



# MONTANA LEGISLATIVE BRANCH

## Legislative Fiscal Division

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Director  
AMY CARLSON

SENATE  
PUBLIC HEALTH, WELFARE & SAFETY  
Exhibit No. 2  
Date 1/7/2015  
Bill No. \_\_\_\_\_

DATE: January 7, 2015  
TO: Senate Public Health, Welfare, and Safety Committee  
FROM: Lois Steinbeck, Senior Analyst  
Cynthia Hollimon, Fiscal Analyst I  
RE: Department of Public Health and Human Services (DPHHS) – Budget and Caseload Highlights

The following information summarizes historic DPHHS expenditures compared to the Governor's present law<sup>1</sup> budget request. DPHHS administers a wide spectrum of programs and projects, including: public assistance, Medicaid, foster care and adoption, nursing home licensing, long-term care, aging services, alcohol and drug abuse programs, mental health services, vocational rehabilitation, disability services, child support enforcement activities, and public health functions (such as communicable disease control and preservation of public health through chronic disease prevention).

With about 2,900 employees, DPHHS has a quarter of the total number of state employees funded in the general appropriations act (HB 2). The 2015 biennium DPHHS appropriation in HB 2 is \$2.8 billion or 42% of the total, including \$907.0 million or 25% of the total general fund.

### Methodology

The time frame used in this expenditure/budget snapshot is generally FY 2007 through FY 2017, with the exception of caseload data, which usually includes FY 2007 to FY 2014. The expenditure and budget data used in the following graphs is drawn from several sources. Expenditures through FY 2014 are those recorded on the state accounting system at fiscal yearend by major type of expenditure and source of funding. FY 2015 data is based on legislatively approved appropriations and the FY 2016 and 2017 data are the Governor's present law executive budget request. The data is limited to those expenditures and appropriations authorized in bills approved by the legislature such as HB 2, the pay plan, and specific bills with appropriations. Two types of expenditures are not included – those made by budget amendment and statutory appropriations authorized by specific sections of the Montana Code. It is important to note that DPHHS expenditures and budget trends could be different depending on the timeframe selected as well as the type of budget data included.

### Expenditures/Budget

The figure on the following page shows DPHHS budgets from FY 2007 through the executive present law budget request for FY 2017. DPHHS expenditures have risen from \$1.3 billion in FY 2007 to the proposed executive present law budget request of \$2.2 billion in FY 2017, which is about 5% annually. The majority of the increase has been in the benefits category, which has risen from \$1.0 billion to \$1.8 billion over the same time period.

<sup>1</sup> Present law is the funding needed to maintain services at the level authorized by the last legislature, including caseload increases. This information does not include any new proposals that the Governor requested such as provider rate increases or service expansions

Benefits represent the cost of services or goods provided to specific individuals who have been determined eligible by meeting income eligibility criteria and, in some instances, disability or age criteria. Some children and some adults, who may be at risk of abuse or neglect, may be eligible for services. The majority of these services are provided by businesses. Examples

include Medicaid services, child care, and low-income energy assistance. Benefits also include transfer payments such as cash assistance and Supplemental Nutrition Assistance Program (SNAP – formerly Food Stamps) services.

Personal services are the next most significant category of expenditure, rising from \$136.2 million in FY 2007 to \$186.4 million in the present law executive request for FY 2017, or about 3% annually. This category represents staff costs of DPHHS.

