pressure ulcers
- Pulmonary fibrosis
- Respiratory failure
- Sarcoidosis (pulmonary, lymph nodes, skin, other and combined organs)
- Schizophrenia (paranoid, disorganized, catatonic, undifferentiated, residual, other)
- Schizotypal disorder
- Sickle cell disease (Hb-SS, Hb-SC, sickle-cell thalassemia, and other types)
- Spina bifida (cervical, thoracic, lumbar, sacral; with/without hydrocephalus)
- Spinal cord injury sequelae — paraplegia, quadriplegia, other paralytic syndromes
- Spinocerebellar ataxias (early-onset, late-onset, X-linked, other hereditary)
- Stimulant use disorder
- Thalassemia major (beta thalassemia / Cooley's anemia)
- Trauma disorders — PTSD, acute stress reaction, adjustment disorders
- Viral hepatitis (chronic hepatitis B, C, and other chronic viral hepatitis)
- Weakness, malaise, fatigue
- Weight loss, underweight, cachexia

Key Implementation Dates



- **July 1, 2026:** Montana CE go-live
- **July 1, 2026 – September 30, 2026:** *Hold Harmless Period*: CE evaluated for new applications and redeterminations, but noncompliance is not enforced with disenrollment
- **October 1, 2026:** CE evaluated for new applications and redeterminations, and noncompliance is enforced with disenrollment
- **January 1, 2027:** Six-month redeterminations for Medicaid Expansion clients begin (does not apply to American Indian or Alaska Native clients)

Benefits of the Hold Harmless Period

In coordination with CMS, DPHHS has elected to include a Hold Harmless Period as part of early CE implementation from July through September 2026. **DPHHS sees the following benefits for existing clients, new applicants, and the Department:**

- Additional time for new applicants and existing clients to become familiar with the requirements, with no adverse action taken.
- A three-month period for DPHHS to evaluate operational and systems processes and make small adjustments if needed before adverse actions are taken.
- Opportunity for DPHHS to collect data on implementation (e.g., use of exclusions, processing times) and make data-informed changes to policy decisions and the implementation approach, if needed.

Community Engagement Requirement Review Process

Step 1	*Step 2*	*Step 3*	*Step 4*	*Step 5*
Client receives CE forms from DPHHS	**Client submits forms to DPHHS for eligibility determination**	**Caseworker evaluates application or redetermination**	**Caseworker makes eligibility determination**	**Client receives notice of eligibility outcome**
Clients can access forms via: • Medicaid Changes Website • Self-Service Portal • Mailed redetermination packet or paper application • Local OPA	Clients can submit forms via: • Self-Service Portal • Mail • In-person drop off at local OPA	Caseworker evaluates information received from the client (e.g., forms, verification documents) along with additional data inputs from the CHIMES eligibility.	Caseworker processes case in CHIMES and makes an eligibility determination.	**During hold harmless**, clients **will not** be denied or disenrolled for CE noncompliance. **After hold harmless**, clients **will** be denied or disenrolled for CE noncompliance.

Verifying Community Engagement Exclusions

- DPHHS carefully evaluated each category excluded from Community Engagement exclusion category and **avoided reliance on self-attestation wherever possible**, instead prioritizing available data sources and other forms of verification.
- Auditable **self-attestation is limited to select exclusion categories** and is permitted only when verification is not reasonably available or would create an undue burden for highly vulnerable populations.
- Where auditable self-attestation is accepted, the Department **generally verifies the information during the next redetermination**, using available data and other verification methods.

Exclusions Verification Matrix (1/2)

Name	Verification Types Accepted
American Indians and Alaska Natives / eligible for IHS services	Enrollment number, letter from IHS, or Auditable Self-Attestation Form
Former foster care children	Auditable Self-Attestation Form (MT verify with CFSD records)
Inmate of a public institution	Facility documentation (e.g., jail or prison records)
Medical condition or health needs that impact ability to work or do other community engagement activities	At application: Provider documentation or Auditable Self-Attestation Form At redetermination: Provider documentation or Auditable Self-Attestation (future claims data)
Individuals compliant with TANF work requirements and individuals in a SNAP household and subject to SNAP work requirements	N/A – Evaluated using existing data
Parent, guardian, caretaker relative, or family caregiver of a dependent child under the age of 14 or an individual with a disability	Caregiver (dependent child under 14): Auditable Self-Attestation Caregiver (disabled individual): Auditable Self-Attestation
Participant in a drug or alcohol treatment or rehabilitation program	Provider or facility documentation (enrollment or attendance letter)
Pregnant or entitled to postpartum coverage	Auditable Self-Attestation Form (required by CMS)
Veteran with a disability rated as total	Statement from the VA showing disability rating of 100%

Exclusions Verification Matrix (2/2)

