

MEDICAID EXPANSION: COMPARISON OF SB 405 AND CMS WAIVERS

Background

Senate Bill 405, the Medicaid expansion bill approved by the 2015 Legislature, included some requirements not typically allowed under federal law for the Medicaid program. As a result, the state had to ask the Centers for Medicare and Medicaid Services (CMS) to waive some federal requirements. SB 405 made the expansion contingent on receiving the federal waivers.

CMS granted the waivers. However, the waivers contained elements that changed the SB 405 requirements in some significant respects. This briefing paper summarizes key differences between the requirements of SB 405 and the waivers from CMS.

Premiums

SB 405 required all expansion enrollees to pay an annual premium equal to 2% of their incomes. CMS excluded people with incomes at or below 50% of the federal poverty level from paying the premiums.

Statistics compiled by the Department of Public Health and Human Services (DPHHS) show that as of Sept. 1, 2017, about 71 percent of expansion enrollees had incomes at or below 50% of poverty and were thus exempt from the premium requirement.

Disenrollment

SB 405 required enrollees with incomes above 100% of poverty to be removed from the program if they failed to pay their premiums within 90 days of being notified that premiums were overdue. The bill allowed people to be re-enrolled in the program after the Department of Revenue assessed the unpaid premium through their income taxes.

CMS said enrollees also could be re-enrolled after the Department of Revenue sent a notice of the debt.

Third-Party Administration

SB 405 required most enrollees to use health care providers who are in a network created by a third-party administrator, or TPA, that contracted with the state to run the expansion program. The bill allowed DPHHS to exempt people from the TPA arrangement if the agency believed the person would be more appropriately served through the regular Medicaid program because the person:

- had exceptional health care needs;
- lived in an area of the state for which the TPA was unable to contract with enough health care providers; or

- needed continuity of care that would not be available or cost-effective through the TPA arrangement.

In addition to those exceptions, CMS excluded enrollees with incomes at or below 50 percent of poverty from the TPA arrangement.

As a result, 71 percent of the expansion enrollees – about 59,200 – were not subject to the TPA arrangement as of Sept. 1.

Enhanced Matching Rate/Continuous Eligibility

SB 405 did not specifically allow for or prohibit what's known as "continuous eligibility," or a full 12 months of Medicaid coverage based on an enrollee's income at the time of application. Under this provision, people may continue to receive Medicaid coverage even if their incomes increase above 138% of poverty during the 12-month period.

When it applied for the waiver, DPHHS asked CMS for permission to provide continuous eligibility to the expansion enrollees. CMS granted the request but also decided not to pay the enhanced matching rate for all expansion enrollees. Instead, the federal government is paying the regular matching rate of about 66% of medical costs for 2.6% of the medical claims of expansion enrollees. The enhanced matching rate allowed under ACA was 100% federal funding in 2016 and 95% this year. The federal share is set to decrease to 94% in 2018, 93% in 2019, and 90% in 2020.

The Legislative Fiscal Division has estimated that this change by CMS results in Montana effectively receiving a matching rate that is slightly less than 1% lower than the enhanced rate allowed under federal law.

Waiver Periods

Montana applied for two different waivers and asked that each waiver be in effect for 5 years. The state requested:

- a research and demonstration project waiver so it could collect the required premiums and copayments, disenroll people for failure to pay, and provide 12-month continuous eligibility; and
- a section 1915(b)(4) waiver so the state could use the TPA to administer the program and create a provider network.

CMS granted both waivers, but limited the section 1915(b)(4) waiver to a period of 2 years, rather than the 5 years requested by the state. CMS said the effectiveness of the TPA arrangement must be evaluated before the waiver could be renewed past 2017.

However, DPHHS has suspended the evaluation process because SB 261 in 2017 called for elimination of the TPA contract if state revenue collections for Fiscal Year 2017 did not meet certain levels. The collections fell below the target levels, triggering the termination of the contract at the end of this year.

Sources

- Montana Health and Economic Livelihood Partnership (HELP) Demonstration Waiver, Centers for Medicare and Medicaid Services, Nov. 2, 2015.
- Section 1915(b) Waiver of Statewidehood and Freedom of Choice, Centers for Medicare and Medicaid Services, Nov. 2, 2015.
- Data provided by Erica Johnston, Manager, DPHHS Business and Financial Services Branch, DPHHS, Oct. 4.

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