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MONTANA LEGISLATIVE FISCAL DIVISION
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MEDICAID 101

December 5, 2013

WHAT IS MEDICAID?

Medicaid is a federal/state program that pays for health care services for low-income:

- Dependent and minor children
- Aged, blind or disabled persons
- Parents of dependent children

It was enacted as Title XIX of the Social Security Act of 1965 and is authorized in Title 53 of the Montana Code Annotated.

What is the Difference Between Medicaid and Medicare?

Medicaid is one of the two major nationwide health care programs supported by the federal government – Medicare is the other. Medicaid and Medicare are sometimes confused. In general:

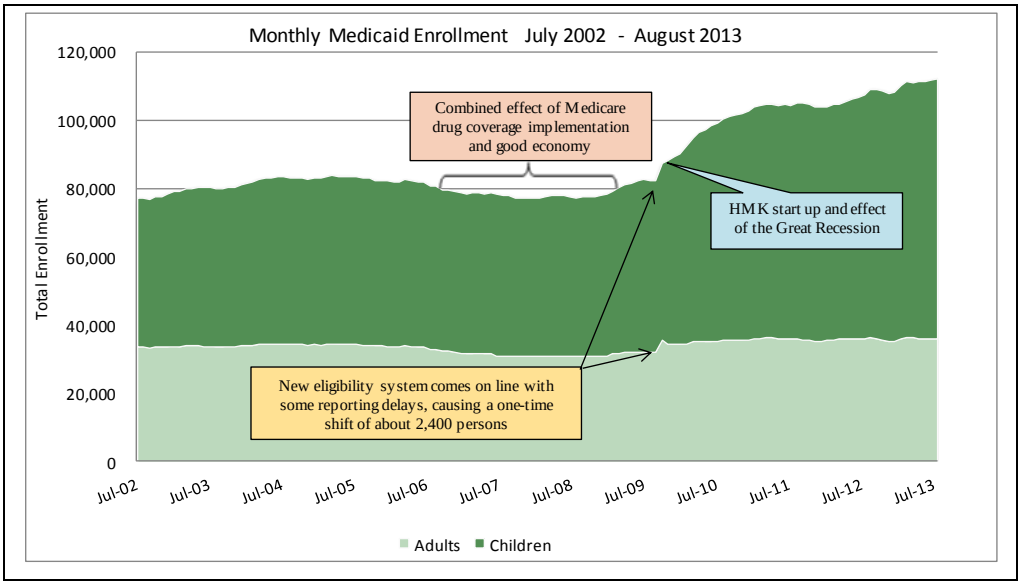
- Medicare is a health care program for all aged citizens over the age of 65 and for citizens who meet certain federal disability criteria. It is funded entirely by federal funds.
- Medicaid is a shared financial responsibility between a state and the federal government and provides health care services for certain low-income persons of all ages who meet certain financial and categorical eligibility criteria.

A low-income Medicare beneficiary may also be eligible for Medicaid.

WHY IS MEDICAID IMPORTANT TO STATE LAWMAKERS?

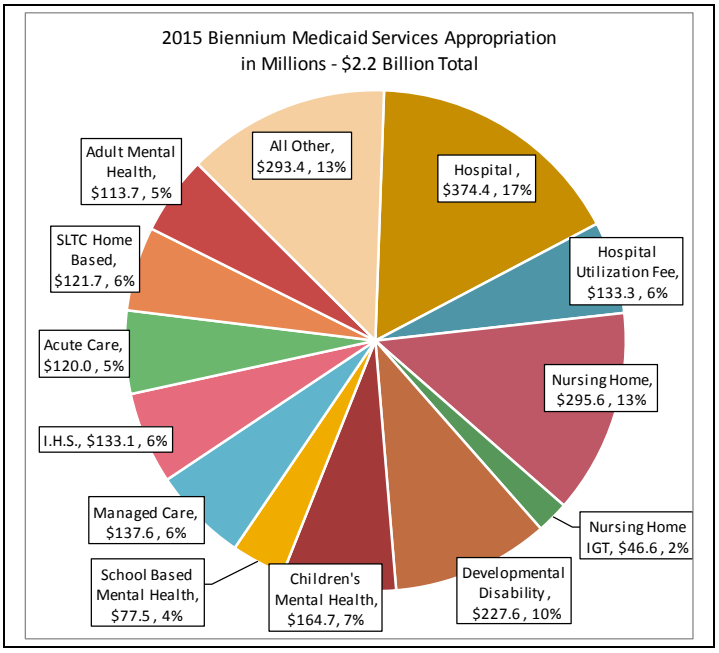
- Medicaid services alone comprise about one fifth of all funds appropriated in the general appropriations act (House Bill 2). In the 2015 biennium Medicaid appropriations are:
  - Total funds: $2.2 billion
  - General fund: $512.2 million general fund
- Medicaid provides a significant source of funding for medical services.
  - Between 10% and 12% of all Montanans are eligible for Medicaid each year
  - Medicaid pays for about 40% of all births in Montana

