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Medicaid Expansion in Montana

On November 2, 2015, the Centers for Medicare and Medicaid Services (CMS) approved Montana's Section 1115 demonstration waiver to expand Medicaid under the Affordable Care Act (ACA) as of January 1, 2016.[1] The waiver implements the Montana Health and Economic Livelihood Partnership (HELP) program, which was adopted by the state legislature in April 2015. CMS also approved Montana's § 1915(b) selective contracting waiver to use a managed fee-for-service (FFS) Third Party Administrator (TPA) to deliver services to the newly eligible adults.[2] Adults who are newly eligible for Medicaid under Montana's expansion are parents from 50-138% of the federal poverty level (FPL) and childless adults from 0-138% FPL (up to $16,242 per year for an individual in 2015) – an estimated 70,000 beneficiaries.[3]

Under the waiver, enrollment began on November 1, 2015, with Medicaid expansion coverage effective on January 1, 2016. The waiver does the following:[4]

- Expands Medicaid coverage to newly eligible adults ages 19-64 through a managed FFS TPA (described below). In order to implement the TPA, the state has approval to waive freedom of choice requirements (except for family planning providers) so that newly eligible adults will receive services from the TPA's provider network.
- Exempts certain groups of people from enrolling in the TPA and all of the Section 1115 waiver provisions except 12-month continuous eligibility including those with incomes at or below 50% FPL, American Indian/Alaskan Natives, individuals who are medially frail, those with exceptional health care needs as determined by the state, people who live in regions where there are an insufficient number of providers contracted with the TPA, and people who require continuity of coverage not available or effectively delivered through the TPA.
- Requires monthly premiums up to 2% of household income for newly eligible adults from 51-138% FPL receiving services through the TPA. Beneficiaries from 101-138% FPL may be dis-enrolled for failing to pay premiums after notice and a 90 day grace period. These beneficiaries may re-enroll upon payment of arrears or when the state Department of Revenue assesses the debt against income taxes, no later than the end of the quarter; re-enrollment shall not require a new application. The state shall establish a process to exempt beneficiaries from dis-enrollment for good cause.
- Subjects enrollees to premiums and copayments up to 5% of income, consistent with federal limits. Beneficiaries subject to premiums will receive a credit toward co-payments accrued up to 2% of income. Certain service categories are exempt from co-payments (including preventive health care, immunizations and medically necessary health screenings), and providers may not deny services for failure to pay copayments for individuals with incomes below poverty.

- Implements twelve month continuous eligibility for all newly eligible adults to reduce the effects of churning between Medicaid and Marketplace coverage as income fluctuates.[5]

As mentioned above, the state also was granted § 1915(b) selective contracting waiver authority to use a managed FFS TPA to deliver services to the newly eligible adults. According to the Section 1915(b) waiver application, the TPA must establish a provider network,[6] reimburse providers on a fee-for-service basis on behalf of the state, collect beneficiary premiums, and assume other administrative functions for most newly eligible adults. The Section 1915(b) waiver application also provides that the TPA would also ensure that services provided are medically necessary,[7] oversee case management and care coordination, and ensure continuity of care.

Given the low population density of the state, Montana will contract with a TPA to deliver services to the newly eligible population to use the provider network and administrative infrastructure of an insurer already providing services to individuals in the state. The state chose a company offering a qualified health plan on the Marketplace with the goal of decreasing churn and increasing continuity of care between Medicaid and the Marketplace. The Section 1915(b) waiver application defines network adequacy standards for the TPA. Currently, the state uses the TPA model to administer and deliver care for the state's Children's Health Insurance Program, Healthy Montana Kids.

