Department Updates

Child, Families, Health and Human Services Interim Committee

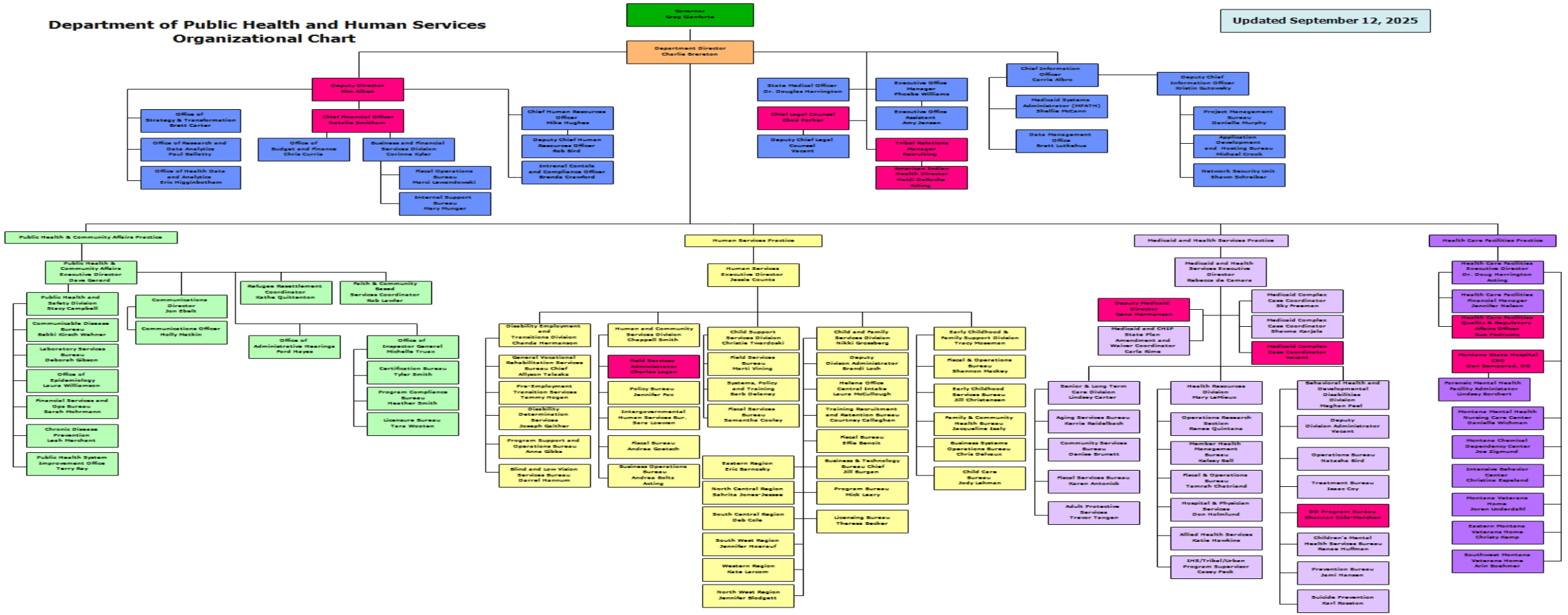
September 23, 2025

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

Agenda

- Today’s Themes
- Federal Actions and Departmental Impacts
- Health and Economic Livelihood Partnership (HELP) 1115 Waiver
- SNAP Payment Error Rate (PER)
- Summer EBT
- HCSD/OPA Customer Service Improvements
- Rural Health Transformation Program
- Montana State Hospital (MSH) Update

DPHHS Organizational Chart



DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

Today’s Themes

Charlie Brereton, Director

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Today's Themes

- **Planning for and Implementing Federal Changes**
  - Monitoring federal funding changes, both immediate and future
  - Implementation planning and operationalization of H.R. 1
    - Projected workload changes related to SNAP PER requirements, Medicaid expansion work requirements and cost sharing, eligibility processing (including more frequent redeterminations), IT system changes, new reporting, staff training, and more
    - Calculating/communicating the projected impact on beneficiaries and community partners
- **Implementing Medicaid Expansion Work and Cost-Sharing Requirements**
  - DPHHS submitted an 1115 waiver to the Centers for Medicare and Medicaid Services (CMS) in early September to require community engagement and cost sharing as a condition of eligibility for the Medicaid expansion program.
- **Rural Health Transformation Program**
  - DPHHS is designing a five-year Rural Health Transformation Plan to be submitted to CMS in early November to access the new $50 billion federal fund.

Today's Themes (cont.)

- **Improving Public Assistance Customer Service**
  - DPHHS continues reducing wait time on the Public Assistance Helpline (PAHL) by expanding queued callback slots and extending queued callbacks to all call types.
  - Offices of Public Assistance (OPAs) and the PAHL are being evaluated and subject to business process improvements and service delivery reform.
  - Forthcoming operational and technology improvements, including the Community Assister Portal
- **Regaining Certification of the Montana State Hospital (MSH)**
  - Pending completion of capital projects and recertification workstreams at the hospital, DPHHS is on track to apply for federal certification of MSH by January 1, 2026.

Federal Action and Departmental Impacts

Kim Aiken, Deputy Director

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H.R. 1: Medicaid Changes

Medicaid Expansion Administrative Costs

Section 71107: Requires semiannual redeterminations for Medicaid eligibility.

- Increased staffing, system automation, and vendor support
- Risk of churn and reprocessing costs

Medicaid Cost-Sharing

Section 71120: Mandates cost-sharing for expansion enrollees.

- Requires modifications to billing and claims processing infrastructure
- May reduce utilization, increasing downstream costs (e.g., ER visits)
- Administrative burden for tracking member maximum-out-of-pocket expenses

H.R. 1: Medicaid Changes (cont.)

Community Engagement Requirements for Medicaid Expansion

Section 71119: Requires states to implement work/community engagement for able-bodied adults.

