THE HENRY J. KAISER FAMILY FOUNDATION

THE KAISER COMMISSION ON
Medicaid and the Uninsured

Filling the need for trusted information on national health issues...

September 2015 | Fact Sheet

Proposed Medicaid Expansion in Montana

In April 2015, Montana's legislature adopted the Medicaid expansion by passing a law called the Montana Health and Economic Livelihood Partnership (HELP) Program. In July 2015, Montana released a proposed § 1115 demonstration to implement the HELP Program and expand Medicaid under the Affordable Care Act (ACA) on January 1, 2016, and also released a proposed § 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.[1] The demonstration would cover newly eligible adults – 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.[2] To be implemented, the waiver would need to be approved by the Centers for Medicare and Medicaid Services (CMS) following a federal public comment period. The state comment period ended on September 7, 2015.

Under the proposed waiver, Medicaid expansion coverage would be effective on January 1, 2016. The waiver would:

- Expand Medicaid coverage to newly eligible adults ages 19-64 through a managed FFS TPA (described below). In order to implement the TPA, the state seeks to waive freedom of choice requirements so that newly eligible adults would receive services from the TPA's provider network. American Indian/Alaskan Natives and individuals who are medially frail are exempt from enrolling in the TPA.[3]
- Require monthly premiums up to 2% of income for all newly eligible adults receiving services through the TPA. Montana proposes dis-enrolling beneficiaries from 100-138% FPL for failing to pay premiums and seeks waiver authority to lock-out these individuals until overdue premiums are paid, or the state Department of Revenue collects the premium debt from their income taxes refunds. Additionally, the waiver mentions that participation in a wellness program could exempt a beneficiary from disenrollment, but details were not provided. While the state is not requesting waiver authority, the proposal would require co-payments according to state plan amounts and consistent with federal law for all newly eligible beneficiaries.[4]
- Implement twelve month continuous eligibility for newly eligible adults that would allow individuals to maintain coverage for twelve consecutive months. The state also seeks separate waiver authority to use Fast Track Express Lane Eligibility (ELE),[5] 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.
- Include newly eligible adults in the voluntary employer sponsored insurance (ESI) premium assistance program currently operating in the state.

As mentioned above, the state also submitted a § 1915(b) selective contracting waiver to use a managed FFS TPA to deliver services to the newly eligible adults. The TPA would be required to provide 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 TPA would also do utilization reviews to ensure services are medically necessary,[7] health risk assessments (HRA), targeted beneficiary outreach (based on HRA results), case management and care coordination, and ensure continuity of care.

Given the low population density of the state, Montana seeks to contract with a TPA to deliver services to the newly eligible population to use the provider network[8] and administrative infrastructure of an insurer already providing services to individuals in the state. The state hopes to choose 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. While the state network adequacy standards would not change from current standards, the contract between the TPA and Montana would clearly define these standards.[9] Currently, the state uses the TPA model to administer and deliver care for the state's Children's Health Insurance Program (CHIP), Healthy Montana Kids (HMK).

To date, CMS has approved Medicaid expansion waivers in five other states (Arkansas, Iowa, Indiana, Michigan, New Hampshire[10]). A sixth state, Pennsylvania, had implemented the Medicaid expansion using a Section 1115 demonstration under Governor Tom Corbett, but later changed to a traditional Medicaid expansion under Governor Tom Wolf. Some provisions in Montana's proposal are similar to provisions approved in other waivers,[11] such as imposing premiums of 2% of income for beneficiaries between 100-138% FPL and providing an option for premium assistance for Medicaid eligible individuals with ESI. Only Indiana has received waiver approval to impose premiums for all new eligibles and to impose a lockout period for beneficiaries with incomes between 100-138% FPL. Compared to Indiana, the premium levels are higher for those with lower incomes and the lock-out period is tied to repayment of premiums or an assessment from the Department of Revenue against income taxes. Montana is one of the only states to seek waiver authority to implement 12 month continuous eligibility and ELE for the newly eligible population. Table 1 describes the major elements of Montana's proposed Section 1115 demonstration.

