MONTANA LEGISLATIVE BRANCH

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MEDICAID WAIVERS IN MONTANA

About Medicaid Waivers – General Information

Under federal Medicaid law, Medicaid waivers are a provision to grant flexibility in the implementation of state Medicaid programs by allowing individual states to forgo various federal requirements. Waivers require lengthy applications and must be renewed periodically; however, they allow individual states to experiment with and implement certain programs in order to reach goals such as reducing cost, expanding coverage, or improving care.

States most commonly seek to waive the statutory principles of:

> 1902(a)(10)(B) — Comparability: Medicaid-covered benefits must be provided in the same amount, duration, and scope to all enrollees. These waivers allow states to limit an enhanced benefit package to a targeted group of persons identified as needing it most and to limit the number of participants to implement a demonstration on a smaller scale.
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> 1902(a)(23) — Freedom of Choice: Beneficiaries have the choice of any provider participating in the Medicaid program. Typically, these waivers are used to allow the implementation of managed care programs or better management of service delivery.
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> 1902(a)(1) — Statewide Applicability: Enrollees or providers are not allowed to be excluded from the Medicaid program because of where they live within the state. These waivers can limit the geographic area in which a new program is tested, allow for a phased-in program implementation, or reduce state expenditures by limiting eligibility.

In order to get these waivers approved, states must meet certain budgetary criteria and provide regular reports to and undergo evaluations by the Centers for Medicare and Medicaid Services (CMS) showing that the waiver requirements are being met.

Types of Waivers

1915(b)

These are typically referred to as managed care waivers. These waivers are used by states to provide services through managed care delivery or otherwise limit participant choice of providers.
There are four types of 1915(b) waivers:

- (b)(1) Freedom of Choice – allows a state to restrict Medicaid enrollees from receiving services within the managed care network
- (b)(2) Enrollment Broker – utilizes a "central broker," or single provider
- (b)(3) Non-Medicaid Services Waiver – uses cost savings to provide additional services to beneficiaries
- (b)(4) Selective Contracting Waiver – restricts the provider from whom the Medicaid population may obtain services

1915(c)
These are typically referred to as Home and Community-Based Services (HCBS) waivers. These waivers are used to keep people in community placements as opposed to institutional settings.

1115 Demonstration
These are typically referred to as research and demonstration waivers. They are intended to allow states to experiment with how best to cover and deliver healthcare for Medicaid and Children's Health Insurance Program (CHIP) recipients. The purpose of these demonstrations is to give states flexibility to design and improve their programs and evaluate policy approaches such as:

- Expanding eligibility to individuals who are not otherwise Medicaid or CHIP eligible
- Providing services not typically covered by Medicaid
- Using innovative service delivery systems that improve care, increase efficiency, and reduce costs

The Approval Process Across Waivers

	§1115	§1915(b)	§1915(c)
Format	Use of CMS preprint form recommended	Use of CMS preprint form required	Use of CMS preprint form recommended
Public review	Robust public process required, with additional requirements added by the ACA	Public process encouraged; tribal input required	Public process encouraged; tribal input required
Federal budget requirements	Budget neutrality required	Cost effectiveness required	Cost neutrality required
Timeframe for approval	No required timeframe for CMS approval	90-day clock	90-day clock
Monitoring and evaluation	Annual state reports required; evaluations required	Must monitor access; independent assessment required	Annual state reports required
Approval period	Initially approved for five years	Initially approved for two years (up to five years if individuals dually eligible for Medicare and Medicaid are included)	Initially approved for three years (up to five years if individuals dually eligible for Medicare and Medicaid are included)
Renewal	Customarily up to three years (up to five years if individuals dually eligible for Medicare and Medicaid are included)	Customarily up to two years (up to five years if individuals dually eligible for Medicare and Medicaid are included)	Customarily up to five years

1 Table provided by www.macpac.gov

ACTIVE MEDICAID WAIVERS IN MONTANA

Montana has three active federal waiver types including 1915(b), 1915(c), and 1115. Montana's active Medicaid waivers are listed below by waiver name and federal authority, along with a brief description of services offered by each waiver.

