

HEALTH CARE FOR HEALTH CARE WORKERS
Senior Long Term Care Division
Medicaid Community Services Bureau
2011 APPLICATION

EXPLANATION AND INSTRUCTIONS

Intent: The 2009 Montana Legislature approved funding of approximately \$5 million through House Bill 2 to sustain provider rate increases for providers that deliver Medicaid personal assistance and private duty nursing services when those providers provide their direct care employees with health insurance coverage that meets defined criteria (providers). The next round of funding is available beginning January 1, 2011 for this insurance program (program). Funds must be used to cover health insurance premiums for eligible workers receiving health insurance coverage that meets the Department of Public Health and Human Services' benchmark standards and criteria.

Health Insurance Plan Benchmarks: The Department is not offering a health insurance plan. Rather, the state is establishing benchmarks that an insurance plan must meet in order to receive the health care for health care worker funds. A provider must sign an agreement that certifies the insurance plan they offer meets the benchmark standards set forth in the Department's application or that they were unable to find a plan that met the benchmark standards and are submitting an alternative plan with the necessary written justification outlined in section 3. A plan is not approved until the Department provides written notification of approval to the provider.

Worker Eligibility: Each provider will define the eligibility criteria for the number of hours a worker must work to receive insurance coverage. The Department will define eligibility as it pertains to the type of worker who is eligible to receive the health care for health care worker funding. The Department will only provide the funds for workers who work a majority of their time in Medicaid personal assistance or Medicaid private duty nursing services. The Department will provide a 90-day grace period for eligibility. If a worker is not able to meet the eligibility criteria after 90 days the provider will no longer be eligible to receive health care for health care worker funds to cover that worker. Providers will be required to report on worker eligibility to remain eligible for the funding.

Distribution Methodology: The Department will provide a monthly gross adjustment to be used only for health insurance coverage to Medicaid enrolled personal assistance and private duty nursing providers who submit an approved application. The Department will determine the monthly adjustment as a share of appropriated funds allocated for health care worker health insurance coverage. The gross adjustment will be in addition to the negotiated Medicaid rate that is established for each provider.

Monthly Gross Adjustment: The amount of the monthly gross adjustment a provider is eligible to receive is related to the portion of Medicaid personal assistance and private duty nursing units a provider provides and the number of eligible workers the provider covers with health insurance. The final negotiated maximum monthly gross adjustment amount will be determined once a provider submits their 2010 application.

The amount that the department determines payable to each provider will be final. No adjustments will be made in the payment amount to account for subsequent changes or adjustments in utilization data or for any other purpose, except that amounts paid are subject to recovery if the provider fails to maintain the required records or to spend the funds in the manner specified in the request.

Request for Funding: To receive Health Care for Health Care Worker funds beginning January 2011, a provider must complete the 2011 application for Department approval. The application should be submitted as soon as a provider selects an insurance plan and defines the pool of eligible workers. The 2011 application includes four sections. Section 1 contains the Certification and Agreement; Insurance Plan Agreement Form; and the Insurance Plan Eligibility and Cost Form. Section 2 is the provider's health insurance plan benchmark comparison. Section 3 is the rationale and justification statement if a provider submits a plan that does not meet all of the Department's benchmark standards. Section 4 should be completed if the provider intends to provide dental coverage through the program. Section 5 is an attached summary of the provider's insurance plan. **The application must be submitted to the Department by Friday, November 26, 2010.**

By Friday, December 10, 2010 the Department will provide written approval or disapproval to providers that submit a complete application. If the Department does not approve a request, it will return the request to the provider with a statement of the reason for disapproval. The provider will then have a limited time within which to provide justification for its proposed use of the funds. Regardless of whether the cost of a proposal approved by the Department exceeds the amount of funds payable to that provider, the Department will not reimburse the provider any more than specified in the approval letter, which will be sent out upon receipt of the application.

An electronic copy of the application material can be found on the web at:
<http://www.dphhs.mt.gov/sltc/services/communityservices/HCWorkers/Index.shtml>

Provider Participation: A provider that does not submit a qualifying application for use of the funds distributed under this program as requested by the Department within the time established by the Department, or a provider that does not wish to participate in this additional funding amount, shall not be entitled to a share of the funds.

Records and Documentation: A provider that receives funds under this program must maintain appropriate records documenting the expenditure of the funds. This documentation must be maintained and made available to authorized governmental entities and their agents to the same extent as other required records and documentation under applicable Medicaid record requirements, including but not limited to ARM 37.40.345, 37.40.346, and 37.85.414. Reports will be requested on a semi-annual basis and as necessary. These reports will include the insurance premium monthly payment and a list of eligible covered workers.

Fund Recovery Recovery will occur if a provider is unable to provide health insurance coverage to the targeted number of eligible workers with a plan that meets the Department's benchmark standards or an approved alternative plan.

Effective Date: The Department will consider health insurance coverage beginning January 1, 2011 as meeting the legislative intent for the health care for health care worker funds.

