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A PROPOSAL TO PROVIDE HEALTHCARE SERVICES TO UNINSURED LOW-INCOME MONTANANS THROUGH AN 1115 MEDICAID WAIVER

Prepared by

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I. MONTANA 1115 WAIVER PROPOSAL EXECUTIVE SUMMARY

Background on Medicaid HIFA Waivers: For a number of years the federal government has employed the Medicaid 1115 Demonstration Waiver as a vehicle through which to enable states to experiment with new ways of delivering healthcare services. The Health Insurance Flexibility and Accountability (HIFA) Waiver is a new version of the existing1115 Demonstration Waiver authority that gives states greater flexibility in designing Medicaid funded healthcare coverage for low-income people who are uninsured and not currently eligible for full Medicaid healthcare benefits. Unlike the case with most of the Medicaid program, HIFA does not create an entitlement to services for eligible individuals. States can (and do) place an upper limit on both the number people served and the total dollars spent on services under the waiver. In addition to providing greater coverage flexibility, HIFA requires that each waiver outline a strategy for exploring ways to better coordinate publicly funded coverage with private insurance. States can meet the coordination requirement by offering individuals who enroll in the waiver the option to receive assistance with paying monthly premiums for health insurance available through their employer rather than receiving direct public benefits. States are permitted to use HIFA to finance certain existing state-funded healthcare benefits as long as any savings are reinvested in expanded healthcare coverage for low income people who are uninsured. All 1115 Demonstration Waivers, including HIFA waivers, are subject to a "cost neutrality test" requiring that federal expenditures for services provided through the waiver are less than or equal to the projected cost of services to the federal government without the waiver. In addition to the requirement to be cost neutral, states must also negotiate an upper limit on the annual rate of growth of the average per person Medicaid expenditure for those individuals covered during the five-year life of the waiver. The federal government will not participate in any of the cost for services provided to the waiver groups that is above the limit set by the caps. The caps apply only to the groups included in the waiver and in no way limit federal Medicaid expenditures on services provided to eligibility groups that are not included in the waiver.

Highlights of Montana's HIFA Waiver Proposal: The Department of Public Health and Human Services (DPHHS) is preparing the outline of an 1115 HIFA waiver proposal for consideration by the 2005 Montana Legislature. At the heart of the Department's proposal is a plan to free-up state money by using the Medicaid waiver to finance a program of mental health services that is currently state-funded. The plan then reallocates the state's savings to provide Medicaid funded healthcare benefits to several thousand low-income Montanans who are currently uninsured. If the concept is approved by the Legislature, a formal waiver proposal will be developed and submitted to the federal government early in state fiscal year 2006, with a target date for implementation of no later than July 1, 2006.

Important Note: Unfortunately, some people are concerned about the prospect of seeking an 1115 HIFA waiver because of the actions taken by some other states to reduce services to existing Medicaid eligibility groups, or increase cost the sharing requirements for the current Medicaid eligible population, as part of their HIFA waivers. While it is true that the federal government has allowed some states to include those kinds of provisions in their waivers, states are not required to do so, and the DPHHS waiver proposal does not make such changes. Montana's waiver proposal would have no negative impact on existing Medicaid eligibility groups or services. No person or group of people currently eligible for Medicaid in Montana would lose their eligibility because of HIFA. There would be no reduction in the type or amount of services provided to people who are currently eligible for the Montana Medicaid program because of HIFA. The important point to

remember is that each HIFA waiver is unique and must be judged on its own merits. A healthcare advocate probably put it best when she said, "If you've seen one HIFA Waiver, you've seen one HIFA Waiver."

The key components of Montana's proposed waiver include:

1. Funding the Mental Health Services Plan with Medicaid: The proposal secures Medicaid financing for a portion of the state-funded Mental Health Services Plan (MHSP) that currently provides mental health services and pharmacy benefits to approximately 2,200 people per month who have a Severe Disabling Mental Illness (SDMI) but are not eligible for Medicaid. In addition to the existing MHSP mental health services and drug benefit, the waiver will provide MHSP participants who do not have health insurance with the opportunity to choose among three physical healthcare benefit options, including: assistance with the cost of the monthly premium of employer based insurance; payment of the monthly premium for private individual insurance policies; or Medicaid fee-for-service benefits of up to $2,000 per person per year. The uninsured MHSP recipients will receive education and assistance in choosing the most appropriate coverage option given their needs.