Name	Verification Required
Individual under the age of 19	N/A – Evaluated using existing data sources
Individual entitled to or enrolled in Medicare benefits under Part A or Part B	Letter from SSA or Medicare card
Eligible for Medicaid for any other eligibility group	N/A – Evaluated using existing data sources
Recently incarcerated in the last three months	Facility documentation (e.g., jail or prison records)
Individual receiving inpatient or institutional services	Provider or facility documentation
Living in a county with high unemployment and/or a disaster declaration	N/A – Evaluated using existing data sources
Applicable individual or dependent who must travel outside their community for an extended period to receive medical services necessary to treat a serious or complex medical condition	Provider documentation

Montana's Approach to Medically Frail: Verification at Go-Live and October-Onward

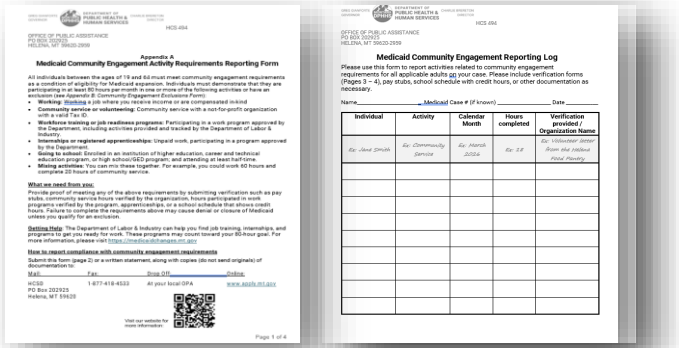
Time Period	Go-Live (7/1) – Through end of Hold Harmless Period (9/30)	Full CE Operations: 10/1 and onward
Verification at **Application**	Provider documentation or Self-Declaration form included in *Appendix B: Community Engagement Exclusions Reporting Form*	Provider verification or Self-Declaration form included in *Appendix B: Community Engagement Exclusions Reporting Form*
Verification at **Redetermin-ation**	Provider documentation or Self-Declaration form included in *Appendix B: Community Engagement Exclusions Reporting Form*	**Evaluation against existing Medicaid claims data,** using established condition list and criteria established by State Medical Officer that indicates impact on ability to work or complete other qualifying activities. Option for clients to provide provider documentation if claims data are not available, and process to submit approvals for conditions not listed in Montana's framework.

Qualifying Activities Verification Matrix

Name	Verification Types Accepted
Employment (including in-kind and/or unpaid work)	Medicaid Community Engagement Activity Requirements Reporting Form (with applicable verification, e.g., pay stubs)
Community Service	Community Service / Apprenticeship / Internship/ GED Verification Form (with signatures and documentation from authorizing official)
Workforce Training	Work Programs Participation Department of Labor and Industry (DLI) Form (signed by DLI representative)
Education	Medicaid Community Engagement Activity Requirements Reporting Form (with applicable verification, e.g., copy of school schedule)

Explanation of Verification Process

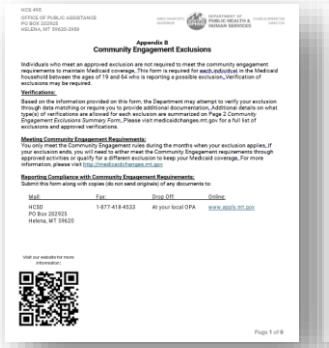
Appendix A: Medicaid Community Engagement Activity Requirements Forms



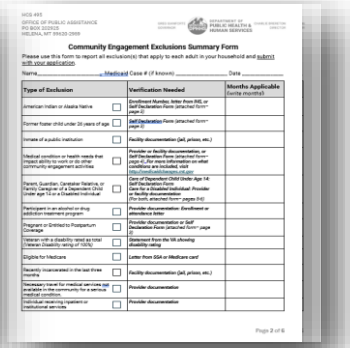
Appendix A
Medicaid Community Engagement Activity Requirements Reporting Form

Medicaid Community Engagement Reporting Log

Appendix B: Community Engagement Exclusions Forms



Appendix B
Community Engagement Exclusions



Community Engagement Exclusions Summary Form

Caseworker screens case for Medicaid eligibility

- Through information that exists in the CHIMES eligibility system and provided in the client's application or redetermination packet, the client is identified as a Medicaid Expansion adult.

Caseworker evaluates for compliance with Community Engagement requirements

- The caseworker then **reviews Appendix A and Appendix B** to identify if the client is compliant with community engagement requirements or qualifies for an exclusion.
- The caseworker uses information across the application or redetermination packet, CE Appendices, and the CHIMES data interfaces to **verify compliance using established Department-wide definitions on qualifying activities, exclusions, and required documentation**
- The caseworker will capture any notable circumstances and considerations for each case in CHIMES.