Reporting Requirements: To the extent of available appropriations, the provider shall provide documentation that these funds are used solely to provide eligible workers with a health insurance plan that has been approved by the Department. Providers must submit both applications and comply with reporting requirements to meet the Department's criteria to remain eligible for these funds.

2011 Application- Section 1

**HEALTH CARE FOR HEALTH CARE WORKERS
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PROVIDER CERTIFICATION AND AGREEMENT

By signing this request and in consideration for the payment of funds based upon this application, the community services provider named below ("Provider") represents and agrees as follows:

1. Provider certifies that statements and information included in this agreement are complete, accurate and true to the best of the undersigned provider administrator's knowledge. The Provider certifies that any funds received on the basis of this request will be used in the manner represented in this application packet to provide health insurance coverage that meets the Department's benchmark standards for eligible personal assistance and private duty nurse workers.
2. Provider agrees to the terms and conditions under which this funding is made available, as stated in this application. Provider agrees that it will make, maintain and provide to authorized governmental entities and their agents, records and documentation in accordance with the requirements specified in this agreement.
3. Provider understands that payment of funds based upon this request will be from federal and state funds, and that any false claims, statement, or documents, or concealment of material fact, may be prosecuted under applicable federal or state laws. Provider understands that the payment made based upon this application is final, that no adjustments will be made in the payment amount to account for subsequent changes in utilization, appropriation amounts, or for any other purpose, except that amounts paid are subject to recovery in the same manner as other overpayments if the provider fails to maintain the required records or to use the funds as represented in this request.
4. Provider understands that the health insurance gross adjustment may not be used to offset health insurance coverage for workers who do not meet the Department's eligibility criteria.

Requesting Provider Identifying Information

Provider Name: _____

Medicaid Provider #: PAS: _____ SDPAS: _____ PDN: _____

Provider Contact Name: _____ **Email:** _____ **Phone:** _____

INSURANCE PLAN AGREEMENT FORM

I, _____, representing _____
Administrator name Provider name

have read and understand the Department's Insurance Plan Benchmark standards and I have reviewed these benchmarks with our insurance representative. To the best of my knowledge our provider has submitted an insurance plan with this application that:

Meets or exceeds all of the Department's benchmark standards
or

Does not meet all of the Department's benchmark standards. Our provider was unable to find a plan that meets all of the Department's benchmark standards. Section 3 of the application includes our provider's justification and rational statement for submitting an alternative plan.

Signature of Administrator: _____ **Date:** _____, 2010

Name of Administrator (please print): _____

INSURANCE PLAN ELIGIBILITY AND COST INFORMATION

1. Insurance Plan Carrier: _____

2. Insurance Plan Name: _____

3. Total monthly Premium: _____

4. Worker Monthly Premium: _____

5. Provider Monthly Premium: _____

6. Provider Worker Eligibility Criteria (please be specific as to worker type and minimum hours a worker must work to be eligible for insurance):

7. Estimated number of eligible PAS/PDN workers who meet provider eligibility criteria: _____

8. Anticipated number of eligible workers who will enroll in Plan: _____

9. Monthly gross adjustment amount requested to cover health insurance premiums (line 5 x line 8) : _____

Note: this amount may not exceed the approved specified in the Application 1 acceptance letter

2011 Application- Section 2
HEALTH CARE FOR HEALTH CARE WORKERS
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Enrolled Medicaid providers will be eligible to receive additional funding for health insurance if they provide a health insurance plan that meets the following standard benchmarks. The Medicaid provider may offer either a traditional or HMO plan. The plan must include coverage for prescription drugs. Dental coverage is optional.

Plan Approval: The benchmark standards are indicated on the Department’s benchmark standards (see attached).

1. If an insurance plan meets all of the benchmark standards it will be approved.
2. If an insurance plan does not meet all of the benchmarks it may still be submitted as an alternative plan. See section 3 for the conditions to submit an insurance plan does not meet all of the Department’s benchmark standards.

Section 2 is the completed insurance plan benchmark summary information. All applications must include a completed summary. Please fill in the blanks with a summary of your insurance plan information.

Complete this side if you plan to offer a traditional plan

Description	Benchmarks for traditional plan	Provider Plan Summary
1. Lifetime Max Benefit	\$2,000,000	
2. Deductible Maximum	\$1,000 individual \$3,000 family	
3. Coinsurance	Plan plays 70% Member pays 30%	
4. Co-Pay	n/a	
5. Out-of-network coinsurance rate (applies to PPO plans)	No greater than 25% of the in and out-of-network difference	
6. Out of pocket	\$2,500 individual \$5,000 family	
7.*Deductible waived for following services*	Preventive health services and first two office visits	
8.*Preventive care*	Deductible waived and coinsurance applies (\$250 min benefit)	
9.*Enrollment*	Premium paid in prior month for effective date on first of the following month	
10.*Benefit Service List Plans must include coverage for the following:	Transplants (min \$500,000) DME/Medical Supplies (min \$500 per year) Chiropractic Services (min 10 visits per year)	
11. *Licensure/Statues	Licensed in Montana (if applicable) -or- Meet Montana and federal legal requirements	
12. *Individual Premium	No greater than \$25/month	
13. *Eligibility	The first day of the month after ninety days or less consecutive employment with employer	
14. Monthly Premium Cost	Department will reimburse an provider up to \$550 per eligible worker	