To date, CMS has approved Medicaid expansion waivers in five other states (Arkansas, Iowa, Indiana, Michigan, New Hampshire[8]). A sixth state, Pennsylvania, initially had implemented the Medicaid expansion using a Section 1115 demonstration, but later changed to a traditional Medicaid expansion. Some provisions in Montana's proposal are similar to provisions approved in other waivers,[9] such as imposing premiums of 2% of income for beneficiaries between 51-138% FPL with the ability to dis-enroll those from 101-138% FPL for non-payment for up to 3 months. Montana's waiver authority to implement 12-month continuous eligibility for the newly eligible population is unique among states seeking Medicaid expansion waivers. Table 1 describes the major elements of Montana's proposed Section 1115 demonstration.

Table 1: Montana's Approved Section 1115 Medicaid Expansion Demonstration Waiver	
Element	**Montana Waiver Provision**
Overview:	Covers approximately 70,000 newly eligible adults through a managed fee-for-service (FFS) Third Party Administrator (TPA). Requires premiums up to 2% of income for newly eligible beneficiaries from 51-138% FPL receiving services through the TPA. Individuals between 101-138% FPL who do not pay their premiums will be dis-enrolled from Medicaid after notice and a 90 day grace period and not allowed to re-enroll until past due premiums are paid or assessed against state income tax refunds by the end of the calendar quarter. Beneficiaries subject to premiums will receive a credit toward accrued co-payments up to 2% of income. The state will implement twelve month continuous eligibility for all newly eligible adults.
Duration:	1/1/16 to 12/31/20, pending state legislative reauthorization of the HELP Program beyond June 30, 2019. If HELP Program is not reauthorized, the state will terminate the waiver.
Coverage Groups:	Covers newly eligible adults ages 19-64 (parents with incomes 50-138% FPL and childless adults with incomes 0-138% FPL).
Exempt Populations:	People with incomes at or below 50% FPL; American Indians/Alaskan Natives; people who have exceptional health needs including but not limited to medical, mental health or developmental conditions (including people who are medically frail); people who live in regions where there are an insufficient number of providers contracted with the TPA; people who require continuity of coverage not available or effectively delivered through the TPA. Individuals exempt from the TPA are also exempt from all demonstration provisions (including premiums) except 12-month continuous eligibility. The waiver application indicated that medically frail beneficiaries will be identified through questions on the Medicaid application and can request an exemption from TPA enrollment at any point thereafter. The 1915(b) selective contracting waiver application also provided that the TPA will refer medically frail individuals that it identifies to the state.
Renewal Simplification:	Twelve month continuous eligibility established for newly eligible adults[10] regardless of the delivery system through which they receive benefits (i.e. even if they are exempt from the TPA).[11]
Premiums:	Newly eligible adults from 51-138% FPL receiving services through the TPA will pay premiums equal to 2% of household income. Beneficiaries may report changes in income to have premiums re-calculated for the following quarter. Beneficiaries from 101-138% FPL can be dis-enrolled for failure to pay premiums after notice and a 90 day grace period. Re-enrollment when overdue premiums are paid or the state Department of Revenue assesses the premium debt against income tax refunds, no later than the end of the calendar quarter. Re-enrollment shall not require a new application. The state shall establish a process to exempt beneficiaries from dis-

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	enrollment for good cause. Authority to charge premiums is contingent upon the state demonstrating the ability to electronically track out-of-pocket costs quarterly and CMS's approval of the state's preventive services protocol (describing services exempt from co-payments). Third parties are permitted to contribute toward beneficiaries' premium and co-payment obligations.
Co-Payments:	Beneficiaries subject to premiums will receive a credit toward accrued co-payments up to 2% of income. [11] Co-payments will be at state plan amounts with certain services exempt including preventive health care services, immunizations and medically necessary health screenings.[12] Providers may not deny services for failure to pay copayments for individuals below poverty. All cost-sharing (including premiums and co-payments) is limited to 5% of quarterly household income.
Delivery System and Benefits:	Most newly eligible Medicaid beneficiaries will be enrolled in the TPA. The TPA will be a commercial insurer that already has an established provider network in the state. The state will contract with the TPA to administer the delivery of and payment for services, establish a provider network, reimburse providers on behalf of the state, collect beneficiary premiums, and assume other administrative functions. The TPA is part of the § 1915(b) selective contracting waiver, not the § 1115 waiver. Beneficiaries will receive an ABP benefit package according to a SPA. The ABP for newly eligible individuals enrolled in the TPA will include all services in the Medicaid state plan benefit package except long term care services. Newly eligible adults who are exempt from TPA enrollment will receive an ABP that includes long-term care services through the state's existing fee-for-service system. The Section 1915(b) waiver application provides that certain benefits, such as non-emergency medical transportation and dental services, will be provided outside TPA.
Next Steps:	State to submit for CMS approval a preventive services protocol for services exempt from cost-sharing by December 11, 2015, and a premium and cost-sharing operations protocol and draft evaluation design by March 1, 2016. State must hold public forum about the demonstration's progress within 6 months of implementation and annually thereafter.