Historic enrollment in Medicaid is shown in the adjacent chart. The majority of enrollees in the Montana Medicaid program are children because most eligibility categories for children do not consider assets for most categories and because income limits for children are higher than adults.



2015 Biennium Appropriation by Service

The following chart shows the 2015 biennium appropriation of $2.2 billion by major service. Hospital services have largest appropriation with $374.4 million or 17% of the total. Adding the funds generated by the hospital utilization fee and passed through to hospitals for Medicaid services, the appropriation for hospital services comes to 23% of the total.



Nursing home services have the next largest appropriation with $295.6 million or 13% of the total. Including funds transferred from counties (IGT – intergovernmental transfer) and matched with federal Medicaid funds, the appropriation for nursing home services rises to 15% of the total.

Other Medicaid services appropriations and proportion of their respective total are:

- Children's mental health services – 7%
- Federal matching funds passed through to school-based mental health programs – 4%
- Managed care (physician services) – 6%
- Federal reimbursements to Indian Health Services (I.H.S.) providers – 6%
- Home based care for the elderly and physically disabled – 6%
- Acute care and pharmacy – 5%
- Adult mental health - 5%
- All other – 13%

Who is Eligible for Medicaid?

There are over 35 types of Medicaid eligibility. In Montana, persons must meet income criteria to be eligible and, in some cases, persons must also meet assets tests and disability criteria.

This summary highlights two broad types of eligibility: 1) aged, blind, or disabled; and 2) nondisabled minor and dependent children, some parents, and pregnant women. In general, nondisabled, nonpregnant, childless adults are not eligible for Medicaid, regardless of income or assets. The adjacent chart shows the major

Summary of Medicaid Eligibility Criteria by Major Category

Group/Category	Household Income*	Assets Limit*
Pregnant Women*	159% FPL	No
Children*	Up to 143% FPL	No
Low Income Parents/Guardians*	Up to 47% FPL	No
Aged, Blind, or Disabled Adults**		
1 Person Household**	$721/Month	Yes - $2,000
2 Person Household**	$1,082/Month	Yes - $3,000

*The Affordable Care Act required eligibility to be based on a modified adjusted gross income (MAGI) standard effective January 1, 2014 and it also eliminated the consideration of assets for these adult groups. Previous to that point in time assets tests were applied to adult groups and income limits were different for parents depending on whether they were working or not. Assets are still considered for aged, blind, or disabled adults.

**Income is determined based on guidelines that include or exclude certain types of income and change yearly. The amounts in this table are effective January 1, 2014. Assets are considered for this group.

categories of eligibility and summarizes income and asset tests.

Federal Poverty Level

The federal poverty level is the minimum amount of gross income that a family needs for food, clothing, transportation, shelter and other necessities as calculated by the federal government. It is updated annually usually in February. The poverty level is geared to family size. The adjacent table shows the 2013 federal poverty level by household size, monthly and annual income, and by various levels.