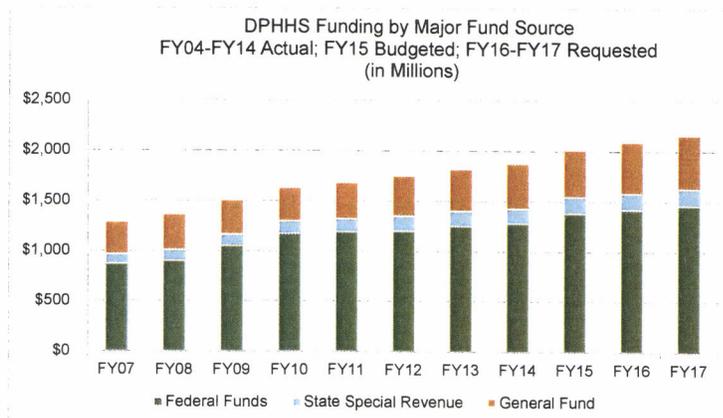
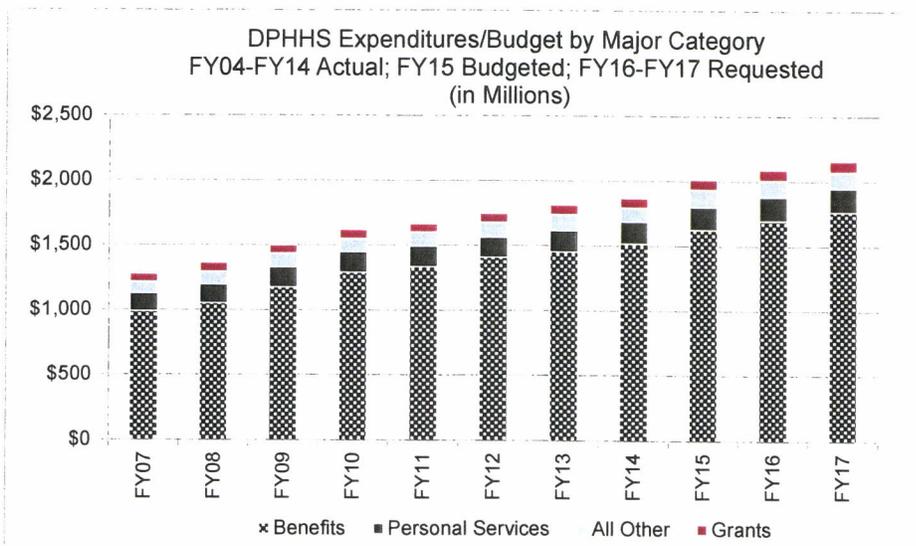
Grants are funds provided to entities that make available certain information or services to people generally, without regard to specific eligibility. Examples include health education and disease prevention.

The “All Other” category in the figure above supports DPHHS operating and equipment costs. Operating costs include expenditures such as rent, travel, office supplies, and communication.

## Funding

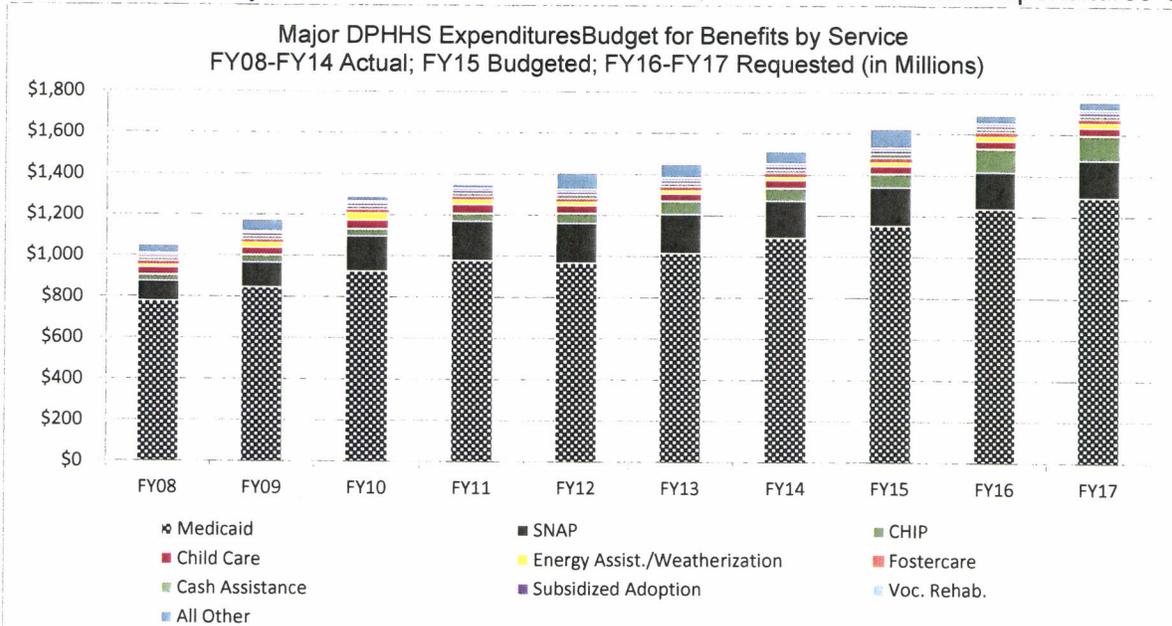
The adjacent figure shows DPHHS funding by major source. Federal funds support the majority of the DPHHS budget – about 70% over the time period shown. General fund is about 23% and state special revenue is about 7%. State special revenue is dedicated or restricted to specific uses while state general fund can be used for any legal purpose.