2. Using the Savings Created by Funding MHSP with Medicaid to Cover the Uninsured: The Department proposes to use the savings realized from securing Medicaid funding of the Mental Health Services Plan as state match to provide a variety of Medicaid funded healthcare benefit packages designed to address the healthcare needs of several thousand low-income uninsured Montanans, from three different groups. The waiver proposal includes two physical healthcare options: one for children and one for adults. In addition to physical healthcare, the waiver will provide an enhanced mental healthcare benefit designed specifically to meet the needs of SED youths. The actual healthcare benefit packages, and the groups and number of people served under the waiver may change as a result of action by the Legislature and/or the negotiations with the federal government. Currently, the proposed uninsured groups and their individual coverage include:

Proposed Group	Proposed Coverage
●Up to 1,800 uninsured children from families whose incomes are under 150% of FPL.	● A Medicaid funded healthcare benefit that is identical to the one provided by CHIP.
●Up to 300 Seriously Emotionally Disturbed youths, ages 18 through 20, who have incomes under of 150% of FPL, are in transition from children's mental health services and are no longer eligible for Medicaid due to their age.	●Up to three years of a Medicaid funded healthcare benefit that is identical to the one provided by CHIP and a set of specialized transitional behavioral health services designed to meet the needs of this group.
●Up to 600 working parents with incomes under 133% of FPL who are no longer eligible for Medicaid themselves, but whose children continue to be enrolled in Medicaid. Most of the parents are in transition from TANF.	●The choice of one of the same three Medicaid funded physical healthcare options available to MHSP recipients, as described earlier in this document.

3. Funding Montana Comprehensive Health Authority Premium Assistance with Medicaid: DPHHS is working with the staff of the State Auditor's Office to include a provision in the waiver that will provide Medicaid funding for a portion of the existing state-funded Montana Comprehensive Health Association (MCHA) Premium Assistance Program. MCHA Premium Assistance is a source of health insurance for people who have serious medical conditions that cause them to be denied coverage by private health insurers and whose incomes are under 150% of FPL. The savings realized from the Medicaid financing of MHCA would be reinvested in the program to maintain the long-term viability of MCHA Premium Assistance, reduce the program's waiting list, and maintain or increase the level of premium assistance to individual MCHA participants.

4. Developing and Implementing a Medicaid Premium Assistance Pilot Program: In order to meet the HIFA requirement that states pursue ways to better coordinate publicly funded healthcare with private insurance, DPHHS will include a provision to develop and implement a Medicaid Premium Assistance pilot program as part of the waiver. The pilot will measure the impact of providing members of one or more of the HIFA waiver groups with the option to choose to receive assistance with paying the cost of the monthly premium for health insurance that is offered through their employer rather than enrolling in the direct coverage available to their eligibility group under the waiver.

5. Meeting the Waiver Cost Neutrality Requirement: Since 1996 Montana has provided a slightly different package of Medicaid optional services, including a reduced set of dental services, to healthy adults who are enrolled in the TANF program. The policy was implemented through a series of federally approved Medicaid waivers, most recently through an 1115 Demonstration Waiver (a.k.a. the "Basic Medicaid Waiver for Able-Bodied Adults") that was approved in February of 2004. In order to meet the requirement that 1115 waivers be cost neutral to the federal government, the Department will propose that the cost saving provisions of Montana's existing 1115 Basic Medicaid Waiver for Able-Bodied Adults be incorporated into the HIFA waiver. Such a change will enable Montana to use the savings that are currently realized through the existing waiver to offset the increases in cost to the federal government that will result from the expanded services that are called for in the HIFA proposal. The consolidated waiver will provide access to additional federal funding with which to provide healthcare to uninsured low-income Montanans, and do so without the need to resort to additional benefit reductions or other unpopular cost savings measures in order to meet the federal cost neutrality test. The integration of the existing savings with new expenditures could be accomplished either through an amendment of the existing Basic Medicaid Waiver, or as part of a new stand alone 1115 Demonstration waiver.

6. Adopting Mechanisms to Maintain Control of Waiver Spending: The proposal will include limits on the numbers of people served in the waiver and the maximum amount of money the state is obligated to spend on benefits to the eligibility groups covered under the waiver. The proposal will also detail the steps the state may take to reduce expenditures should it appear that there is a risk of exceeding the spending or enrollment limits.

