MEDICAID 101

January 17, 2015

WHAT IS MEDICAID?

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

- Aged, blind or disabled persons
- Dependent and minor children
- Some parents and guardians 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.

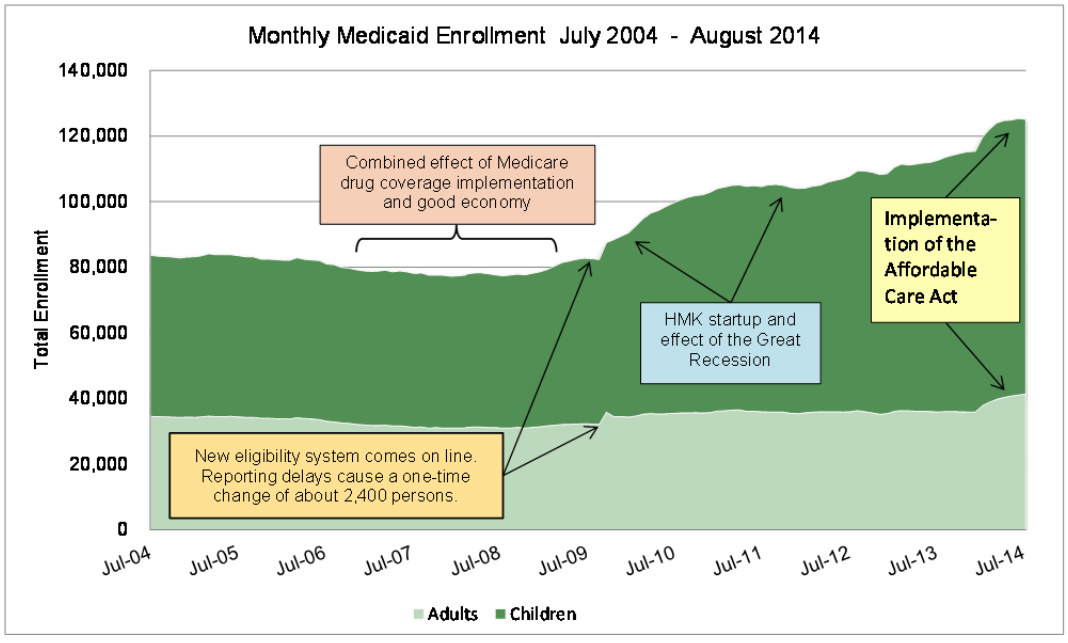
WHAT IS THE DIFFERENCE BETWEEN MEDICAID AND MEDICARE?

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 specific financial and categorical eligibility criteria
- A low-income Medicare beneficiary may also be eligible for Medicaid (called dual eligible)

WHY IS MEDICAID IMPORTANT TO STATE LAWMAKERS?

Medicaid services alone comprise about one-fifth of all funds in the general appropriations act (HB 2) for the 2015 biennium - $2.2 billion total funds, which includes $512.2 million general fund. Medicaid provides a significant source of funding for medical services. Between 10% to 12% of all Montanans are eligible for Medicaid each year. Medicaid pays for about 40% to 43% of all births in Montana. The adjacent chart shows Medicaid enrollment over the last 10 years and highlights some of the reasons for enrollment changes.

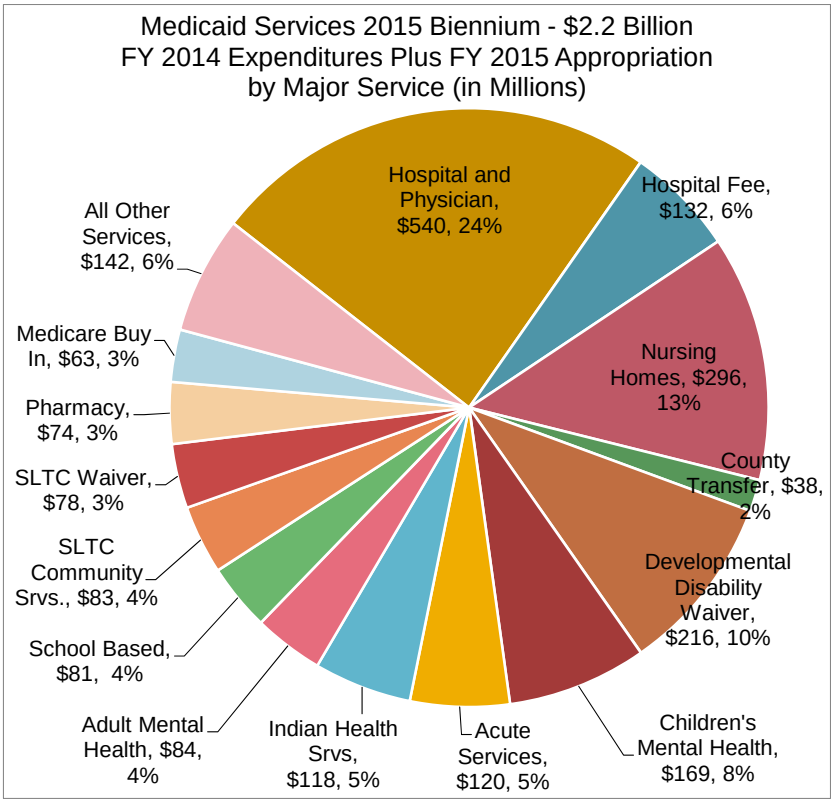


Most enrollees in Medicaid are children, and passage of the citizen initiative to raise financial eligibility for Medicaid as part of the Healthy Montana Kids

(HMK) program increased enrollment in Medicaid.