Federal funds are usually governed by specific criteria and must be spent within certain guidelines. There are some federal block grants, although a relatively small portion of the total, that have broad guidelines that allow for some state flexibility in administration. Many federal funding sources require a state match or state maintenance of effort (set spending level) in order to spend the federal funds.



## Benefit Expenditures/Budget Request

The figure below shows DPHHS benefit expenditures by major service from FY 2008 through FY 2014, the appropriation for FY 2015, and the Governor's present law budget request for the 2017 biennium. Only those services with more than \$10 million in annual expenditures are



shown separately. Medicaid services comprise the majority - accounting for just under 75% of the total. SNAP is the second largest category at 13% of the total. The remaining benefit programs each comprise less than 4% of the total. Over the time period from FY 2008 to FY 2014, aggregate, department wide benefits costs were funded from 74% federal funds, 18% general fund, and 8% state special revenue.

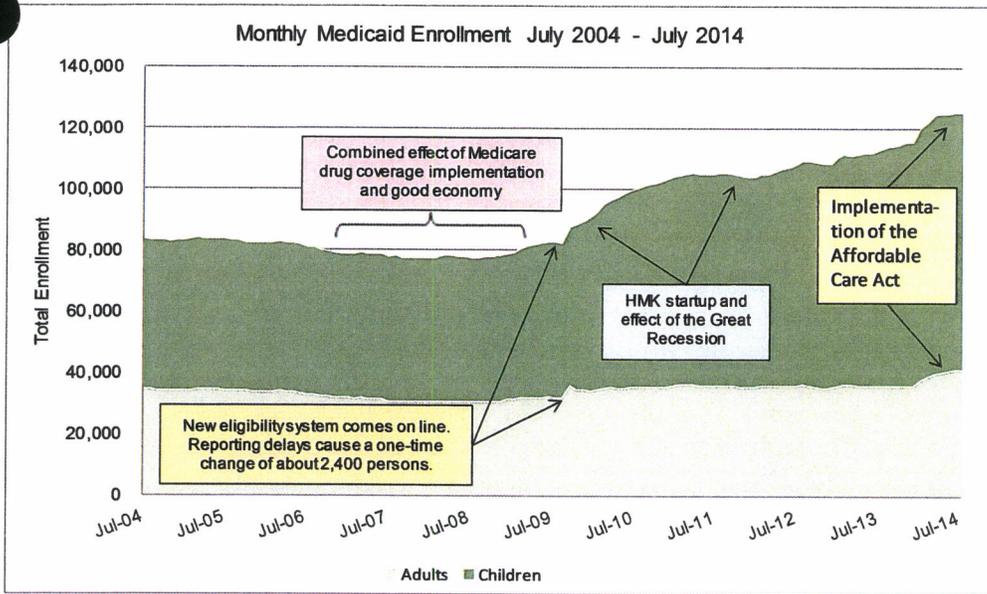
## Reasons for Cost Growth

DPHHS benefit expenditures have risen over the last decade due to a number of factors including enrollment levels, programmatic changes, the cost and utilization of services, and economic conditions in Montana. Some programmatic changes are attributable to federal and state legislative changes as well as citizen initiatives. For instance, the passage of a citizen initiative November 2008 to create the Healthy Montana Kids (HMK) program and raise financial eligibility for children's health services raised enrollment and spending in Medicaid and the Children's Health Insurance Program (CHIP). Most recently, implementation of the Affordable Care Act and the health insurance exchange is reflected in higher enrollment in Medicaid since some Montanans who accessed the exchange to purchase health insurance were determined to be Medicaid eligible.