2013 Federal Poverty Index
Levels of Poverty by Family Size

Family Size	Annual Household Income - 2013			
	47%	100%	133%	250%
1	$5,400	$11,490	$15,282	$28,725
2	7,290	15,510	20,628	38,775
3	9,179	19,530	25,975	48,825
4	11,069	23,550	31,322	58,875
5	12,958	27,570	36,668	68,925
6	14,847	31,590	42,015	78,975
7	16,737	35,610	47,361	89,025
8	18,626	39,630	52,708	99,075
Family Size	Monthly Household Income - 2013			
	47%	100%	133%	250%
1	$450	$958	$1,273	$2,394
2	607	1,293	1,719	3,231
3	765	1,628	2,165	4,069
4	922	1,963	2,610	4,906
5	1,080	2,298	3,056	5,744
6	1,237	2,633	3,501	6,581
7	1,395	2,968	3,947	7,419
8	1,552	3,303	4,392	8,256

Aged, Blind, or Disabled Medicaid Eligibility

Eligibility for an aged, blind or disabled adult is governed by federally established criteria. Aged, blind, or disabled persons who meet federally established criteria may receive a Supplemental Security Income (SSI) payment and are also automatically eligible for Medicaid.

In order to be SSI eligible, persons must be over the age of 65, or they must be determined blind or disabled by the Social Security Administration. In addition persons must meet income and assets tests. Examples of assets are savings and checking accounts, land, vehicles, promissory notes, trusts, stocks and bonds.

The federal government establishes asset limits at $2,000 for an individual and $3,000 for a couple seeking to establish eligibility for a monthly SSI payment (and automatic Medicaid eligibility). The federal government also establishes income limits that change each calendar year. Generally, starting January 1, 2014 an individual can have countable income no greater than $721 a month and a couple can have countable income no greater than $1,082 a month in order to be eligible for Medicaid.

Dual Eligibles

SSI eligible individuals are eligible for both Medicare and Medicaid. Generally, in those circumstances, Medicare pays for covered medical services first and then Medicaid pays the costs not covered by Medicare. Medicare does not cover some services or limits coverage for some services that are funded by Medicaid, such as nursing home services.

Medicaid Eligibility for Families

The federal government has established minimum eligibility criteria for low-income children and certain low-income parents or guardians of children. States are prohibited from considering assets for either of these groups after January 1, 2014 per the Affordable Care Act (ACA). Previous to that date, Montana imposed asset tests for Medicaid eligibility for low-income parents and guardians.

Medicaid Eligibility – Children

Generally, states must cover children up to age 6 in households with incomes up to 133% of the federal poverty level and children up to the age of 19 in households with incomes up to 100% of the federal poverty level. Montana covers all children in households with incomes up to 143% of the federal poverty level and does not consider family assets.

A citizen initiative that created the Healthy Montana Kids (HMK) program establishes Medicaid eligibility for children in households with incomes up to 185% of the federal poverty level (53-6-131(1)(g), MCA) and eligibility for the Children's Health Insurance Program (CHIP) for children in families with incomes up to 250% of the federal poverty level (53-4-1004, MCA).

Children with a Developmental or Physical Disability

Family income is not considered for Medicaid eligibility for children with a developmental or physical disability when the child is requesting admittance to community programs provided under a waiver of Medicaid regulations (discussed in more detail later). A waiver allows a state to provide certain community services not routinely eligible for federal Medicaid reimbursement and to cap enrollment in these services. However, once a child is enrolled in waiver services, the child is eligible for all other Medicaid services as well.

ACA Maintenance of Effort

A state faces a substantial monetary penalty if it reduces Medicaid (or CHIP) eligibility for children from levels in effect as of March 23, 2010. The ACA maintenance of effort (MOE) for children's eligibility is in effect until federal fiscal year 2020, which begins October 1, 2019.

Medicaid Eligibility – Low-Income Parents/Guardians and Pregnant Women

Under ACA, effective January 1, 2014 states must use modified adjusted gross income (MAGI) to determine Medicaid eligibility for low-income parents and guardians and pregnant women. The Medicaid MAGI calculation is very similar to the modified adjusted gross income reported on federal income tax forms. The MAGI level for parents/guardians will be 47% of the federal poverty level.
In Montana, pregnant women may have household income up to 159% of the federal poverty level.