- Costs for appeals and technology enhancements for employment verifications
- Exemption verifications and processing (e.g., tribal members, caregivers)
- Client outreach and stakeholder communication

Medicaid Provider Taxes

Section 71115: Imposes new restrictions on health care-related taxes.

- Must meet stricter federal standards to qualify for federal matching
- Moratorium on New or Increased Provider Taxes
    - New provider tax 2025 session (HB 56)
        - Ambulance – impact of H.R. 1 – the tax can be implemented since it became state law prior to H.R. 1 passage, but the tax % is required to be phased down from 5.75% to 3.5% by FFY 2032/
    - Existing provider taxes in Montana
        - H.R. 1 does not impact current hospital (inpatient and outpatient) and nursing home taxes, but the new law does preclude Montana from increasing the percentage of these taxes in the future.

H.R. 1: SNAP Changes

SNAP Program Changes

Sections **10002–10012**: Tighten eligibility and redefine exemptions

- System reprogramming and staff retraining
- Risk of higher payment error rates (PER) and potential federal sanctions
- Outreach and education costs to prevent client confusion

SNAP FMAP Changes

- **Administrative Match Reduction**: Section 10007 reduces federal reimbursement for SNAP administrative costs from 50% to 25%, increasing Montana's share to 75%. Effective date is 10/01/2026.
- **Benefit Match Requirement**: Section 10006 introduces a state match for SNAP benefits starting FFY2028.
    - The benefit cost share will be based on the payment error rate from the third preceding fiscal year – except for FY 2028, when states may choose either FY 2025 or FY 2026.

SNAP Payment Error Rate	State Match
Less than 6%	0%
6% to 7.99%	5%
8% to 9.99%	10%
10% or higher	15%

SNAP Benefits Changes [1]	State	Federal
AVERAGE SNAP Benefit 24/25	$ -	$168,092,180
Projected Change for SFY 2028 at 5%	$6,303,457	$161,788,723
Projected Change for SFY 2028 at 10%	$12,606,914	$155,485,267
SNAP Admin Changes [2]	**State**	**Federal**
Average Expense at 50/50 [3]	$12,373,791	$12,373,791
SFY 2027 Expense at 75/25	$18,560,686	$6,186,895
Potential annual net increase based on Average Expense	$6,186,895	($6,186,895)
Net increase for 75% of SFY 2027	$4,640,171	($4,640,171)

1. Implementation is 10/01/2027 - No Impact will occur in this biennium
2. Implementation is 10/01/2026 - 75% impact for SFY 2027
3. Does not include SNAP E&T

Other Federal Impacts

Health and Human Services Federal Appropriations

- **FFY 2026 "Skinny" Budget - Examples**
  - Early indications that CDC funding for chronic disease would be significantly reduced
  - LIHEAP – proposed elimination
  - VR – proposed elimination of Client Assistance state grants but maintains the requirement of operating Client Assistance programs to retain VR funding (shift to state)
- **House and Senate Appropriations Bills**
  - The House appropriations bill maintains some of the proposed elimination and reductions of HHS funding, while the Senate bill restores some funding proposed for reduction and increases funding in other areas, notably child care.
- **Implications**
  - Final outcomes depend on negotiations between the House and Senate versions of proposed appropriations.

Other Federal Impacts (cont.)

Department Planning and Preparation

- Comprehensive auditing of federal funding streams, identifying high-risk programs
- Program-level data collection (award numbers, grant years, PBs, and administrative costs)
- Contingency planning, including cost-saving measures and alternative funding source identification
- Cash flow modeling
- RIF and furlough process planning

Health and Economic Livelihood Partnership (HELP) 1115 Demonstration Waiver Overview