Caseworker makes eligibility determination

- **Information Incomplete:** The caseworker sends a request for additional verification to the client.
- **CE Requirements not Met and Exclusion not Applicable:** Client is sent a notice of noncompliance and denied / disenrolled.*
- **CE Requirements Met or Exclusion Applicable:** Client is determined eligible and case is processed for Medicaid.

*no adverse action will be taken during the hold harmless period, July-September 2026, due to noncompliance with CE requirements.

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Stakeholder Engagement and Readiness Activities

DPHHS has implemented a phased communications strategy in preparation for go-live. This approach is designed to deliver clear information early, reinforce it across channels, and educate clients, partners, and staff about the requirements and what actions are needed to maintain compliance.

Clients

- Public website
- Fact sheets
- Press releases
- Required member notices, including:
  - Overview of Community Engagement requirements
  - Action needed to maintain coverage
  - Where to find more information

Stakeholders

- Community partner webinars (4/28, 5/13)
- Provider education webinars (5/21)
- Department of Labor and Industry (DLI) staff training (5/20)
- Required public and tribal outreach related to MT administrative rulemaking and State Plan Amendment (SPA) changes
- Biweekly system demonstrations with CMS

Staff

- Business Process Documentation
- Training and call center script development
- Delivery of CE training, system demonstrations, and caseworker Q&A sessions

CMS Readiness Requirements and Demos

- CMS outlined **minimum viable product (MVP) requirements for states** that detail key eligibility system functions required to implement Community Engagement requirements.
- DPHHS has been meeting with CMS on a biweekly basis to demonstrate how Montana's implementation approach, including CHIMES eligibility system changes, meets the MVP requirements in preparation for our July 1, 2026 go-live. Recent demonstrations include:

Date	Demonstration Key Features
4/23/2026	**CMS Demo 1:** CHIMES Eligibility System Design Documentation
5/21/2026	**CMS Demo 2:** Notices and Forms
6/4/2026	**CMS Demo 3:** Review of Staff Training Materials and Business Processes
6/18/2026	**CMS Demo 4:** Full CHIMES Eligibility System Demonstration

Medicaid Process Demonstration

Jessie Counts, Human Services Executive Director
Tori Von Bruening, System Tester

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Rural Health Transformation Program (RHTP) Update

Michelle McNamee, RHTP Director

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Implementation Updates

Recent Accomplishments

- Onboarded **RHTP Program Director**
- **Completed first RHTP CMS site visit**
- Closed **first wave of RFPs on May 15 and 21**– CoE Strategy and Analytics and CoE Implementation
- Closed **RFI to solicit feedback on potential interventions for Medicare/Medicaid dual eligible** on June 5
- Signed MOU with DLI, kicking off **implementation of health care workforce Initiative 1**

Current priorities

- Posting **priority procurements,** including extensions to existing contracts – e.g., **school-based care, TA for providers participating in VBC**
- Developing **Wave 2 procurements and grant programs** (e.g., EMS infrastructure grants, EHR modernization grants)
- **Evaluating responses for CoE RFPs**
- Refining implementation approach for **tribal Community Health Aide Program (CHAP)**

Upcoming milestones

- Announcing Center of Excellence (CoE) **Advisory Council members**
- Refining next steps on **policy commitments** (e.g., EMS Compact, SPAs), *ongoing*
- Convening second **Stakeholder Advisory Committee,** August 6
- **Preparing for year 1 reporting and year 2 application**, due end August
- **Awarding** CoE strategy and analytics RFP and CoE implementation RFP