Historically, Montana has had different poverty thresholds for Medicaid eligibility based on whether parents were employed or not. In addition, households could not have assets above $3,000. However, as noted those eligibility criteria were changed by ACA.

The Montana Medicaid Program – Eligibility and Service Cost

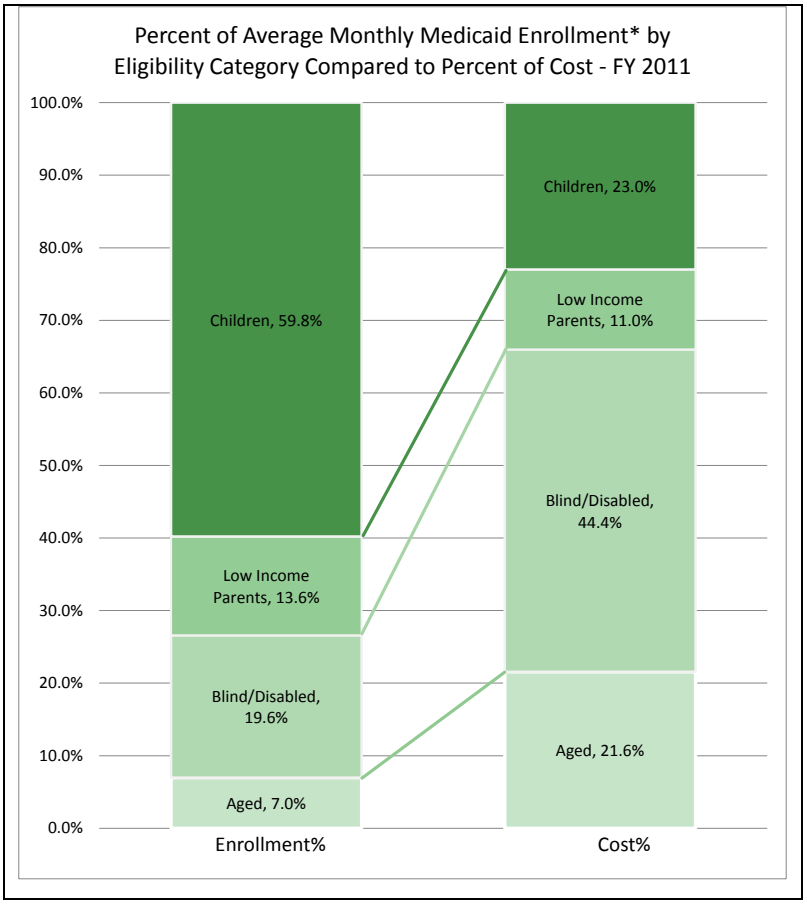
The chart on the following page shows the total number of persons eligible for Medicaid compared to the total cost for FY 2011. While low-income children comprised the largest share of eligibles (60%), they incurred only 23% of the costs. In contrast, aged recipients accounted for 7% of the eligible persons, yet incurred 22% of the total cost. Disabled or blind recipients were 20% of the number eligible and accounted for 44 % of the costs. Low-income adults were 14% of the recipient population and comprised 11% of the costs.

Medicaid expenditures totaled about $963 million in FY 2011, the most recently completed year for Medicaid cost data. Enrollment averaged 99,692 persons each month.

MEDICAID PROGRAM CHARACTERISTICS

All states administer a Medicaid program. Once a state opts to participate, it must abide by federal criteria since the federal government pays for a substantial portion of Medicaid costs. Federal criteria establish:

1. Certain mandatory services and categories of eligibility that a state must include in its state Medicaid program; and
2. Optional services and eligibility categories that a state can add at its discretion.



Mandatory services include:

- Inpatient hospital (excluding inpatient services in institutions for mental disease – Montana State Hospital)
- Outpatient hospital
- Federally qualified health centers
- Physician and nurse practitioner
- Nurse midwife
- Medical and surgical service of a dentist
- Laboratory and x-ray
- Rural health clinics
- Family planning
- Nursing facility
- Home health
- Durable medical equipment
- Early and periodic screening, diagnosis and treatment (EPSDT) for children

States may elect to cover other optional services. Montana covers the following optional services:

- Outpatient drugs
- Dental and denturist services
- Comprehensive mental health services
- Ambulance
- Physical and occupational therapies and speech language pathology
- Transportation and per diem
- Home and community based services
- Eyeglasses and optometry
- Personal assistance services
- Targeted case management
- Podiatry

Some optional services may substitute lower cost care for or prevent placement in more expensive mandatory services. For example, coverage of prescription drugs may prevent hospitalization for chronic health conditions such as diabetes.