Rebecca de Camara, Medicaid and Health Services Executive Director

Jessie Counts, Human Services Executive Director

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History

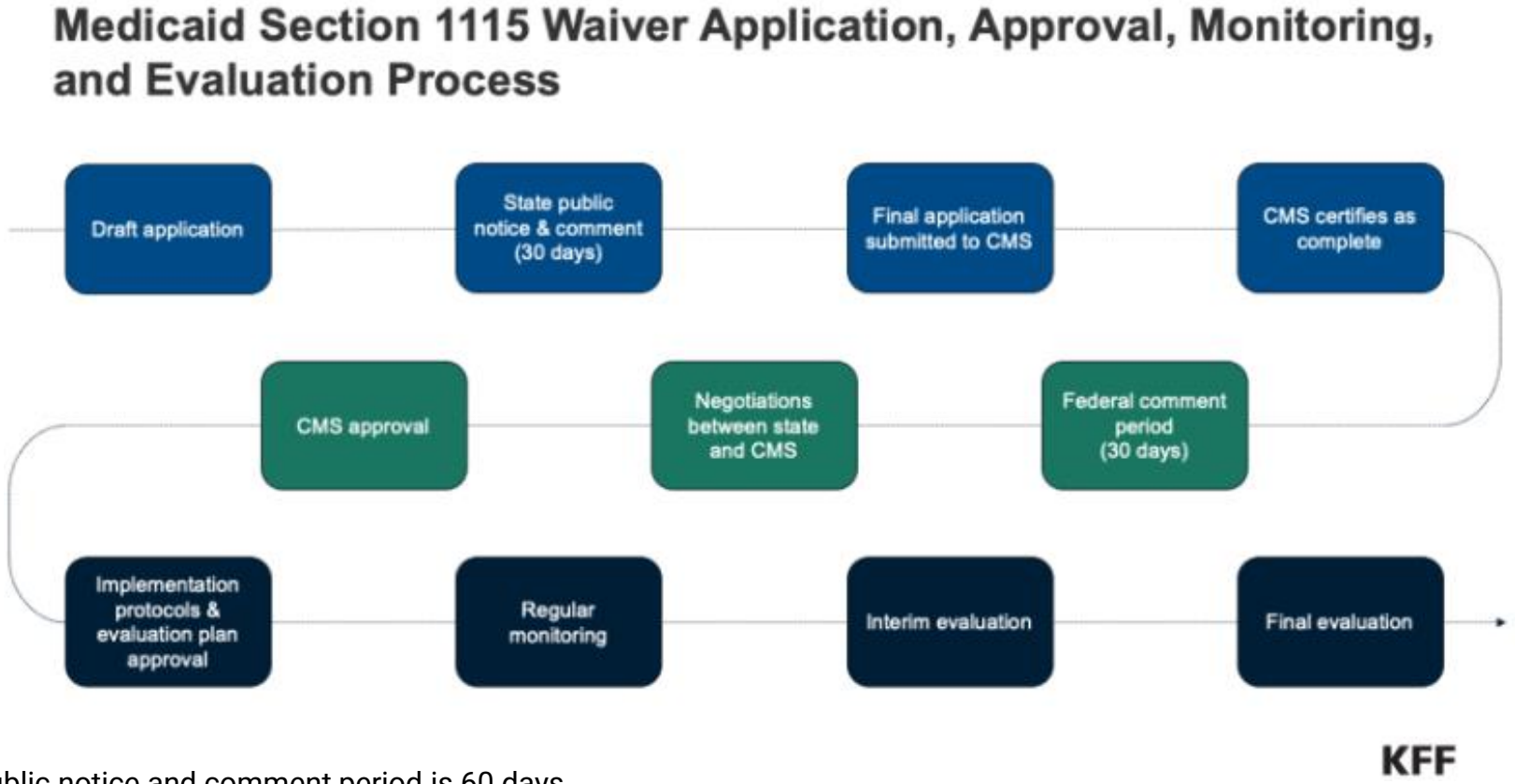
- The original HELP waiver was **introduced in 2015 as part of Medicaid expansion** and included features tailored to Montana, such as a voluntary workforce program, 12-month continuous eligibility, premiums, and copayments.
- In 2019, the state enacted a Medicaid reform bill that **mandated community engagement for those in the Medicaid expansion population**; however, it was not put into practice due to shifts in federal policies.
- Over the years, the initial HELP waiver adapted as federal guidelines and permissible program features changed. Ultimately, the waiver came to an end in December 2022.
- The new HELP waiver is structured to **align closely with Montana state law** while also fulfilling the updated federal statutory requirements (H.R. 1).

Why an 1115 Waiver?

The HELP 1115 Demonstration Waiver:

- Allows for robust public comment on the design of the program.
- Fulfills commitments made by the Department during the 2025 legislative session to pursue all available avenues for implementing community engagement and cost sharing as required by MCA.
- Is necessary to implement monthly premiums as required by MCA.
- Utilizes the earliest available vehicle to implement these program elements, while retaining the flexibility to transition to a State Plan Amendment.
- Requires the State to formally assess the efficacy of the program.

1115 Waiver Demonstration Steps



Note: Montana's state public notice and comment period is 60 days.
Source: https://www.kff.org/medicaid/medicaid-section-1115-waivers-the-basics/

Additional Context

Population Covered by Waiver

- Affects only those who qualify for Medicaid due to expansion
  - Adults between the ages of 19 and 64
  - Income ranging from 0 to 138% of the federal poverty level (FPL)

Benefits and Services Covered by the Waiver

- Existing benefit package remains unchanged

The HELP waiver does not apply to:

- **Pregnant women**
- **Children**
- **Adults over age 64**
- **Individuals eligible for Medicaid due to disability**

Additional Context (cont.)

Two Major Program Components

Both components required by state and federal law

Community Engagement

Community engagement requirements as condition of eligibility:

- Participate in qualifying community engagement activities for 80 hours per month; or
- Meet a standard or short-term hardship/good cause exemption

Cost Sharing

- Monthly premiums at 2% of income, with gradually increasing amounts up to 4% for some individuals
- Payment of premiums required to maintain eligibility for some individuals
- Copayments for certain services as required by federal law by 2028

Community Engagement

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Qualifying Activities

- Work
- Community service
- Work programs, including work readiness, workforce training activities, internships, or registered apprenticeship
- Educational programs (half-time or more), including secondary education, post-secondary education, vocational education, or registered apprenticeship
- Any other activity required by the Centers for Medicare & Medicaid Services (CMS) for the purpose of obtaining necessary waivers

Individuals will be compliant with community engagement by participating in any qualifying activity (or combination of activities) for 80 hours or more per month.

Standard Exemptions

- Enrolled in (or eligible for) Medicare
- A former foster youth under age 26
- A Native American or Alaska Native
- The parent, guardian, caretaker relative, or family caregiver of:
  - a dependent child 13 years of age and under;
  - a disabled individual; or
  - a foster child under the age of 19
- A veteran with a disability (100% disabled)
- Medically frail, including an individual:
  - Who is blind or disabled;
  - With a substance use disorder;
  - With a disabling mental disorder;
  - With a physical, intellectual, or developmental disability that significantly impairs their ability to perform one or more activities of daily living; or
  - With a serious or complex medical condition
- Pregnant or postpartum
- Participating in a drug addiction or alcoholic treatment and rehabilitation program
- In compliance with Temporary Assistance for Needy Families (TANF) or Supplemental Nutrition Assistance Program (SNAP) work requirements
- Recently released from Department of Corrections, specifically:
  - An inmate or recently released within the last 90 days; or
  - Under the supervision of the Department of Corrections, a county jail, or another entity.

Individuals who meet the criteria for a standard exemption are not subject to the community engagement requirements.

Short-Term Hardship/Good Cause Exemptions

- Individual receiving (or caring for an immediate family member receiving) one of the following:
  - Inpatient hospital services;
  - Nursing facility services;
  - Services in an intermediate care facility for individuals with intellectual disabilities (ICF/IID);
  - Inpatient psychiatric hospital services; or
  - Other services of similar acuity (including outpatient care relating to these services)
- Individual who resides in a county
  - In which an emergency or disaster is declared; or
  - That has an unemployment rate that is at or above 8% or 1.5 times the national unemployment rate
- Individual experiencing homelessness
- A victim of domestic violence
- Individual (or their dependent) who must travel outside of their community for an extended period to receive medical services that are not available within their community

Individuals who meet the criteria for a short-term hardship/good cause exemption are not required to meet community engagement criteria for a specified number of months.