Center of Excellence (CoE) Advisory Council

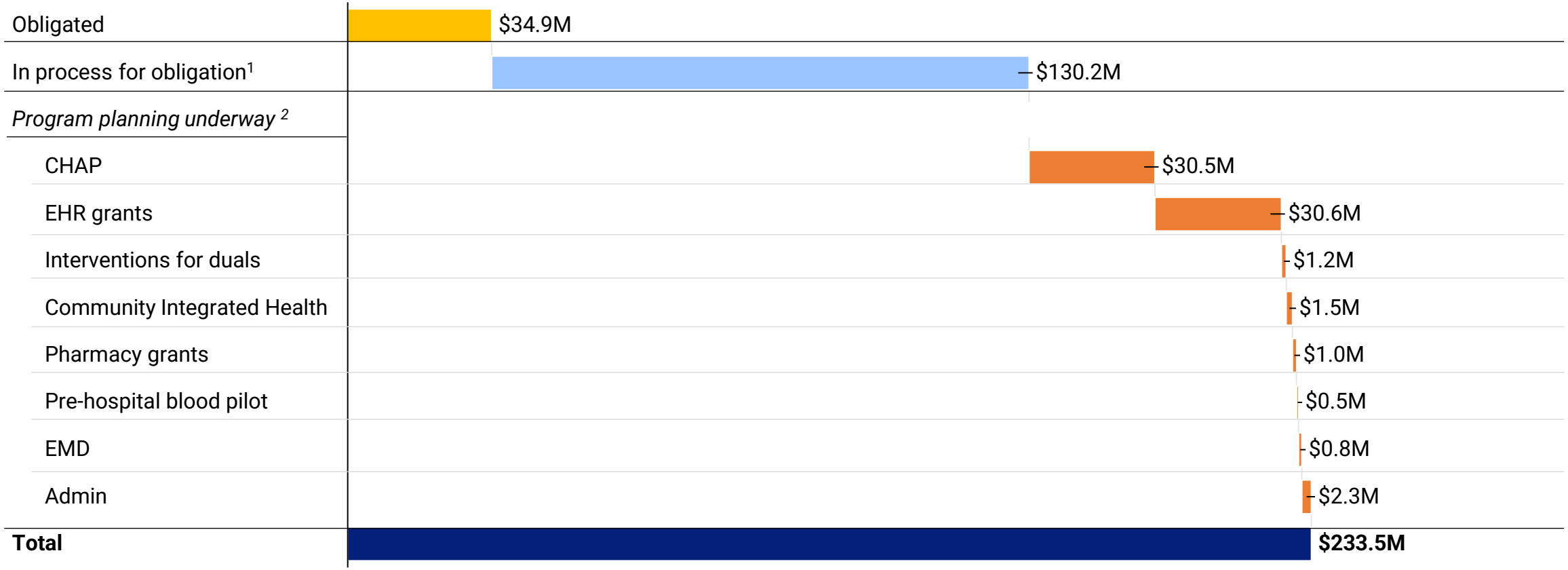
CoE Advisory Council Membership – 26 Members

- 1 Rural Health Care Consumer
- 1 Rural Primary Care Clinician
- 1 Tribal Health Representative
- 4 Prospective Payment System (PPS) Hospital Representatives
- 6 Critical Access Hospitals (CAH)/Rural Emergency Hospitals (REH) Representatives, including:
  - 2 owned by or affiliated with a PPS hospital
  - 4 independent, non-affiliated CAH or REH facilities
- 2 Federally Qualified Health Center Representatives
- 2 DPHHS representatives
- 3 legislators
- 1 Statewide hospital organization representative
- 1 Statewide primary care organization representative
- 1 Health care facility owned organization/professional network representative
- 3 health insurance carrier representatives

CMS Site Visit Debrief

CMS feedback	Key themes and takeaways	Potential follow-ups
"We're surprised at how much progress you've made…" "[Montana] has set a high bar…"	• **Site visits demonstrated to CMS the importance of flexible and locally-informed solutions** rather than a one-size-fits-all model to address the unique needs and challenges of communities • **CMS showed the strongest interest in the CoE initiative,** with rural providers discussing implications and past examples of rightsizing activities • **Workforce and technology** (e.g., interconnectivity) **were common challenges raised** across rural providers visited • **CSKT requested a simplified and streamlined RHTP process for tribes**, particularly for accessing funds and reporting on outcomes	• **Continue engagement with CMS:** provide regular briefings on CoE progress • **Assess opportunities to streamline provider access:** explore ways to reduce administrative burden and streamline access to funding for rural provides (e.g., not inundating strapped health care systems with 5 separate grant applications to complete)

Status of RHTP Funds



1. Funds operationalized through active RFPs or existing contract amendments
2. Program design and associated budgets are being finalized and may vary

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Upcoming RHTP Milestones

NOT EXHAUSTIVE

	Q2 (Apr-Jun)	Q3 (Jul-Sep)	Q4 (Oct-Dec)
Cross-cutting	• Refined **next steps for State policy commitments** • Refined RHTP **data and reporting mechanisms**, including external facing dashboards	• CMS **Annual Report 1** due • CMS **non-competing continuation application** due • Second **Stakeholder Advisory Committee** takes place	• **FFY27 funding** awarded by CMS • CMS **Quarterly Report 1** due
Initiative-specific	2 Began data analysis for rural health profile 3 Began developing EMS infrastructure grant 5 Conducted EHR readiness assessment and began stakeholder consultations	1 Launch pre-apprenticeship pilot 2 Convene CoE advisory council and identify initial sites for transformation 3 Launch EMS infrastructure grants 4 Distribute CHAP award 5 Launch EHR modernization grants	1 Clinical training pilots launched 2 Begin transformation at initial CoE sites 3 Continue site identification and roll out of pharmacy pilot program

Source: Montana RHTP Project Narrative, Budget Narrative, Implementation Plan as of April 2026

Conclusion

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