7. Negotiating Reasonable Expenditure Caps: The critical final step in the federal waiver approval process is the negotiation of an average annual per person limit on the growth of expenditures for the eligibility groups covered under the waiver. The Department will ensure that any budget

growth caps required by the federal government are set at reasonable levels that do not expose the state to an unacceptable risk of overspending, and the potential loss of federal funding for expenditures above the budget caps. Montana's existing Basic Medicaid Waiver includes caps of 7.7% per year. The projected annual expenditure growth rate for the adults currently covered under the Basic Medicaid Waiver is about one-half of the 7.7% permitted by the waiver cap for this group. While the potential to provide a significant number of uninsured Montanan's with healthcare benefits is very appealing, if in the end the federal government seeks to impose limits on average growth in expenditures or other requirements that expose Montana to an undue financial risk, the Department will withdraw it's waiver proposal and maintain the existing MHSP services as currently funded.

Total Impact of Montana's HIFA Proposal: If approved by the Montana Legislature and the federal government, the proposed waiver would produce almost $11.0 million dollars per year in additional federal revenue with which to provide Medicaid funded healthcare benefits to several thousand low-income uninsured Montanans. It would do so without creating an open-ended entitlement to services and without the need for the additional state funding beyond the levels that are currently appropriated to the MHSP and MCHA programs. The waiver would also free up state dollars for use as match to fund one-time enhancements to the Medicaid Management Information System (MMIS), some of which are required in order to implement the waiver.

Additional Changes to the Waiver Proposal are Likely to Occur: The proposal outlined in this document reflects the evolution of the Department's thinking over the past year regarding the potential for developing and submitting a Medicaid 1115 Demonstration Waiver for Montana. The proposal has changed substantially during that time. While some of the changes reflect a better understanding of HIFA, the majority of the modifications are the product of an effort by the Department to meld the many values and interests of the groups with a potential stake in this project into a coherent waiver proposal that is both creative and fiscally accountable. It is likely that the waiver will continue to evolve. For example, in the normal course of business it would be reasonable to expect that the Legislature might propose additional changes to the waiver as a result of its deliberations. The probability of changes to the waiver proposal has increased with the passage of Initiative 149. Because some of the potential waiver services and target populations, such as low-income children, are also addressed by I-149, it will be important that the Department and the Legislature ensure that the services funded through an 1115 Waiver, and the new I-149 healthcare expenditures, complement each other.

II. BACKGROUND

Challenge of Providing Healthcare Coverage to the Uninsured:

The large number of citizens without access to public or private healthcare coverage is a vexing problem in states across the county, including ours. A survey of Montana households conducted in 2003 as part of the activities of the Montana State Planning Grant found that 173,000 Montanans, 19% of the state's total population, had no public or private health insurance. At the time of the survey 17% of Montana children were uninsured, one of the highest rates in the U.S. One of the most disturbing findings was the large number of Montanans who were working, but were uninsured either because their employers did not offer health insurance, or the available group or individual coverage was too expensive. For example, forty-three percent of surveyed households with incomes

between 125% and 150% of the Federal Poverty Level (between $22,625 and $27,150 per year for a family of four) did not have health insurance. People seeking ways to provide affordable healthcare to low-income citizens often look to government for the answer. In the past, efforts to address the issue of the large number of uninsured Montanans have included proposals to extend the reach of existing state and federally funded healthcare programs such as Medicaid and the Children's Health Insurance Program (CHIP). When contemplating expansions of Medicaid or CHIP the unique characteristics of each program must be understood in order to make informed policy decisions regarding potential changes to the programs.

Covering the Uninsured through Traditional Medicaid:

Medicaid, a jointly funded state and federal program that is administered by the states, is the primary source of publicly funded healthcare for low-income families with children, people with disabilities and the elderly. Each state participating in the Medicaid program is required to fund a percentage of Medicaid expenditures with state matching dollars. The matching percentage varies by state, based on a federal formula related to changes in average per capita income. Montana's Medicaid matching requirement is relatively low compared to other states, with the federal government paying approximately $.70 of every dollar spent on Medicaid services. While Medicaid specifies a set of mandatory services that must be provided, and eligibility groups that must be served, states have the discretion to add other services, and the option to make more groups of low-income people eligible for the program. However, once a state elects to add an optional eligibility category to its Medicaid program *every person* determined to meet the eligibility criteria for the new group is *entitled to receive all of the Medicaid services* offered by the state for which they have a medical necessity, regardless of the availability of state funding.