Cost Sharing

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Graduated Premiums

Premium Amount

- Monthly premiums are set at **2% of income** for the initial two years of enrollment.
- After this period, the premium will **rise by 0.5% each subsequent year** during Medicaid participation, reaching a maximum of 4% of total household income.

Unpaid Premiums

- Individuals whose income is **below 100% FPL will maintain their coverage** while any unpaid premiums will be assessed against their annual income tax.
- Those whose income is at or **above 100% FPL risk disenrollment** if they do not pay their premiums.

All cost sharing is subject to a 5% of income out of pocket maximum

Year of Participation in HELP Demonstration Program*	Premium Amount
Year 1	2% of an enrollee's household income
Year 2	2% of an enrollee's household income
Year 3	2.5% of an enrollee's household income
Year 4	3% of an enrollee's household income
Year 5	3.5% of an enrollee's household income
Year 6 and beyond	4% of an enrollee's household income

*Individuals exempt from community engagement requirement are also exempt from premium increases

Copayments

Mandated by H.R. 1, despite the prohibition in MCA

- As of October 1, 2028, copayments are **mandated by federal law**.

Individuals Affected

- Required for adults in the expansion population with incomes between 100-138% of the FPL

Limits and Exemptions for Copayments

- Copayments will not apply to primary care, mental health, substance use disorder services, and services from certain safety net providers.
- No single copayment will exceed $35 for an individual service.

All cost sharing is subject to a 5% of income out of pocket maximum.

Public Notice Process and Project Timeline

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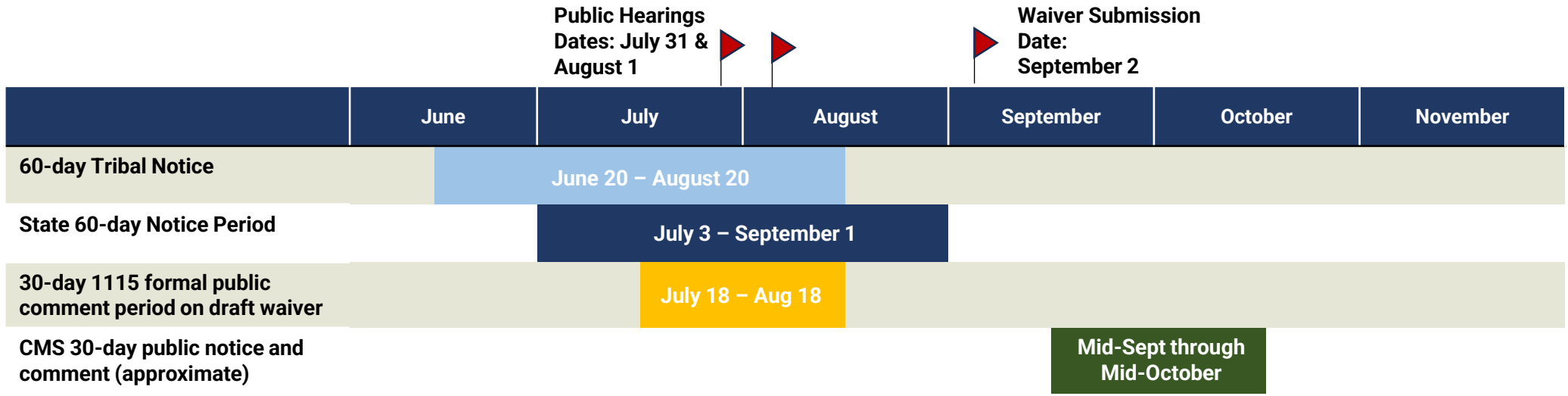
Public Notice Process

Public Announcement, Draft Waiver, Public Feedback, and Public Hearing Registration Details

- Available on the state agency website at help.mt.gov
- Montana accepted public comments as part of the mandatory federally required 30-day public comment period until **August 18, 2025**.



Public Comment Themes

- Operational aspects of proposed eligibility changes
- Administrative burdens on enrollees and State staff
- Compliance review period
- Implementation timing
- Community engagement exemption policies
- Enrollee communications and implementation plan
- Premiums
- Copayments
- Alignment with MCA

HELP Waiver Project Timeline

Activity	Timeframe
Public Notice/Comment	
Federally-required tribal notice sent	June 20, 2025
State 60-day public comment period began	July 3, 2025
Tribal consultation	July 29, 2025
Draft waiver becomes available for Federal 30-day public comment period	July 18, 2025
Public hearing #1	Thursday, July 31, 2025, 3:00-5:00 pm MST
Public hearing #2	Friday, August 1, 2025, 3:00-5:00 pm MST
Federal 30-day public comment period ends	August 18, 2025
Waiver Submission	
Waiver submitted	September 2, 2025
CMS 15-day completeness letter	September 17
CMS 30-day public comment period (approximately)	September 17-October 17
Review comments from federal comment period	October 17 – 24
Begin formal CMS negotiations	TBD

