SB 405
MEDICAID EXPANSION UPDATE

A Report Prepared for the
Legislative Finance Committee

By
Quinn Holzer

December 7, 2015

LFD
MONTANA LEGISLATIVE FISCAL DIVISION

INTRODUCTION

The HELP Act (SB 405) of the 2015 Montana Legislature expands Medicaid in Montana, as allowed by the Patient Protection and Affordable Care Act (PPACA or ACA). Specifically, this will provide Medicaid coverage for adults ages 19-64, with incomes less than 138% of the federal poverty rate for Montana (approximately $16,000 per year for an individual or $28,000 per year for a family of three, per the DPHHS website). The implementation of this Act will significantly impact the budget of the State of Montana. Currently, the expansion population will be covered 100% by federal funds, with a phased-in reduction beginning in 2017 to an eventual final federal matching rate of 90% (90% federal, 10% state) in 2020 and beyond. The purpose of this report is to provide an up-to-date synopsis of the Medicaid expansion and any financial implications.

EXPANSION IMPLEMENTATION STATUS

THIRD PARTY ADMINISTRATOR (TPA)

Blue Cross/Blue Shield has been selected as the TPA for this Medicaid population. As of the writing of this report, the contract has not yet been finalized.

CENTER FOR MEDICARE & MEDICAID SERVICES (CMS) WAIVER

Waivers were necessary for implementation of Medicaid expansion in order to be consistent with SB 405. DPHHS filed two waiver applications to accomplish:

1) the 1115 Research and Demonstration Waiver was necessary for implementation of cost sharing with both a premium and a copay, as well as for 12 month continuous eligibility
2) the 1915 (b)(4) Waiver Fee-for-Service Selective Contracting Program allowing a Third Party Administrator to develop a specific network of service providers, which limits service provider options for eligible participants.

These waivers were officially approved November 2, 2015. Per the contingent effective date in SB 405, this action officially made the Montana HELP Act effective in Montana. As a result of this, DPHHS can begin to establish the statutory appropriations and expenditures in SABHRS from the general fund and federal funds for all necessary expenses, including both benefits and administrative costs.

CMS did provide further guidance regarding specific aspects of the waivers, which will have financial impacts on the overall expenses and anticipated savings to the State of Montana. Some of the notable aspects of the CMS guidance include:

Premiums

As required in SB 405, the 1115 waiver includes a premium of 2% of income. At 138% of Federal Poverty Level (FPL), which is approximately $16,000, this would reflect a premium of almost $27 per month.

The 1115 waiver further delineates the premium will be applied only to individuals with incomes between 50% and 133% FPL. (The waiver uses 133% FPL as the upper limit, consistent with the federal code authorizing the Medicaid expansion. However, as there is also a 5% disallowance of income in the federal code, the upper limit is effectively 138%, which is the number used in SB 405. As a result, the 133% referenced in the waiver, is effectively the 138% referenced in state law.) This would mean that those participants with an annual income less than 50% FPL, approximately $6,000, would not have to pay premiums. A premium at this level would have been less than $10 per month.

Copayments

Copayments are allowed as authorized in SB 405, but the 1115 waiver requires that the premiums paid be used as a credit toward copayments due. Total cost share (copayments and premiums together) is limited to a total of 5% of household income.

Example: A qualified individual pays a $20 premium, and then receives treatment with a copay of $8. Because they already paid more than this as a premium, they will not have to pay the copay out of pocket. However, if they receive treatment with a total copay of $35, they will be liable for $15 out of pocket. ($35 copay - $20 premium paid = $15 additional cost share owed)

Disenrollment

As directed by SB 405, those individuals above 100% FPL may be disenrolled for non-payment of premiums. The 1115 waiver includes rules for allowing those individuals to be re-enrolled, after either the payment of premiums in arrears, or after the Department of Revenue sends a statement officially assessing these premiums as officially owed to the state. (Note that the assessment indicates the premiums in arrears are not paid, but remain a debt payable to the State of Montana.) Individuals may then be re-enrolled, and are specifically exempted from having to re-apply for such enrollment.

Continuous Eligibility

As proposed by DPHHS, the expansion population will be granted "continuous eligibility," meaning that once they are determined eligible during the benefit year, they are assumed to be eligible for a period of 12 months. Continuous eligibility required approval through the 1115 waiver process, and was neither included nor explicitly excluded in SB 405. The department has reported that a high percentage of those who experience a spike in pay and would therefore be ineligible are again eligible in a short time-frame. Maintaining continuous eligibility is at least partially offset by the reduction in administration that would be required for multiple changes in enrollment status within a single year.

CMS has approved this aspect of the waiver, but requires the department to make a downward adjustment of 2.6% in claimed expenditures that will receive the enhanced matching rate (currently 100% federal), but will instead receive the traditional matching rate (currently 65.24% federal for most services).

Assuming the majority of the expansion population are adults, and the average spending per adult enrollee in Montana in FY 2011 was approximately $4,700, we can estimate a financial impact. Using the low end of the estimated range of potential new enrollees (45,000), the estimated annual impact of this could be approximately $1.9 million general fund. (Actual costs will vary depending upon the rate of enrollment, as well as the average cost per enrollee for this new population.)

