MEDICAID WAIVERS

State Medicaid programs may request from the Centers for Medicare and Medicaid Services (CMS) a waiver(s) of certain federal Medicaid requirements that are found in the Social Security Act. A common public misconception is that any portion of the Medicaid program can be waived by CMS. In reality, only certain requirements such as statewideness, freedom of choice, and comparability of eligibility and/or benefits can be waived. Waivers are also limited in that they must always be cost neutral to the federal government.

The following is a brief description of the three types of waivers that Montana operates:

- **Section 1115 waivers** authorize experimental, pilot, or demonstration project(s). The Secretary of Health and Human Services has complete discretion as to whether an 1115 waiver is granted. This kind of waiver is granted only when the Secretary feels that a state will demonstrate something that is of interest in promoting the objectives of the Medicaid program. Our experience has been that CMS approval of these waivers takes several years. An 1115 waiver can be used to expand eligibility for Medicaid. The number and type of services can either be limited or expanded under this type of waiver.

- **Section 1915(b) waivers** allow States to waive statewideness, comparability of services, and freedom of choice. 1915(b) waivers cannot be used for eligibility expansions. There are four 1915(b) Freedom of Choice Waivers available:
  (b)(1) mandates Medicaid enrollment into managed care
  (b)(2) utilize a "central broker"
  (b)(3) uses cost savings to provide additional services
  (b)(4) limits the number of providers for services

- **Section 1915(c) waivers** are referred to as Medicaid Home and Community-Based Services (HCBS) waivers. They are alternatives to providing long-term care in an institutional setting (Medicaid defines an institution as a nursing facility, hospital, or Intermediate Care Facility for the Mentally Retarded.) A 1915(c) waiver enables a state to pay for an expanded array of medical care and support services that assist people to continue to live in their homes and/or communities. These waivers also allow a state, if it wishes, to count only the income of the affected individual rather than that of the whole family when determining eligibility.

- States also have the discretion to provide a combination 1915(b) and 1915(c) waiver.

Montana operates a number of different waivers in order to better customize services for key populations. A brief description of our current waivers is found on the next several pages:

1115 Basic Medicaid Waiver – Health Resources and Addictive and Mental Disorders Division – Approved in 1996, this waiver offers a limited benefit package of services to Medicaid eligible adults, age 21 to 64. Participants cannot be pregnant or disabled, with the exception that is noted below. Participants receive a basic package of Medicaid benefits that excludes: audiology, dental and denturist, durable medical equipment, eyeglasses, optometry and ophthalmology for routine eye exams, personal care services, home infusion and hearing aids. DPHHS recognizes there may be situations where these excluded services are necessary in an emergency situation, when they prevent more costly care, or when they are essential to obtain or maintain employment. In these instances, excluded services may be provided at the State's discretion. Examples of discretionary circumstances include coverage for emergency dental situations, medical conditions of the eye, which include but are not limited to annual dilated eye exams for individuals with diabetes or other medical conditions, and certain medical supplies such as diabetic supplies, prosthetic devices and oxygen.

Effective December 2010, the state received approval for the long-awaited "HIFA" waiver. CMS approved the addition of up to 800 individuals who previously qualified for the state funded Mental Health Services Plan. Eligible participants must be at least 18 years of age and have schizophrenia or bipolar disorder. Under the "MHSP" portion of the Basic Waiver, individuals are eligible to receive medical care as well as psychiatric services. Federal savings generated from the Basic Medicaid Waiver Able Bodied population described above are used to maintain federal cost neutrality.

In SFY 2011 the waiver served a total of 17,848 individuals. 17,512 were Able Bodied Adults and 336 were individuals with schizophrenia or bipolar disorder. SFY 2011 total state and federal waiver expenditures were $26,427,915; $950,396 of this amount was for individuals with schizophrenia or bipolar disorder. In SFY 2012, 898 individuals with schizophrenia or bipolar disease were served.

1115 Plan First Waiver – Health Resources Division - This waiver covers family planning services for eligible women. Some of the services covered include office visits, contraceptive supplies, laboratory services, and testing and treatment of STDs. Eligible women must be:

- Age 19 through 44
- Able to bear children and not presently pregnant
- Have annual household income up to 200% Federal Poverty Level
- Have no other family planning health coverage (i.e. through insurance)

This program is limited to 4,000 women at any given time. CMS notified the department of the approval of this waiver on May 30, 2012 and this waiver is approved through December 31, 2013. 888 women were enrolled as of October 2012.

1915(b) Waiver Passport to Health - Health Resources Division – Passport to Health is the primary care case management program in which most Medicaid and HMK *Plus* eligible individuals are enrolled. A client chooses a primary care provider who delivers all medical services or furnishes referrals for other medically-necessary care.