Anticipated Stakeholder Impacts

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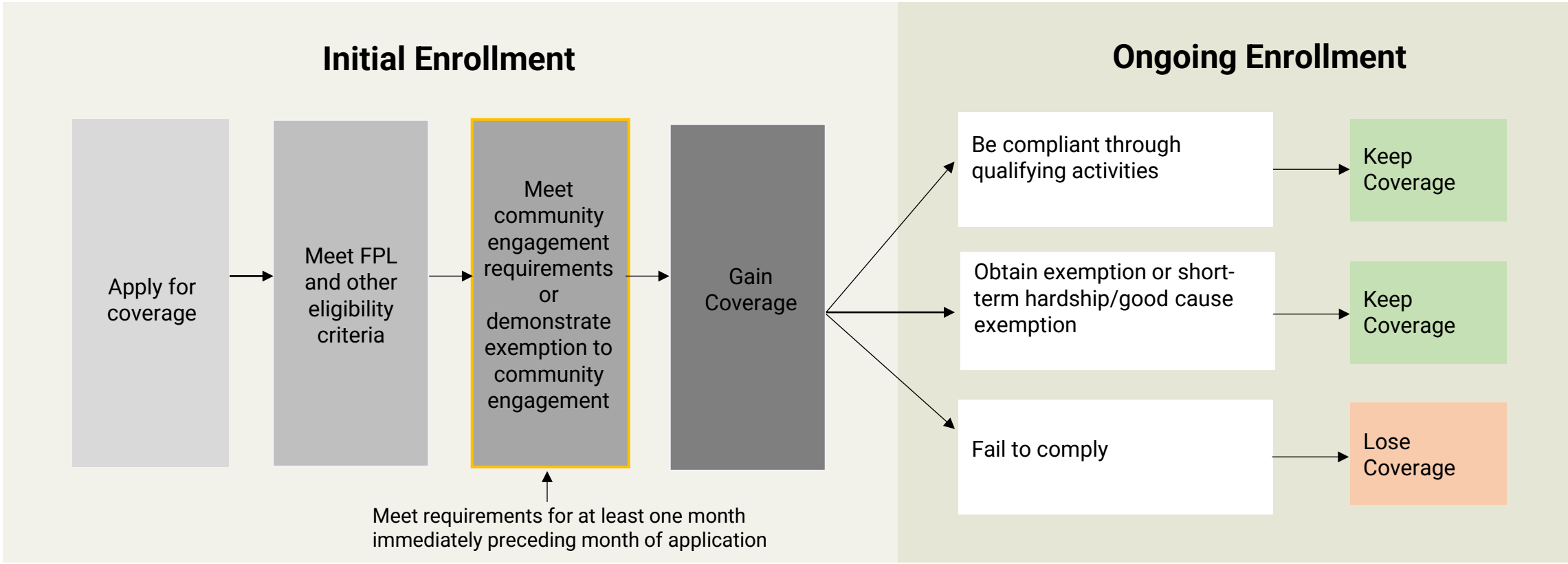
Community Engagement as a Condition of Eligibility



Compliance Monitoring

Enrollees will be reviewed for compliance with community engagement or verification of exemption at least every six months.

Mid-Year Check (6 Months Post Enrollment)	**Annual Redetermination** (12 Months Post Enrollment)	**Non-Compliance**
DPHHS will redetermine eligibility at six months (as required by H.R. 1) and verify that the enrollee either **met community engagement requirements** or qualified for an exemption **for the past 30 days**.	At annual redetermination, enrollee will be required to **demonstrate compliance for the past 30 days.** DPHHS will do an additional case review of a statistically valid sample of cases to verify compliance for an additional 4 months during the eligibility period (for a total of 6 months verified).	Enrollees will have **30 days to come into compliance** or be disenrolled. Disenrolled individuals must reapply and demonstrate compliance or exemption to regain coverage.

Anticipated Client Impacts

Children and Traditional Medicaid

- Retroactive coverage limited to two months (not part of waiver)

Expansion Adults

- Retroactive coverage limited to one month (not part of waiver)
- Additional requirements for new eligibility
  - Compliance with community engagement one month pre-application
- Two redeterminations per year (except AI/AN)
  - Additional documentation requirements for community engagement activities
  - Most current program rules do not change
    - Financial requirements remain in place
    - Changes must be reported
    - Eligibility is determined by the individual applicant, not the case
- Additional quality assurance reviews
  - Clients will be required to provide additional community engagement verifications if selected for additional review
- Cost Sharing Requirements
  - Premiums to maintain eligibility (part of waiver)
  - Future copayments for some services (not part of waiver)

Anticipated Provider Impact

- Understanding eligibility changes to help educate clients on changes
- More frequent changes in client eligibility
- Cost sharing for clients
  - Understanding which services require co-payments
  - Understanding when a co-payment can be collected (client exemptions, client already has reached maximum out-of-pocket)
  - Responsibility for collecting co-payments

Anticipated Agency Impacts and Implementation Considerations

Anticipated Agency Impacts

Eligibility Processes

- CHIMES updates to implement system logic changes
  - Program rule changes
  - Exceptions documentation
  - Auto-renewal/Ex Parte changes
  - Client communication cadence changes
  - Cost-sharing calculation
  - Data exchanges and referrals with DLI
- Increase in case actions and documentation
  - Training
  - Staffing increases

Anticipated Agency Impacts (cont.)

- System updates to implement claims-related logic changes
  - Premium Invoicing and Processing
  - Incorporating co-payments into claims processing logic
  - Calculation of the 5% maximum out-of-pocket (MOOP) limit – a combination of data from multiple systems (premium payments + co-payments)
  - Correspondence related to premiums, co-payments, and MOOP
- Increase in client and provider interactions
  - Staffing for premium collections processing
  - Increase in calls from providers related to co-payments, MOOP, and other changes

Anticipated Agency Impacts (cont.)

Verification of Community Engagement Activities

- Verification processes exist for most activities
- Verification forms/processes will need to be developed for some activities, including community service, work readiness activities, and internships (unpaid).

Verification of Exemptions

- Nearly all proposed exemptions have an existing verification process for a public assistance program.
- Some verification processes may need to be refined based on current processes.
    - Examples: AI/AN exemption, ongoing medical-based exemptions
- Some verifications will be “until benefits closure,” and others will need to be verified at each redetermination.
- Administrative rules will be developed to provide additional clarity.

