Medicaid Monitoring
An Overview of Medicaid Waivers

Prepared by Sue O'Connell
for the Children, Families, Health, and Human Services Interim Committee
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Background

Federal law establishes the basic requirements for state Medicaid programs. However, states may receive exemptions, or "waivers," from some requirements in order to try out new ideas, serve selected groups of enrollees, or provide care in a less restrictive setting.

This briefing paper provides an overview of the types of waivers allowed under federal law, the waivers currently in effect in Montana, and Montana laws related to waiver proposals.

Waiver Types

Waivers are named for the section of Medicaid law that authorizes them. They provide specific exemptions from federal requirements, as follows:

- Section 1115 waivers allow for research or demonstration projects that test new or alternative policy approaches. They give states flexibility in a variety of ways, from expanding Medicaid to new populations to trying new service delivery systems. The proposed changes must be cost neutral to the federal government.

- Section 1915(b) waivers allow states to put managed care systems into place or otherwise limit enrollees' choice of Medicaid providers. States may waive requirements that similar services be offered statewide, that services be comparable, or that patients have freedom of choice among providers. The waivers may not be used to expand the Medicaid program to people who would not otherwise be eligible.

- Section 1915(c) waivers allow states to use Medicaid to pay for long-term care services in community settings rather than institutional settings. These waivers are also known as Home and Community-Based Services, or HCBS, waivers. They allow states to offer services in specific areas, rather than statewide; to provide services only to targeted individuals, rather than to all Medicaid enrollees; or to make exceptions to income and resource rules. States may limit the number of enrollees served in an HCBS program.

Waivers in Montana

Montana has obtained several waivers for its Medicaid program, as follows:

- a Section 1115 waiver to provide mentally ill adults with basic Medicaid benefits and to provide services to up to 800 individuals with schizophrenia or bipolar disorder who previously were eligible for the Mental Health Services Plan, which is funded solely with state general fund dollars;

- Section 1915(b) waivers for three primary care case management programs — Passport to Health, the Health Improvement Program, and Team Care; and

- several HCBS waivers that allow the state to provide:

  - intensive services to autistic children who are 15 months to 7 years of age;

  - home- or community-based services for developmentally disabled adults as an alternative to residential care at the Montana Developmental Center in Boulder;

  - services to individuals who would otherwise be placed in a nursing facility or hospital; and

  - community-based services to some adults with a severe disabling mental illness who meet the criteria for nursing home level of care.

Montana Laws Governing Waiver Proposals

Montana law creates certain requirements for Section 1115 waiver proposals. It also creates public and legislative review requirements for various types of waiver requests.

Section 53-2-215, MCA, specifies the types of services and individuals that a Section 1115 waiver may cover. It also requires that before submitting an 1115 proposal to the federal government, the Department of Public Health and Human Services (DPHHS) must:

- provide notice of the proposal and its general purpose;

- present the proposal to "the appropriate Medicaid advisory council";

- present the proposal to the House Appropriations Committee, if the Legislature is in session, or the Children, Families, Health, and Human Services Interim Committee;

- allow for a minimum 60-day public comment period; and

- make all information related to the waiver available on its Web site.

If a waiver application is approved, DPHHS also most provide information about the waiver to the appropriate legislative committee and report on the waiver's status to future legislatures.

In 2011, the Legislature extended the public notice, public comment, and legislative presentation requirements of 53-2-215 to any type of waiver proposal that would create a capitated managed care system. The change was made with passage of Senate Bill 351.

And 53-6-116, MCA, requires proposals for any type of managed care system to be submitted to the Legislative Finance Committee for review and comment.