Medicaid Programmatic Criteria

There are certain programmatic criteria that a state must meet if it administers a Medicaid program. Several basic criteria are:

- Services must be available statewide
- There must be freedom of choice among providers
- Reimbursement levels must be sufficient to attract providers
- Services must be medically necessary
- Co-payments are subject to federal limits
- Once a person meets eligibility criteria, he or she is entitled to receive services

In general, a state needs a waiver of federal regulations in order to bypass compliance with any of the criteria. For instance, Montana received a waiver of freedom of choice when it implemented the statewide contract for mental health managed care administered by a single provider in in the mid-1990s.

A waiver must be cost neutral to the federal government, meaning that the federal share of Medicaid costs can be no more under a waiver than without the waiver. States are liable for the federal share of costs if a waiver program is not cost neutral. Sometimes, cost neutrality can be an impediment to creative health care policies that states may wish to consider.

STATE MEDICAID COST SHARE

States must share in the cost of Medicaid. In general, administrative or operating costs (staff, rent, travel, supplies) are shared equally between the state and federal governments, with some costs at enhanced federal matching rates of 75% and, in limited instances, up to 90%. Most recently the 90% match rate has been offered to states that undertake major upgrades to Medicaid management information and payment systems.

Benefit or services costs are matched at least 50% by the federal government, with some services such as Indian Health Services fully funded with federal funds. The state match rate is based on per capita state income compared to national per capita income over the most recent three years. The state Medicaid service match rate is about 34% over the 2014 biennium.

The federal Medicaid match rate or federal medical assistance percentage (FMAP) also determines the match rate for the federal share of foster care services (Title IV-E of the Social Security Act) and for the Children's Health Insurance Program (CHIP). The CHIP match rate is 90% of the federal Medicaid match (about 24% during the 2015 biennium). A 1% change in FMAP causes state spending to change by about $9.0 million per year in the 2015 biennium.

Federal Restrictions on Source of State Matching Funds

There are some federal restrictions on sources of matching funds. States can get no more than 60% of the nonfederal share from county or local governments. Provider taxes levied specifically to match federal Medicaid funds must be broad based (levied on all payers, including Medicare and Medicaid) and an individual provider cannot be guaranteed Medicaid revenue sufficient to cover the cost of a provider tax. Provider tax revenue may comprise no more than 25% of the total state matching requirements. In addition, the total revenue raised by a provider tax cannot be more than 6.0% of total provider revenue, which is measured by classes of providers established in federal regulation.

Montana has two major sources of provider tax revenue: hospital utilization fees and nursing home bed day fees. Montana also receives some county funds, primarily related to management of county nursing homes

and to a more limited extent from county funds that support Community Mental Health Centers. These funds are used to match federal Medicaid funds and support services directly related to the source of match.

LEGISLATIVE OPTIONS TO INFLUENCE MEDICAID FUNDING

The legislature has several options to influence the funding for the Medicaid program. It can within federal limits:

- Change services, and, in some instances, the level of services included in the Medicaid program
- Alter eligibility levels
- Establish provider payments

If the legislature wishes to seek federal approval to waive certain federal requirements governing the Medicaid program, it can implement creative approaches in many different areas of the program.

The legislature has delegated authority to the Department of Public Health and Human Services (DPHHS) to make certain changes to the Medicaid program. For instance, DPHHS can establish levels of provider reimbursement and make changes to services within federal and Montana statutory guidance. If Medicaid costs are projected to exceed appropriations, DPHHS can … "set priorities to limit, reduce, or otherwise curtail the amount, scope, or duration of the medical services made available under the Montana Medicaid program, if available funds are not sufficient to provide medical assistance for all eligible persons" (section 53-6-101(11), MCA).