The following figures show enrollment in all of the programs from separately in the graph of major benefits expenditures except vocational rehabilitation. Reasons for enrollment changes and basic funding information are also discussed.

## Medicaid Enrollment

Medicaid enrollment has increased over the most recent 10 state fiscal years. Some of the reasons that enrollment has changed are shown in the graph on the following page. Total enrollment has grown from about 83,600 persons to about 125,100. Enrollment of children has

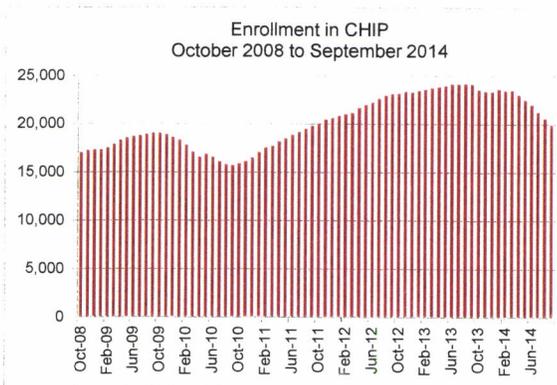
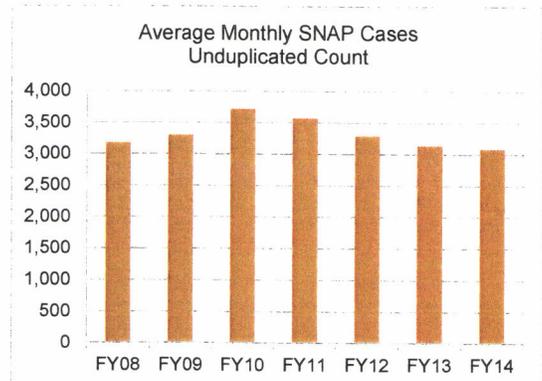


increased the most, largely due to implementation of HMK and the effect of the Great Recession, which caused household income to decline. Medicaid services are funded from federal funds that require a state match. The match rate changes annually is based on state per capita income compared to national per capita income over a three year period. If a state's per capita income improves

relative to national per capita income, the state match rate increases and the federal match rate declines. The same match rate is used for Medicaid services, some child care services, and some foster care services. The state match rate for Medicaid services in the 2017 biennium is about 34%. A 1% change in the Medicaid match rate causes state costs to change about \$9 to \$10 million each year of the 2017 biennium. The federal share of administrative costs to manage these services is generally 50%.

### SNAP

The average number of households receiving SNAP benefits each month rose from FY 2008 through FY 2010 and then began to decline through FY 2014. The number shown in the graph is an unduplicated count, meaning that a household is counted only once. Participation in SNAP increased, largely due to the effect of the Great Recession. Recent enrollment in SNAP has been declining as household incomes improve. SNAP benefits are funded 100% from federal funds.