Waiver for Additional Services and Populations (WASP) – 1115

Provides health coverage for up to 3,000 waiver mental health service plan (WMHSP) beneficiaries ages 18 and older and diagnosed with a severe disabling mental illness (SDMI) who qualify for or are enrolled in the state-financed Mental Health State Plan program. These beneficiaries with SDMI are otherwise ineligible for Medicaid by either having an income between 133.0%-150.0% of the federal poverty level (FPL), or by having an income at or below 133.0% of the FPL but are eligible for or enrolled in Medicare. Montana provides a full state plan benefit package to WMHSP beneficiaries in the demonstration. Beneficiaries who fall within the aged, blind, and disabled (ABD) category receive unlimited dental services above the state plan's current $1,125 dental services annual limit.

Montana Big Sky (Elderly and Physically Disabled) – 1915(c)

Provides adult day health and habilitation; case management, independence advisory, supported employment, supported living, family training and support; prevocational services, dietetic services, financial management services; adult foster care, homemaker chore, respite, consumer goods and services; community supports, community transition, community adult group homes, community first choice/personal assistance and specially trained attendant care; consultative clinical and therapeutic services, environmental accessibility adaptations, health and wellness, nutrition, audiology, pain and symptom management; level 1 assisted living, level 2 assisted living, level 3 assisted living; speech therapy, respiratory therapy, occupational therapy, physical therapy; personal emergency response systems, post-acute rehabilitation services, private duty nursing, senior companion, non-medical transportation; specialized child care for medically fragile children, specialized medical equipment and supplies, and vehicle modifications for aged individuals 65+ and individuals with physical disabilities and other disabilities ages 0 – 64 years.

An additional waiver was approved for the renewal of this program to serve 2,580 members in waiver years one through five.

MT Home and Community-Based Waiver for Individuals with Developmental Disabilities (0208) – 1915(c)

Provides day supports and activities; homemaker, residential habilitation, respite; occupational therapy, physical therapy, speech therapy; private duty nursing, supports brokerage, adult foster support, assisted living, caregiver training and support; nutritionist services, retirement services, community transition services, companion services, behavioral support services, individual goods and services; environmental modifications, meals, personal care, personal emergency response system (PERS), personal supports; psychological evaluation, counseling and consultation services; remote monitoring and equipment, specialized medical equipment and supplies; supported employment - follow along support, co-worker support, individual employment support, and small group employment support; and transportation for individuals of all ages.

Severe and Disabling Mental Illness (SDMI) – 1915(c)

Provides adult day health, case management, residential habilitation, respite, supported employment, behavioral intervention assistant, community transition, consultative clinical and therapeutic services, environmental accessibility adaptations, health and wellness, homemaker chore, life coach, meals, non-medical transportation, pain and symptom management, personal assistance service, personal emergency response system, private duty nursing, and specialized medical equipment and supplies for individuals with mental illness ages 18+.

An additional waiver was approved in congruence with the original SDMI to extend the program and increase the members able to be served. The number of unduplicated members able to be served increased from 357 to 600 in waiver year one, 650 in waiver year two, and 750 in waiver years three through five.

MT Plan First Family Planning Demonstration – 1115

Provides family planning services to women statewide who are Montana residents ages 19 through 44 with income up to and including 211.0% of the federal poverty level and not otherwise eligible for Medicaid, able to bear children, and not presently pregnant. Some of the services covered include office visits, contraceptive supplies, laboratory services, and testing and treatment of sexually transmitted diseases (STDs). The program is capped at 4,000 members.

MT Passport to Health – 1915(b1), 1915(b2), 1915(b4)

Provides primary care case management (PCCM) services for Montana Medicaid and Healthy Montana Kids (HMK) *Plus* members. These services include locating, coordinating, and monitoring primary healthcare services. They work closely with other care coordination programs such as the *Nurse Advice Line* (Nurse First), *Team Care*, and *Health Improvement Program* (HIP).

Montana Healing and Ending Addiction Through Recovery and Treatment (HEART) – 1115

Provides enhanced access to mental health services, opioid use disorder (OUD), and other substance use disorder (SUD) services. It also provides a comprehensive continuum of behavioral health services and SUD treatments to Medicaid beneficiaries with SUD who would otherwise be ineligible for payment. This demonstration grants the state authority to provide high quality, clinically appropriate treatment to beneficiaries with SUD while they are short-term residents in residential and inpatient treatment settings that qualify as an institution for mental disease. It also supports state efforts to link individuals with the appropriate level of care, improve the availability of Medication Assisted Treatment (MAT), and improve access to a continuum of SUD evidence-based services at varied levels of intensity, including withdrawal management services.