The option to extend Medicaid eligibility to additional groups of low-income people, coupled with our state's attractive matching rate, have made expanding Medicaid coverage the subject of many discussions concerning strategies to reduce the number of Montanans without health insurance. Attempts to increase the availability of healthcare coverage by expanding access to the traditional Medicaid program have met with limited success. Most states, including Montana, have been reluctant to add additional Medicaid eligibility groups due, in part, to recent experiences with rapidly increasing Medicaid expenditures, coupled with what seem to be perpetually tight state budgets and persistent revenue shortfalls. Even in better fiscal times, the all or nothing entitlement nature of Medicaid has proven to be a barrier that inhibits the use of the program as a vehicle to provide expanded healthcare. Many policy makers believe that intentionally increasing the number of people eligible for Medicaid has a high probability of producing expenditures that far exceed the estimates on which the original policy initiative and budgets are based. They also know that should Medicaid budget deficits loom they will face the choice of spending additional money that the state may not have, or making painful and unpopular reductions in the quality and quantity of services.

Covering the Uninsured through the CHIP program:

Recent efforts to bring affordable healthcare within the reach of uninsured people with low incomes have focused on the expansion of the Children's Health Insurance Program (CHIP), the jointly funded state and federal program that provides health insurance to low-income uninsured children. CHIP provides comprehensive healthcare coverage, including services such as physician, lab and x-ray, hospitalization, pharmacy and dental. Unlike the Medicaid entitlement, the federal funding for

CHIP comes through an annual capped grant award to each state. In addition to the annual grant award, states may also be eligible to receive a periodic redistribution of a portion of any unexpended funds from the CHIP grants made to other states. Currently, there are over 11,000 children from families with incomes under 150% of the Federal Poverty Level (FPL) enrolled in Montana's CHIP program, at a total annual cost of $16.5 million dollars (FY2004), twenty-percent of which consists of state matching funds. In addition to its obvious value as a source of funding for badly needed healthcare services, one of the most appealing features of the CHIP program from the perspective of state and federal policy makers is the fact that, unlike Medicaid, states are permitted to cap enrollment and clearly limit the amount of money they are obligated to spend on the program. While there continues to be a good deal of interest in, and support for, increasing the number of children covered under CHIP in Montana, the lack of the required 20% state match, coupled with uncertainty regarding the exact level of additional federal grant funds that will be available in the future, have restrained efforts to cover more children by expanding CHIP. While the primary mission of CHIP is clearly to provide a source for healthcare for children from families with low-incomes, federal regulations give states the option to cover parents of children who are enrolled in CHIP as well. If states choose to cover parents in CHIP, federal regulations require that they must then enroll all eligible children who apply. For those seeking ways to provide healthcare coverage for young adults, Montana's age group with the highest percentage of people who do not have insurance, a policy decision to extend eligibility for CHIP to even a small number of parents is very attractive, especially in light of the 80/20 federal and state matching ratio. While the logic behind such a policy may be compelling, the fact that it effectively removes the state's ability to cap enrollment in CHIP would eliminate one of the characteristics of the program that is most appealing to many policy makers.

III. HEALTH INSURANCE FLEXIBILITY AND ACCOUNTABLITY WAIVERS

New Coverage Options Available For The Uninsured Through HIFA Waivers:

Health Insurance Flexibility and Accountability Waiver (a.k.a. HIFA) is a new type of Medicaid 1115 Demonstration waiver that enables state to provide Medicaid funded healthcare to additional groups of low-income people without some of the concerns regarding the Medicaid program requirements that have restricted such expansion in the past. The HIFA waiver program is not the product of a new piece of legislation, but rather a policy initiative by the federal Centers for Medicare and Medicaid Services (CMS) the purpose of which is to encourage states to explore creative ways to expand private and/or public healthcare coverage through proposals that go beyond the all or nothing approach that inhibits the use of traditional Medicaid as a vehicle to address unmet healthcare needs. HIFA places special emphasis on expanding healthcare coverage to currently uninsured individuals with incomes under 200% of the Federal Poverty Level.

While much of what HIFA does is theoretically available under the existing federal 1115 Demonstration Waiver authority, the promotion of this new policy option, with its submission guidelines and expedited review process, sends a clear signal to the states that CMS is open to, and encouraging, proposals that increase the availability of healthcare through the development of unique new benefit packages for optional and non-traditional Medicaid eligibility groups. While Medicaid law currently allows states to provide an extensive array of medical services to a wide variety of eligibility groups, it almost always requires that *all* of the members of each eligibility group receive *all* of the medically necessary services offered by the state's Medicaid program.

Detailed Overview of Medicaid HIFA Waiver Option:

New Flexibility Under HIFA – Among the noteworthy features of the new policy option is the flexibility it gives states to:

1. Design alternative Medicaid benefit packages to meet the unique healthcare needs of some existing and new eligibility groups;

2. Require increased cost sharing for some eligibility groups (e.g. premiums, deductibles and co-payments);

3. Limit or cap the state's financial obligation for services to new eligibility groups; and

4. Provide waiver participants with the option to receive financial assistance to help with the purchase of private insurance that is offered through their employer rather than receiving direct public benefits.