Qualifying Activities

- Work (monthly income that is not less than the applicable minimum wage requirement)
- Community service
- Work programs, including work readiness, workforce training activities, internships, or registered apprenticeships
- Educational programs (half-time or more), including secondary education, post-secondary education, and vocational education
- Any other activity required by the Centers for Medicare & Medicaid Services (CMS) for the purpose of obtaining necessary authority

Verification processes exist for highlighted items, but some processes may need to be refined. DPHHS is exploring the potential availability of additional interfaces to automate verification.

Standard Exemptions

- Enrolled in (or eligible for) Medicare
- A former foster youth under age 26
- A Native American or Alaska Native
- The parent, guardian, caretaker relative, or family caregiver of:
  - a dependent child 13 years of age and under;
  - a disabled individual; or
  - a foster child under the age of 19
- A veteran with a disability (100% disabled)
- Medically frail, including an individual:
  - Who is blind or disabled;
  - With a substance use disorder;
  - With a disabling mental disorder;
  - With a physical, intellectual, or developmental disability that significantly impairs their ability to perform one or more activities of daily living; or
  - With a serious or complex medical condition
- Pregnant or postpartum
- Participating in a drug addiction or alcoholic treatment and rehabilitation program
- In compliance with Temporary Assistance for Needy Families (TANF) or Supplemental Nutrition Assistance Program (SNAP) work requirements
- Recently released from Department of Corrections, specifically:
  - An inmate or recently released within the last 90 days; or
  - Under the supervision of the Department of Corrections, a county jail, or another entity.

Verification processes exist for highlighted items, but some processes may need to be refined. DPHHS is exploring the potential availability of additional interfaces.

Short-Term Hardship/Good Cause Exemptions

- Individual receiving (or caring for an immediate family member receiving) one of the following:
  - Inpatient hospital services;
  - Nursing facility services;
  - Services in an intermediate care facility for individuals with intellectual disabilities (ICF/IID);
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  - Other services of similar acuity (including outpatient care relating to these services)
- Individual who resides in a county
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- Individual experiencing homelessness
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- Individual (or their dependent) who must travel outside of their community for an extended period to receive medical services that are not available within their community

Individuals who meet the criteria for a short-term hardship/good cause exemption are not required to meet community engagement criteria for a specified number of months.

Interfaces / Electronic Verification Sources

Existing Interfaces (State and Federal Sources)

- DLI wage information
- IRS income information
- Citizenship
- Social security
- Incarceration
- Out-of-state benefits (SNAP)
- Asset verification
- SNAP/TANF information (same system)

For Future Consideration

- Enhanced income verification through CMS Hub
- DLI work activities (i.e., apprenticeship participation, workforce training)
- Verification of receiving a service from an Indian Health Service

Non-Systems Operational Planning

Example of ongoing DPHHS non-system requirements planning

HR1 - Medicaid							
Requirement	**Steps**	**Sept 2025**	**Oct 2025**	**Nov 2025**	**Dec 2025**	**Jan 2026**	**Feb 2026**
Medicaid Program Changes	Finalize exemption definitions	■	■				
	Finalize verification methods (including data matches)	■	■				
	Update rules (i.e., AI/AN)	■	■				
	Develop / refine DLI referral process	■	■				
	Develop eligibility scenarios		■	■			
	Develop business processes		■	■			
	Develop training		■	■			
	Conduct training			■			
Client Communication	Medicaid application			■			
	Changes coming to Medicaid (all)			■	■		
	Supplement to Renewal Packet			■	■		
	Renewal Packet			■	■		
	Reminder to Complete Renewal			■	■		
	Renewal / Reported Change Approval Notice			■	■		
	Renewal / Reported Change Closure Notice			■	■		
	Verification Approval/Compliance Notice			■	■		
	No Verification/Non-Compliance Closure Notice			■	■		
External Communication	Website update			■			
	Community partner communication				■	■	
	Community partner webinar				■	■	
	Tribal communication				■	■	
	Tribal webinar				■	■	

- Most elements are estimated for specific time frames that will adjust based on the anticipated implementation date.
- Staff changes and communication will need significant lead time and may start prior to finalization of the anticipated implementation date.

Systems Operational Planning

Example of system requirements planning

Medicaid Eligibility System Changes - Timeline Estimates							
Requirement	Steps	Sept 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026
Implement Additional System Verifications / Interfaces	Design	■	■				
	Development		■	■	■		
	Implementation				★★		
Work requirements for certain Medicaid Enrollees	System ticket estimate	■					
	Design • Finalize requirements		■				
	Development • System code • UAT • Scenario-based UAT			■	■	■	
	Implementation • Go/No-go decision • Go-Live					★★	
Expansion 6-month redetermination	System ticket estimate	■					
	Design • Finalize requirements		■				
	Development • System code • UAT • Scenario-based UAT			■	■	■	
	Implementation • Go/No-go decision • Go-Live					★★	
Requiring Cost Sharing for Certain Medicaid Expansion Enrollees	System ticket estimate	■					
	Design • Finalize requirements		■				
	Development • System code • UAT			■	■	■	
	Implementation • Go/No-go decision • Go-Live					★★	

- Planning has been integrated into the larger systems and process planning.
- Other program changes to be considered:
  - Legislative requirements (provider portal)
  - SNAP changes related to H.R. 1
  - Annual changes (COLA, allotment adjustments)
  - Customer service changes
  - Typical maintenance and operations tasks

SNAP Payment Error Rate (PER)

Jessie Counts, Human Services Executive Director

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

SNAP Payment Error Rate (PER)

What is the SNAP Payment Error Rate?

- The SNAP PER is a measure of a state's accuracy in determining eligibility and the correct benefit amounts for households.
- The PER includes two types of errors:
  - Overpayments: When a household receives more benefits than they are entitled
  - Underpayments: When a household receives less benefits than they are entitled
- A "tolerance threshold" is in place. Small errors below a certain dollar amount (adjusted annually) are not counted in the PER calculation.
- The PER is calculated as a percentage of sampled benefits that were in error.
- Cases are reviewed by an unbiased third party (OIG). The case review process requires ALL eligibility elements to be verified/re-verified by the client.

SNAP PER (cont.)