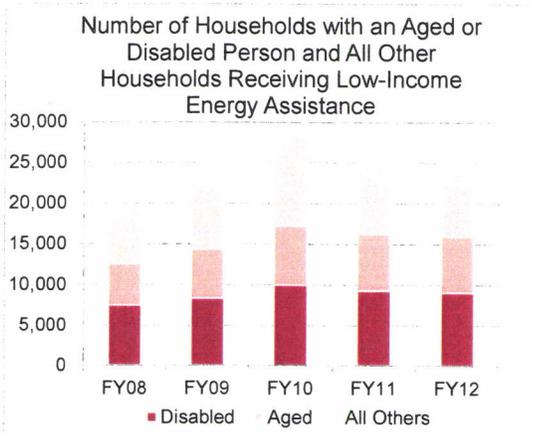
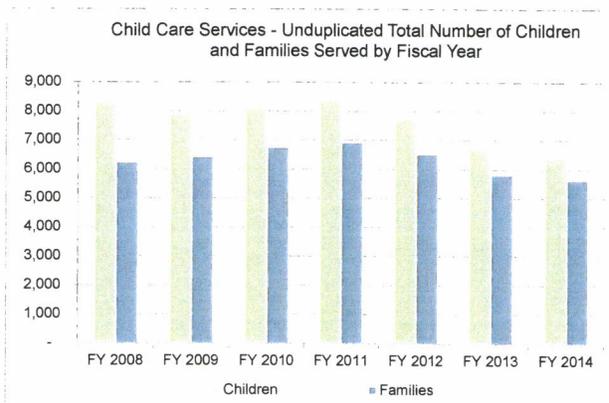
### CHIP

The figure on the left shows monthly CHIP enrollment from October 2008, just prior to implementation of the HMK program, to the most recent data available as of September 2014. Enrollment grew slowly in the initial months following the passage of the citizen initiative. However, as children's eligibility for continued enrollment in CHIP was examined, many children

were determined to be eligible for Medicaid due to changes enacted as part of the HMK program. CHIP enrollment declined from October 2009 through October 2010 as children migrated from CHIP to Medicaid coverage.<sup>2</sup> CHIP enrollment then gradually increased due to the Great Recession. Recent declines in CHIP enrollment may be related to changes in the use of modified adjusted gross income to determine Medicaid eligibility effective January 1, 2014. Children may be migrating from CHIP to Medicaid coverage. CHIP is funded from a federal grant that requires a state match.

### Child Care Services

The adjacent figure shows the number of children and families served from FY 2008 through FY 2014. Numbers served peaked in FY 2011 and have gradually declined in tandem with SNAP and cash assistance caseloads. Child care services are funded through several federal and state sources. One federal source requires a state match. Another federal source requires a state maintenance of effort (defined level of funding), and a third federal source is a block grant.

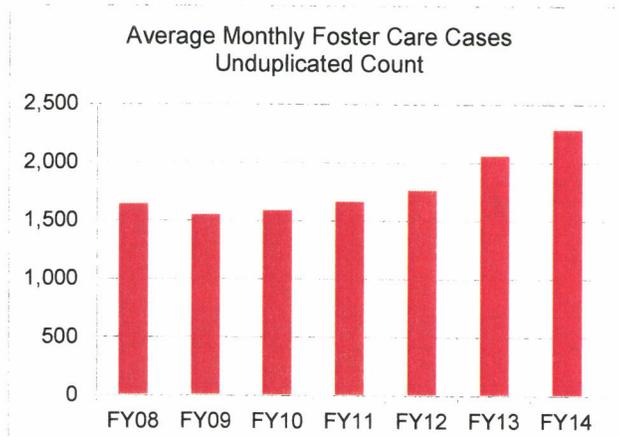


### Energy Assistance & Weatherization

The figure on the left shows the unduplicated number of households that received energy assistance or weatherization services by fiscal year. The number fluctuates due to federal grant funding, which increased during the Great Recession. Weatherization and heating assistance are largely funded from federal grant funds.

