

MEDICAID: AN OVERVIEW

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INTRODUCTION

In 1965, Congress created the medical assistance program for low-income people that's known as Medicaid. The program pays the medical bills of people who meet certain income-based criteria, with the federal government and state governments sharing in the costs.

State Medicaid programs must follow specific requirements set out in federal law and regulations, but states do have some flexibility in determining:

- which individuals qualify for services;
- the optional medical services the state program will cover; and
- the amount of money the state will pay to health care professionals and facilities that provide services to Medicaid patients.

The number of Medicaid patients has increased both nationally and at the state level in the past two years, because of economic conditions.

An average of about 81,600 Montanans were enrolled in Montana's Medicaid program each month in state fiscal year 2009, the most recent year for which full enrollment and spending figures are available. About 60% were children.¹ Federal and state spending on medical benefits totaled about \$844 million that year.²

Enrollment in the Medicaid program stood at about 104,600 Montanans in May 2011, the most recent month for which figures are available. The increase in Medicaid patients has, in turn, resulted in greater costs to the state. And the federal health care legislation approved in 2010 is expected to increase costs down the road, because it calls for Medicaid to cover additional people starting in 2014. States will eventually pay a portion of the costs of covering those new Medicaid patients.

This briefing paper is designed to provide the Select Committee on Efficiency in Government with a general overview of:

- who is served by the Montana Medicaid program;
- the medical services they receive;
- how the costs of services are shared;
- the options available to states for managing costs; and
- issues facing the program into the future.

MEDICAID ELIGIBILITY

The Medicaid program primarily serves low-income people, particularly pregnant women, children, and aged, blind, or disabled adults. Within that broad eligibility brush, states may establish their own guidelines for serving people with higher incomes than the minimum set by federal law and for serving populations other than those required by federal law. Income limits usually are based on a percentage of the federal poverty level, or FPL. The U.S. Department of Health and Human Services updates the poverty guidelines annually. The table below shows the income that families of different sizes earn at the federal poverty level, which is often described as 100% of FPL.

2011 Federal Poverty Level

Family Size	Yearly Gross	Monthly Gross	Family Size	Yearly Gross	Monthly Gross
1	\$10,890	\$908	5	\$26,170	\$2,181
2	\$14,710	\$1,226	6	\$29,990	\$2,499
3	\$18,530	\$1,544	7	\$33,810	\$2,818
4	\$22,350	\$1,863	8	\$37,630	\$3,136

Montana generally has chosen to keep its eligibility guidelines in sync with or lower than those required by federal law and has rarely expanded the Medicaid program to cover additional people. The state provides Medicaid coverage to able-bodied adults only if the adults have dependent children and a very limited income.

The Medicaid program establishes a number of different categories of eligibility, with separate requirements. In some cases, people may meet the income guidelines but don't qualify for the program because they have assets that exceed the limits set by law or rule. Some assets, such as homes and vehicles, are not counted in determining whether a person is eligible for Medicaid.

Some Montanans are eligible for Medicaid coverage under certain circumstances and sometimes only for a specified amount of time. For example, infants born to women receiving Medicaid at the time of their birth qualify for coverage through the first year of their lives. And some families may receive up to 1 year of Medicaid coverage after their eligibility normally would end because of an increase in earned income.

The tables on the following page show:

- the range of eligibility levels for key Medicaid categories and the number of Montanans enrolled in those categories in May 2011; and
- the corresponding income levels allowed for those categories.

Montana Medicaid Eligibility

Category	Income as % of FPL	Allowable Assets	Enrollees*
Adults with Children	22% to 33%	\$3,000	7,770 adults 12,212 children
Aged, Blind, Disabled	Individual: \$674/month Couple: \$1,011/month	Individual: \$2,000 Couple: \$3,000	27,068
Children Under 19	133%	Not Counted	43,632**
Pregnant Women	150%	\$3,000	4,077
Children in Foster Care or Subsidized Adoption	Varies	Foster Care: \$3,000 Sub Adoption: Not Counted	3,688
Breast/Cervical Cancer	200%	Not Counted	188
Workers with Disabilities	250%	Individual: \$8,000 Couple: \$12,000	465

* Source: *Medicaid Enrollment by Eligibility Category for Most Recent 24 Months*, DPHHS

** The costs of the Medicaid benefits provided to 5,867 children were paid for by the Children's Health Insurance Program, rather than Medicaid.

Income as a Percentage of the Federal Poverty Level

Size	Gross Yearly Income					Gross Monthly Income				
	33%	133%	150%	200%	250%	33%	133%	150%	200%	250%
1	\$3,594	\$14,484	\$16,335	\$21,780	\$27,225	\$300	\$1,207	\$1,361	\$1,815	\$2,269
2	\$4,854	\$19,564	\$22,065	\$29,420	\$36,755	\$405	\$1,630	\$1,839	\$2,452	\$3,065
3	\$6,115	\$24,645	\$27,795	\$37,060	\$46,325	\$510	\$2,054	\$2,316	\$3,088	\$3,860
4	\$7,376	\$29,726	\$33,525	\$44,700	\$55,875	\$615	\$2,477	\$2,794	\$3,725	\$4,656
5	\$8,636	\$34,806	\$39,255	\$52,340	\$65,425	\$720	\$2,901	\$3,271	\$4,362	\$5,452
6	\$9,897	\$39,887	\$44,985	\$59,980	\$74,975	\$825	\$3,324	\$3,749	\$4,998	\$6,248
7	\$11,157	\$44,967	\$50,715	\$67,620	\$84,525	\$930	\$3,747	\$4,226	\$5,635	\$7,044
8	\$12,418	\$50,048	\$56,445	\$75,260	\$94,075	\$1,035	\$4,171	\$4,704	\$6,272	\$7,840

The Department of Public Health and Human Services (DPHHS) administers the Medicaid program in Montana and determines whether individuals qualify for participation.