Prescription Drug Plan Note: All plans must include prescription drug coverage

Category	Benchmark Level	Provider Plan Summary
Deductible	\$200/ per member per year	
Coverage	Coverage for all three kinds (generic, formulary, brand name)	

Dental Plan

Category	Benchmark Level	Provider Plan Summary
Deductible	\$50/member \$150/family	
Minimum Maximum benefit	\$1000 per member/ year	
Coverage	Preventive and diagnostic 100% Fillings/oral surgery 80% Dentures, bridges, etc 50%	

* All submitted insurance plans must meet this benchmark to be eligible for health insurance for health care workers funding

2010 Application - Section 2
HEALTH CARE FOR HEALTH CARE WORKERS
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Medicaid Community Services Bureau

Complete this side if you plan to offer an HMO plan

Description	Benchmarks for HMO Plan	Provider Plan Summary
1. Lifetime Max Benefit	\$2,000,000	
2. Deductible Maximum	\$1,000 individual \$3,000 family	
3. Coinsurance	Plan pays 70% Member pays 30%	
4. Co-Pay	\$20/visit (must include preferred provider office visits, preventive services, outpatient mental health services, chiropractic and chemical dependency services)	
5. Out-of-network coinsurance rate (applies to PPO plans)	N/A	
6. Out of pocket	\$2,500 individual \$5,000 family	
7.*Deductible waived for following services*	N/A	
8.*Preventive care*	Deductible waived and coinsurance applies (\$250 min benefit)	
9.*Enrollment*	Premium paid in prior month for effective date on first of the following month	
10.*Benefit Service List Plans must include coverage for the following:	Transplants (min \$500,000) DME/Medical Supplies (min \$500 per year) Chiropractic Services (min 10 visits per year)	
11. *Licensure/Statues	Licensed in Montana (if applicable) -or- Meet Montana and federal legal requirements	
12. *Individual Premium	No greater than \$25/month	
13. *Eligibility	The first day of the month after ninety days or less consecutive employment with employer	
14. Monthly Premium Cost	Department will reimburse an provider up to \$550 per eligible worker	

Prescription Drug Plan Note: all plans must include prescription coverage

Category	Benchmark Level	Provider Plan Summary
*Deductible	\$200/ per member per year	
*Coverage	Coverage for all three kinds (generic, formulary, brand name)	

Dental Plan

Category	Benchmark Level	Provider Plan Summary
Deductible	\$50/member \$150/family	
Minimum Maximum benefit	\$1000 per member/ year	
Coverage	Preventive and diagnostic 100% Fillings/oral surgery 80% Dentures, bridges, etc 50%	

* All submitted insurance plans must meet this benchmark to be eligible for health insurance for health care workers funding

2011 Application- Section 3
HEALTH CARE FOR HEALTH CARE WORKERS
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Application process for plans that do not meet the Department’s benchmark criteria:

Section 3 must be completed if the provider is submitting an insurance plan that does not meet all of the Department’s benchmark standards or if the plan costs more than \$550.

Insurance plans must meet benchmarks number 7-13 and include prescription drug coverage. The Department will consider insurance plans that do not meet some of the other benchmark standard, however the provider must submit the following documentation in order for the plan to be considered.

1. **Submit a complete Application no later than November 26 with the insurance plan the provider has selected**
2. **Provide an alternative insurance plan that meets all of the Department’s benchmarks. Include the insurance plan’s premium quote and insurance plan summary.**
3. **Provide written documentation that addresses the following:**
 - a. **Explanation for why the submitted plan was selected over other plans**
 - b. **Rationale for why the benchmarks could not be met**
 - c. **Justification for how the selected plan provides accessible and affordable insurance coverage to workers**

Section 4
Dental Coverage

There is no longer additional funding available to cover the cost of dental premiums. If a provider is interested in providing dental coverage the cost of the coverage must be included in the allocation amount approved by the Department for that provider. If the requested amount exceeds the Department’s authorized allocation the provider’s application will be denied.

DENTAL PLAN ELIGIBILITY AND COST INFORMATION

1. **Dental Insurance Plan Carrier:** _____

2. **Dental Insurance Plan Name:** _____

4. **Dental Monthly Premium:** _____

4. **Number of eligible workers who will enroll in Dental Plan:** _____

5. **Monthly gross adjustment amount requested to cover dental insurance premiums (line 3 x line 4) :** _____

Note: Line 9 from section 1 + line 5 from section 4 cannot total more than the Department approved monthly allocation amount for your agency.

Section 5
Insurance Plan Submission

All applications must include a copy of the insurance plan summary that the agency will provide to all of the eligible workers. Be sure to include the prescription drug plan and dental plan (if applicable). Please attach the summary with this application.

PLEASE RETURN THE SIGNED AND DATED
APPLICATION BY:
Friday November 26, 2010

Submit Applications to:
DPHHS -SLTC – Health Insurance Initiative
PO Box 4210
Helena MT 59604