PER Calculation Inconsistencies

- QC Guidance and federal policy do not align
  - Example: Policy requires states not to “over verify.” QC is required to verify each element.
- A subsample of cases is reviewed at the federal level. If there is a variance in the subsample, it is applied to the full sample. This can result in a calculation based on a number of cases that is not statistically significant.
- Errors are designated as household-caused or agency-caused. Both are included in the PER calculation
  - Approximately 41% of errors in FFY 2024 were household-caused.

SNAP PER (cont.)

- FFY 2024 MT PER – 8.89%
  - The threshold for a corrective action plan is 6%; 45 states have a PER above 6%.
- National average - 10.93%
- Cases are reviewed by HHS OIG team and validated by FNS.
- Strategies to decrease PER
  - Error-specific training
  - Updated interview strategies for open-ended interview questions
  - Increased communication between OIG and DPHHS
  - Alignment of processing policies with review guide

H.R. 1 Impact : SNAP PER

- H.R. 1 establishes a matching funds requirement based on the payment error rate, requiring states to bear a percentage of the cost of SNAP benefit allotments in FFY 2028
- States can choose to use the FFY 2025 or FFY 2026 error rate for the first year. Subsequent years use the PER from three years prior
  - PER 0% - 5.99% = Matching funds of 0%
  - PER 6% - 7.99% = Matching funds of 5%
  - PER 8% - 9.99% = Matching funds of 10%
  - PER greater than 10% = Matching funds of 15%

H.R. 1 Impact: SNAP Client

- Changes to utility allowance will reduce benefits for many clients.
- Expanded Work Requirements:
  - Age maximum for able-bodied adults without dependents (ABAWDs) was raised from 54 to 64.
  - Parents with children aged 14 and older are required to meet work requirements (previously under 18).
  - Veterans, people experiencing homelessness, and former foster youth are no longer excluded.
  - New exemption for Indian, Urban Indian, and Californian Indian
- Changes to categories of eligible aliens

Summer EBT

Jessie Counts, Human Services Executive Director

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Summer EBT (SEBT) Overview

- SEBT program launched in 2024 to provide food security benefits to qualified families during the summer when schools are closed
- The program was a partnership between OPI and DPHHS; DPHHS will begin leadership of the program in October

	SEBT Benefit Issuance	
	Number of Children	**Benefits Issued**
2024	76,295	$9,155,400
2025	67,021	$8,042,520

HCSD/OPA Customer Service Improvements

Jessie Counts, Human Services Executive Director

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

Customer Service Improvements: Completed

- **PAHL redesign** – implementation of a statewide model and queued callbacks, resulting in less than 25-minute average wait time
- **Internal organizational alignment** - moved specialized Medicaid units under the Policy Bureau for closer coordination and oversight; beginning hiring process of new staff from the 2025 legislative session
- **Targeted training** to reduce known errors and improve error rates
- Development of **customer service capability maturity matrix** and roadmap to plan and manage upcoming milestones

Customer Service Improvements: Upcoming Activities

Technology

- Community assister portal to provide the ability for community assisters to help with public assistance access – February 2026
- Increased text messaging reminders for clients - February 2026
- Case-based processing to increase operational efficiencies within CHIMES integrated eligibility system – March 2026

Operations

- Internal call center model to improve wait times on the PAHL and decrease processing time – Fall 2025
- Modify Office of Public Assistance lobby schedule to allow staff to serve clients on the PAHL and process cases - Fall 2025
- Explore client correspondence and application redesign – End of 2025

Rural Health Transformation Program (RHTP)

Rebecca de Camara, Medicaid and Health Services Executive Director

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

Overview

- Established by H.R.1 Section 71401 to stabilize and strengthen rural health care delivery systems, including hospitals and other providers
- Historic $50 Billion investment over five years (2026-2030) with $10 Billion distributed each year
    - Funds awarded each fiscal year must be spent prior to the end of the following fiscal year.
    - Two tranches:
        - 50% baseline funding – equal share distributed to each state with an approved CMS plan
        - 50% workload funding based on factors including:
            - Content and quality of application
            - Rural factors—rural facility and rural population score factors

Five Strategic Goals

Make Rural America Healthy Again

- Support rural health innovations and new access points to promote preventative health and address root causes of diseases
- Use evidence-based, outcomes-driven interventions to improve disease prevention, chronic disease management, behavioral health, and prenatal care

Sustainable Access

- Help rural providers become long-term access points for care by improving efficiency and sustainability
- Help rural facilities work together—or with high-quality regional systems—to share or coordinate operations, technology, primary and specialty care, and emergency services

Workforce Development

- Attract and retain a high-skilled health care workforce by strengthening recruitment and retention of healthcare providers in rural communities
- Help rural providers practice at the top of their license and develop a broader set of providers to serve a rural community's needs

Innovative Care

- Innovative care models to improve health outcomes, coordinate care, and promote flexible care arrangements
- Develop and implement payment mechanisms incentivizing providers or Accountable Care Organizations (ACOs) to reduce health care costs, improve quality of care, and shift care to lower cost settings

Tech Innovation

- Foster use of innovative technologies that promote efficient care delivery, data security, and access to digital health tools by rural facilities, providers, and patients
- Support access to remote care, improve data sharing, strengthen cybersecurity, and invest in emerging technologies

What is in the One-Time Application?

Statutory Requirements

- Detailed rural health transformation plan
- Initiatives that align with at least three statutorily approved use of funds categories

Strategic Alignment

- Measurable outcomes
- Stakeholder engagement plan
- Highlight impacted counties across the State
- Sustainable
- Impacts health care of rural residents

Budget and Operations

- Workplan and timeline
- Budget milestones
- Data tracking
- If appropriate, commitment to state policy changes within two years

Rural Health Transformation Plan

States must submit a plan to CMS that describes how the state would use funds to:

- Improve access to hospitals, other health care providers, and health care items and services furnished to rural residents of the state
- Improve health care outcomes for rural residents
- Prioritize the use of new and emerging technologies that emphasize prevention and chronic disease management
- Initiate, foster, and strengthen local and regional strategic partnerships between rural hospitals and other health care providers to promote measurable quality improvement, increase financial stability, maximize economies of scale, and share best practices in care delivery

Rural Health Transformation Plan (cont.)