Third Party Administrator

The 1915(b)(4) waiver which allows for a TPA was applied for with a five year time-frame, consistent with the 1115 waiver. However, the 1915(b) waiver was only approved for two years. In order to then apply again, Montana will be required to obtain an independent assessment to evaluate the TPA. Additionally, CMS limited the ability of the TPA to restrict the provider network, requiring a minimum of 90% of hospitals and 80% of the non-hospital licensed health care providers in the state. Additionally, if the network cannot provide necessary services, the TPA must cover those services out of network.

MONTANA HELP ACT OVERSIGHT COMMITTEE

The second meeting of the Montana HELP Act Oversight Committee was held Tuesday, December 1, 2015. This meeting served primarily to provide updated information on the status of several components, including:

- An update on the number of members enrolled since the November 2 open enrollment began. Current enrollment is approximately 10,500.
- Third Party Administrator (TPA) status. Blue Cross Blue Shield is the TPA, and is preparing to have ID cards, IT systems, and a complete provider network ready for a January 1 rollout. The TPA is reportedly nearing the threshold necessary to meet the requirements of the 1915 (b) waiver.
- An emphasis is being placed on education, outreach, and assistance for enrolling eligible members. The Montana Primary Care Association has received multiple grants to assist with this process (CoverMT.org), in addition to the efforts being made by the department.
- The Department of Labor and Industry (DOLI) has been preparing to augment their job training and assistance programs, with plans to offer programs to enrolled Medicaid expansion members beginning January 1, 2016. Multiple examples were given of training and educational opportunities that intersect with the healthcare industry. Additionally, DOLI reported that the interaction with this program will give them a unique ability to monitor results that they have not had previously.
- An update on the Administrative Rules was provided by DPHHS. These rules have been published for public comment, and will be re-published in December with updates and changes as a result, with these rules set to become official prior to the end of calendar year 2015.
  - Additional rules will be necessary in the future. These rules were fast-tracked to be ready prior to January 1, and others will be necessary as the process continues.

FINANCIAL UPDATE

The executive branch could not set up financial accounting funds and controls until receipt of the CMS waivers to implement the Medicaid expansion. At this point in time, they have begun establishing those controls, and future reports will include basic financial data.

CHANGES TO FISCAL NOTE ASSUMPTIONS

The Fiscal Note for SB 405 made numerous assumptions, and numerous circumstances have changed since then that will result in changes to State of Montana expenses.

Net Positive Changes:

Montana's Medicaid program had previously instituted a program to allow some participant expansion in the 25%-50% FPL that would not have traditionally been included. CMS initially indicated that while this population met the definition of the expansion population, because they were already included in the state Medicaid plan, these participants would continue to be covered at the traditional FMAP, rather than the enhanced FMAP. However, upon review, CMS has indicated that the state's Alternative Benefit Plan does not meet the minimum requirements of the expansion, and as such this group's benefits would be required to change, aligning with the benefit plan for the expanded population, and as a result, they will receive the enhanced FMAP, resulting in a lower general fund cost to the state.

TPA exclusion: While certain groups were explicitly excluded from TPA management in SB 405, the CMS Waiver further limited this by excluding all members with less than 50% FPL. This will eliminate the payment of a Per Member Per Month fee for those members, which is paid at a rate of 50% federal and 50% state match from the general fund.

Net Negative Changes:

Continuous Eligibility: As mentioned before, CMS is partially offsetting the cost of this inclusion by reducing the population covered by the enhanced FMAP by 2.6%.

Copay/Premium interaction: As approved in the waivers, a 2% premium will be allowed, but only for those members above 50% FPL. Additionally, while copays will be allowed as well (excluding those below 50% FPL), members will be credited the amount of their premiums paid toward an equivalent copayment. Once copays exceed the 2% premium level, out-of-pocket copays will be allowed to a maximum of 5% total cost share. The first part of copays (up to the premium amount) will be paid from the premiums received by the state. This reduces expected cost share receipts. (In the Medicaid expansion, premiums are payable to the state, and copays are payable to the provider.)

TPA cost: The assumed rate was $20.07 per member per month (PMPM), which receives 50% federal match. Blue Cross/Blue Shield will be the TPA, and their proposal included a PMPM cost of $26.39. This will be paid for with 50% general fund and 50% federal funds

INFORMATION TECHNOLOGY

Included in the TPA proposal from Blue Cross Blue Shield was an expense for IT totaling $3.75 million. While most TPA costs are reimbursed at a 50% federal match, qualifying IT projects are typically reimbursed at a 90% federal matching rate. DPHHS is currently working to qualify this IT development for the enhanced federal match. The original fiscal note did include $1.9 million for "System Integration Costs," and it is unclear what the department intends from an IT perspective at this time.

SUMMARY

The 1115 waiver and the 1915(b) waiver Montana applied for have been received. Each necessary component of the Act is addressed in the waivers, with additional limitations being applied in several cases. DPHHS has begun enrolling members (with a reported 5,500 new enrollees in the first week) with an anticipated benefit plan implementation January 1, 2016. Certain aspects of the waiver and TPA contract will impact the overall cost of the expansion, but benefits will not be provided until the second half of FY 2016.