### Foster Care & Subsidized Adoption

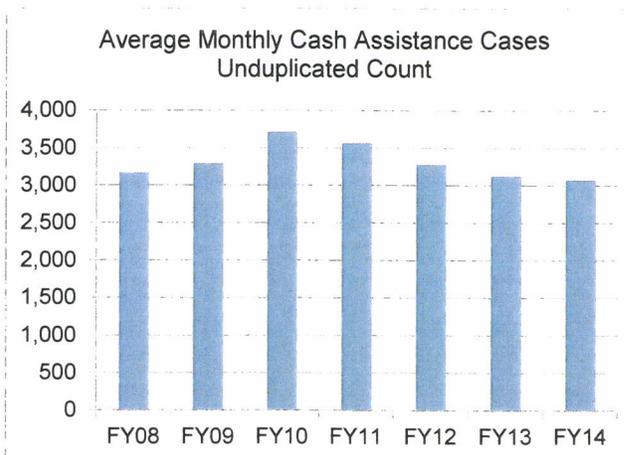
The figure to the right shows the average monthly caseload for children in foster care. After declining slightly from FY 2008 to FY 2010, the caseload began to increase. Caseload growth may be related to a combination of recent increases in drug use, impacts from the Bakken area, and/or changes in intake policies. Foster care services are funded with the general fund, state special revenue, and federal funds. General fund provides the majority of funding and is used as state match if the child is eligible for federal funding.



<sup>2</sup> HMK removed consideration of household assets (checking and savings account balances for example) in determining eligibility for Medicaid for children so some CHIP enrollees in lower income households with excess resources became eligible for Medicaid.

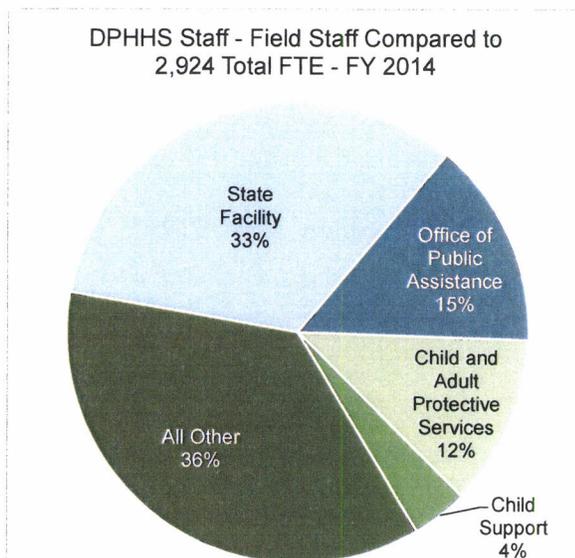
## Cash Assistance

The adjacent figure shows the average number of households receiving cash assistance each month by fiscal year. The number of households increased due to the Great Recession and then began to gradually decline until the FY 2014 average was slightly lower than the FY 2008 amount. Cash assistance is funded predominantly from the federal Temporary Assistance for Needy Families (TANF) block grant, with a portion of the state general fund maintenance of effort needed to draw down the block grant, and a small amount of state special revenue.



## Personal Services

Personal services are the second largest category of expenditure for DPHHS. The pie chart shows DPHHS FTE (full time equivalent employees) by major function. The majority of DPHHS employees – nearly 2/3 – are located in regional and local offices, and six state facilities. Facility staff is 1/3 of total DPHHS FTE. Offices of Public Assistance (OPAs) around the state have 15% of the total DPHHS workforce while child and adult protective services workers in local offices are about 12% of the total. Child support regional workers are about 4%.



Personal services costs change due to several factors including the number and type of positions filled, changes in workload, pay plan increases, including employer contributions toward group health insurance and retirement benefits, and implementation of new functions.

Some DPHHS staff provides direct services to individuals. For instance, state facility staff delivers medical care and treatment services to persons with mental health and chemical dependency diagnoses and to those with development disabilities as well as long term nursing home services for veterans and for persons with mental health issues. Public assistance staff determines financial eligibility for

many services administered by DPHHS. Protective services workers investigate allegations of abuse and neglect of children and adults as well as helping children and families access supportive services. Child support enforcement staff determines and helps collect child support.

Personal services are funded based on an employee's activities. Some administrative functions are fully funded by state funds and some by federal funds. However, most activities are paid from a combination of federal and state funds governed by federal funding rules. Total personal services costs are about \$186.5 million each year of the 2017 biennium. From FY 2007 to FY 2014, department wide personal services were funded at the following ratios: general fund - 53%, state special revenue - 9%, and federal funds - 38%.