- Enhance economic opportunity for, and the supply of, health care clinicians through improved recruitment and training strategies
- Prioritize data-and technology-driven solutions that help rural hospitals and other rural health care providers furnish high-quality care as close to patients' homes as possible
- Outline strategies to manage the long-term financial solvency and operating models of rural hospitals in the state
- Identify specific factors driving the increasing rate of closures, conversions, or service reductions among stand-alone rural hospitals

Stakeholder Engagement

Request for Information (RFI)

- Issued August 8
- Solicited stakeholder input to inform Montana's application and overall strategy
- 120 unique responses included stakeholder ideas, possible projects, and recommendations for preliminary consideration

Themes

- Technology and virtual care
- Workforce development and care delivery
- Behavioral health and specific health needs
- Access and infrastructure
- Tribal sovereignty and partnerships

Montana State Hospital (MSH)

Dr. Douglas Harrington, State Medical Officer

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

General MSH Updates

- Recruited Dr. Daniel Bemporad, DO as the permanent CEO. He had been the psychiatrist at Galen for three years.
- Recruited Sue Podruzny as the first HFD Quality and Regulatory Affairs Officer. She will coordinate a unified approach to QA at all HFD facilities with a focus on MSH.
- Hired an MSH Quality Improvement Manager.
- DPHHS leadership continues to emphasize the importance of permanent, stable leadership at MSH to support culture and regulatory compliance.
- Implementing strategies for cost containment:
  - Negotiated rate reductions for traveling staff within existing contracts for a current projected savings of $5.8 million over FY 2025 expenses
  - Reduction in 1:1 and 2:1 monitoring
  - 15 MSH nurses hired since December 2024, leading to a reduction in the RN vacancy rate by approximately 35%

MSH Recertification

Certification Application to CMS

- **DPHHS has commenced the process of drafting the application and plans to submit it to CMS by December 31, 2025.**

Operational Improvements

- The Department remains focused on attracting and hiring qualified personnel, particularly floor nurses:
  - A dedicated recruiter for Health Care Facilities Practice has been brought on board.
  - Efforts are underway to connect with Montana nursing programs to create recruitment pipelines.
  - There is a strong emphasis on converting traveling nurses to State FTE positions.
  - Salary adjustments have been implemented to encourage the recruitment and retention of Nurse Supervisors.
  - For the first time in four years, MSH has reduced nurse employee vacancies to below 50%.
  - MSH Medical Staff Bylaws are being revised reviewed and are to align with CMS Conditions of Participation (CoP) for recertification.
  - MSH Policies and Procedures have been thoroughly reviewed, streamlined, and updated to meet standards in accordance with CoPs.

MSH Recertification (cont.)

Staffing Improvements

- Key CoP positions are filled and operational:
  - Infection Control Specialist
  - Quality Improvement Manager
  - Patient Advocate
  - Occupational Health Specialist
- Due to improved staffing models and fewer 1:1s, the average hours of floor staff overtime has been trending down over the last year, from a high of 14.7% in August of 2024, to a low of 2.65% in July of 2025.
- Provider and nursing staff ratios are being adjusted with consideration for both caseload and patient acuity.

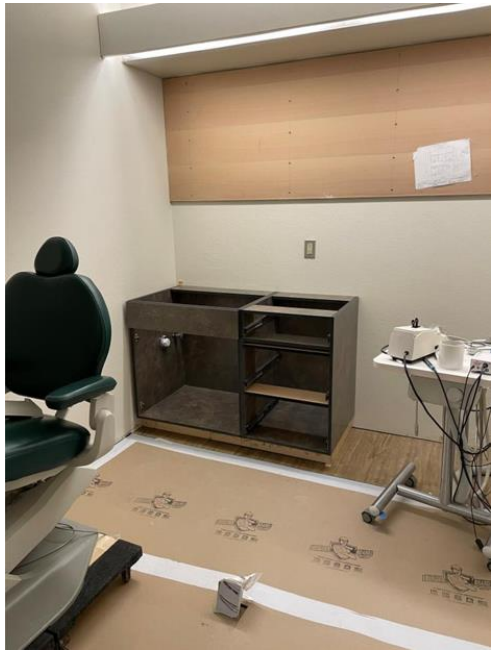
MSH Recertification (cont.)

Oversight and Monitoring Improvements

- 70% of the necessary work to meet the Conditions of Participation (CoPs) is completed and operational, with continuous daily monitoring conducted by various tools and on-site staff from Helena.
- An external review process for all medical charts and practices at the facility has been established via the Ongoing Professional Practice Evaluation (OPPE).
- An external assessment of the medical work performed by MSH practitioners has been initiated through the Focused Practitioner Performance Evaluation (FPPE).
- Reviews of medical necessity for MSH admissions are conducted to ensure that patient charts contain relevant information regarding the medical need for the services provided.
- Helena-based personnel are present on-site three or more days each week to facilitate the progression of CoP implementation activities, monitor compliance, and promote corrective actions.
- An electronic survey tool has been implemented by the MSH Executive Team to monitor CMS CoP compliance in real-time.

Montana State Hospital Construction

- **Compliance and Recertification Construction**
  - Target completion: Dec 2025
  - Total project cost: $21.3M
- **Percentage of Completion as of 8/25/25 is 78.4%**
  - Bravo Unit – 99% complete; expected completion Sept 2025
  - Delta Unit – 95% complete; expected completion Sept 2025
  - Med Clinic – 99% complete; expected completion Sept 2025
  - Alpha Unit – In Progress; expected completion Dec 2025
  - Echo Unit – 99% Complete; expected completion Dec 2025



Conclusion