SB 405: Medicaid Expansion
Summary of Waiver Requests

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for the Children, Families, Health, and Human Services Interim Committee
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Background

The 2015 Legislature passed Senate Bill 405 to expand the Montana Medicaid program to cover most adults with incomes of up to 138 percent of the federal poverty level, as allowed by the federal Affordable Care Act. However, SB 405 included some elements that do not comply with federal requirements for the Medicaid program. The state must ask the federal government to waive those requirements before SB 405 can go into effect.

The Department of Public Health and Human Services released two draft waiver applications on July 7 and plans to submit final applications to the Centers for Medicare and Medicaid Services (CMS) on Sept. 15.

One of the waivers is known as a Section 1115 waiver. It proposes a demonstration project to carry out several parts of SB 405. The other waiver is known as a Section 1915(b) waiver. It would suspend the requirement that Medicaid enrollees have a freedom of choice in health care providers. This waiver is needed because a private company — commonly referred to as a third-party administrator — will establish the network of providers that new enrollees must use.

The state is applying for five-year waivers that will be effective from Jan. 1, 2016, through Dec. 31, 2020. The applications both note that SB 405 sunsets on June 30, 2019. If the Legislature does not extend or remove that termination date, the waivers would terminate at the same time.

Required Reviews

State law establishes several review requirements for the Section 1115 waiver before it can be submitted to CMS for approval. Under 53-2-215, MCA, the department must:

- provide for a 60-day public comment period during which it must accept comment by electronic means or regular mail and hold at least one public forum;
- present the proposal to a Medicaid advisory council; and
- present the proposal to the Children, Families, Health, and Human Services Interim Committee "for review and comment at a public hearing."

The 60-day public comment period opened on July 7 and will close on Sept. 7. DPHHS held public meetings in Billings on Aug. 18 and in Helena on Aug. 20, when it also presented the proposal to the Montana Health Coalition. That group serves as the Medicaid advisory council.

DPHHS will present the waiver proposal to the Children and Families Committee on Sept. 14.

Elements of the Section 1115 Waiver
A Section 1115 waiver is also known as a "research and demonstration" waiver. These types of waivers allow states to forgo some federal requirements so they can to test out new ideas.

The waiver is needed because SB 405 requires that Medicaid expansion enrollees:

- pay a monthly premium equal to 2 percent of their income;
- be removed from the program if they have incomes of 100 percent or more of poverty and have failed to pay their premiums;
- pay a small portion of the bill for the health care services they use, as allowed under federal law; and
- receive health care services through the providers designated by the third-party administrator.

In addition to seeking a waiver for those elements, DPHHS is seeking approval for the following features that were not included in SB 405.

- Total premiums and copayments would be capped at 5 percent of an enrollee's income. SB 405 does not provide for a cap on those combined costs. However, federal law establishes the 5 percent cost-sharing limit, and DPHHS is not seeking a waiver of the federal cap.
- New enrollees would be eligible for benefits for a full year. This would allow people to remain in the Medicaid program even if their incomes increase above 138 percent of poverty during that time. SB 405 did not expressly provide for 12-month eligibility. But existing state law on Section 1115 waivers allows the department to set up waiver programs in ways that provide for efficient and effective delivery of the services.
- The state would use the federally allowed "Fast Track Express Lane Eligibility" process to inform people who have already qualified for other public assistance programs about how they could apply for the expanded Medicaid program.

The table on Page 3 provides more detail about the federal laws or rules that would be waived if CMS approves the state's application.

Elements of the Section 1915(b) Waiver
The Section 1915(b) waiver would allow DPHHS to selectively contract for Medicaid services. The waiver is needed because SB 405 requires a third-party administrator to handle most aspects of the expansion program, including setting up the network of health care providers.

Section 1915(b) waivers are not subject to the same public comment requirements as Section 1115 waivers. They also do not have to be presented to the Children and Families Committee before they're submitted to CMS. However, DPHHS has been accepting comments on this waiver, as well, during the current public comment period.

Elements of the Section 1115 Waiver
The table below shows the Medicaid requirement that would be waived under the state's Section 1115 waiver application, the SB 405 provision that requires waiver, the idea DPHHS is proposing to test, and the way DPHHS will evaluate whether the idea is successful.

Federal Requirement	SB 405 Provision	Idea Being Tested	Means of Evaluation
All enrollees must be treated similarly	Expansion enrollees must pay monthly premiums and make copayments for most health services	The payments will not be a barrier to eligible participants	Data on the number of people signing up for Medicaid expansion
Expansion enrollees cannot be required to pay premiums	Expansion enrollees must pay premiums equal to 2 percent of their annual income	Premiums will not deter people from enrolling in coverage	Data on the number of people signing up for Medicaid
All eligible individuals must have the ability to apply for Medicaid and be furnished assistance with reasonable promptness	Expansion enrollees with incomes of 100 to 138 percent of poverty must lose coverage if they fail to pay their premiums. They can maintain coverage if they take part in certain education, workforce, or wellness activities.	The disenrollment penalty will encourage payment and result in continuity of care. The exemption for people enrolled in a wellness program will encourage healthy behaviors.	Data on the number of people losing and regaining coverage because of premium payments/nonpayments
All enrollees must have freedom of choice in health care providers	Expansion enrollees must use the network of providers established by the third-party administrator	Enrollees will have appropriate access to care and equal or greater provider access than would be available without a third-party administrator	Data on medical claims, surveys of enrollees and providers, and the Medical Expenditure Panel Survey conducted by the Agency for Healthcare Research and Quality
States must periodically review whether enrollees still meet Medicaid's income eligibility requirements	SB 405 did not provide for 12-month eligibility. Existing state law on waivers allows DPHHS to structure waiver programs for efficient and effective delivery of services.	Continuous 12-month eligibility will promote continuity of coverage and minimize “churn,” or the need for expansion enrollees to change insurance plans if their income changes	Data on churn for the expansion population compared to other groups

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