2015 Biennium Budget by Service

The 2015 biennium budget for Medicaid services is $2.2 billion, which includes actual expenditures in FY 2014 and the FY 2015 appropriation. The graph to the right shows the budget by service.



Hospital and physician services are the largest portion of the budget. Including the portion of hospital costs reimbursed with the hospital utilization fee, the budget for hospital and physician services is 30% of the total with $672 million.

Nursing home services, including the portion reimbursed through the county transfer (intergovernmental transfer) are 15%. Other major services include:

- Developmental disability community waiver services – 10%
- Children's mental health – 8%
- Acute services (eg physical therapy, occupational therapy, dental, optometry) – 5%
- 100% federal reimbursements to Indian Health Services providers for Medicaid services – 5%
- Adult mental health – 4%
- Federal portion of Medicaid services provided by schools, which pay the state match – 4%
- Senior and long term care (SLTC) community services, including personal assistance – 4%
- Senior and long term care waiver services – 3%
- Pharmacy – 3%
- Medicare buy in (payment of Medicare premiums through Medicaid funds for hospital and physician services) – 3%
- All other services – 6%

Medicaid costs have increased over the years for several reasons. As with other health care programs, advances in medical technology and pharmaceuticals have contributed to some of the growth. Provider rate increases authorized by the legislature have also contributed to cost growth. In addition, the legislature has approved service expansions and funded the citizen initiative to raise Medicaid eligibility for children under the HMK program. As noted earlier, there have been enrollment increases.

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 plan, and;
2. Optional services and eligibility that a state can add at its discretion.

Examples of mandatory services are inpatient hospital, physician, nursing home and well child services. Optional services include pharmacy, mental health services, and outpatient therapies. Some optional services may substitute lower cost care for or prevent placement in more expensive mandatory services

or can reduce the need for higher cost mandatory services. For instance, provision of prescription drugs that may prevent hospitalization for chronic health conditions such as asthma.

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

- All 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.

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 systems, which can cost in the tens of millions of dollars.

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 for Medicaid services is unique to each state and is based on per capita state income compared to national per capita income over the most recent three years. The Montana share of Medicaid service costs has ranged from a high of about 39% to a low of about 27% in FY 2002. The FY 2015 rate is about 34%, with an expected increase to about 35% for the 2017 biennium.

The federal Medicaid match rate also determines the match rate for the federal share of foster care services (Title IV-E of the Social Security Act), some childcare services, and for the Children's Health Insurance Program (CHIP). A 1% change in the match rate causes state spending to change by about $9.0 to $10.0 million per year.

Historically, the CHIP match rate has been 90% of the federal Medicaid match (about a 24% state match rate during the 2015 biennium). However, the Patient Protection and Affordable Care Act raised the federal share of CHIP costs by 23% effective October 1, 2015 and extends the enhanced rate through September 30, 2019. However, Congress has not authorized CHIP funding to continue beyond September 30, 2015.

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 payors, including Medicare and Medicaid) and an individual provider cannot be guaranteed Medicaid revenue sufficient to cover the cost of a provider tax.

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) Supplemental Security Income (SSI) aged, blind, or disabled; and 2) nondisabled minor and dependent children and some parents. Nondisabled, nonpregnant, childless adults between the ages of 19 - 64 are not eligible for Medicaid, regardless of income or assets, without a waiver of federal eligibility criteria or if a state implements an expansion of Medicaid as, which is a statutory change authorized by the Patient Protection and Affordable Care Act. The chart on the right shows the major categories of eligibility in the Montana Medicaid program and summarizes income and asset tests by broad eligibility group.

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*	About 47% FPL	No
Aged, Blind, Disabled Adults		
1 Person Household**	$733/Month	Yes - $2,000
2 Person Household**	$1,100/Month	Yes - $3,000
Developmentally Disabled or Physically Disabled Child in Waiver Services	No Limit	No

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

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

2014 Federal Poverty Index
Levels of Poverty by Family Size

Family Size	Annual Household Income - 2014 47%	100%	143%	159%
1	$5,485	$11,670	$16,688	$18,555
2	8,872	18,876	26,993	30,013
3	11,162	23,748	33,960	37,759
4	13,451	28,620	40,927	45,506
5	15,741	33,492	47,894	53,252
6	18,031	38,364	54,861	60,999
7	20,321	43,236	61,827	68,745
8	22,611	48,108	68,794	76,492

Family Size	Monthly Household Income - 2014 47%	100%	143%	159%
1	$457	$973	$1,391	$1,546
2	739	1,573	2,249	2,501
3	930	1,979	2,830	3,147
4	1,121	2,385	3,411	3,792
5	1,312	2,791	3,991	4,438
6	1,503	3,197	4,572	5,083
7	1,693	3,603	5,152	5,729
8	1,884	4,009	5,733	6,374

For family units of more than 8 members, add $406 for each additional member

Federal Poverty Level

The federal poverty level is updated annually, usually in late February or early March. The poverty level is geared to family size. The table on the left shows the 2013 federal poverty level by household size and by various levels.