Endnotes

[1] CMS, Special Terms and Conditions, *Montana Health and Economic Livelihood Partnership Program Demonstration* (approved Nov. 2, 2015), http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mt/mt-HELP-program-ca.pdf.

[2] Provider reimbursement will be FFS and the TPA will receive an administrative fee. Montana Dep't of Health & Human Servs., *Montana Health and Economic Livelihood Partnership Program, Section 1915(b)(4) Waiver Fee-for-Service Selective Contracting Program Application* (Montana Dep't of Health & Human Servs., Sept. 15, 2015), http://dphhs.mt.gov/medicaidexpansion/waiversubmission.

[3] Montana Dep't of Public Health & Human Servs., *Montana Health and Economic Livelihood Partnership Program Section 1115 Research and Demonstration Waiver Application* (Montana Dep't of Health & Human Servs., Sept. 15, 2015), http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mt/mt-HELP-program-pa.pdf.

[4] Montana's waiver application also indicated that it would assess a $100 per month fee on demonstration beneficiaries with assets beyond limits in the state statute, but no waiver authority to do so was requested or granted. These limits include a primary residence and attached property above $250,000, one light vehicle, and more than $50,000 cash/cash equivalent. The fee is $100 per month with an additional $4 per month for each $1000 in excess of the limit. Mont. Health and Economic Livelihood Partnership Act, § 18, http://leg.mt.gov/bills/2015/sb0499/SB0405_x.pdf.

[5] The waiver application submitted for state level public comment also proposed seeking separate authority to use Fast Track Express Lane Eligibility, which allows states to use data and eligibility findings from other public benefit programs to determine eligibility for Medicaid at application or renewal for these same beneficiaries.

[6] The Section 1915(b) selective contracting waiver application provides that the TPA's provider network would be comparable to or broader than the state's current Medicaid FFS provider network.

[7] The Section 1915(b) waiver application indicates that state believes that the TPA arrangement is structured to avoid the incentive to limit services because the TPA assumes no insurance risk, and administrative fees are not based on performance related to total medical expenses for new adults.

[8] NH is currently implementing a traditional expansion under state plan authority and will transition to demonstration authority as of 2016.

[9] Robin Rudowitz, Samantha Artiga, MaryBeth Musumeci. *The ACA and Medicaid Expansion Waivers* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, February 2015), http://kff.org/medicaid/issue-brief/the-aca-and-medicaid-expansion-waivers/.

[10] Montana is expected to amend its other Section 1115 demonstration waiver to also implement 12-month continuous eligibility for other coverage groups.

[11] Claimed expenditures at the enhanced matching rate will be adjusted downward by 2.6% to account for the fact that the regular matching rate applies to a proportion of expenditures for 12-month continuous eligibility consistent with CMS guidance.

[12] CMS, Special Terms and Conditions, *Montana Health and Economic Livelihood Partnership Program Demonstration, Attachment A, Copayment Schedule and Exempt Services* (approved Nov. 2, 2015), http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mt/mt-HELP-program-ca.pdf.