Mandatory Benefits and Eligibility Groups: HIFA *does not allow* states to adjust the benefits or eligibility of the mandatory eligibility groups (low-income aged, disabled, children, etc.) that states are *required* to serve under the Medicaid state plan. HIFA does, however, identify two groups whose benefit packages may be adjusted with a waiver from CMS. They are:

1. Optional Populations: These are waiver eligibility groups that states have the option to cover under Medicaid or "CHIP", *regardless of whether or not they are currently covered.* Examples of potential Optional Populations under a waiver include parents and children with incomes above the federal minimums for Medicaid eligibility. "CHIP" children and their parents are also considered optional populations.

2. Expansion Populations: Expansion Populations are those low-income individuals who are members of groups that are never eligible for coverage under the existing Medicaid or "CHIP" programs. Low-income childless adults are an example of a potential waiver Expansion Population that could never be eligible for Medicaid without a waiver.

Flexible Benefit Packages: States can alter the benefit package offered to the Optional and Expansion eligibility groups included in a waiver. HIFA specifies that benefits for Optional Populations must minimally include hospital, physician, laboratory and x-ray, and well-baby and well-child services. It does not mandate a specific level for these services. Benefits for Expansion Populations must only include basic primary care services from physicians. HIFA allows for increased cost sharing for both the Optional and Expansion Populations in the form of larger co-payments, deductibles and/or premiums.

Cost Neutrality: As is the case with all Medicaid waivers, states must demonstrate that federal expenditures under the proposed waiver will be less than or equal to federal expenditures without the waiver. The state must also demonstrate that the additional cost of serving any proposed Expansion Population will be offset in one of the following three ways:

1. Offsetting Savings - Savings achieved from providing reduced benefits package(s) to existing, *or future*, optional eligibility groups may be used to offset additional spending for new services provided under the waiver;

2. Unused Federal "DSH" Spending Authority – Excess federal Disproportionate Share Hospital (DSH) spending authority may be used to cover the federal share of the additional spending for new services provided under the waiver; and

3. Unused federal "CHIP" Allocation - States may choose to apply any unused portion of their federal SCHIP allocation to offset the federal share of spending for new services provided under the waiver, even if the expenditures are for services to eligibility groups that are not ordinarily eligible for CHIP.

Optional Populations meet the waiver cost neutrality test as long as the average cost to Medicaid for all of their services while enrolled in the waiver is less than the amount Medicaid would have spent had the state exercised its "hypothetical option" to adjust its eligibility standards in order to make all of the members of that Optional Population eligible for Medicaid, and therefore entitled to all of the services provided by the traditional Medicaid program.

Maintenance of Effort Requirement: The waiver may not be used to simply refinance existing state healthcare programs. States wishing to use HIFA to fund services they already provide under state financed healthcare programs will be subject to a Maintenance Of Effort (MOE) requirement. The MOE requires that states maintain their current level of spending on any existing state program that is included in a HIFA Waiver. While states are required to maintain the level of state spending that existed prior to a program's inclusion in the waiver, HIFA does not require that all of the money continue to be spent in the same state program. States have the flexibility to redistribute those dollars as long as they are used to purchase healthcare benefits for low-income people who are uninsured. The MOE precludes states from employing schemes that seek to use HIFA waivers as a vehicle through which to secure Medicaid refinancing for state healthcare programs and then using the savings for purposes other than to increase the number of low-income people with healthcare benefits.

Limits on the Growth of Average Per Person Expenditures for Waiver Groups: One of the federal requirements for securing the approval of all 1115 Waivers, including HIFA waivers, is the negotiation of expenditure limits, or growth caps, for each of the Medicaid populations covered by the waiver. Each mandatory or optional eligibility group included in the waiver is a separate Medicaid Eligible Group or "MEG." The expenditure limits are expressed as an average cost of Medicaid services Per Member Per Month (PMPM) for each waiver MEG. The use of an average cost per month rather than average cost per year is intended to control for the impact of people who are enrolled in the waiver for less than a full 12 months in a single year. The PMPM amount for a waiver MEG for any given year is computed by dividing the total Medicaid expenditures for services to that group during that year by the total number of months in which the members of that MEG were eligible for services. It is not necessary that a person receive services in a month, just that they be eligible to receive them. The following is a formula for computing the average PMPM cost for a waiver MEG:

The Average PMPM for MEG #1 for a waiver year is equal to "A" divided by "B" where: