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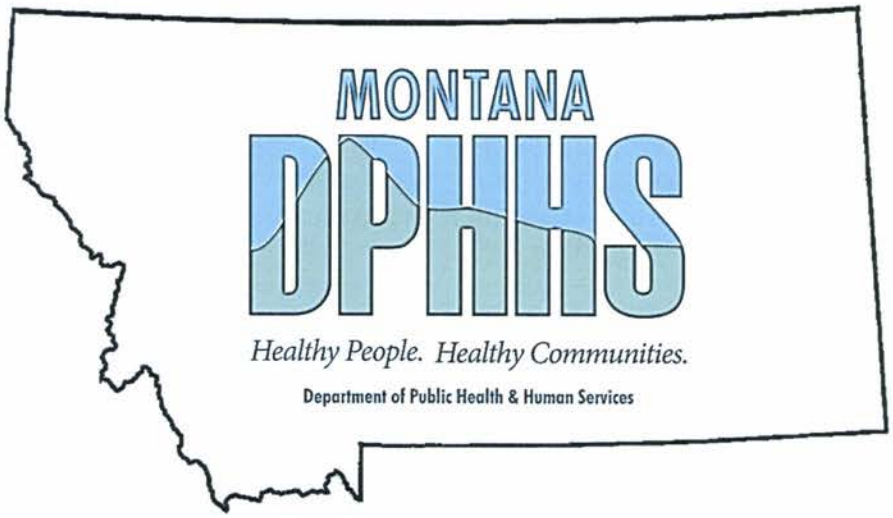
THE MONTANA MEDICAID PROGRAM



Montana Department of Public Health and Human Services Report to the 2015 Legislature

State Fiscal Years 2013/2014

January 5, 2015

The Montana Medicaid Program

Report to the 2015 Legislature

January 5, 2015

Dear Legislators:

The Department of Public Health and Human Services (DPHHS) is pleased to provide the Montana Medicaid Program Report to the 2015 Legislature, as is required by 53-6-110 Montana Code Annotated. This report provides insight into Montana's Medicaid Program and its multiple activities and numerous accomplishments.

Medicaid is a joint federal-state program that pays for a broad range of medically necessary health care services for certain low income populations. (Not everyone who is low income qualifies for Medicaid; you must also meet certain qualifications such as being a child or elderly.) DPHHS administers the program in partnership with the federal Centers for Medicare and Medicaid Services.

Medicaid reimbursed over $1 billion dollars in 2013. Most of these funds were spent in Montana and went to private providers. These funds are a major contributor to the Montana economy and help assure access to services in rural and frontier areas of our state.

Montana Medicaid is the state's largest public/private health care coverage program. It touched the lives of approximately 15% of Montanans in state fiscal year 2013. The majority of Montanans eligible for Medicaid are children; elderly or disabled adults; and pregnant women. Medicaid is the primary (and often the only) payment source for long term care services for the elderly and people with an intellectual disability or a serious mental illness.

This report provides a basic explanation of Medicaid eligibility; benefits; waivers; cost containment and cost avoidance measures; interactions with other payment sources; and rate setting methodologies. It also provides an overview of projected expenditures for state fiscal years 2016 and 2017.

I hope that you find this report useful. If you have any questions, or if we can provide additional information, please contact me at (406) 444-4084 or mdalton@mt.gov. This report is also available on our website at dphhs.mt.gov.

Sincerely,

Mary E. Dalton

Mary E. Dalton
Montana State Medicaid Director

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The Montana Medicaid Program

Report to the 2015 Legislature

The Montana Medicaid Program is authorized under 53-6-101, Montana Codes Annotated, and Article XII, Section 3 of the Montana Constitution. The Department of Public Health and Human Services (DPHHS) administers the program.

Program Mission:

Assure necessary medical care is available to all eligible Montanans within available funding resources.

Goals:

- Improve health outcomes by emphasizing primary care, improving access to services for underserved and vulnerable populations, promoting appropriate utilization of preventive and other necessary services, and reducing the number of uninsured people.
- Provide community-based services as an alternative to institutional care.
- Ensure cost effectiveness in the delivery of health care services by using efficient management practices and maximizing revenue opportunities.
- Assure the integrity and accountability of the Medicaid health care delivery system.
- Implement measures that will constrain the growth in Medicaid expenditures while improving services.

MEDICAID PROGRAM OVERVIEW

The Montana Medicaid program is a joint federal-state program. The State administers the program in partnership with the federal Centers for Medicare and Medicaid Services (CMS). States are required to provide the same amount, duration, and scope of services to all people who receive a Medicaid benefit unless they have a waiver. The State is responsible for determining eligibility for low-income populations including pregnant women, children, individuals with disabilities and the elderly. As a general rule, the Montana Medicaid program has flexibility within certain guidelines established by CMS to: 1) design our own eligibility package; 2) design our own benefit package; and 3) determine provider reimbursement.

Medicaid services are funded by a combination of federal and state (and in some situations, local) funds. In Montana, the matching rate is approximately 66% federal and 34% state funds. Simply stated, if DPHHS receives 34 cents in general funds, the 34 cents becomes a Medicaid dollar. Some Medicaid services receive an enhanced federal match rate such as: services provided by Tribal Health Services at 100% federal dollars; family planning services at 90% federal; and services through the breast and cervical cancer program at 76%. In addition, administrative costs of the State are matched at 50% and data systems are matched at 75%.

MEDICAID ELIGIBILITY

The rules governing Medicaid eligibility changed with the passage of the Affordable Care Act. As of March 2010, a state is ineligible for federal payments if it decreases eligibility for Medicaid below the level in place as of that date. Montana can still choose to add eligibility categories but we cannot decrease either the number of categories/groups that we cover nor can we decrease the level of poverty for existing coverage groups.

The following are the existing groups /populations for whom Montana provides Medicaid coverage.

Children – Healthy Montana Kids is the largest provider of health care coverage for children in the State of Montana. The Healthy Montana Kids Program covers children through Medicaid and CHIP funding. The Medicaid portion of this program is Healthy Montana Kids ***Plus*** and during State Fiscal year 2013, an average of 75,916 children enrolled in Medicaid per month. For State Fiscal Year 2014, an average of 83,306 children were enrolled.

The Children's Health Insurance Program (CHIP) portion of this program is Healthy Montana Kids. In 2013, an average of 23,241 children were covered each month. In 2014, this number rose to an average of 23,441 per month.

Children are covered by Medicaid under one of the following three programs:

- **Healthy Montana Kids *Plus*** - Children up to the age of 19 in families with countable income equal to or less than 143% of the Federal Poverty Level (FPL).

- **Infants** - Children born to women who receive Medicaid at the time of their birth automatically qualify for Medicaid coverage through the month of their first birthday.

- **Subsidized Adoption, Subsidized Guardianship and Foster Care** – Children, eligible for an adoption or guardianship subsidy through the Department, are automatically eligible for Medicaid coverage. This coverage may continue through the month of the child's 21st birthday. Children, placed into licensed foster care homes by the Child and Family Services Division, are also Medicaid eligible.

Pregnant Women – Medicaid is provided to eligible pregnant women with countable income equal to or less than 157% FPL. The coverage extends for 60 days beyond the child's birth.

2014 Federal Poverty Levels & Gross Monthly Income		
Family Size	Pregnant Woman 157% FPL	Child 143% FPL
1	$1,528	$1,391
2	$2,058	$1,875
3	$2,589	$2,358
4	$3,121	$2,843
Resource Test	No Test	No Test

Families with Dependent Children – Parents or related caretakers (grandparents, aunts/uncles, etc.) whose countable income is below the Family Medicaid income level (approximately 47% FPL or $916/month earnings for family of four) may receive Medicaid. TANF cash assistance eligibility is determined separately from Medicaid.

Family-Transitional Medicaid - Under certain conditions, families are eligible for up to 12 months of extended Medicaid coverage after their Family Medicaid eligibility coverage ends due to new or increased earned income. Family-Transitional Medicaid coverage is not dependent on income, and there is no resource limit. The family must meet all other eligibility criteria for the entire 12 months.

Aged – Individuals, age 65 or older, may be eligible for Medicaid if their countable income is within allowable guidelines and their resources do not exceed $2000 for an individual or $3000 for a couple.

Blind/Disabled – Individuals may be eligible for Medicaid if determined blind or disabled using Social Security criteria, and if their income is within allowable limits and their resources do not exceed $2000 for an individual or $3000 for a couple.

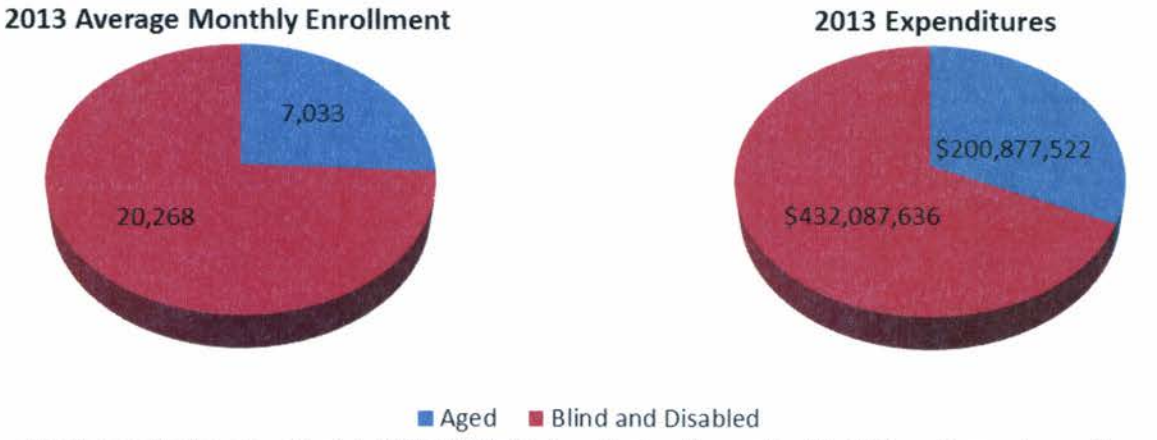
Income limits for the aged, blind and disabled populations are $721 per month for an individual and $1,082 for a couple.

People Who Are Aged, Blind, or Disabled and Receive Supplemental Security Income (SSI)

In Montana, under an agreement with the Social Security Administration, any individual determined eligible for Supplemental Security Income (SSI) receives Medicaid. These individuals with low income are aged, blind, or disabled and make up a large group within the Medicaid program. Many of these clients live alone and struggle to maintain independence despite health conditions requiring regular medical attention. New SSI monthly income standards for 2014 are $721 per month for an individual and $1,082 for a couple.

2014		
Family Size	Resource Limit	Monthly SSI Income Limit
1	$2,000	$721
2	$3,000	$1,082

Enrollment and Expenditure Comparison Aged and Blind / Disabled



Note that graphs above do not include HMK (CHIP), Medicare Savings Plan, or Plan First Waiver clients and expenditures.

Breast and Cervical Cancer Treatment - This program is for women diagnosed with certain breast or cervical cancer or pre-cancerous conditions of the breast or cervix. An eligible woman must be under 65 years old, not have insurance considered to be 'creditable coverage,' meet citizenship or qualified alien requirements, be a Montana resident, and have been screened through the Montana Breast and Cervical Health Program. Countable income cannot exceed 200% of the Federal Poverty Level and there is no resource test.

Montana Medicaid for Workers with Disabilities (MWD) – Montana implemented MWD effective July 1, 2010, based on provisions of the Balanced Budget Act of 1997 (BBA). MWD allows certain current and former Social Security Disability Insurance (SSDI) and SSI recipients who are not financially eligible for Medicaid to pay affordable premiums in order to receive Medicaid coverage. Individuals must be employed (either through an employer or self-employed) to be considered for this program. MWD resource and income standards are

significantly higher than many other Medicaid programs: $8000 for an individual and $12,000 for a couple; while the countable income limit is 250% of the Federal Poverty Level.

Medically Needy – This is coverage for certain individuals or families whose income exceeds the program standards but who have a significant medical need. The individual or family pays the difference between their countable income and the Medically Needy Income Level toward medical expenses each month. This difference is called an "incurment" or "spenddown" and an individual may be Medicaid eligible once they make a cash payment for the 'incurment' or spend down amount, or incur medical bills equal to the amount of the "incurment", or combine a monthly cash payment with existing medical bills. The resource limit is $2000 for an individual, and $3000 for a couple or family. In Montana, there are medically needy Medicaid programs for those who are aged, blind, disabled, children and/or pregnant. Countable income is reduced by earned income deductions and a $100 general income deduction per household.

State Fiscal Year **2014** Limits for Medically Needy

Family Size	Resource Limit	Monthly Income Limit
1	$2,000/$3,000**	$525
2	$3,000	$525
3	$3,000	$658
4	$3,000	$792
5	$3,000	$925
6	$3,000	$1,058
**$2,000 for aged, blind, or disabled individuals, $3,000 for children, pregnant women and for aged, blind, or disabled couples.		

Comparison between Categorically Needy and Medically Needy

Note that graphs above do not include HMK (CHIP), Medicare Savings Plan, or Plan First Waiver clients and expenditures.

Summary of Medicaid Enrolled Persons for State Fiscal Year 2013

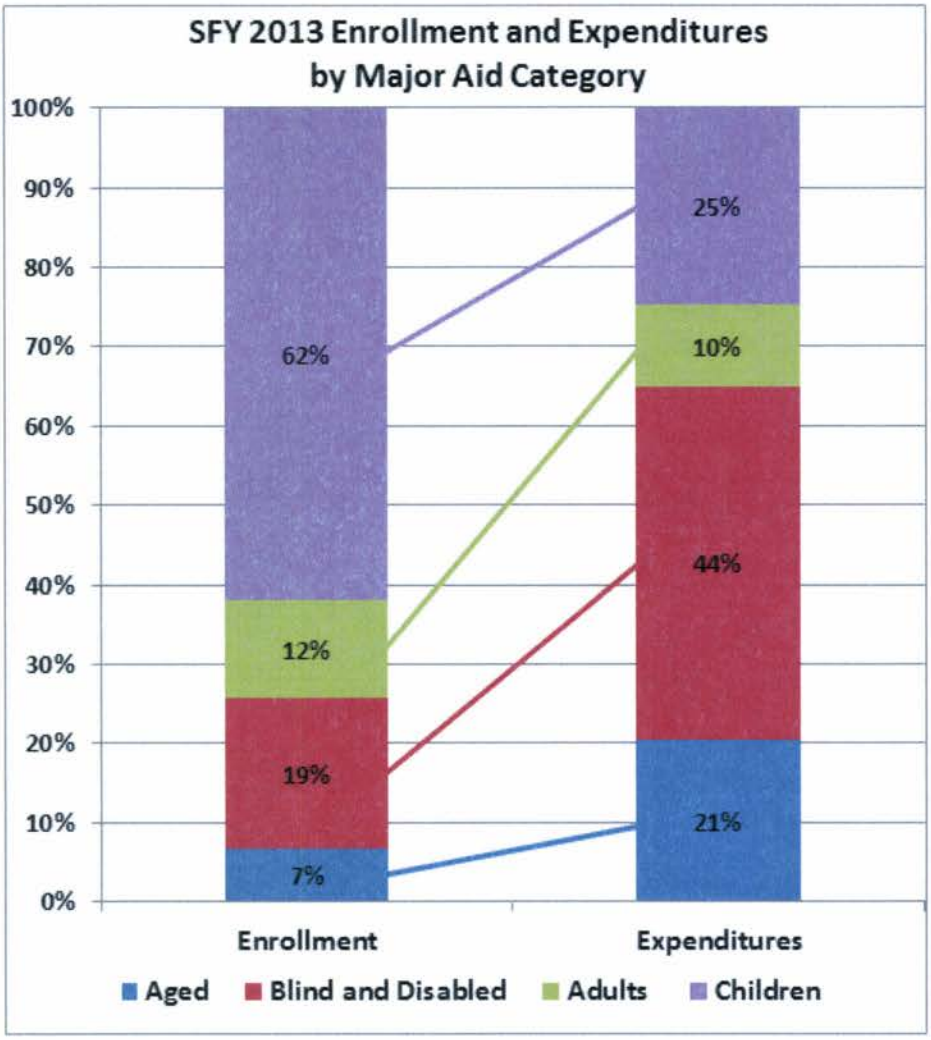
Average Monthly Enrollment

Beneficiary Characteristic	All	Aged	Blind & Disabled	Adults	Children	% of Medicaid Total	% of Montana Population
Total	**105,696**	**7,033**	**20,268**	**12,895**	**65,500**	**100%**	
Age							
0 to 1	5,893	0	50	0	5,843	6%	1%
1 to 5	24,411	0	573	0	23,838	23%	6%
6 to 18	38,282	0	2,463	0	35,819	36%	17%
19 to 20	1,475	0	505	970	0	1%	2%
21 to 64	28,398	0	16,473	11,925	0	27%	57%
65 and older	7,237	7,033	204	0	0	7%	17%
	105,696	7,033	20,268	12,895	65,500		
Gender							
Male	48,381	2,203	10,095	3,005	33,078	46%	50%
Female	57,315	4,830	10,173	9,890	32,422	54%	50%
	105,696	7,033	20,268	12,895	65,500		
Race							
White	79,762	6,141	16,747	9,170	47,704	75%	92%
Native American	22,337	709	2,907	3,323	15,398	21%	5%
Other	3,597	183	614	402	2,398	3%	3%
	105,696	7,033	20,268	12,895	65,500		
Assistance Status*							
Medically Needy	2,121	971	1,100	6	44	2%	
Categorically Needy	103,575	6,062	19,168	12,889	65,456	98%	
	105,696	7,033	20,268	12,895	65,500		
Medicare Status							
Part A and B	14,710	6,649	7,671	389	1	14%	
Part A only	59	14	27	18	0	0%	
Part B only	362	359	3	0	0	0%	
None	90,565	11	12,567	12,488	65,499	86%	
	105,696	7,033	20,268	12,895	65,500		
Medicare Saving Plan (not included in total)							
QMB Only	4,201	1,984	2,217	0	0		
SLMB - QI Only	3,971	3,971	0	0	0		
Other Medicaid Eligibles (not included in total)							
HK Exp (CHIP Funded)	7,340	0	0	10	7,330		
Plan First Waiver	1,316	0	0	1,316	0		

* Medically Needy clients are responsible for their medical bills each month until they have incurred enough medical expenses equal to the difference between their countable income and the Medically Needy income level.

Excludes HMK (CHIP) and State Fund Mental Health. For QMB only enrollees Medicaid pays for Medicare premiums, co-insurance, and deductibles. For SLMB - QI only enrollees Medicaid pays for Medicare Premiums.

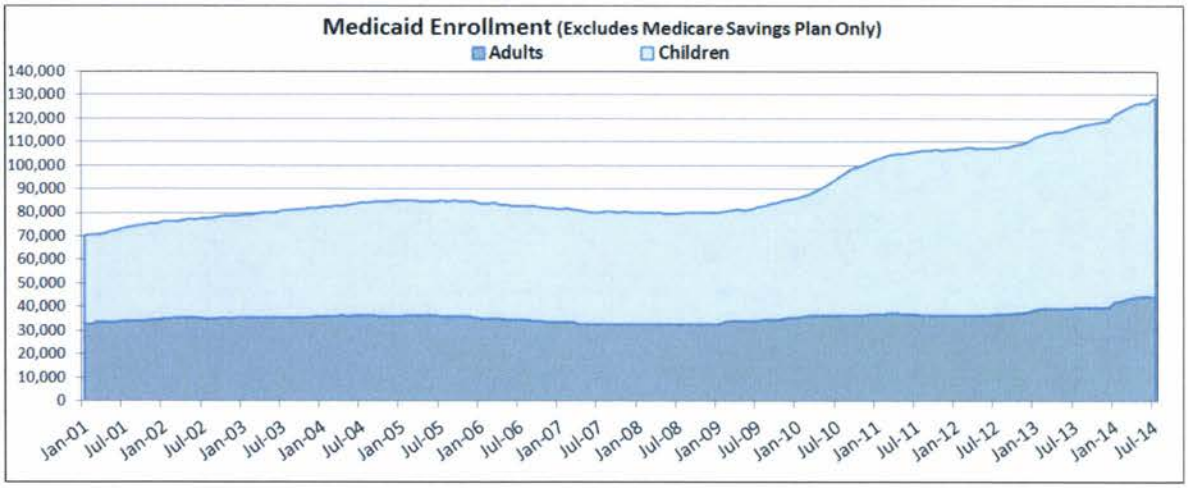
The column in the above chart "% of Montana Population" shows the percentage of Montana population for that beneficiary characteristic. For example, 50% of Montana's population is female, but 54% of the total Medicaid population in Montana is female.

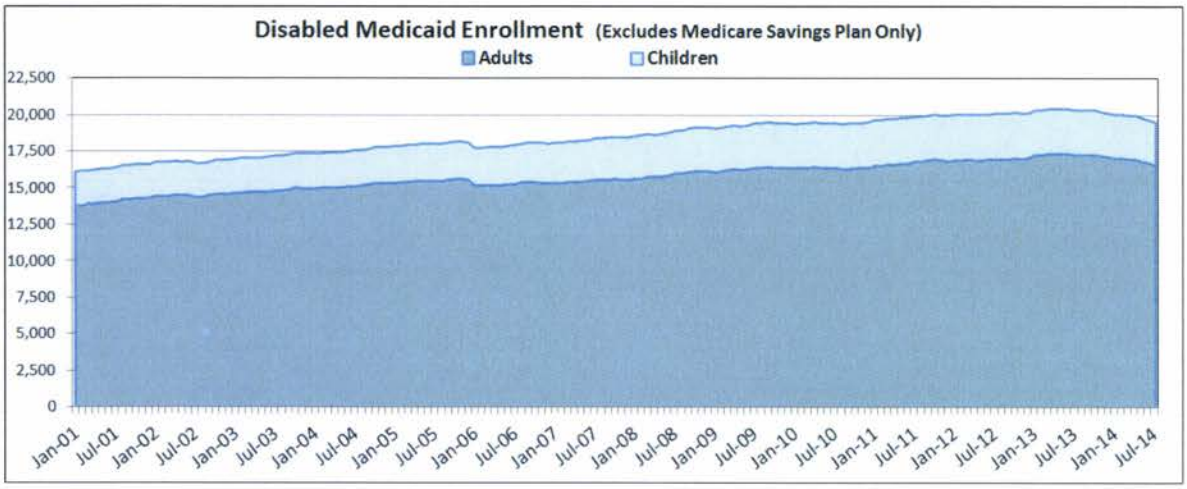


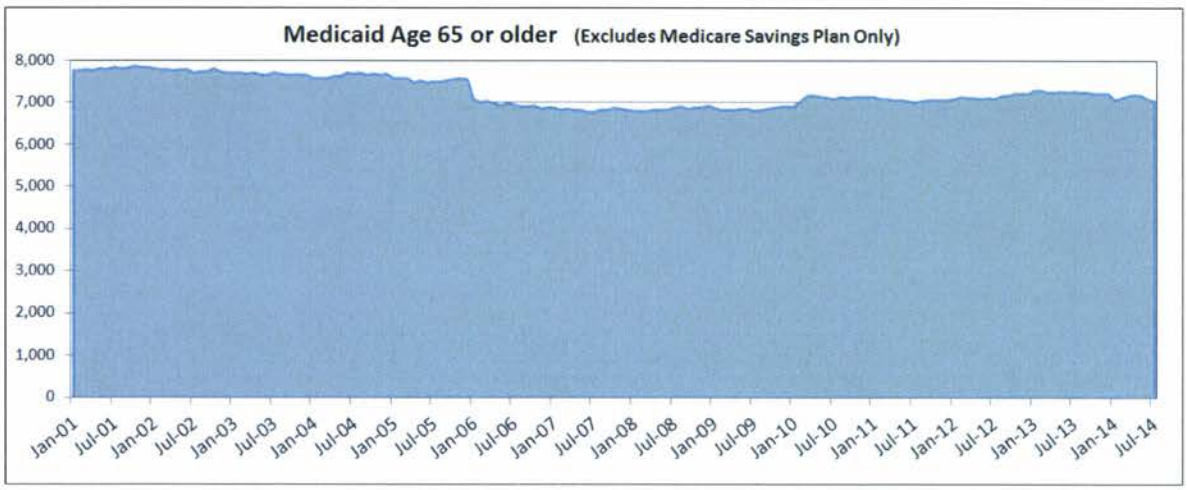
SFY 2013 Enrollment and Expenditures by Major Aid Category

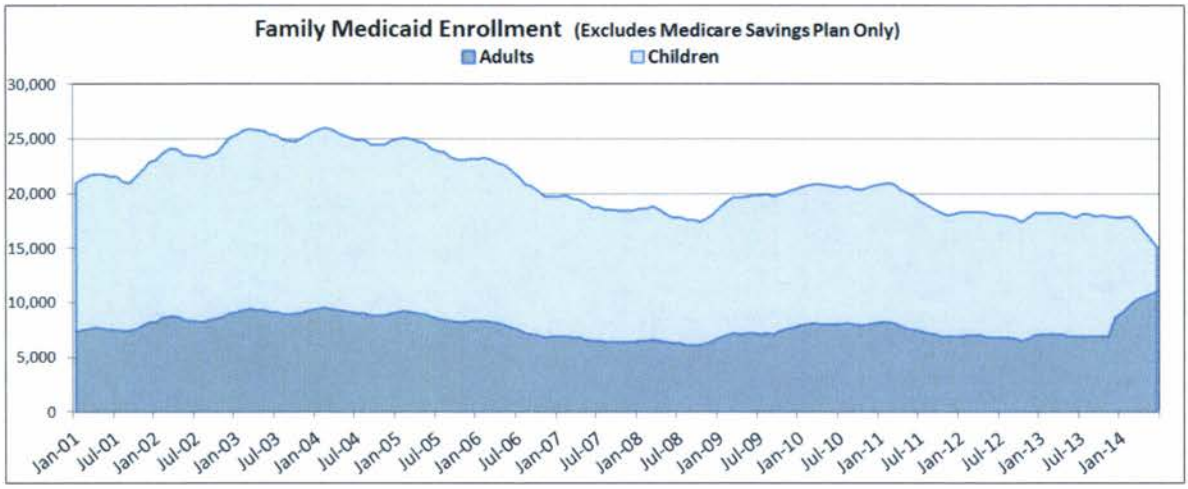
Aid Category	Average Monthly Enrollment	Percent of Enrollment	Expenditures	Percent of Expenditures
Aged	7,033	7%	$200,877,522	21%
Blind and Disabled	20,268	19%	$432,087,636	44%
Adults	12,894	12%	$101,014,986	10%
Children	65,500	62%	$242,031,389	25%
Total	105,695	100%	$976,011,533	100%

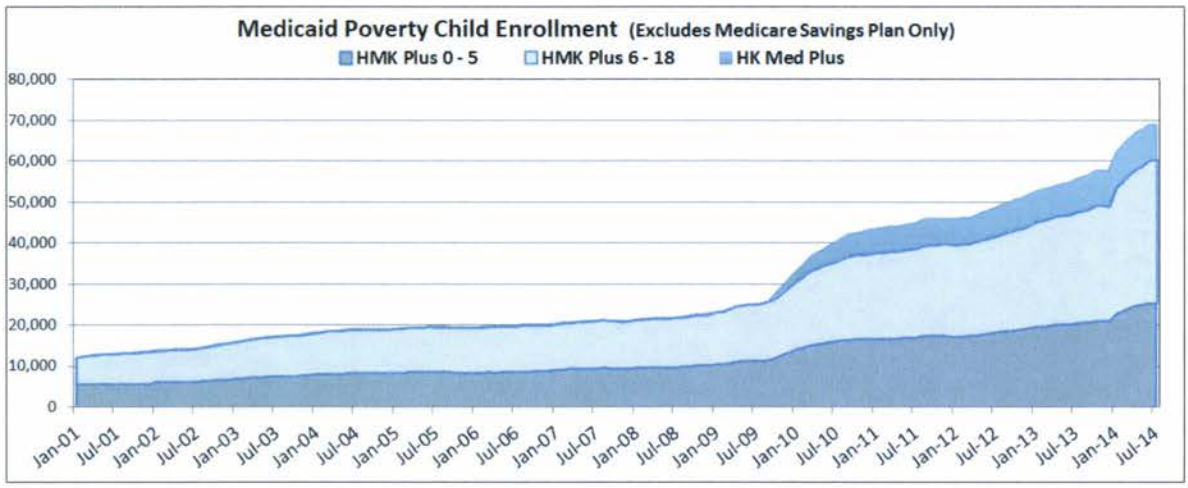
Note that graphs above do not include HMK (CHIP Funded), Medicare Savings Plan, or Plan First Waiver clients and expenditures.

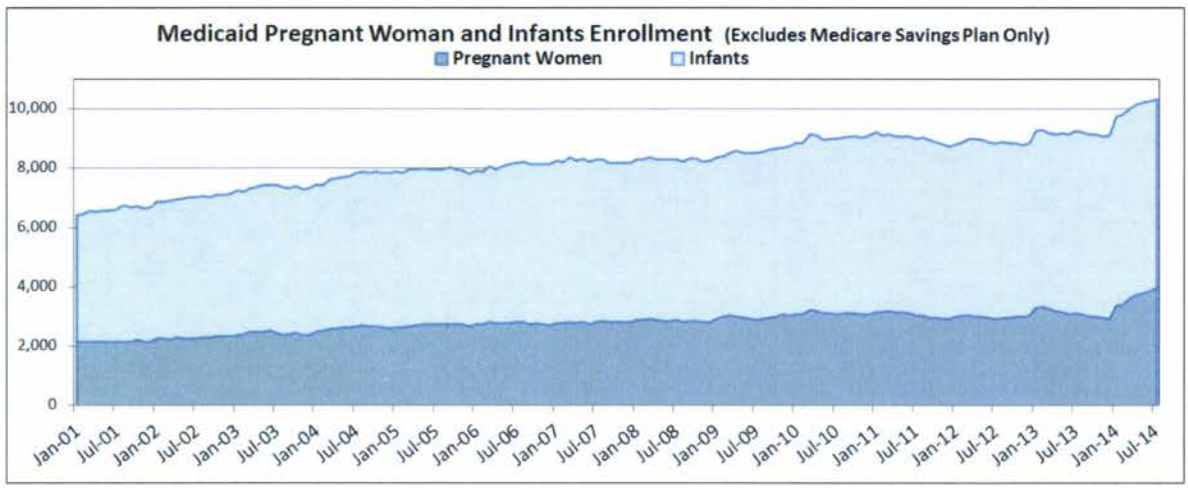

Medicaid Enrollment (Excludes Medicare Savings Plan Only)
Adults
Children
140,000
130,000
120,000
110,000
100,000
90,000
80,000
70,000
60,000
50,000
40,000
30,000
20,000
10,000
0
Jan-01 Jul-01 Jan-02 Jul-02 Jan-03 Jul-03 Jan-04 Jul-04 Jan-05 Jul-05 Jan-06 Jul-06 Jan-07 Jul-07 Jan-08 Jul-08 Jan-09 Jul-09 Jan-10 Jul-10 Jan-11 Jul-11 Jan-12 Jul-12 Jan-13 Jul-13 Jan-14 Jul-14


Disabled Medicaid Enrollment (Excludes Medicare Savings Plan Only)
Adults
Children
22,500
20,000
17,500
15,000
12,500
10,000
7,500
5,000
2,500
0
Jan-01 Jul-01 Jan-02 Jul-02 Jan-03 Jul-03 Jan-04 Jul-04 Jan-05 Jul-05 Jan-06 Jul-06 Jan-07 Jul-07 Jan-08 Jul-08 Jan-09 Jul-09 Jan-10 Jul-10 Jan-11 Jul-11 Jan-12 Jul-12 Jan-13 Jul-13 Jan-14 Jul-14


Medicaid Age 65 or older (Excludes Medicare Savings Plan Only)
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
Jan-01 Jul-01 Jan-02 Jul-02 Jan-03 Jul-03 Jan-04 Jul-04 Jan-05 Jul-05 Jan-06 Jul-06 Jan-07 Jul-07 Jan-08 Jul-08 Jan-09 Jul-09 Jan-10 Jul-10 Jan-11 Jul-11 Jan-12 Jul-12 Jan-13 Jul-13 Jan-14 Jul-14


Family Medicaid Enrollment (Excludes Medicare Savings Plan Only)
Adults
Children
30,000
25,000
20,000
15,000
10,000
5,000
0
Jan-01 Jul-01 Jan-02 Jul-02 Jan-03 Jul-03 Jan-04 Jul-04 Jan-05 Jul-05 Jan-06 Jul-06 Jan-07 Jul-07 Jan-08 Jul-08 Jan-09 Jul-09 Jan-10 Jul-10 Jan-11 Jul-11 Jan-12 Jul-12 Jan-13 Jul-13 Jan-14


Medicaid Poverty Child Enrollment (Excludes Medicare Savings Plan Only)
HMK Plus 0 - 5
HMK Plus 6 - 18
HK Med Plus
80,000
70,000
60,000
50,000
40,000
30,000
20,000
10,000
0
Jan-01 Jul-01 Jan-02 Jul-02 Jan-03 Jul-03 Jan-04 Jul-04 Jan-05 Jul-05 Jan-06 Jul-06 Jan-07 Jul-07 Jan-08 Jul-08 Jan-09 Jul-09 Jan-10 Jul-10 Jan-11 Jul-11 Jan-12 Jul-12 Jan-13 Jul-13 Jan-14 Jul-14


Medicaid Pregnant Woman and Infants Enrollment (Excludes Medicare Savings Plan Only)
Pregnant Women
Infants
10,000
8,000
6,000
4,000
2,000
0
Jan-01 Jul-01 Jan-02 Jul-02 Jan-03 Jul-03 Jan-04 Jul-04 Jan-05 Jul-05 Jan-06 Jul-06 Jan-07 Jul-07 Jan-08 Jul-08 Jan-09 Jul-09 Jan-10 Jul-10 Jan-11 Jul-11 Jan-12 Jul-12 Jan-13 Jul-13 Jan-14 Jul-14

MEDICAID BENEFITS

The Montana Medicaid benefits package meets federal guidelines. Medicaid benefits are divided into two classes. Federal law requires that adults eligible for Medicaid are entitled to the following services unless waived under Section 1115 of the Social Security Act. These are referred to as mandatory services and include:

- Physician & Nurse Practitioner
- Nurse Midwife
- Medical & Surgical Service of a Dentist
- Laboratory and X-ray
- Inpatient Hospital (excluding inpatient services in institutions for mental disease)
- Outpatient Hospital
- Federally Qualified Health Centers
- Rural Health Clinics
- Family Planning
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
- Nursing Facility
- Home Health
- Durable Medical Equipment

States may elect to cover other optional services. Montana has chosen to cover a number of other cost-effective optional services including, but not limited to, the following:

- Outpatient Drugs
- Dental and Denturist Services
- Comprehensive Mental Health Services
- Ambulance
- Physical & Occupational Therapies and Speech Language Pathology
- Transportation & Per Diem
- Home & Community Based Services
- Eyeglasses & Optometry
- Personal Assistance Services
- Targeted Case Management
- Podiatry
- Community First Choice

There is an exception to a state's ability to decide which optional services it will cover. **Early and Periodic Screening, Diagnosis and Treatment (EPSDT)** services must be covered under the Medicaid program for categorically needy individuals under age 21. The EPSDT benefit is optional for the medically needy population. However, if the EPSDT benefit is elected for the medically needy population, it must be made available to all Medicaid eligible individuals under age 21. Under the EPSDT regulations, a state must cover all medically necessary services available under the federal Medicaid program to treat or ameliorate a defect, physical and mental

illness, or a condition identified by a screen. This is true of whether the service or item is otherwise included in the State Medicaid plan.
The following table outlines services reimbursed by the Montana Medicaid Program:

Montana Medicaid and HMK *Plus* Medicaid Covered Services

The description of services presented here is a guide and not a contract to provide medical care. Administrative rules of Montana, Title 37, Chapters 81 through 88, govern access and payment of services.

	Categorically and Medically Needy: Children and Adults	Family Related Adult Basic
Alcohol, drug treatment: hospital inpatient, outpatient, non-hospital	1	1
Anesthesia	1	1
Audiology	1, 2	3
Case management—targeted	1, 2	1, 2
Chiropractic	5	7
Circumcision	7	7
Clinic: IHS, FQHC, RHC, public health	1	1
Community First Choice	1,2	7
Dental, denturist	1	3
Developmental disability	1, 6	1, 6
Dialysis, outpatient and training for self-dialysis	1	1
Durable medical equipment	1, 2	3
EPSDT: Early and Periodic Screening, Diagnosis, and Treatment	5	7
Eye glasses, eye exams, optician	1, 2	3
Family planning services, birth control	1	1
Group home care	5	7
Hearing aids, hearing exams, audiology	1, 2	3
Home, community based, home health	4	7
Home infusion	1	7
Hospital: inpatient, outpatient, emergency department, urgent care, birth center, transitional	1	1
Immunizations	1	1
Interpreter	1	1
Laboratory, imaging, X ray	1	1
Long term care, nursing home, hospice	1, 6	1, 6
Mental health	1	1
Nurse advice line	1	1
Nutrition counseling	1, 2	1, 2
Obstetric, pregnancy, child birth	1	1
Orientation and mobility specialist	1,5	7
Orthodontia	5	7
Personal assistant	1, 2	7
Pharmacy: prescription and over-the-counter	1, 2	1, 2
Podiatry	1	1
Private duty nursing	1,5	7
School-based	5	7
Surgery	1	1
Therapies: occupational, physical, speech	1, 2	1, 2
Therapy: respiratory	5	7
Tobacco cessation drugs and counseling	1	1
Transplants	1	1
Transportation, including ambulance for emergency	1, 2	1, 2

1. Covered. **2**. Limits may apply for adults **3**. Usually not covered. Services may be authorized in emergency situations, if essential for employment, or for some medical conditions. **4**. Home and community based services waiver may include coverage for these services for individuals covered by the waiver. **5**. Covered for children only. **6**. Level of care requirements. **7**. Not covered

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. This 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 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 do have the discretion to provide a combination of waivers. A combination 1915 (b) / 1915(c) or an 1115/1915 (b) waiver are the most common combinations.

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 Basic Medicaid benefit package of optional services to 'able-bodied' 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. In SFY 2013, there were 13,746 able-bodied adults served at a cost of $44,538,790.

In December 2010, the state received approval to use the federal savings generated from able-bodied adults to expand the waiver and cover up to 800 adults who previously qualified for the state-funded Mental Health Services Plan. Individuals are covered up to 150 percent of the federal poverty level. (This waiver is commonly referred to as the HIFA or MHSP waiver.) For the first time, these individuals who had either schizophrenia or bipolar disorder qualified for physical health benefits as well as a more comprehensive mental health benefit.

On January 1, 2014 the waiver expanded to serve up to 2000 individuals and to include the diagnosis of major depressive disorder. In December 2014, the waiver was expanded to cover up to 6000 individuals with a diagnosis of serious mental illness. Again, federal savings generated from the Basic Medicaid Waiver Able Bodied population are used to fund the federal benefit costs. General fund previously spent on the state MHSP is used as the state match. SFY 2013 waiver expenditures were $7,689,703 for 920 individuals with schizophrenia or bipolar disorder. This portion of the waiver will continue to grow for the next several years as we "re-finance" people now covered under MHSP move to Medicaid.

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. In general, eligibility is open to:

- Montana Residents
- Females age 19 through 44
- Able to bear children and not presently pregnant
- Annual household income up to and including 211% Federal Poverty Level

This program is limited to 4,000 women at any given time. CMS approved this waiver on May 30, 2012. In SFY 2013, 1,316 women were served. This waiver saves the state and federal government money by avoiding unintended pregnancies. It will continue to grow for the next several years.

1915(b) Waiver Passport to Health - Health Resources Division – The Passport to Health waiver has four components. All four components help people access and utilize services appropriately. The first service, **Passport to Health**, is the primary care case management program in which most Medicaid and HMK *Plus* eligible individuals are enrolled. A member chooses or is assigned a primary care provider who delivers all medical services or furnishes referrals for other medically-necessary care. Care management offered under the waiver enhances care while reducing costs to Medicaid and HMK *Plus* by minimizing ineffective or inappropriate medical care. The waiver is operated in all 56 counties and involves 70 percent of all Montana Medicaid members.

This second component is **Team Care**, a program for individuals identified with inappropriate or excessive utilization of health care services. Members are identified for Team Care through claim reviews, provider referrals, and Drug Utilization Review Board referrals. Individuals are enrolled in Team Care for at least 12 months and receive services from one pharmacy and one medical provider. Approximately 600 Medicaid and HMK *Plus* members are currently enrolled in the Team Care program.

The third component, the **Health Improvement Program,** is an enhanced primary care case management program, administered in partnership with 13 community health centers and the Fort Peck Tribes. The top five percent of high-cost, high-risk Medicaid and HMK *Plus* members are identified by Medicaid through the use of predictive modeling software and provider referrals. Care managers and health coaches employed by community health centers provide in-person and telephonic health care management services to improve health outcomes, increase the ability of members to self-manage their health conditions and reduce costs.

This fourth component is **Nurse First**, a 24/7 nurse advice line available to all Medicaid and HMK *Plus* members. The advice line is operated by a vendor and through clinically-based algorithms directs callers to the most appropriate level of care: self-care, provider visit, or emergency department visit.

Quality, access to care, and health outcomes are continuously monitored, tracked, and reported. Clients and providers report satisfaction with these care management programs that document annual cost avoidance to Medicaid.

1915 (c) HCBS Children's Autism Waiver - Developmental Services Division - CMS approved the waiver on January 1, 2009 to serve Montana children age 15 months through 7 years old with autism and adaptive behavior deficits. This children's autism waiver provides early intervention based upon applied behavioral analysis (ABA) training models. Children receive up to 20 hours of intensive training per week that is focused on improving skills in the areas of communication, socialization, academics, and activities of daily living while reducing maladaptive behaviors. The waiver serves 60 children per year at an approximate cost of $2.5 million per year. Children may be served for a maximum of three years. Seven agencies across the state provide program design and training, case management services, and other supports to enrolled children and their families. As of November, 2014 there are approximately 90 children (under the age of 5) currently on the waiting list for Children's Autism Waiver services. This

waiver, targeted at very young children, has shown phenomenal success at reducing or eliminating serious life-long disability.

1915 (c) HCBS Comprehensive Services Waiver for Individuals with Developmental Disabilities - Developmental Services Division - This waiver for people with Developmental Disabilities (DD) was initiated in 1981. It was the second waiver in the country approved to provide community based services to persons needing DD services. The majority of reimbursement for adults goes to group home, supported living, work/day, and transportation services. Children's services include caregiver training and support and children's case management. Specialized services available under this waiver include the following: psychological services, board certified behavioral analyst (BCBA) consultation, personal care, homemaker, respite, occupational therapy, physical therapy, speech therapy, environmental modifications, nutritional evaluations, private duty nursing, meals, personal emergency response systems (PERS), and respiratory services. A smaller waiver, formerly known as the community supports waiver, was combined with this waiver to achieve more administrative efficiencies in 2014. Approximately 2600 people are served. The current average time on the wait list is two years. There are approximately 635 individuals on the wait list.

1915 (c) HCBS Supports for Community Working and Living Waiver - Developmental Services Division – Beginning January 21, 2014, a new HCBS waiver was implemented. This waiver prioritizes serving youth transitioning out of high school who have an interest in working in an integrated community setting. This waiver currently serves 30 individuals. The youngest individual served in this waiver is 17, with the oldest being 52. The average age is 26. There are approximately 40 individuals on the wait list for this waiver.

1915(b)(4) and 1915(c) The Montana Big Sky Waiver - Senior and Long Term Care Division - This is a concurrent or combination 1915(b)(4) and 1915(c) waiver (see earlier description of Medicaid Waivers). The HCBS Waiver, serving the elderly (age 65 and older) and people with physically disabilities started in 1982. The program recognizes that many individuals at risk of being placed in institutional settings can be cared for in their homes and communities, preserving their independence and ties to family and friends, at a cost no higher than that of institutional care. To qualify a person must be financially eligible for Medicaid and meet the program's level of care requirements in a nursing facility or hospital. The Department contracts with case management teams to develop an individual plan of care in conjunction with the consumer. This waiver has an extensive menu of services which includes case management, respite, adult residential care, specialized services for those with traumatic brain injuries, environmental modifications, health and wellness, consumer directed services and personal emergency response systems. On July 01, 2011, Montana added the 1915 (b) component, which limits the number of case management teams available. In 2014 more than 2,500 individuals received Montana Big Sky Waiver funded services.

1915(c) HCBS Severe Disabling Mental Illness Waiver (SDMI) - Addictive and Mental Disorders Division - Implemented in December 2006, this waiver allows Medicaid reimbursement for community-based services for individuals who are 18 years of age or older with SDMI who meet certain criteria for nursing home level of care. The waiver's 198 slots are

distributed among five geographic core areas including Billings, Great Falls, Missoula, Helena and Butte plus surrounding counties for each. In each site, services are coordinated by a team that is made up of a registered nurse and a social worker. Services provided to persons enrolled in the SDMI waiver include case management, wellness recovery action plan (WRAP), illness management and recovery (IMR) program, non-medical transportation, specialized medical equipment and supplies, personal emergency response, adult day care, respite, private duty nursing, prevocational services, supportive employment, additional occupational therapy, habilitation aide, substance use related disorders services, residential and day habilitation, supportive living, personal assistance and specially trained attendants, psychosocial rehabilitation, consultation, community transition, health and wellness, and pain and symptom management. The waiver operates at full capacity of 198 people.

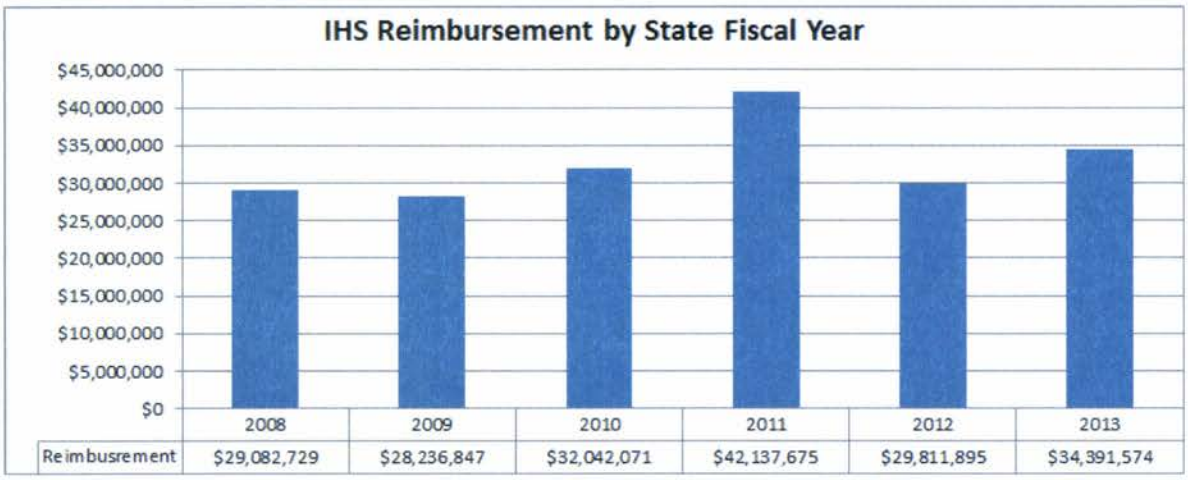
Upcoming Issue - One of the upcoming issues facing all 1115 and 1915 (c) waivers is a new regulation issued by CMS in March 2014. This regulation, among other things, redefines the characteristics of a home-based setting and may mean that some providers of assisted living facility services may need to change the physical characteristics of their facility if they wish to continue serving waiver clients. The Department will work closely with waiver consumers and providers to mitigate the impact of this regulation. The state must be in compliance by March 2019.

Indian Health Service (IHS) and Tribal Activities

The Indian Health Service (IHS) is the primary federal health care provider for Native Americans due to a unique relationship that exists between the federal government and Indian tribes. IHS is a grant and is not considered a health insurance policy. Historically, IHS has been underfunded.

IHS and Medicaid work together to provide medical care to an underserved population. While some Native Americans are eligible only for Medicaid, others may be eligible for both IHS and Medicaid services. In either of these circumstances, Medicaid reimburses IHS units and tribal health departments for care provided. The Blackfeet, Crow/Northern Cheyenne and Fort Belknap hospitals provide both inpatient and outpatient services. Outpatient-only services are available in Arlee, Elmo, Hays, Heart Butte, Lame Deer, Lodge Grass, Polson, Poplar, Pryor, St. Ignatius, Rocky Boy Agency, Ronan and Wolf Point.

The Montana Medicaid Program passes through 100% federal reimbursement for covered medical services for Medicaid-eligible Native Americans who receive services through an IHS unit or Tribal health department. Medicaid reimburses outpatient IHS services on an encounter basis and pays for inpatient services using a per diem payment.



	2008	2009	2010	2011	2012	2013
Reimbusrement	$29,082,729	$28,236,847	$32,042,071	$42,137,675	$29,811,895	$34,391,574

Five major urban Indian health centers provide care to Indians who reside off a respective Indian reservation. The Indian Health Board of Billings, the Helena Indian Alliance, the Indian Family Health Clinic of Great Falls, the Missoula Indian Center and the North American Indian Alliance of Butte operate and are paid as Federally Qualified Health Care Centers and are not eligible under federal law to receive 100% federal reimbursement.

Tribal Consultation and Reservation Visits

The Department continues an extensive effort to build and foster effective government-to-government relationships with tribal governments. With assistance from the Department's Tribal Relations Manager, the State Medicaid Director and Medicaid staff have made historic visits to

reservation communities to meet with the governing bodies of each tribal government to discuss the Medicaid program, billable services and Medicaid reimbursements. The goal of these visits is to increase Medicaid reimbursement. Increased reimbursement will benefit both Tribes and the state. Tribes will benefit because Medicaid is an important revenue source for medical services they provide. Additional revenue will allow Tribes to offer more services closer to home, thus increasing access to care. The state benefits because services provided by the Tribes (and IHS) are financed 100% by the federal government. As an example, if an eligible Indian person is served at a tribal health clinic rather than the private clinic in the next town, the state saves $.34 on every dollar spent.

Montana Medicaid is also evolving our relationships with urban Indian health centers and the Indian Health Service area office and its respective service units. During the many visits to tribal communities and urban areas, meetings have been held with each Tribal Health Director, IHS Area Director, IHS Service Unit Chief Executive Officers and Urban Indian Health Center Executive Directors. Tours of each of the tribal, IHS and urban facilities continue to occur as the Department learns more about how health care is delivered in each tribal community. Department Director Richard Opper has joined in these meetings and tours throughout Indian Country in Montana.

Medicaid Administrative Match (MAM)
MAM is a federal reimbursement program for the costs of "administrative activities" that directly support efforts to identify, and/or to enroll individuals in the Medicaid program or to assist those already enrolled in Medicaid to access benefits. Through MAM, tribes who have entered into contracts with the state of Montana are reimbursed for allowable administrative costs directly related to the Montana State Medicaid plan or waiver service. The Montana Tribal Cost Allocation Plan gives Tribes a mechanism to seek reimbursement for Medicaid administrative activities that Tribes perform. The program, the first of its kind in the country, began July 1, 2008. The Chippewa Cree, Confederated Salish Kootenai and Northern Cheyenne Tribes are currently under contract.

Medicaid Eligibility Determination Agreement
The agreement that allows the Chippewa Cree Tribe to determine eligibility for Medicaid for residents on the Rocky Boy's reservation was renewed in 2014. This historic agreement allows tribal members to apply for services locally and reduces barriers/delays that may impede tribal members from obtaining Medicaid benefits and proper medical care. The Confederated Salish and Kootenai Tribes are currently in discussions with the Department as they too have expressed interest in a similar agreement.

Most of the $1 billion in Medicaid expenditures supported private providers in the Montana economy in SFY 2013.

Enrollment and Expenditures by County SFY 2013

County	County Population 7/1/2013	Average Monthly Medicaid Enrollment	Percent on Medicaid	Rank by Percent on Medicaid	Expenditures	Average Expenditure per Enrollee	Rank by Average Expenditure per Enrollee
BEAVERHEAD	9,208	759	8%	32	$8,429,311	$11,106	17
BIG HORN	12,856	3,217	25%	1	$19,701,310	$6,125	55
BLAINE	6,510	1,194	18%	4	$11,268,141	$9,441	28
BROADWATER	5,611	413	7%	35	$3,003,578	$7,265	51
CARBON	10,192	659	6%	38	$5,648,313	$8,567	38
CARTER	1,157	54	5%	51	$705,284	$13,122	10
CASCADE	81,208	8,339	10%	21	$87,888,709	$10,540	22
CHOUTEAU	5,765	340	6%	43	$2,892,964	$8,513	39
CUSTER	11,780	1,147	10%	24	$13,115,444	$11,439	13
DANIELS	1,765	107	6%	40	$2,364,359	$22,131	2
DAWSON	9,310	551	6%	42	$6,735,552	$12,217	12
DEER LODGE	9,196	1,088	12%	16	$14,813,604	$13,615	8
FALLON	3,035	138	5%	53	$2,011,403	$14,575	6
FERGUS	11,337	954	8%	29	$16,348,009	$17,142	4
FLATHEAD	91,739	10,423	11%	18	$83,726,091	$8,033	44
GALLATIN	93,368	4,945	5%	47	$35,671,089	$7,214	53
GARFIELD	1,272	74	6%	44	$960,456	$13,023	11
GLACIER	13,543	3,375	25%	3	$25,269,994	$7,488	50
GOLDEN VALLEY	847	88	10%	19	$638,312	$7,233	52
GRANITE	3,093	175	6%	45	$1,518,829	$8,675	36
HILL	16,331	2,875	18%	6	$21,565,469	$7,502	49
JEFFERSON	11,348	906	8%	33	$22,214,409	$24,533	1
JUDITH BASIN	1,987	123	6%	39	$921,642	$7,503	48
LAKE	28,603	4,875	17%	7	$40,521,416	$8,313	41
LEWIS AND CLARK	64,405	5,949	9%	26	$51,921,110	$8,728	35
LIBERTY	2,335	117	5%	49	$1,206,382	$10,289	23
LINCOLN	19,182	2,556	13%	10	$24,699,082	$9,663	26
MADISON	7,602	372	5%	50	$3,961,495	$10,664	21
MCCONE	1,685	57	3%	56	$515,509	$9,044	31
MEAGHER	1,909	252	13%	11	$1,953,961	$7,762	45
MINERAL	4,214	619	15%	8	$5,197,506	$8,403	40
MISSOULA	110,211	10,951	10%	23	$102,840,038	$9,391	30
MUSSELSHELL	4,563	574	13%	14	$4,917,959	$8,573	37
PARK	15,458	1,161	8%	34	$10,954,050	$9,439	29

Enrollment and Expenditures by County SFY 2013 Continued

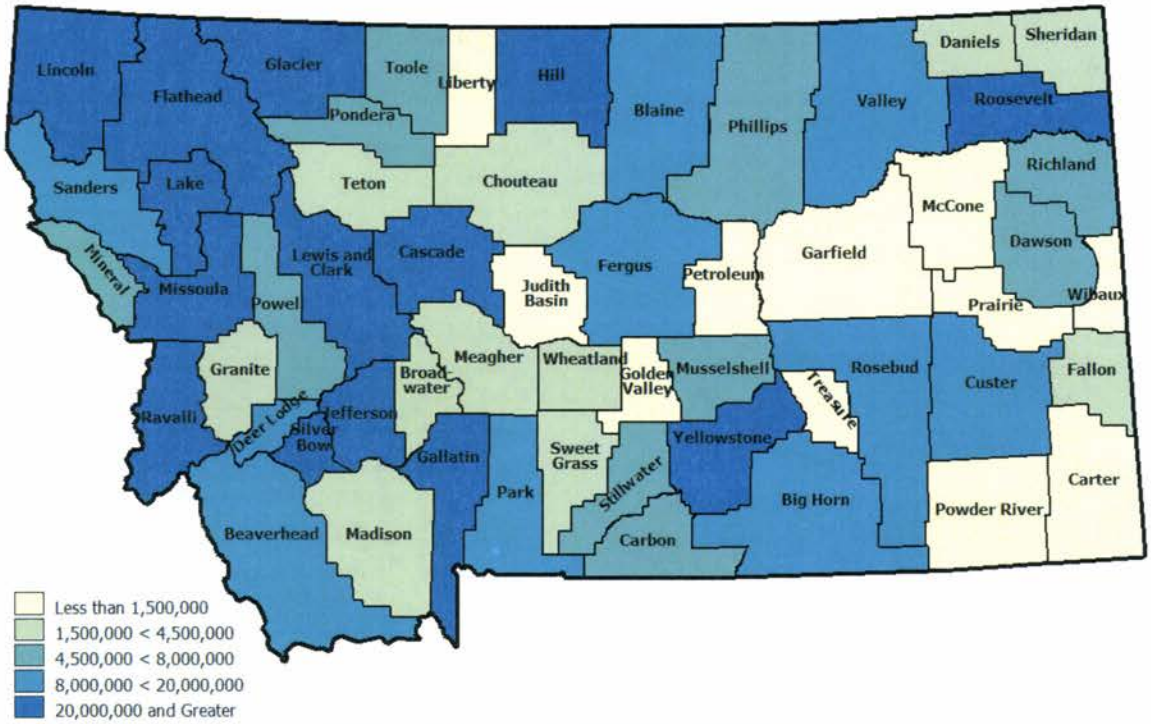
County	County Population 7/1/2013	Average Monthly Medicaid Enrollment	Percent on Medicaid	Rank by Percent on Medicaid	Expenditures	Average Expenditure per Enrollee	Rank by Average Expenditure per Enrollee
PETROLEUM	499	23	5%	52	$161,557	$6,999	54
PHILLIPS	4,119	524	13%	13	$5,946,350	$11,350	14
PONDERA	6,122	874	14%	9	$7,679,002	$8,787	34
POWDER RIVER	1,723	59	3%	55	$1,148,617	$19,579	3
POWELL	6,893	623	9%	27	$7,023,013	$11,279	15
PRAIRIE	1,162	82	7%	36	$888,494	$10,824	19
RAVALLI	40,240	4,188	10%	20	$34,613,293	$8,266	43
RICHLAND	11,054	601	5%	46	$6,652,172	$11,078	18
ROOSEVELT	10,966	2,742	25%	2	$26,997,996	$9,848	25
ROSEBUD	9,196	1,667	18%	5	$13,819,007	$8,291	42
SANDERS	11,201	1,377	12%	15	$13,071,789	$9,495	27
SHERIDAN	3,616	215	6%	41	$3,014,874	$14,028	7
SILVER BOW	34,030	4,414	13%	12	$47,689,991	$10,805	20
STILLWATER	9,185	645	7%	37	$4,990,714	$7,744	46
SWEET GRASS	3,617	156	4%	54	$2,046,048	$13,144	9
TETON	5,978	504	8%	28	$4,454,303	$8,841	33
TOOLE	5,065	425	8%	30	$4,737,752	$11,156	16
TREASURE	690	57	8%	31	$318,567	$5,548	56
VALLEY	7,521	862	11%	17	$8,659,966	$10,052	24
WHEATLAND	2,104	198	9%	25	$1,512,966	$7,628	47
WIBAUX	1,105	58	5%	48	$863,850	$14,937	5
YELLOWSTONE	151,961	15,547	10%	22	$139,306,163	$8,960	32
Other / Institution		439			$4,314,269	$9,839	
Sub Total	**1,000,670**	**105,696**	**11%**		**$976,011,533**	**$9,234**	
Plan First		1,316			$996,859	$758	
QMB Only		4,201			$10,811,649	$2,573	
SLMB - QI Only		3,971			$5,132,398	$1,293	
HK (CHIP Funded)		7,340			$20,495,670	$2,792	
Grand Total	**1,000,670**	**145,808**	**15%**		**1,013,448,109**	**$6,951**	

Population estimates as of July 1, 2013. Columns may not sum to total due to rounding.

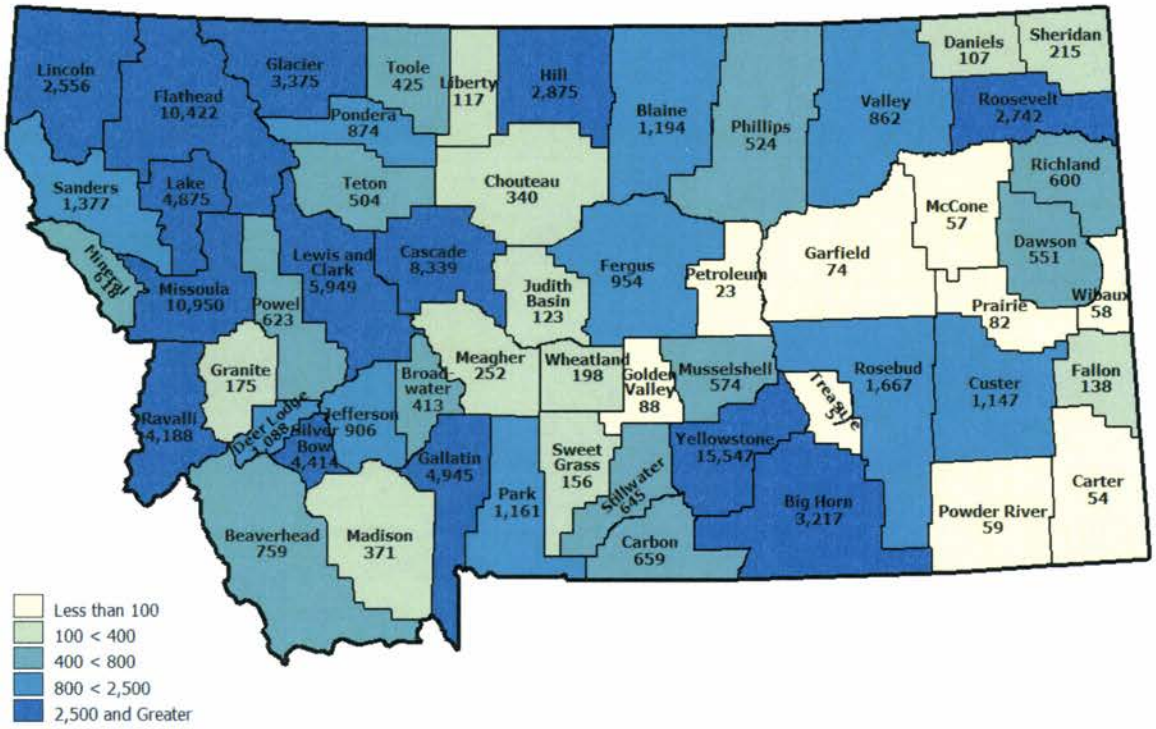
Excludes HMK (CHIP) and State Fund Mental Health. For QMB only enrollees, Medicaid pays for Medicare Premiums, co-insurance, and deductibles. For SLMB - QI only enrollees, Medicaid pays for Medicare Premiums.

The charts on the following pages graphically represent the data presented in the above table.

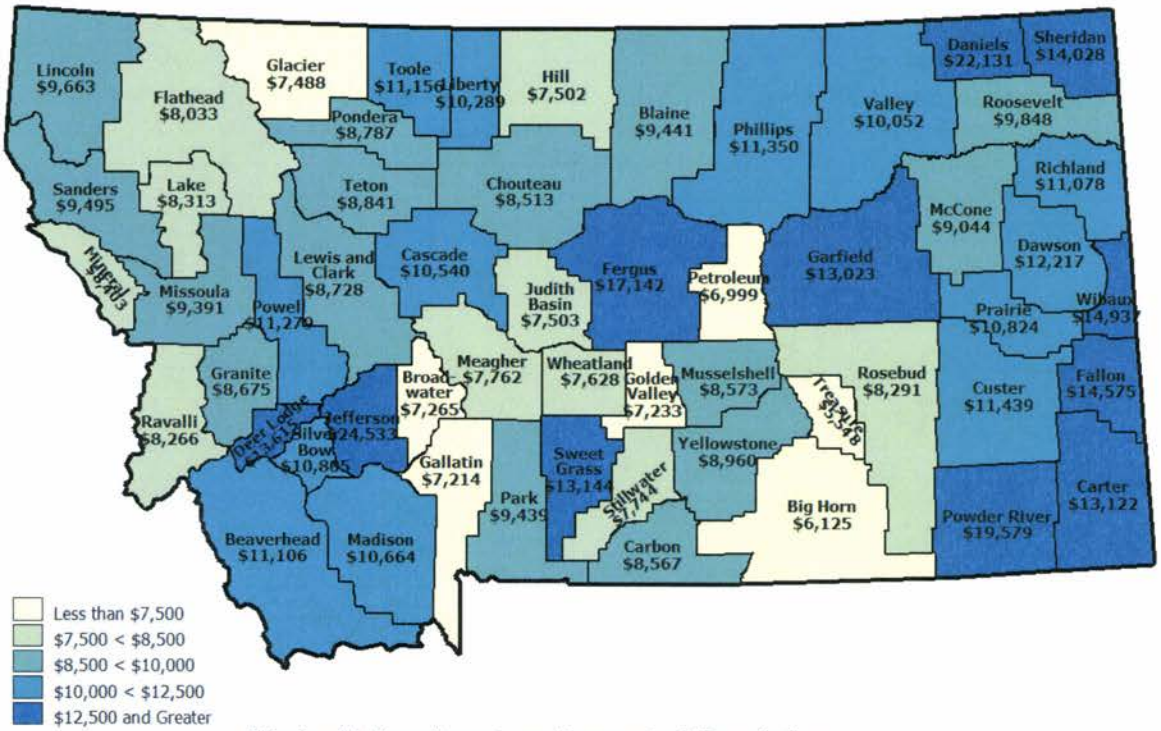
Total Medicaid Expenses
State Fiscal Year 2013



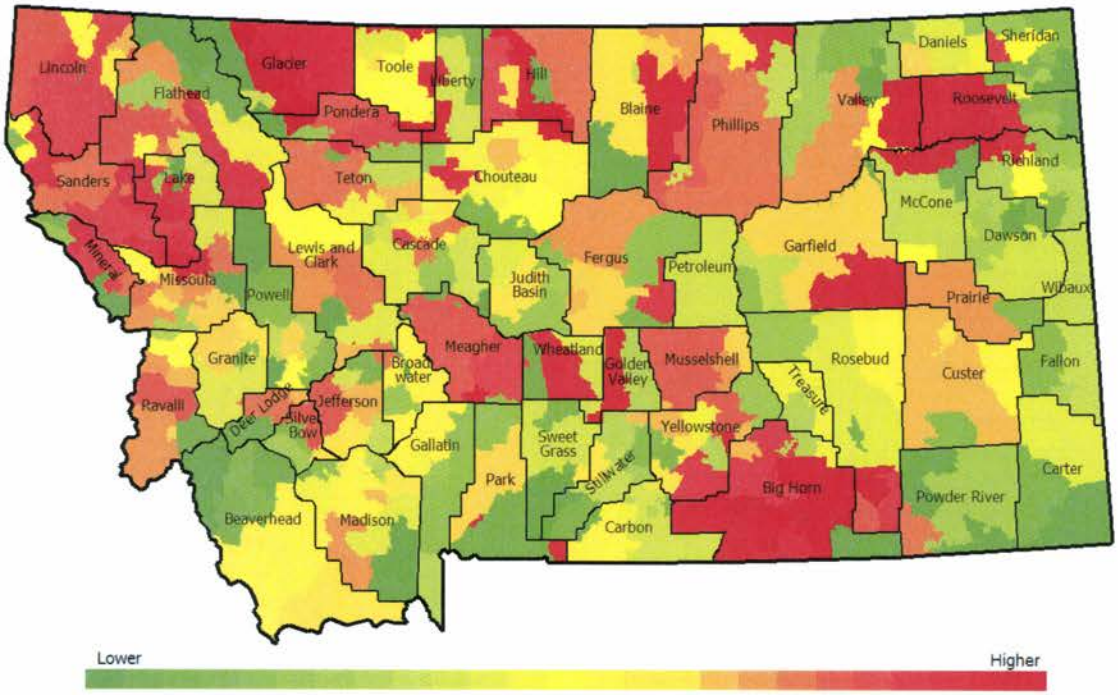
Medicaid Average Monthly Enrollment
State Fiscal Year 2013

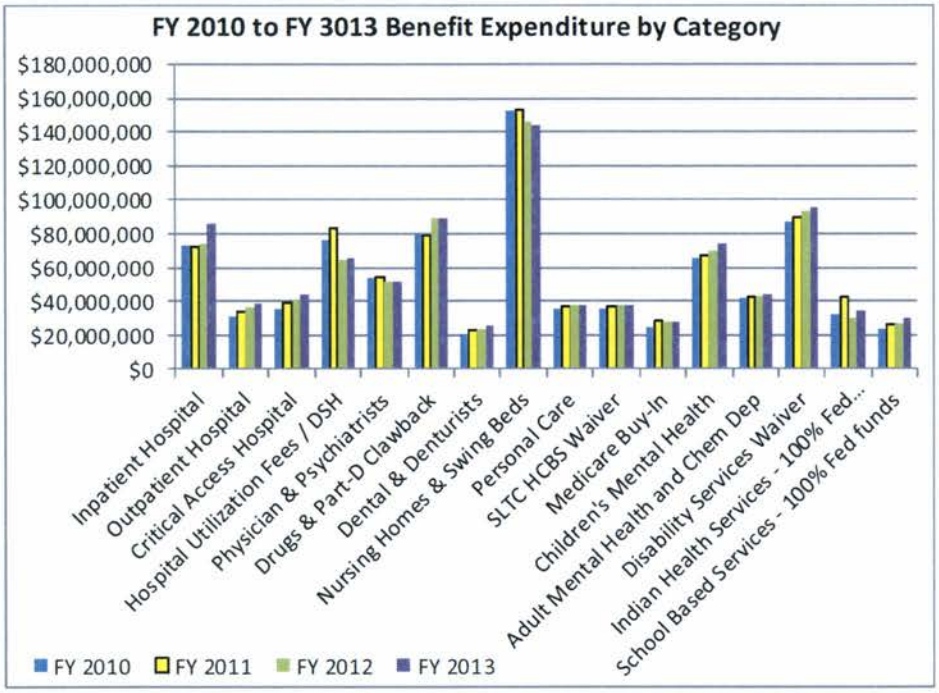


Average Expenditure per Enrollee
State Fiscal Year 2013

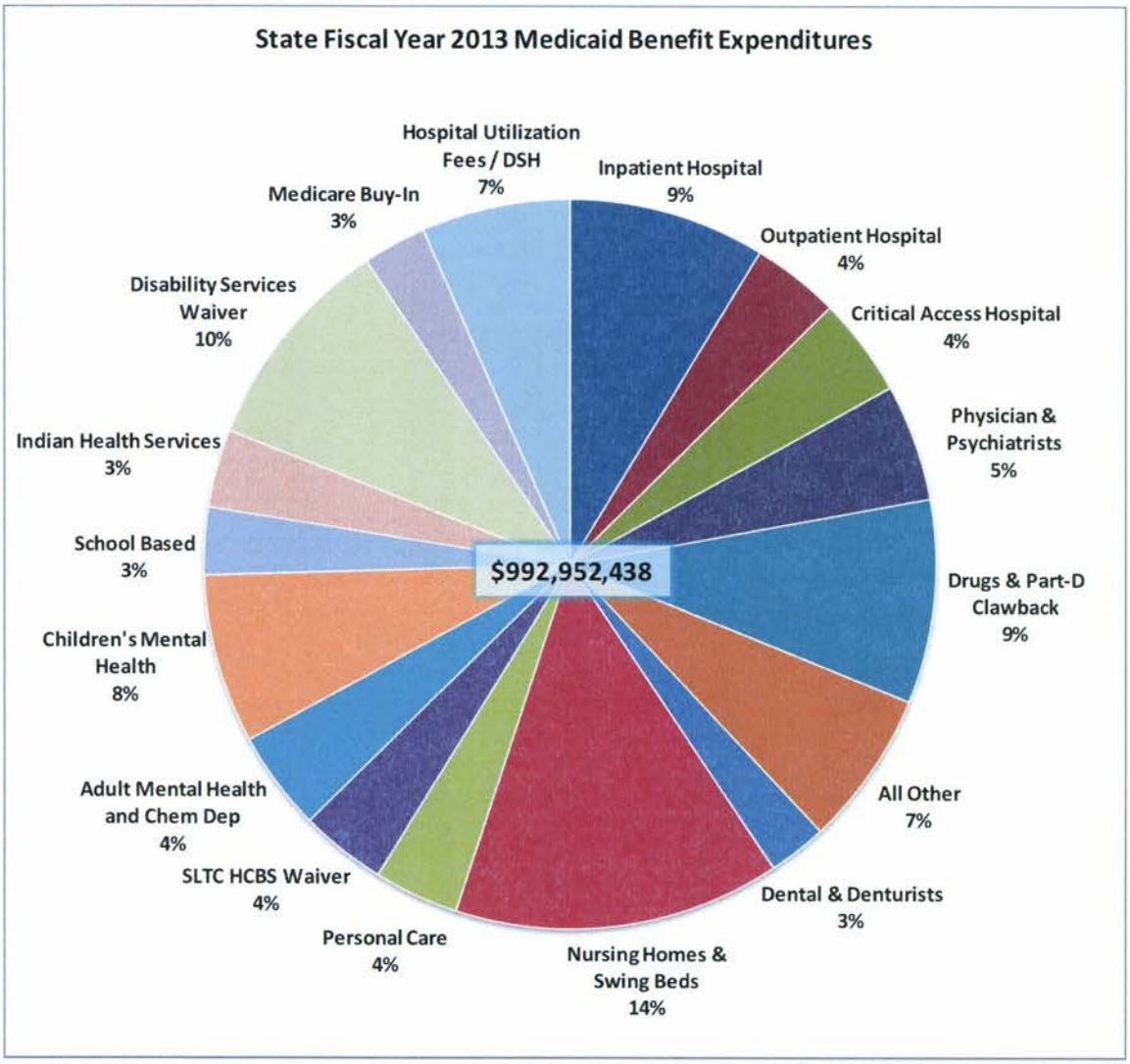


Medicaid Enrollment as Percent of Population
State Fiscal year 2013





	Medicaid Expenditures			
Categories	FY 2010	FY 2011	FY 2012	FY 2013
Inpatient Hospital	$ 72,854,446	$ 72,994,411	$ 74,489,667	$ 86,298,648
Outpatient Hospital	31,395,814	33,895,624	36,466,846	38,531,037
Critical Access Hospital	35,203,504	39,618,220	40,941,235	43,576,948
Hospital Utilization Fees / DSH	76,397,030	82,974,552	63,996,224	65,313,864
Other Hospital and Clinical Services	16,798,917	20,278,690	20,345,818	21,334,479
Physician & Psychiatrists	53,255,184	53,723,103	51,426,086	51,330,868
Other Practitioners	15,862,391	17,170,987	16,925,276	17,251,788
Other Managed Care Services	6,946,131	8,576,917	8,600,743	10,016,114
Drugs & Part-D Clawback	78,979,604	78,584,700	89,391,673	89,567,833
Drug Rebates	(27,238,227)	(29,809,486)	(48,090,298)	(42,546,104)
Dental & Denturists	19,981,116	23,390,123	23,358,568	25,756,407
Durable Medical Equipment	12,745,605	13,756,975	14,207,693	14,951,877
Other Acute Services	2,771,667	2,621,284	2,557,646	2,891,055
Nursing Homes & Swing Beds	152,904,654	152,872,475	146,107,349	143,565,202
Nursing Home IGT	3,977,854	10,729,944	16,100,124	15,745,215
Personal Care	35,193,587	37,280,868	37,727,708	37,329,608
Other SLTC Home Based Services	11,085,490	11,206,390	10,344,719	9,487,549
SLTC HCBS Waiver	35,502,742	36,501,317	37,640,206	37,755,892
Medicare Buy-In	24,636,881	28,579,323	27,934,865	28,153,453
Children's Mental Health	65,361,684	67,075,994	69,564,235	74,479,177
Adult Mental Health and Chem Dep	41,680,676	42,201,677	42,739,847	43,590,929
HIFA Waiver	75	967,327	5,660,297	7,449,015
Disability Services Waiver	87,163,567	89,439,291	93,562,549	95,600,410
Indian Health Services - 100% Fed funds	32,042,071	42,137,675	29,811,895	34,391,574
School Based Services - 100% Fed funds	23,877,319	25,980,483	26,978,363	29,605,648
MDC & ICF Facilities - 100% Fed funds	15,097,759	12,690,679	9,896,811	11,523,954
Total	$ 924,477,541	$ 975,439,542	$ 948,686,144	$ 992,952,438


State Fiscal Year 2013 Medicaid Benefit Expenditures
$992,952,438
Hospital Utilization Fees / DSH 7%
Inpatient Hospital 9%
Outpatient Hospital 4%
Critical Access Hospital 4%
Physician & Psychiatrists 5%
Drugs & Part-D Clawback 9%
All Other 7%
Dental & Denturists 3%
Nursing Homes & Swing Beds 14%
Personal Care 4%
SLTC HCBS Waiver 4%
Adult Mental Health and Chem Dep 4%
Children's Mental Health 8%
School Based 3%
Indian Health Services 3%
Disability Services Waiver 10%
Medicare Buy-In 3%

The charts and tables below show the average per-member per-month reimbursement for various age groups and Medicaid eligibility categories. This calculation merges claims and eligibility data. While eligibility is updated over time, once a claim is processed, the information on the claim is static. The new methodology ensures a client's enrollment and reimbursement are counted in the same category and the updated enrollment information takes precedence over the claim information.

History of Expenditures and Enrollment

Enrollment and expenditures exclude administrative costs, Medicare Savings Plan, HMK (CHIP) and State Funded Mental Health. Decline in per-member reimbursement is attributable to increased enrollment of low cost children.

Medicaid Average Enrollment per Month

		State Fiscal Year					
Age	**Category**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**
< 1	Blind/Disabled	79	69	75	70	64	50
< 1	Child	5,298	5,373	5,642	5,854	5,816	5,843
1 to 5	Blind/Disabled	615	627	655	629	601	573
1 to 5	Child	15,812	16,481	19,357	22,170	22,525	23,838
6 to 18	Blind/Disabled	2,205	2,284	2,324	2,395	2,436	2,463
6 to 18	Child	22,675	23,128	26,971	31,598	32,923	35,819
19 to 20	Blind/Disabled	491	501	532	525	516	505
19 to 20	Adult	1,119	1,192	1,289	1,226	1,035	970
21 to 64	Blind/Disabled	14,422	14,911	15,366	15,823	16,231	16,473
21 to 64	Adult	10,363	10,252	11,486	12,349	11,856	11,925
65 +	Aged	6,084	6,125	6,467	6,959	6,922	7,033
65 +	Blind/Disabled	751	754	526	156	170	204
Total		**79,915**	**81,698**	**90,688**	**99,754**	**101,093**	**105,696**
All	Plan First					15	1,316
All	QMB	3,139	3,187	3,363	3,651	3,809	4,201
All	SLMB - QI	2,665	2,895	3,132	3,485	3,653	3,971
Total	**All Medicaid**	**85,719**	**87,780**	**97,183**	**106,890**	**108,571**	**115,184**
6 to 18	HK Med Plus			2,071	5,553	6,305	7,340
Total	**All Categories**	**85,719**	**87,780**	**99,254**	**112,443**	**114,876**	**122,524**

Categories may not sum to totals due to rounding. For QMB only enrollees, Medicaid pays for Medicare Premiums, co-insurance, and deductibles. For SLMB - QI only enrollees, Medicaid pays for Medicare Premiums. HK Med Plus are Medicaid clients age 6 to 18 that are funded through CHIP. Plan First clients receive a limited benefit for family planning services.

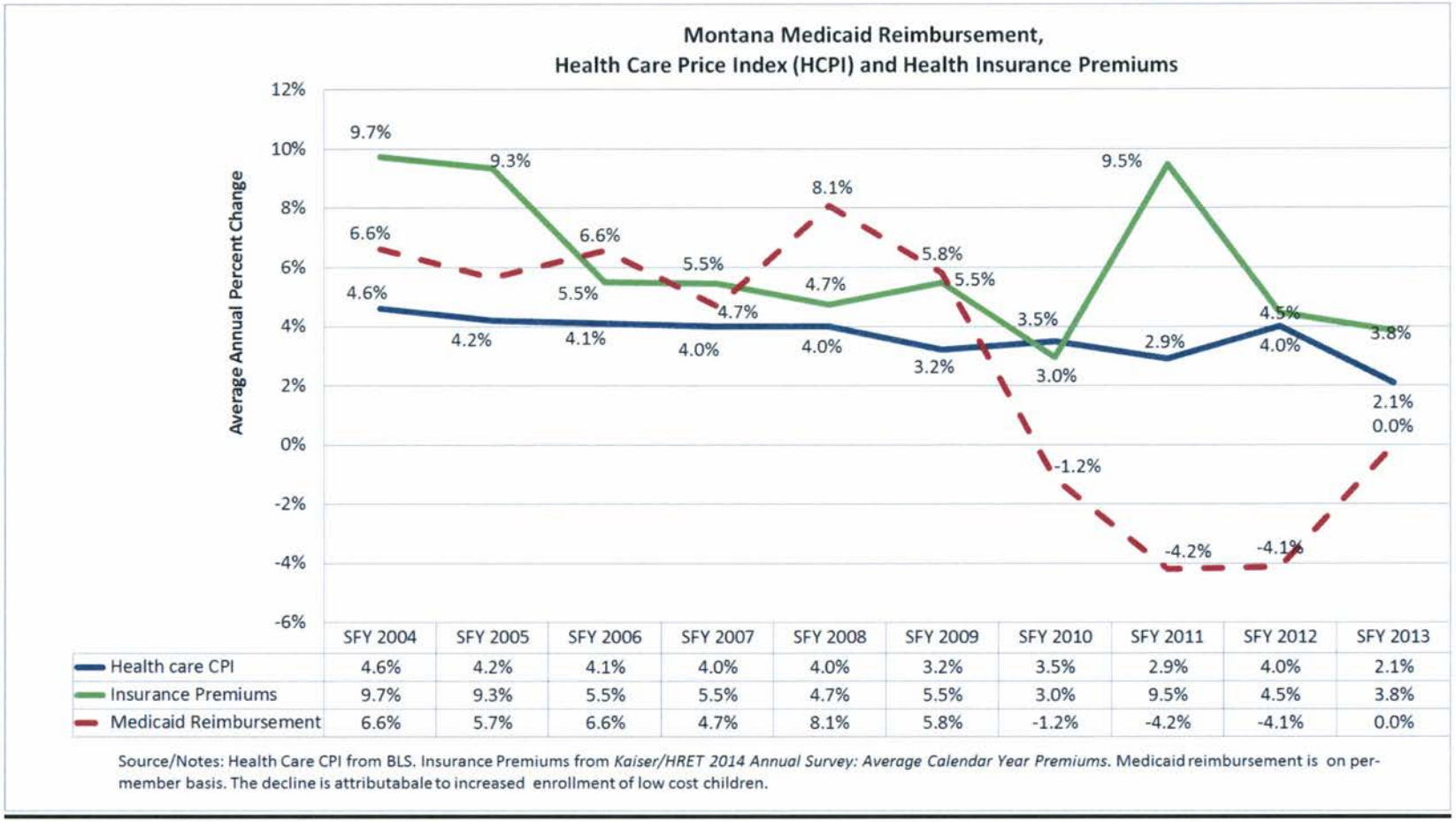
Medicaid Per Member Per Month Reimbursement

		State Fiscal Year					
Age	**Category**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**
< 1	Blind/Disabled	$4,624	$3,702	$5,975	$3,975	$4,995	$4,491
< 1	Child	$728	$735	$661	$724	$650	$767
1 to 5	Blind/Disabled	$1,289	$1,516	$1,655	$1,748	$1,711	$1,640
1 to 5	Child	$139	$151	$168	$168	$156	$163
6 to 18	Blind/Disabled	$1,922	$1,863	$1,921	$1,902	$1,908	$2,021
6 to 18	Child	$320	$351	$354	$336	$326	$330
19 to 20	Blind/Disabled	$1,532	$1,531	$1,291	$1,547	$1,444	$1,294
19 to 20	Adult	$650	$699	$713	$758	$702	$754
21 to 64	Blind/Disabled	$1,572	$1,699	$1,812	$1,800	$1,716	$1,760
21 to 64	Adult	$567	$614	$630	$648	$625	$645
65 +	Aged	$2,384	$2,473	$2,496	$2,464	$2,437	$2,380
65 +	Blind/Disabled	$1,005	$1,081	$1,243	$1,218	$1,132	$1,113
Total		**$801**	**$847**	**$838**	**$803**	**$770**	**$770**
All	Plan First					$84	$63
All	QMB	$182	$220	$214	$217	$218	$214
All	SLMB - QI	$98	$122	$106	$119	$113	$108
Total	**All Medicaid**	**$756**	**$800**	**$793**	**$760**	**$728**	**$718**
6 to 18	HK Med Plus			$183	$208	$215	$233
Total	**All Categories**	**$756**	**$800**	**$780**	**$733**	**$700**	**$689**

For QMB only enrollees, Medicaid pays for Medicare Premiums, co-insurance, and deductibles. For SLMB - QI only enrollees, Medicaid pays for Medicare Premiums. HK Med Plus are Medicaid clients age 6 to 18 that are funded through CHIP. Plan First clients receive a limited benefit for family planning services.

Medicaid Reimbursement							
		State Fiscal Year					
Age	Category	2008	2009	2010	2011	2012	2013
< 1	Blind/Disabled	$4,402,477	$3,053,961	$5,359,495	$3,343,327	$3,826,537	$2,699,332
< 1	Child	$46,309,938	$47,406,421	$44,767,497	$50,857,926	$45,337,453	$53,752,254
1 to 5	Blind/Disabled	$9,502,473	$11,411,132	$13,003,483	$13,205,019	$12,334,490	$11,278,233
1 to 5	Child	$26,298,747	$29,834,907	$38,997,021	$44,648,031	$42,063,901	$46,579,168
6 to 18	Blind/Disabled	$50,847,861	$51,066,090	$53,560,273	$54,685,940	$55,767,775	$59,720,047
6 to 18	Child	$87,164,346	$97,360,354	$114,414,815	$127,386,272	$128,805,634	$141,699,967
19 to 20	Blind/Disabled	$9,031,722	$9,213,983	$8,233,085	$9,744,945	$8,945,917	$7,838,865
19 to 20	Adult	$8,727,562	$9,995,938	$11,020,611	$11,150,549	$8,719,926	$8,777,120
21 to 64	Blind/Disabled	$272,122,953	$304,061,127	$334,079,485	$341,832,599	$334,308,622	$347,820,629
21 to 64	Adult	$70,555,258	$75,527,865	$86,839,182	$96,092,740	$88,883,098	$92,237,865
65 +	Aged	$174,069,013	$181,740,843	$193,722,509	$205,756,913	$202,430,401	$200,877,522
65 +	Blind/Disabled	$9,060,733	$9,783,528	$7,837,553	$2,277,355	$2,307,791	$2,730,530
Total		**$768,093,081**	**$830,456,149**	**$911,835,009**	**$960,981,616**	**$933,731,544**	**$976,011,533**
All	Plan First					$15,293	$996,859
All	QMB	$6,868,008	$8,396,204	$8,655,356	$9,490,065	$9,987,258	$10,811,649
All	SLMB - QI	$3,148,786	$4,238,449	$3,987,176	$4,967,860	$4,952,049	$5,132,398
Total	**All Medicaid**	**$778,109,875**	**$843,090,802**	**$924,477,541**	**$975,439,542**	**$948,686,144**	**$992,952,438**
6 to 18	HK Med Plus			$4,537,995	$13,887,439	$16,272,873	$20,495,670
Total	**All Categories**	**$778,109,875**	**$843,090,802**	**$929,015,537**	**$989,326,981**	**$964,959,017**	**$1,013,448,109**

Categories may not sum to totals due to rounding. For QMB only enrollees, Medicaid pays for Medicare Premiums, co-insurance, and deductibles. For SLMB - QI only enrollees, Medicaid pays for Medicare Premiums. HK Med Plus are Medicaid clients age 6 to 18 that are funded through CHIP. Plan First clients receive a limited benefit for family planning services.



	SFY 2004	SFY 2005	SFY 2006	SFY 2007	SFY 2008	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013
Health care CPI	4.6%	4.2%	4.1%	4.0%	4.0%	3.2%	3.5%	2.9%	4.0%	2.1%
Insurance Premiums	9.7%	9.3%	5.5%	5.5%	4.7%	5.5%	3.0%	9.5%	4.5%	3.8%
Medicaid Reimbursement	6.6%	5.7%	6.6%	4.7%	8.1%	5.8%	-1.2%	-4.2%	-4.1%	0.0%

Source/Notes: Health Care CPI from BLS. Insurance Premiums from *Kaiser/HRET 2014 Annual Survey: Average Calendar Year Premiums*. Medicaid reimbursement is on per-member basis. The decline is attributabale to increased enrollment of low cost children.

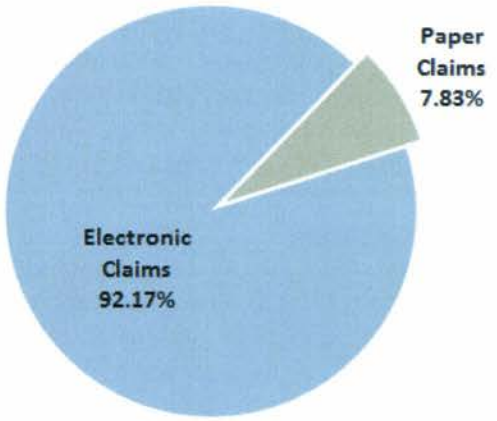
PROVIDERS

Medicaid provides services through a statewide network of private and public providers. In SFY 2013, payments were made to over 13,000 providers who participated and offered services to Medicaid members. These providers predominately live and work in communities across the state. In many cases (nursing facilities, hospitals) they are a major employer. In SFY 2014, Medicaid reimbursement of approximately $1 billion was a vital part of the Montana economy.

CLAIMS PROCESSING

The Department contracts with Xerox to process claims for reimbursement. Xerox meets the rigorous requirements established by the Centers for Medicare and Medicaid Services to be a Medicaid fiscal agent. Xerox processed nearly 8 million claims in SFY 2013.

Claim Type	*Number Processed*	*% of Total*
Paper Claims	621,214	7.83%
Electronic Claims	7,312,552	92.17%
Total Claims	7,933,766	100%



RATE SETTING PROCESS

The Montana Medicaid Program uses several methods to establish payment rates for services. The methodology used for reimbursement varies from service to service.

Reimbursement Systems for Hospitals

Montana Medicaid's reimbursement systems include a Diagnosis Related Groups (DRG) system for inpatient services for some hospitals, Ambulatory Payment Classification (APC) for these same hospitals for outpatient hospital services, cost based reimbursement for hospitals classified as Critical Access Hospitals and Resource Based Relative Value Scale (RBRVS) for physician/professional services. These reimbursement systems use cost, utilization, and other factors – such as measures of relative value or relative acuity – in determining provider payment rates.

Resource Based Relative Value System (RBRVS)

Montana Medicaid reimburses physicians and other providers who bill on CMS-1500 forms with Medicare's resource based relative value system (RBRVS). Reimbursement is based on the value of a service relative to all other services. The calculations compare the resources needed for a specific service (office expenses, malpractice insurance, and provider work effort and complexity) to those needed for other services. Each service code is assigned one or more relative value units (RVU's) designating its position on the relative value scale. This system was developed nationally by Centers for Medicare & Medicaid Services (CMS), the American Medical Association, and non-physician provider associations; it is adjusted annually. Montana receives the benefit of this large, ongoing investment in research and policy-making without yielding control of costs. The fee for each code is determined by multiplying the RVU by a conversion factor with a dollar value. The conversion factor is Montana-specific to insure the overall budget neutrality of the Medicaid appropriation. The conversion factor is adjusted annually based on the Montana Legislature's most recent biennial appropriation.

Price-Based Reimbursement System

Nursing facilities are reimbursed under a case mix, price-based system where rates are determined annually, effective July 1. Each nursing facility receives a facility specific rate. The statewide price for nursing facility services is established annually through a public process. Each nursing facility's payment is comprised of two components, the operating component including capital and the direct resident care component. Each nursing facility receives the same operating per diem rate, which is 80% of the statewide price. The remaining 20% of the statewide price represents the direct resident care component of the rate and is acuity adjusted using minimum data set (MDS). Each facility's direct resident care component rate is specific to the facility based on the acuity of the Medicaid residents served in the facility.

Fee-for-Service

Fee-for-service simply means that a fee is established for a certain product or service. Pharmacy services are one of the major services reimbursed under the fee for service methodology. Pharmacies receive both a dispensing fee for each prescription plus the cost of the ingredient. Ingredient costs are reimbursed at the estimated acquisition cost for each product.

Medicaid uses the Medicare fee-for-service rates and per encounter payment systems for some programs. This allows efficient maintenance and the use of already established fee schedules for certain areas. Some examples of programs that use Medicare fee schedules include Durable Medical Equipment, Ambulatory Surgical Centers, and Federally Qualified Health Clinics.

COST CONTAINMENT MEASURES

The Medicaid program continues to develop cost containment measures that enhance the cost effectiveness and efficiency of the program. Some examples include:

School Based Services

- Services previously provided by local school districts have been refinanced using federal Medicaid match. This allows children to receive additional needed services such as mental health care and speech therapy at no additional cost to the school district. The Office of Public Instruction certifies the match for the general fund portion for Medicaid reimbursed health-related services provided as part of the child's Individualized Education Plans.

Physician / Mid-Level Practitioner

- **Nurse Advice Line** - Toll free, confidential advice line available to all people with Medicaid. Registered nurses triage caller's symptoms and guide callers to obtain care in appropriate settings (self-care, physician, or urgent or emergent care).

- **Team Care** - Medicaid members with a history of using Medicaid services at an amount or frequency that is not medically necessary are required to participate in order to control utilization. Team Care members are managed by a team consisting of a PASSPORT primary care provider, one pharmacy, the Nurse Advice Line, and DPHHS staff. Team Care currently has 600 members.

- **Passport to Health** - Primary Case Management Program was implemented in 1993 to cost-avoid medical costs and improve quality of care. A member chooses one primary care provider who performs or provides referrals for almost all of the member's care. Periodic surveys show that more than 80% of both providers and members are satisfied with Passport to Health.

Patient-Centered Medical Home

- The Patient-Centered Medical Home model of care, implemented in December 2014, is designed to provide Medicaid members with a comprehensive, coordinated approach to primary care. Primary Care Providers (PCPs) will receive additional reimbursement for each panel member enrolled for providing enhanced services and a supported infrastructure. The Department has offered contracts to 5 providers to test the efficiency of the program. If all providers participate, over 8,800 members will be served.

Hospital

- **Out-of-State Inpatient and Outpatient Hospital** - Prior authorization requiring a mandatory advance approval for all inpatient hospital services out-of-state. Encourage the utilization of available health resources in-state.

Transportation

- Prior authorization and assistance with obtaining transportation services.

Eyeglasses

- Bulk purchase of eyeglasses through a contract with a significantly reduced price.

Long Acting Reversible Contraceptives (LARC)

- Hospitals can bill for the LARC, inserted at the time of delivery, separately to receive reimbursement and potentially increase the use of LARC and reduce unplanned pregnancies.

Early/Elective Inductions and Cesarean Sections

- Elective inductions, cesarean sections, and early deliveries all increase the risk to both mother and infant, and there is no evidence that they confer any health benefits in the absence of medical indications. Reimbursement reductions are taken on claims for non-medically necessary inductions prior to 39 weeks and 0/7 days or non-medically necessary cesarean deliveries at any gestation.

Pharmacy

- **Prior Authorization -** Mandatory advance approval of certain drugs before they are dispensed for any medically accepted indication. This process is handled either by a live person at the Drug PA unit or through the pharmacy claims processing program.

- **Drug Utilization Review** - Prospective and retrospective review of drug use to ensure proper utilization

- **Over-the-Counter Drug Coverage** - When prescribed by a physician a cost effective alternative to higher priced federal legend drugs.

- **Mandatory Generic Substitution** - Requires pharmacies to dispense the generic form of the drug which is less expensive than brand name drugs.

- **Dispensing Restrictions** - Minimum or maximum quantities per prescription or number of refills.

- **Preferred Drug List and Supplemental Rebates** - Medicaid's Drug Utilization Review Board/Formulary committee selects drugs in various classes of medications. Extensive review of the medications by the Board yields drugs that represent the best value to the Medicaid program. Many of the preferred drugs also provide supplemental rebates above what is currently offered through the federal Medicaid program.

- **Drug Rebate Collection** - The Department has four full-time staff dedicated to the rebate program and the use of the Drug Rebate Analysis and Management System. The staff conducts claims audits and invoice audits prior to invoicing pharmaceutical manufacturers. These staff procedures assure more accurate invoices being sent to the manufacturers and eliminate or reduce disputes with the manufacturers. This results in more timely payments being received from the manufacturers. Drug rebates average approximately 50% of the Medicaid pharmacy expenditures. In SFY 2013, drug rebates were approximately $42.5 million.

- **State Maximum Allowable Cost (SMAC) –** The SMAC list is comprised of multiple source drugs meeting the following criteria: marketed and sold by three or more manufacturers; eligible for federal rebate; and product must be in sufficient supply and attainable by MT pharmacies. In addition, pharmacies may submit a SMAC pricing inquiry form along with their purchasing invoice if they find the SMAC price to be below their acquisition cost. The SMAC is the state average acquisition cost per drug as determined by direct pharmacy survey, wholesale survey, and other relevant cost information. SMAC pricing is part of the Department's lesser of drug pricing algorithm and results in several million dollars in savings to the state.

- **Consistent formulary** – Children that change eligibility between HMK Plus and HMK are now on the same prescription drug formulary. This provides continuity of care and decreases drug changes.

Long Term Care

- **Money Follows the Person (MFP)** - Montana was awarded a Money Follows the Person (MFP) demonstration grant from the Centers for Medicare and Medicaid Services (CMS) to augment existing Montana's community-based long term services and supports and to increase home and community based services. The grant provides a temporary increase in the federal share of the Medicaid matching rate to pay for services to people who are already receiving Medicaid funded care in an institutional setting and choose to move into certain types of community settings.

  Montana's MFP demonstration project will target persons in Montana Developmental Center (MDC) transitioning to the community; persons with Severe Disabling Mental Illness (SDMI) in nursing homes; persons with physical disabilities and elders in nursing homes; persons with complex needs in nursing homes, including those with a traumatic brain injury; 18-21 year olds in the Montana State Hospital; and youth in PRTF transitioning to community settings.

  All waiver and demonstration services receive an enhanced FMAP rate for Medicaid benefits for a period of 365 days of service. At day 366, a participant is served under their qualified waiver at their regular FMAP. Grant funding was awarded up to $12,303,184 effective September 27, 2012 through March 31, 2016. The transition time has been extended through December 31, 2017 with services continuing through 2018.

- **Community First Choice** - Montana is the fourth state to have a Community First Choice (CFC) state plan approved by the Centers for Medicare and Medicaid (CMS) to implement the CFC option, of Section 2401 of the Affordable Care Act and Section 1915(k) of the Social Security Act. Montana's Medicaid State Plan Amendment adding CFC services was approved on July 8, 2014, with a retroactive effective date of October 1, 2013. Montana's program covers home and community-based attendant services and supports to assist members with activities of daily living (ADLs), instrumental activities of daily living (IADLs), health-related related tasks, and related support services, as specified in the ACA regulations. The incentive to adopt this option is a permanent 6% increase in the federal share of Medicaid's cost for CFC services (the FMAP Rate).

- **Long term care insurance** - Long term care insurance partnerships were added to the insurance options that are available in Montana for consumers. Purchase of insurance will help defray Medicaid costs in the future once partnership policies are utilized. An institutionalized/waiver individual or spouse who purchased a Qualified Long Term Care Partnership (LTC) policy or converted a previously-existing LTC policy to a Qualified LTC Partnership policy on or after July 1, 2009 may protect resources equal to the insurance benefits received from the policy.

  Asset protection through LTC Partnership is available only after Qualified LTC Partnership policy lifetime limits have been fully exhausted on LTC services for the Medicaid applicant or spouse. The amount of assets protected will be equal to the insurance benefits paid.

- **Prior authorization** - Prior authorization for personal assistance services.

- **Intergovernmental fund transfer** - Intergovernmental fund transfer for counties to provide additional payments to at-risk nursing facilities. Nursing facilities pay a fee that is matched with federal funds. This is an important component of nursing home reimbursement.

- **Nursing facility transitions** - Nursing facility transitions have been used as a vehicle to provide services in the least restrictive setting to consumers who move from the nursing facility into community services; with dollars for services following them from the nursing facility budget in a money follows the person approach to rebalancing the long term care system. Typically individuals can be served in the community at a lower cost than in the institution. Since FY 2004, over 300 people have transitioned from nursing facilities into community services; with dollars for services following them from the nursing facility into the community. During FY 2014, 72 members were transitioned from nursing facilities into community service placements.

Third Party Liability (TPL):
The Human and Community Services Division and Quality Assurance Division lead the Department efforts to identify third parties liable for payment of a Medicaid member's medical

costs. Third parties include Medicare, private health insurance, auto accident policies and workers compensation. Medicaid also recovers payments made from the estates of members who have passed away or certain long term services. This identification of third party liability resulted in avoidance of over $179.5 million in SFY 2014.

Medicaid Buy-In and Medicare Savings Program
Medicare Buy-in results in major cost avoidance for Montana Medicaid by making Medicare the primary payer for people who have both Medicare and Medicaid ("full" dual eligible). Medicare Part-B premiums are paid directly to CMS for certain low income "full" dual eligible. Medicare Part-A premiums are also paid for those Medicaid enrollees receiving Supplemental Security Income (SSI) payments who become entitled to Medicare at age 65.

The Medicare Savings Program also provides Medicare Buy-in benefits to people with Medicare who are not eligible for full Medicaid services but have limited income and assets. Depending on income, an individual may be classified as a qualified Medicare Beneficiary (QMB), which covers both the Medicare Part A and B premiums and some co-payments and deductibles; Specified Low Medicare Beneficiary (SLMB), which covers the Medicare Part-B premium only; or Qualified Individual (QI-1), which covers the Medicare Part-B premium through 100% federal dollars. All three programs automatically entitle the enrollee to Low Income Subsidy (LIS) or "Extra Help" status for the Medicare Prescription Drug Plan (Part-D).

Due to the cost efficiency of having Medicare as the first payer, a concerted effort is ongoing to ensure that anyone meeting the eligibility criteria is enrolled.

PROGRAM AND PAYMENT INTEGRITY ACTIVITIES

Improper payments in Medicaid drain vital program dollars, impacting members and taxpayers. Such payments include those made for treatments or services not covered by program rules; that were not medically necessary; that were billed but never actually provided; or that have missing or insufficient documentation to show the claim was appropriate. Improper payments are most often the result of inadvertent errors due to clerical errors or a misunderstanding of program rules. Medicaid also has programs to detect fraud and abuse. Fraud involves an intentional act to deceive for gain, while abuse typically involves actions that are inconsistent with acceptable business and medical practices. Medicaid's claim processing system (MMIS) has hundreds of edits that stop payment on many billing errors. However, no computer system can be programmed to prevent all potential Medicaid billing errors.

Medicaid protects taxpayer dollars and the availability of Medicaid services to individuals and families in need by coordinating or cooperating with efforts to identify, recover and prevent inappropriate provider billings and payments.

Two state agencies share responsibility for protecting the integrity of the state Medicaid program. The Quality Assurance Division is responsible for insuring proper payment and recovering misspent funds and the Attorney General's Medicaid Fraud Control Unit (MFCU) is responsible for investigating and ensuring prosecution of Medicaid fraud. At the federal level,

both the Centers for Medicare and Medicaid Services (CMS) and the Office of inspector General (OIG) of the Department of Health and Human Services oversee state program and payment integrity activities. Both CMS and OIG audit the state's Medicaid program on a regular basis.

The Medicaid program is also audited by two federal audit contractors. The Payment Error Rate Measurement (PERM) audit is conducted every three years. This is a comprehensive audit of claims payment and eligibility determination. The total overpayment identified for Montana in 2011 was $11,580. Montana's eligibility audit error rate was 0.4% and the fee-for-service payment error rate was 2.7%. This compares to a 5.8% error rate nationally for both measures. The second audit is the Recovery Audit Contractors (RAC), which is targeted to look at high risk and/or high cost services. The contractor receives 10 percent of recovered funds. In 2014, RAC recoveries totaled $62,980.

Actions resulting from the program and payment integrity efforts may include:

- Clarification and streamlining of Medicaid policies, rules and billing procedures
- Increased payment integrity , recovery of inappropriately billed payments and avoidance of future losses
- Education of providers regarding proper billing practices
- Termination of providers from participation in the Medicaid program
- Referrals to the Attorney General's Medicaid Fraud Control Unit

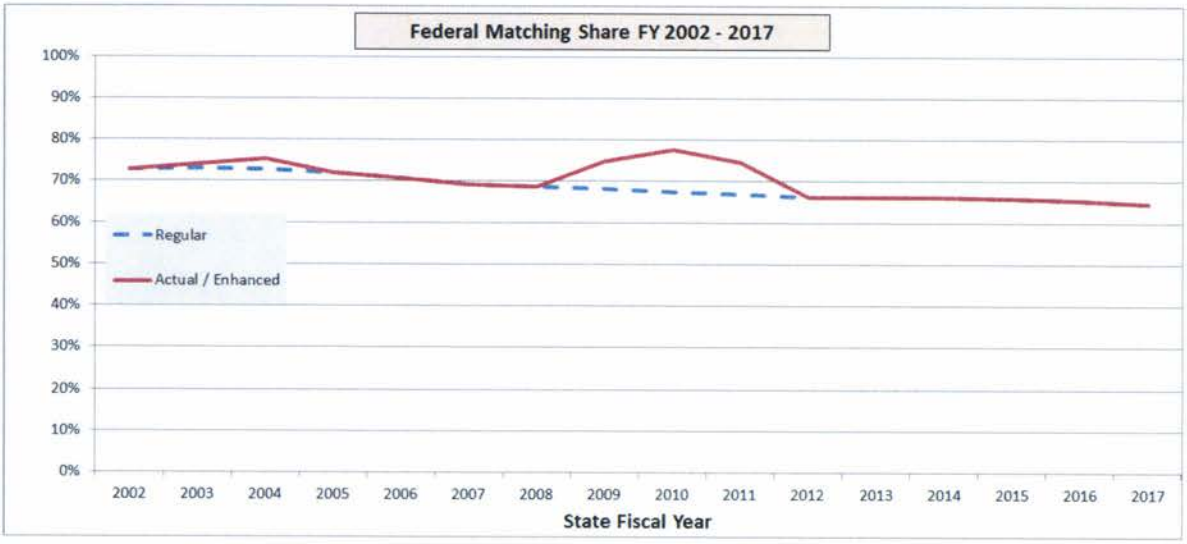
EXPENDITURE ANALYSIS

Medicaid services are funded by a combination of federal and state (and in some situations local) funds. The federal match rate for Medicaid services is based on a formula that takes into account the state average per capita income compared to the national average. For example in Fiscal Year 2008 for every Medicaid dollar, the federal share was 68.59 cents and the Montana state share was 31.41 cents.

Montana Medicaid Benefits Federal Matching

State Fiscal Year	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Federal Match Rate	68.59%	74.80%	77.65%	74.58%	66.21%	66.04%	66.25%	65.92%	65.30%	64.72%
State Match Rate	31.41%	25.20%	22.35%	25.42%	33.79%	33.96%	33.75%	34.08%	34.70%	35.28%

The following chart illustrates the increase in the federal share of Medicaid costs that were made available by the federal government during past economic downturns. The increase in federal match for FY2003-04 was implemented as a result of the Jobs and Growth Tax relief Reconciliation Act of 2003. Federal match was increased in FY2008-11 due to the enactment of the American Recovery and Reinvestment Act.

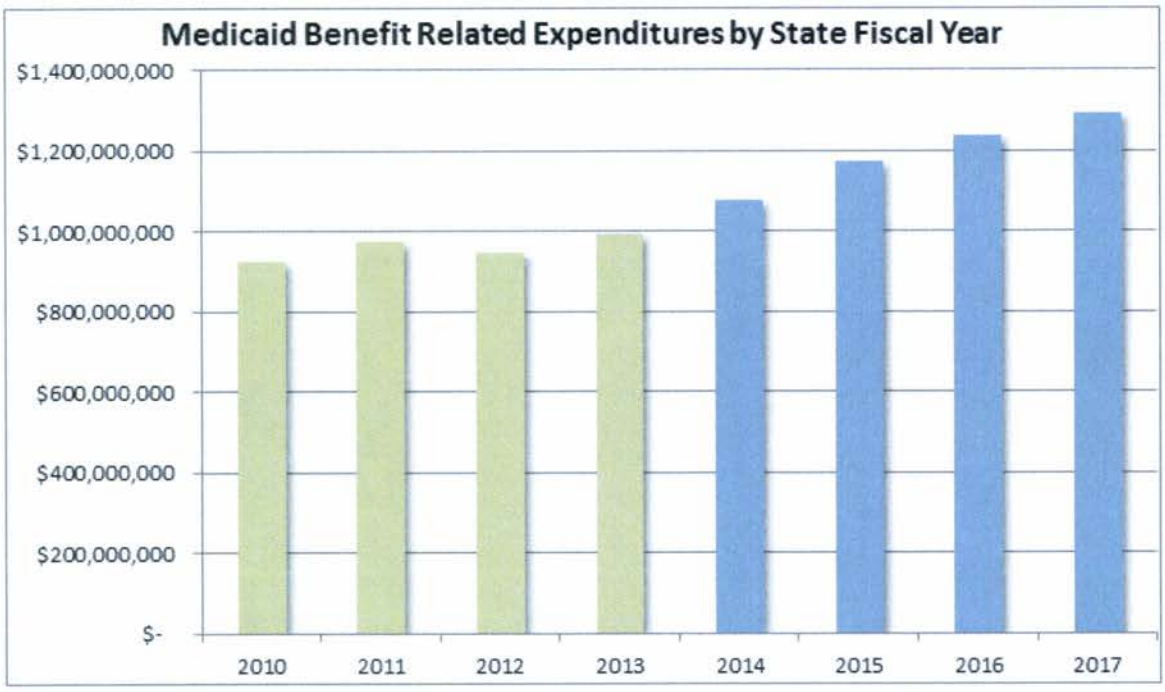


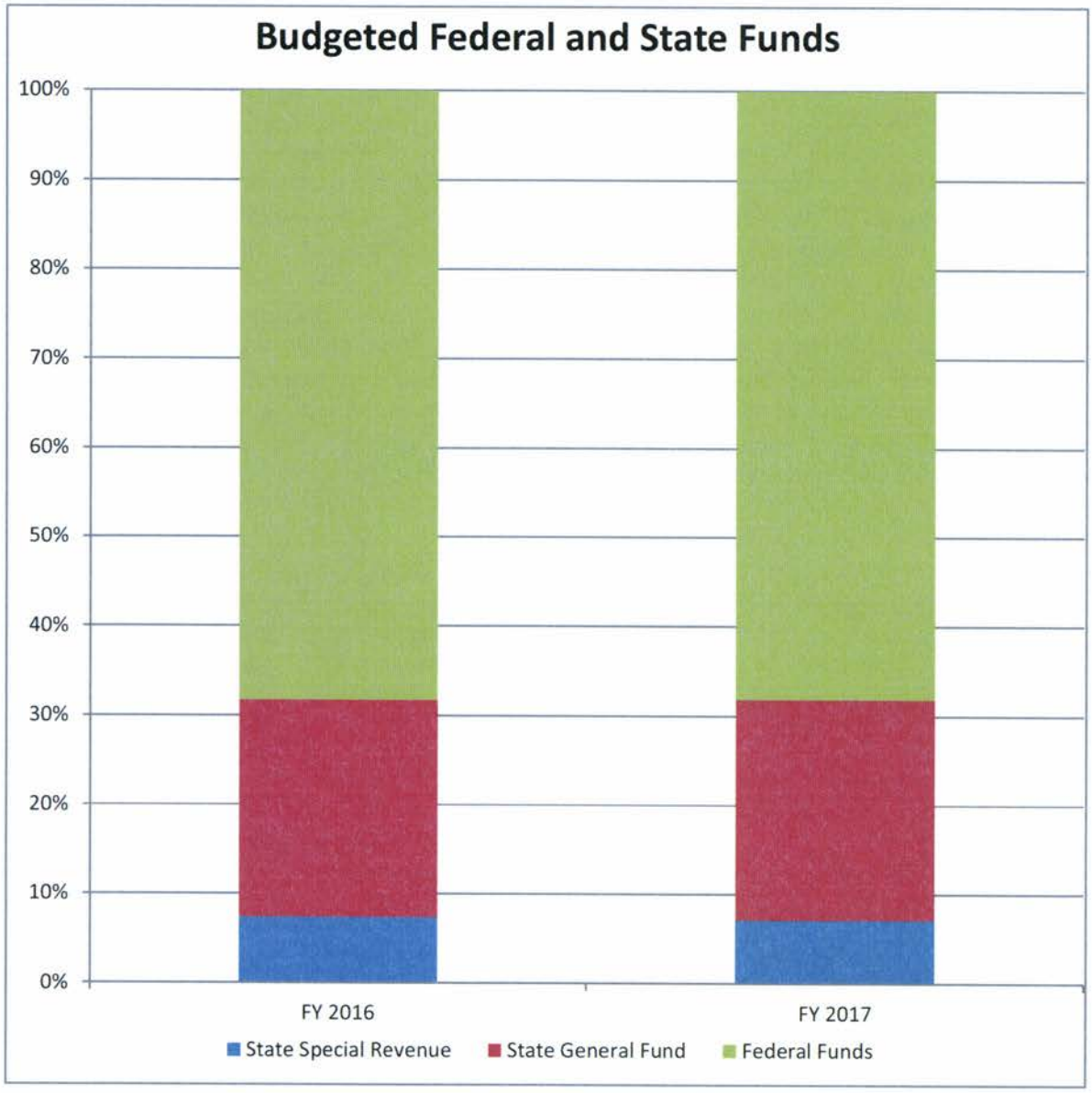
State Fiscal Year	2002	2003	2004	2005	2006	2007	2008	2009
Regular	72.88%	72.96%	72.81%	71.96%	70.66%	69.29%	68.59%	68.08%
Actual / Enhanced	72.88%	74.15%	75.36%	71.96%	70.66%	69.29%	68.59%	74.80%

State Fiscal Year	2010	2011	2012	2013	2014	2015	2016	2017
Regular	67.48%	66.86%	66.21%	66.04%	66.25%	65.92%	65.30%	64.72%
Actual / Enhanced	77.65%	74.58%	66.21%	66.04%	66.25%	65.92%	65.30%	64.72%

Montana Medicaid Benefits Related Expenditures

The following series of Medicaid expenditure data only includes benefit related expenditures. It does not include administrative activity costs. Benefit related expenditures for Hospital Utilization Fee distributions, Medicaid Buy-in, Intergovernmental Transfers (IGT), Pharmacy Rebates, Part-D Pharmacy Clawback, and Institutional Reimbursements for Medicaid, Third Party Liability (TPL), and Medically Needy offsets are included. These are non-audited expenditures on a date of service basis. Unless otherwise noted all reimbursement and eligibility data in the report was collected from the month end reports on September 2014. Data for state fiscal years 2014 to 2017 are the Governor's budgeted amounts and/or estimates.




Budgeted Federal and State Funds
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
FY 2016
FY 2017
State Special Revenue
State General Fund
Federal Funds

Medicaid Reimbursement has been grouped into four types to better analyze past costs and predict future expenditures.

- Core Medicaid consists of reimbursement for traditional medical services. Major categories that are included in Core Medicaid are Inpatient Hospital, Nursing Homes, and Physicians.
- Other Medicaid Components consists of Medicaid reimbursement that is made in addition to medical services, but cannot be matched to a specific client service. Major categories of this type are Nursing Home IGT, Drug Rebate and Clawback.
- Waiver consists of waiver services provided by Medicaid. A further description of the numerous waivers Montana operates is found on page 14-18. Waiver services are provided to people who are aged and/or have a physical disability, developmental delay, or mental illness to allow them to receive care in the community setting.
- Federal Only consists of services where the DPHHS state share for the service is zero. For these services the federal share is either 100% of the service or, as in the case of CSCT services, another entity other than DPHHS pays the state share. Major categories in this type include Indian Health Service and School Services.

	Medicaid Expenditures			
Type	FY 2010	FY 2011	FY 2012	FY 2013
Core Medicaid	$ 625,190,164	$ 650,203,018	$ 656,295,310	$ 679,824,476
Waiver	125,229,233	129,786,897	140,883,373	145,421,476
Federal Only	71,017,149	80,808,837	66,687,069	75,521,176
Other Medicaid Components	103,040,996	114,640,789	84,820,393	92,185,310
Total	$ 924,477,541	$ 975,439,542	$ 948,686,144	$ 992,952,438

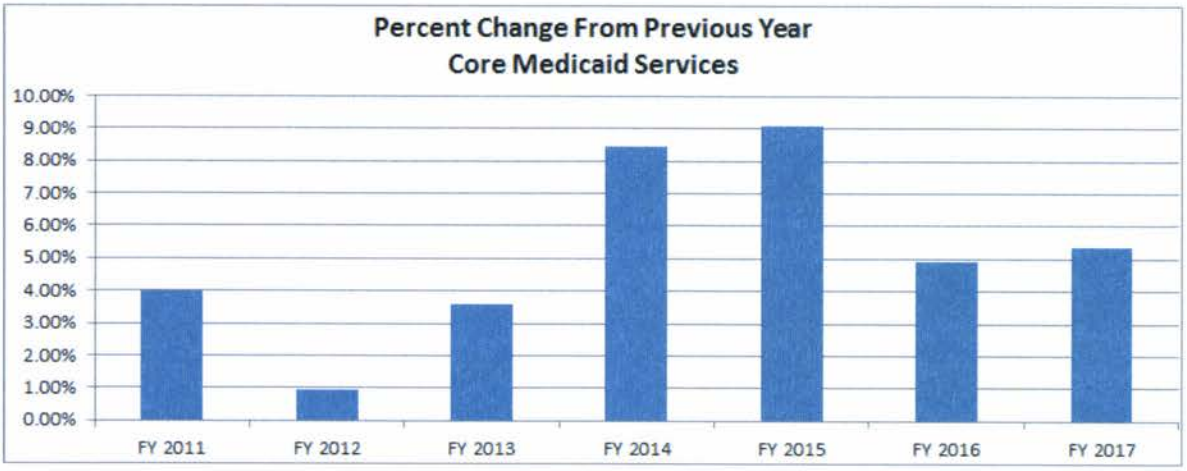
	Percent Change from Previous Year		
Type	FY 2011	FY 2012	FY 2013
Core Medicaid	4.00%	0.94%	3.59%
Waiver	3.64%	8.55%	3.22%
Federal Only	13.79%	-17.48%	13.25%
Other Medicaid Components	11.26%	-26.01%	8.68%
Total	5.51%	-2.74%	4.67%

The top half of the chart above shows the historical expenditures for each reimbursement type from FY 2010 to FY 2013. The bottom of the chart shows the percent change by reimbursement type from the previous year. For example, Waiver type reimbursement in FY 2012 increased by 8.55% over FY 2011.

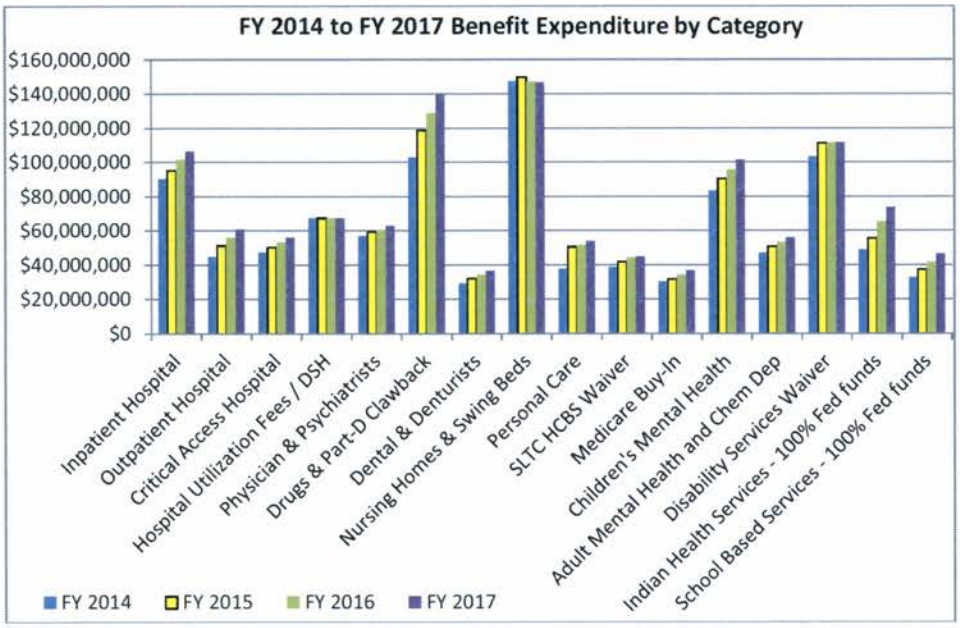
The table on the following page shows the same information for projected Medicaid expenditures in FY 2014 and the Governor's budget for FY 2015 to FY 2017.

Type	Medicaid Expenditures (Projected / Gov's Budget) FY 2014	FY 2015	FY 2016	FY 2017
Core Medicaid	$ 737,425,439	$ 804,504,514	$ 844,095,264	$ 889,244,876
Waiver	156,950,885	171,550,547	187,270,024	188,224,498
Federal Only	93,430,081	104,622,204	118,805,002	132,086,913
Other Medicaid Components	87,233,029	90,765,750	85,143,298	83,338,407
Total	$ 1,075,039,433	$ 1,171,443,015	$ 1,235,313,587	$ 1,292,894,694

Type	Percent Change from Previous Year FY 2015	FY 2016	FY 2017
Core Medicaid	9.10%	4.92%	5.35%
Waiver	9.30%	9.16%	0.51%
Federal Only	11.98%	13.56%	11.18%
Other Medicaid Components	4.05%	-6.19%	-2.12%
Total	8.97%	5.45%	4.66%



The above chart illustrates the percent change from the previous year for each reimbursement type. For FY 2015 to FY 2017 these are the projected budget amounts. The graph shows that projected growth in FY 2016 and FY 2017 is lower than actual growth in FY 2013 to FY 2014. The projected amounts are broken out in more detail on the following page.



	Medicaid Expenditures			
Categories	FY 2014	FY 2015	FY 2016	FY 2017
Inpatient Hospital	$ 90,300,490	$ 95,182,936	$ 101,660,270	$ 106,531,716
Outpatient Hospital	44,860,929	51,373,993	55,931,350	60,892,988
Critical Access Hospital	47,402,831	50,323,872	53,157,788	56,151,292
Hospital Utilization Fees / DSH	67,251,332	67,277,843	67,304,818	67,304,818
Other Hospital and Clinical Services	24,328,484	27,802,221	30,455,030	33,398,531
Physician & Psychiatrists	56,852,089	59,348,478	60,547,255	62,860,003
Other Practitioners	18,938,379	20,660,457	22,059,757	23,560,005
Other Managed Care Services	11,218,501	12,563,167	12,821,953	13,088,023
Drugs & Part-D Clawback	102,832,867	118,771,737	128,862,259	139,899,965
Drug Rebates	(50,938,420)	(53,766,296)	(63,285,743)	(69,138,103)
Dental & Denturists	29,361,019	32,021,100	34,246,997	36,631,471
Durable Medical Equipment	14,854,801	15,596,233	16,292,798	17,020,473
Other Acute Services	3,192,524	3,638,434	4,076,040	4,576,594
Nursing Homes & Swing Beds	147,514,263	149,786,418	147,242,377	146,847,975
Nursing Home IGT	14,247,725	17,885,738	19,003,357	20,150,700
Personal Care	37,565,195	50,487,703	51,602,492	53,868,278
Other SLTC Home Based Services	9,648,479	10,516,210	11,320,689	11,772,559
SLTC HCBS Waiver	38,508,286	41,718,520	44,196,157	44,887,177
Medicare Buy-In	30,266,987	31,679,949	34,115,536	36,777,308
Children's Mental Health	83,366,944	90,334,655	95,664,953	101,533,611
Adult Mental Health and Chem Dep	46,965,484	50,703,470	53,164,391	55,949,361
HIFA Waiver	9,764,473	11,584,215	24,570,027	24,570,027
Disability Services Waiver	103,305,690	111,329,756	111,498,034	111,673,010
Indian Health Services - 100% Fed funds	48,801,397	55,554,356	65,293,125	73,566,629
School Based Services - 100% Fed funds	32,698,000	37,137,165	41,581,192	46,589,600
MDC & ICF Facilities - 100% Fed funds	11,930,684	11,930,684	11,930,684	11,930,684
Total	$ 1,075,039,433	$ 1,171,443,015	$ 1,235,313,587	$ 1,292,894,694

CHRONOLOGY OF MAJOR EVENTS IN MONTANA MEDICAID

2014 - The Patient-Centered Medical Home model of care, implemented in December 2014, is designed to provide medical members with a comprehensive, coordinated approach to primary care. Primary Care Providers (PCPs) will receive additional reimbursement for each panel member enrolled for providing enhanced services and a supported infrastructure. The Department has offered contracts to 5 providers to test the efficiency of the program. If all providers participate, over 8800 members will be served.

2014 - HCBS Settings Regulation were issued by the Centers for Medicare and Medicaid Services (CMS) on March 17, 2014 defining permissible Home and Community Based settings. These regulations require states to submit a "transition plan" of how the State proposes to comply with the new settings requirements. The transition plan was submitted to CMS in December of 2014.

2014 - HIFA waiver amendment submitted June 30, 2014 to include up to 6000 individuals previously eligible for the state-funded Mental Health Services Plan.

2013 - Montana is the fourth state to have a Community First Choice state plan approved by the Centers for Medicare and Medicaid (CMS) to implement the CFC option, of Section 2401 of the Affordable Care Act and Section 1915(k) of the Social Security Act. Montana's Medicaid State Plan Amendment adding CFC services was approved on July 8, 2014, with a retroactive effective date of October 1, 2013. The incentive to adopt this option is a permanent 6% increase in the federal share of Medicaid's cost for CFC services (the FMAP Rate).

2012 - Montana was awarded a Money Follows the Person (MFP) demonstration grant from the Centers for Medicare and Medicaid Services (CMS) to augment existing Montana's community-based long term services and supports (LTSS), and to increase home and community based services (HCBS). The grant provides a temporary increase in the federal share of the Medicaid matching rate to pay for services to people who are already receiving Medicaid funded care in an institutional setting and choose to move into certain types of community settings. All waiver and demonstration services receive an enhanced FMAP rate for Medicaid benefits for a period of 365 days of service. At day 366, a participant is served under their qualified waiver at their regular FMAP. Grant funding was awarded effective 9/27/12 through 3/31/16. The transition time has been extended through 12/31/17 with services continuing through 2018.

2011 – An across-the-board provider rate reduction was implemented in order to comply with 17-7-140 of the Montana Code Annotated which requires a certain ending fund balance.

2011 - The Program for All Inclusive Care for the Elderly (PACE) program originally adopted in 2009 was eliminated by the Montana Legislature as part of the 17-7-111 5% reduction proposals. The PACE program transitioned its last person into other community alternatives and was discontinued on June 30, 2011.

2010 – Provider rate increases were funded with one time only funds.

2010 - The HIFA Waiver was approved by CMS, effective December 1, 2010. CMS approved the addition of 800 individuals who qualified the state funded Mental Health Services Plan and are at least 18 years of age and no older than 64.

2009 - The Disabilities Services Division was renamed the Developmental Services Division and includes Children's Mental Health, the Developmental Disabilities Program, and Montana Developmental Center.

2009 - On January 1, the Developmental Disabilities Program received approval from CMS for the Children's Autism Waiver. Within the year, 50 children were selected and services were implemented.

2009 - On October 1, 2008 a new program was implemented to serve elderly Montanan's in a community setting. The Program for All Inclusive Care for the Elderly (PACE) is a capitated managed care model that offers a comprehensive service delivery system and integrated Medicare and Medicaid funding. This program is exclusively for individuals 55 and older who live in Yellowstone County or Livingston and meet nursing facility level of care.

2008 - The 2007 Legislature provided Medicaid funding to provide a rate increase when health insurance is provided for direct care workers in the personal assistance and private duty nursing program. The 2009 Legislature annualized these funds in the Health Care for Health Care Worker program to cover the cost of premiums for health insurance that meets defined benchmark criteria.

2008 - In fiscal year 2008 the department began claiming 100% federal match for tribal entities providing Medicaid funded personal assistance services. Currently the Blackfeet, Rocky Boy and Fort Belknap Reservations provide personal assistance services that are reimbursed at 100% federal match.

2008 - The Medicaid Administrative Match (MAM) is a federal reimbursement program for the costs of "administrative activities" that directly support efforts to identify, and/or to enroll individuals in the Medicaid program or to assist those already enrolled in Medicaid to access benefits. Through MAM, contracted Montana Tribes are able to be reimbursed for allowable administrative costs directly related to the Montana State Medicaid plan or waiver service. The Montana Tribal MAM Cost Allocation Plan will give tribes a mechanism to seek reimbursement for the Medicaid administrative activities the Montana tribes now perform. (delete since 3 contracts currently exist?)

2008 - The Hospital & Clinic program implemented the APR-DRG payment system and changed the ACS pricing methodology. On October 1, 2008, Montana Medicaid implemented a new inpatient reimbursement methodology for all hospitals, which is based on "All Patient Refined Diagnosis Related Groups" (APR-DRGs). In-state critical access hospitals will continue to be paid percent of charges using their cost-to-charge ratio. All other hospitals will be paid a

prospective APR-DRG payment that reflects the cost of hospital resources used to treat similar cases.

2008 - On July 1, 2008 the Department submitted a Medicaid family planning waiver to the Centers for Medicare and Medicaid Services (CMS) for approval. Upon approval from CMS family planning services are anticipated to be provided to about 4,000 low-income women of child bearing age beginning in July 2009. The waiver will decrease the number of unintended pregnancies, improve the overall health of enrollees, and save money for the Montana Medicaid program.

2008 - In June of 2008 a pared down Health Insurance Flexibility and Accountability (HIFA) waiver was resubmitted to the Centers for Medicare and Medicaid Services for their consideration. The targeted uninsured (those without physical health care coverage) populations to be assisted with Medicaid benefits were refocused to include 1,600 individuals receiving limited mental health benefits through Mental Health Services Plan, 200 youth with a Serious Emotional Disturbance that had aged out of the Montana Foster Care system, and 150 individuals to be assisted with the costs of affordable health care coverage through their ability to participate in the Montana Comprehensive Health Association Premium Assistance Plan.

2008 - Increased the base wage rates for direct-care staff providing services to consumers with developmental disabilities and raised direct-care wages to at least $9.50 an hour.

2008 - The 2007 Legislature increased direct care worker wage to a minimum of $8.50 per hour, but in addition in SLTCD community based services was raised to $9.35 per hour and nursing homes to $9.20 per hour for certified nurse aides and personal care attendants. Also, direct care wage adjustments were legislatively approved for the providers who contract with the Children Mental Health Bureau.

2007 - Nursing facility provider tax was increased by $1.25 from $7.05 to $8.30 per day to fund nursing facility rates and services.

2007 - The eligibility requirements for pregnant women increased from 133% to 150% of the federal poverty level by legislative action.

2007 - The 2007 Legislature increased health-care provider rates, the increases vary across services and provider types, from a low of 1.39% to a high of 4.26%. The increases for SFY2007 generally began in October 2007 and the SFY2008 increases generally began in July 2008.

2007 - Home and Community-Based Services (HCBS) waiver for adults age 18 and over with severe disabling mental illness (SDMI), who without the waiver would be in nursing homes, was implemented. The SDMI waiver is available in certain core areas of the state and the surrounding counties. The waiver team in each core area consists of a nurse and a social worker who coordinates services provided to the covered individuals.

2007 - Executed an agreement with the Chippewa Cree Tribe to facilitate the provision of Medicaid benefits to reservation residents. The agreement enables the Tribe to make Medicaid

eligibility determinations on the reservation, reducing barriers or delays that might otherwise impede tribal members from obtaining Medicaid benefits and proper medical care.

2006 - Medicare Modernization Act implemented the Medicare Part D drug program that applied to approximately 16,000 Montanans who were eligible for both Medicare and Medicaid (dual eligibles). With the implementation of the Act, the dual eligibles will no longer receive prescription drug coverage through Medicaid, instead their prescription drugs are covered by a Medicare Part D plan. The Department is mandated to pay a portion of the drug cost through a Phased-Down Contribution (clawback) for dual eligible clients enrolled in Medicare Part D. Medicaid continues to cover barbiturates, benzodiazepines, smoking cessation drugs, prescription vitamins and the over-the-counter drugs for the dual eligibles as allowed in the Medicaid program.

2006 - The amount of assets a family can have and still qualify for children's Medicaid increased from $3,000 to $15,000 as a result of 2005 Montana Legislative action. Families must continue to meet income requirements to be eligible for children's Medicaid.

2006 - The most recent amendment to the Developmentally Disabled Waiver occurred. The waiver serves people with significant support needs and the amendment expanded service options to include adult foster support, community transition services, adult companionship, assisted living and residential training support.

2006 – The Health Insurance Flexibility and Accountability (HIFA) waiver was submitted to the Centers for Medicare and Medicaid Services (CMS). The Waiver is intended to create a mechanism for Medicaid to pay for services that have historically been funded entirely with state dollars. This will allow the freed up state dollars to leverage additional Medicaid federal dollars.

2006 – The Deficit Reduction Act of 2005 (DRA) mandated certain Medicaid eligibility changes for people who are going to be institutionalized, reside in a nursing home or who are on a waiting list for a Waiver opening. The DRA eligibility changes include increasing the penalty look-back period from three years to five years for nursing home benefits for individuals who transfer assets at less than fair market value, with the look-back period changed to begin when the individual becomes eligible for Medicaid; new citizenship and identity verification requirements of applications for Medicaid; annuities owned by an ineligible or community spouse are considered countable resources for Medicaid applicants; the unpaid balance of a promissory note is considered a countable resource for Medicaid applicants; and the establishment of a $500,000 home equity exclusion limit for long term care applicants/recipients.

2006 – Direct care worker wage increase of $1.00 per hour for nursing facilities and community service providers were implemented utilizing I-149 funding. Also, direct care wage adjustments were legislatively approved for the providers who contract with the Children Mental Health Bureau.

2006 – Implemented a 3% provider rate increase to nursing facilities and community service providers utilizing I-149 funding.

2006 – Nursing facility provider tax was increased by $1.75 from $5.30 to $7.05 to fund nursing facility provider rates and services.

2005 - As a result of the Montana Health Care Redesign Project the 2005 Montana Legislature authorized DPHHS to revise the asset test used to determine children's eligibility for Medicaid and the submission of a Health Insurance Flexibility and Accountability (HIFA) Waiver.

2005 - Montana joined the National Medicaid Pooling Initiative (NMPI) in implementing a Preferred Drug List (PDL). The pooling initiative included seven other states: Nevada, Michigan, Vermont, New Hampshire, Alaska, Minnesota and Hawaii and will be implemented through a contract with First Health Services Corporation (FHSC). Under the initiative, the state Medicaid program will create a list of preferred medications in 50 classes of drugs. Preferred drugs are chosen based on their clinical efficiency by a committee of Montana physicians and pharmacists and by the Department based on cost savings. By contracting with FHSC, Montana was able to combine our 80,000 covered lives with covered lives of the other NMPI states resulting in over 3,000,000 covered lives which allow our contractor to negotiate lower discounts with Pharmaceutical Manufacturers.

2005 - The first five year renewal of the Developmental Disabilities Community Supports Waiver occurred. The waiver offers a number of innovative and flexible service options for persons with limited support needs.

2005 - Nursing facility provider tax was increased from $4.50 to $5.30 to fund nursing facility provider rates.

2004 - Team Care program was implemented targeted to people who over-use the Medicaid system. The program requires a group of identified Medicaid clients to enroll in the program and choose one primary care provider and one pharmacy to manage their health care. Clients will receive the professional care they need and have a team to help them decide how and when to access care.

2004 - Montana Health Care Redesign Project Report was published. The Project resulted from 2003 Montana Legislative action and was intended to examine the various options for redesigning the Montana Medicaid program. The Report was provided to the 2005 Legislature outlining the options that could be undertaken to redesign the identified health programs in a fashion that was financially sustainable into the future.

2004 – Nurse First Care Management program was implemented to reduce ineffective use of medical services. Key components are a Nurse Advice Line for most individuals on Medicaid and a Disease Management program for those with chronic conditions such as asthma, diabetes and congestive heart failure.

2004 - FAIM Basic Medicaid waiver expired on January 31, 2004. A replacement 1115 waiver was approved effective February 1, 2004 continuing basic Medicaid coverage for able-bodied

adults ages 21 - 64 who are not disabled or pregnant and who are eligible for Medicaid under - Sections 1925 or 1931 of the Social Security Act.

2004 - Hospital tax was implemented. This change provided increased reimbursement to hospitals using a state tax on hospitals matched with federal Medicaid dollars.

2004 - Nursing facility provider tax increased from $2.80 to $4.50 to fund nursing facility provider rates.

2003 – Children's Mental Health Bureau was created in the Health Resources Division.

2003 - Eliminated coverage of gastric bypass surgery and routine circumcisions at the recommendation of the Medicaid Coverage Review Panel composed of Montana physicians.

2003 - Child and Family Services Division began billing Medicaid for targeted case management services provided to children at risk of abuse and neglect.

2003 - Outpatient reimbursement methodology was changed to Ambulatory Payment Classification (APC).

2003 - On January 10, 2003 implemented a 7% net pay reduction to providers (sunset June 30, 2003).

2003 - On February 1, 2003 reduced inpatient base rate for hospitals reimbursed by DRG prospective payment system (sunset June 30, 2003).

2003 - On August 1, 2003, reduced inpatient base rate for hospitals reimbursed by DRG prospective payment system. Changed all interim reimbursement rates for cost-based facilities to the hospital specific cost to charge ratio.

2002 - Increase cost sharing requirements for which the Medicaid eligible persons are responsible.

2002 - Began covering outpatient chemical dependency for adults.

2002 - Implemented a 2.6% net pay reduction to providers (sunset June 30, 2002).

2002 - Implemented reimbursement reductions to hospital inpatient services by reducing the base rates, decreasing the DRG weights by 2%, and eliminating the additional catastrophic case payment.

2002 - July 1, 2001 moved to a case mix price-based system of reimbursement for nursing facility providers.

2001 - Implemented a mandatory generic substitutive policy for pharmaceuticals in the outpatient drug program.

2001 - The Montana Legislature passed legislation creating the Montana Breast and Cervical Cancer Treatment program for low income uninsured women with breast or cervical cancer diagnosed through the National Breast and Cervical Cancer Early Detection Program, for their cancer treatment.

2001 - Implemented new reimbursement methodology for Ambulance & Dental Services. Included an 18% increase in funding for the dental program.

2000 - Medicaid HMO program was discontinued due to low penetration and high administrative expenses.

2000 - Nursing Facility Intergovernmental Transfers are implemented to save state general fund.

2000 – Hospital Intergovernmental Transfers are implemented.

2000 - Prior Authorization was required in Personal Assistance Services.

1999 - Mental Health Managed Care abandoned per legislative requirement.

1999 - Ambulatory Surgical Center provider reimbursement was restructured to align with Medicare reimbursement methodologies.

1998 - Area Agencies on Aging converted state general fund to buy slots to expand Waiver.

1997 - New MMIS contract was instituted with Consultec as the fiscal agent (Consultec later changed its name to Affiliated Computer Services – ACS).

1997 - Resource Based Relative Value System (RBRVS) was implemented to reimburse Physicians, Mid-Level Practitioners and Therapies.

1997 - Mental Health Managed Care was implemented. This program institutes a full-risk, capitated managed care contract for all mental health services statewide.

1997 - Prior authorization was required of Home Health Agency services.

1996 - Federal welfare reform was passed on August 22, 1996. Under the Personal Responsibility and Work Opportunities Reconciliation Act, Medicaid was "de-linked" from AFDC/TANF and began operating without regard to eligibility for cash assistance.

1996 - Departmental reorganization was implemented. Reorganization results in a decentralization of Medicaid; services are managed in divisions primarily responsible for services to specific populations. For example, the Addictive and Mental Disorders Division manages all Medicaid mental health services.

1996 - New outpatient prospective payment system was introduced. The system uses Day Procedure Groups (DPGs) to bundle services at one basic rate.

1995 - Liens and Estates Recovery Program was implemented by the legislature.

1995 - The Families Achieving Independence in Montana (FAIM), welfare reform waiver, received federal approval. The FAIM program began phasing-in implementation in February 1996. Even though the cash assistance caseload experienced a significant reduction, Medicaid eligibility continued for most of families. Cost savings were due to the reduced package of services under FAIM Basic Medicaid, not because of decreased caseloads.

1995 - The Medicaid HMO program was implemented for AFDC recipients in counties where HMOs exist.

1993 - Passport to Health program was implemented. The program assigns a primary care case manager provider to each participating Medicaid enrollee as a health care manager and gatekeeper of services. The program has yielded significant savings in subsequent years and maintained quality of care.

1993 - New hospital reimbursement system was implemented. The system features updated DRG rates and restrictions on procedures outside of the basic reimbursement package. This change results in significant savings in subsequent years.

1993 - Out of state hospital initiative was implemented. This program restricts the use of higher cost out of state hospitals when in state hospitals provide the same services. This initiative results in significant savings in subsequent years.

1993 - Medicaid coverage for inpatient hospital psychiatric services for individuals under 21 was terminated by the legislature. Coverage for residential treatment and treatment in an acute care hospital remains.

1992 - Federal OBRA 89 increased eligibility for pregnant women and children under age 6 to 133% of the federal poverty level. OBRA 89 stipulates that children are eligible for all medically necessary services.

1992 - Federal OBRA 90 was implemented. A major component of this mandate is to increase eligibility for children aged 6 through 18 to 100% of the federal poverty level. This mandate is being phased in through 2002.

1992 - "Residential Psychiatric Services" was implemented as a Medicaid Service. This service brings rapid increases in cost for the next several years.

1992 - Drug Rebate Program was implemented and began to return a significant portion of prescription drug costs to the state in the form of rebates.

1992 - Formulary and Drug Utilization Review Program was implemented for Medicaid pharmacy services. This program provides significant internal controls and cost savings in subsequent years.

1991 - Nursing home provider tax was implemented. This change increased reimbursement to nursing homes using a state tax on nursing homes matched with federal Medicaid dollars.

1990 - Federal OBRA 87 was implemented. This federal mandate imposed new regulations for nurse aides, client safety, and client screening. This mandate affects primarily the nursing home industry and increased Medicaid costs through increased reimbursement to providers. OBRA87 also raised the threshold for financial eligibility to 100% of poverty for pregnant women and children younger than 6 years.

1988 - "Inpatient Psychiatric Services for Children under age 21" became a Medicaid service. This service increased costs rapidly for the next several years.

1987 - New Hospital reimbursement system was instituted. This Diagnosis Related Group (DRG) system is a prospective rate system.

1985 - New MMIS was instituted with Consultec as the fiscal agent.

1983 - Department lost Boren Amendment lawsuit to Montana Health Care Association (Nursing Homes) for insufficient reimbursement rates. Financial implications include: 1) retroactive payments for prior years; 2) increased reimbursement rates for subsequent years.

1982 - The HCBS waiver was implemented. This program consists of multiple services not traditionally offered to Medicaid recipients and designed to help people stay in their own homes rather than moving to an institution.

1982 - Prospective reimbursement system was instituted for the Nursing Home program.

GLOSSARY OF ACRONYMS

ACS: Affiliated Computer Services

AFDC: Aid to Families with Dependent Children

AMDD: Addictive and Mental Disorders Division

APC: Ambulatory Payment Classification

CD: Chemical Dependency

CFC: Community First Choice

CFSD: Child and Family Services Division

CMS: Centers for Medicare and Medicaid Services

CPI: Consumer Price Index

DD: Developmental Disabilities

DPGs: Day Procedure Groups

DRAMS: Drug Rebate Analysis and Management System

DRG: Diagnosis Related Group

DSD: Developmental Services Division

EFE: Essential For Employment

EPSDT: Early and Periodic Screening, Diagnosis, and Treatment

FAIM: Families Achieving Independence in Montana

FFS: Fee-for-Service

FMAP: Federal Medical Assistance Percentage (the Federal reimbursement percentage for approved medical services)

FPL: Federal Poverty Level

FQHC: Federal Qualified Health Center

FY: Fiscal Year (state FY is July 1—June 30; federal FY is October 1—September 30)

HCFA: Health Care Financing Administration (now Centers for Medicare and Medicaid Services – CMS)

HCBS: Home and Community Based Services

HCPI: Health Care Price Index

HCSD: Human and Community Services Division

HMK: Healthy Montana Kids

HMO: Health Maintenance Organization

HRD: Health Resources Division

ICF/MR: Intermediate Care Facility for Mental Retardation

IHS: Indian Health Service

IMD: Intermediate Care Facility for Mental Disease

MCDC: Montana Chemical Dependency Center

MDC: Montana Developmental Center

MFP: Money Follows the Person

MH: Mental Health

MHO: Mental Health Organization

MMHNCC: Montana Mental Health Nursing Care Center

MMIS: Medicaid Management Information System

MSH: Montana State Hospital

NDC: National Drug Code

NH: Nursing Home

OBRA: Omnibus Budget Reconciliation Act

PAS: Personal Assistance Services

PD: Physically Disabled

QAD: Quality Assurance Division

RBRVS: Resource-Based Relative Value Scale

RHC: Rural Health Clinic

RVU: Relative Value Unit

SAMHSA: Substance Abuse and Mental Health Services Administration

SDMI: Severe and Disabling Mental Illness

SED: Serious Emotional Disturbance (children and adolescents)

SFY: State Fiscal Year (July 1—June 30)

SLTC: Senior and Long Term Care Division

SSI: Supplemental Security Income

TANF: Temporary Assistance for Needy Families