Table 1: Montana's Proposed Section 1115 Medicaid Expansion Demonstration Waiver	
Element	**Montana Waiver Proposal**
Overview:	Would cover approximately 70,000 newly eligible adults through a managed fee-for-service (FFS) Third Party Administrator (TPA). Would require premiums up to 2% of income and copayments for all newly eligible beneficiaries receiving services through the TPA. Individuals between 100 and 138% FPL who do not pay their premiums would be dis-enrolled from Medicaid and not allowed to re-enroll until past due premiums are paid. The state plans to add the newly eligible adult population to the voluntary employer sponsored insurance (ESI) premium assistance program currently operating in the state. The state would also implement twelve month continuous eligibility and Fast Track Express Lane Eligibility (through a separate waiver) for 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.
Evaluation Questions:	What are the effects of applying premiums for newly eligible adults enrolled through the TPA?; What are the effects of dis-enrollment for failure to pay premiums for participants with incomes above 100% FPL?; and What are the effects of contracting with a TPA to administer benefits for most HELP Program participants?
Coverage Groups:	Covers newly eligible adults ages 19-64 (parents with incomes 50-138% FPL and childless adults with incomes 0-138% FPL). The 1915(b) selective contracting waiver says that the TPA will conduct health risk assessments within 90 days and then refer medically frail individuals to the state. However, it does not specify whether this is the only way the state will identify medically frail individuals.
Exempt Populations:	American Indians/Alaskan Natives; people who have exceptional health needs including but not limited to medical, mental health or developmental conditions; and those otherwise exempt under federal law. These populations may also be exempt: 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.
Enrollment and Renewal Simplification:	State seeks separate § 1902(e)(14)(A) waiver to implement Fast Track Express Lane Eligibility for these beneficiaries. State also seeks to establish twelve month continuous eligibility for newly eligible adults in § 1115 waiver.
Premiums:	All newly eligible adults receiving services through the TPA will pay premiums equal to 2% of their income. State also proposes dis-enrolling beneficiaries from 100-138% FPL for failure to pay premiums until overdue premiums are paid or until the state Department of

Table 1: Montana's Proposed Section 1115 Medicaid Expansion Demonstration Waiver	
Element	**Montana Waiver Proposal**
	Revenue collects the premium debt from their income tax refunds.[12] The waiver mentions that participation in a wellness program could exempt a beneficiary from disenrollment, but details were not provided in the waiver.
Co-Payments:	Individuals with incomes up to 138% FPL enrolled in TPA coverage with will be required to pay copayments up to the maximum allowable amount under federal law.[13,14] All cost-sharing (including premiums and co-payments) is limited to 5% of quarterly household income. No waiver authority is requested to implement co-payments.
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. 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. Certain benefits, such as non-emergency medical transportation and dental services, will be provided outside TPA.
Financing:	The waivers do not address budget neutrality requirements.
Next Steps:	The state comment period ended September 7, 2015. State must then conduct tribal consultation, submit proposal to CMS, allow for federal 30 day public comment period, and obtain federal approval of the waiver. The state plans to have Medicaid expansion coverage in effect by January 1, 2016.

Endnotes

[1] Provider reimbursement will be FFS and the TPA will receive an administrative fee.

[2] Montana Health and Economic Livelihood Partnership (HELP) Program Proposal (July 7, 2015), available at http://dphhs.mt.gov/Portals/85/Documents/MedicaidExpansion/MontanaSection1115and1915b4Waivers.pdf.

[3] These populations may also be exempt: 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.

[4] Maximum cost-sharing, including premiums and copays, would remain capped at 5% of income consistent with federal law.

[5] To implement ELE for children and pregnant women, states must have an approved and implemented State Plan Amendment from CMS. The state must seek § 1902(e)(14)(A) waiver authority to implement ELE for parents and adults.

[6] As required in the Section 1915(b) selective contracting waiver, the TPA's provider network would be comparable to or broader than the state's current Medicaid FFS provider network.

[7] The 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] As required in the Section 1915(b) selective contracting waiver, the TPA's provider network would be comparable to or broader than the state's current Medicaid FFS provider network.

[9] The waiver defines standards for timely access, provider capacity, utilization, quality, and coordination and continuity of care.

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

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

[12] CMS approved a six month lock-out after disenrollment for failure to pay premiums for individuals from 100-138% FPL who are not medically frail in Indiana.

[13] *Cost Sharing Out of Pocket Costs* (Centers for Medicare and Medicaid Services, Department of Health and Human Services), http://www.medicaid.gov/medicaid-chip-program-information/by-topics/cost-sharing/cost-sharing-out-of-pocket-costs.html

[14] The state will not require copayments for preventive health care services; immunizations provided according to a schedule established by the DPHHS that reflects guidelines issued by the Centers for Disease Control and Prevention; medically necessary health screenings ordered by a health care provider, or any other services that are legally exempt.