Aged, Blind Disabled Category

Eligibility for an aged, blind, or disabled adult is governed by federally established criteria. Aged, blind, or disabled persons who meet federal 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. 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 SSI type Medicaid eligibility.

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 fully 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.

ACA Maintenance of Effort

A state faces a substantial monetary penalty if it lowers Medicaid eligibility for children from levels in effect as of March 2009. 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. 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 is about 47% of the federal poverty level, but can vary slightly based on the number of persons in the household. In Montana, pregnant women may have countable income up to 159% of the federal poverty level.

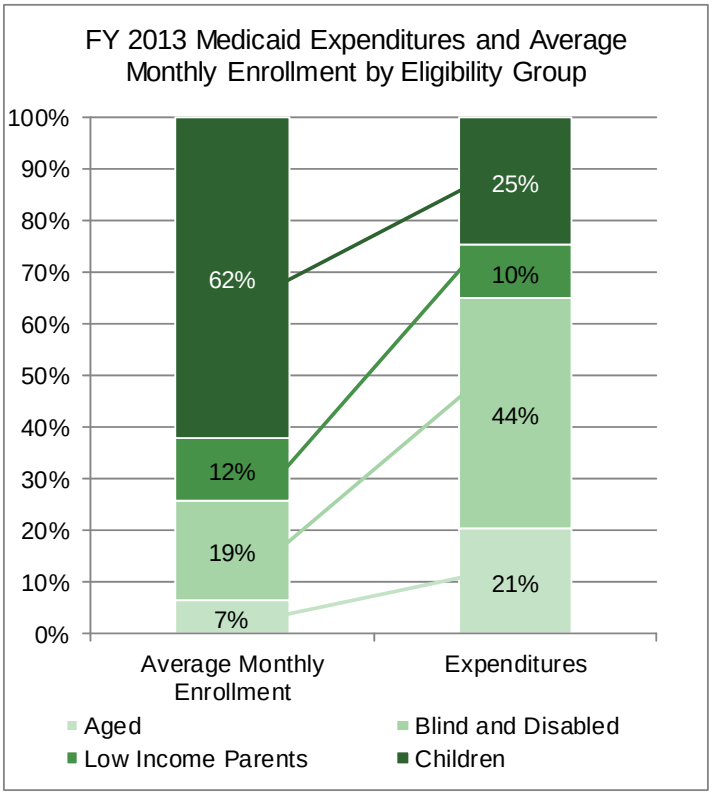
Historically, Montana has had different poverty thresholds for Medicaid eligibility based on whether parents were employed or not. In addition, households could not have assets above $3,000. However, as noted those eligibility criteria were changed by ACA.

The Montana Medicaid Program – Eligibility and Service Cost

The total number of persons eligible for Medicaid varies by month. Some individuals move in and out of Medicaid coverage depending on changes in income and assets (as noted for some eligibility groups). Medicaid enrollment as of September 2014 was 126,811, the highest to date. Medicaid enrollment rarely declines; however, it fell to a low of 66,041 during fiscal year 1998. The decline was due to cash assistance caseload reductions associated with welfare reform and elimination of the requirement that persons eligible for cash assistance were also eligible for and enrolled in Medicaid.

The adjacent graph shows the percentage of persons eligible for Medicaid services by major type of eligibility in FY 2013 compared to the percentage of total cost. The table below the graph shows the actual data.

While low-income children comprised the largest share of Medicaid enrollees (62%), this group incurred only 25% of the total expenditures. In contrast, aged recipients accounted for 7% of enrollees, yet incurred 21% of the total cost. Disabled or blind recipients were 19%of the number eligible and accounted for 44% of the costs. Low-income adults were 12% of the enrollee and accounted for 10% of the costs.



Legislative Options to Influence Medicaid Budgets

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

- Change services or limit services covered by the Medicaid program for certain eligibility groups
- Alter eligibility levels for certain groups
- Change provider reimbursement levels
- Change reimbursement methodologies

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

While some options to reduce expenditures appear fairly straight forward, there can be unintended consequences for some actions that need to be considered, such as cost shift to higher cost services. In addition, federal approval may be required for some proposals.

FY 2013 Medicaid Expenditures and Average Monthly Enrollment by Eligibility Group

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

Source: Department of Public Health and Human Services, Biennial Medical Report to the State Legislature - Fiscal Years 2013/2014, p. 9. *Totals do not include HMK - Children's Health Insurance Program costs, Medicare savings plan, or family planning waiver costs.

The legislature has delegated authority to the Department of Public Health and Human Services (DPHHS) to make certain changes to the Medicaid program. 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).