MEDICAID BENEFITS

Federal law requires that adults covered by Medicaid receive certain services, while children are eligible for those services as well as any others that are needed to treat or alleviate a physical defect, physical or mental illness, or a condition identified through regular screening. A state also may choose to cover more services than the minimum set in federal law.

All state programs must meet the following four broad federal guidelines related to services:

- each service must be sufficient in amount, duration, and scope to achieve its purpose;
- services must be available in equal amount, duration, and scope to all categorically eligible people;
- services generally must be the same statewide; and
- beneficiaries must have reasonable freedom of choice among providers.

The table below shows the benefits provided under Montana's Medicaid program.

Montana Medicaid Services

Services Required by Federal Law	Optional Services Offered by State
Physician Services	Prescription Drugs
Dentist Services	Dental and Denturist Services
Advanced Practice Registered Nurse Services	Eyeglasses and Optometrist Services
Inpatient Hospital Services	Mental Health Services
Federally Qualified Health Clinic or Rural Health Clinic Services	Ambulance Services
Free-Standing Birth Center Services	Physical, Occupational, and Speech Therapy
Nursing Facility Services	Transportation Services
Outpatient Hospital Services	Home and Community-Based Services
Laboratory Services and X-rays	Personal Assistance Services
Family Planning Services	Targeted Case Management
Home Health Services	Podiatry
Durable Medical Equipment	
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) for Children	

PAYMENT FOR SERVICES

The federal and state government generally pay for the medical services provided to people in the Medicaid program. Recipients may be required to pay a small share of the costs, but federal law limits the deductible they may be charged to \$2.30 per month per family and limits co-payments for most services.

The Montana Medicaid program does not impose a deductible, but does require a minimum co-payment for many services. Payments for non-hospital services range from at least \$1 to a maximum of \$5 or 5% of the average allowable cost for the service, whichever is less. The co-payment for inpatient hospital services is up to \$100 per discharge, but may not exceed the cost of services. Some groups of beneficiaries, such as pregnant women or people in hospice care, are exempt from cost-sharing requirements.³ And cost-sharing may not, under federal regulation, exceed 5% of a family's income.

The federal government pays the larger share of Medicaid costs in Montana, but not in all states. Each year, the amount that states contribute to their Medicaid programs is calculated using a formula that takes into account each state's average per capita income as compared to the national average. This results in what's known as the Federal Medical Assistance Percentage, or FMAP.

States pay a maximum of 50% of the medical costs of their Medicaid enrollees, but many states pay less. Montana currently pays slightly more than 33% of the costs of most medical services, while the federal government pays nearly 67%. Ten years ago, Montana's FMAP was 73%, but it has gradually dropped to the current level.

The federal government pays anywhere from 50% to 90% of a state's cost of running the program, depending on the administrative function involved. For example, the federal match for eligibility and claims processing systems is 75%.

For the current biennium ending June 30, 2013, medical costs for Montana's Medicaid program are estimated to total about \$2 billion in state and federal funds, representing 23% of the state's \$6.9 billion budget. The state's share of the cost is estimated at about \$642.1 million, with about \$467 million coming from the general fund and the remainder paid for with special revenue funds. The general fund costs represent 14% of the state's general fund spending.⁴

States set the rates that will be paid to health care professionals and facilities for the services that they provide to Medicaid patients. Providers range from hospitals and nursing homes to physicians, nurses, and mental health professionals. Montana establishes its provider rates by administrative rule, based on the amount of money budgeted by the Legislature. Physician reimbursement rates in Montana are driven somewhat by Medicare rates, because the state uses the same system as Medicare for assigning a value to each service billed by a physician. In addition, state law establishes a formula to be used in calculating physician rates.

MANAGING PROGRAM COSTS

Medicaid is an entitlement program for those individuals who qualify. If an enrollee has high or long-term medical costs, the program covers those costs.

However, states may use some strategies for managing costs within their Medicaid programs. The strategies must still meet Medicaid's general guidelines for scope, amount, and duration of benefits and for providing similar services statewide, unless the federal government waives those requirements at a state's request.

Medicaid waivers fall into the following three categories:

- Research and demonstration projects authorized under a so-called Section 1115 waiver. These waivers allow states to forego some requirements, such as freedom of choice of provider or comparability or "statewideness" of services. The federal government still provides the same matching rate, but the estimated spending on the waiver program can't exceed the estimated cost of the state's existing program.
- Waivers of statewideness, comparability of services, or freedom of choice, authorized by Section 1915(b) waivers. Among other things, these waivers allow for managed care programs or limits on the number of providers for certain services.
- Payment for home and community-based services (HCBS) as an alternative to long-term care in a nursing facility, hospital, or institution for the developmentally disabled. These Section 1915(c) waivers are also known as HCBS waivers.

Montana has applied for and received the following waivers:

- a 1915(b) waiver to operate the Passport to Health program, in which a primary care provider either provides all medical services or makes referrals for medically necessary services. Most Medicaid enrollees participate in this program.
- a 1915(b) waiver to operate, in conjunction with community health centers, a primary care case management program for high-cost, high-risk Medicaid patients.
- an HCBS waiver that provides up to 50 autistic children who are 15 months to 7 years of age with intensive services for up to three years, in an effort to improve their communication, education, and other skills.
- an HCBS waiver that pays for group homes, supported living situations, work or day activities, and transportation for people with developmental disabilities, as an alternative to residential care at the Montana Developmental Center in Boulder.

- an HCBS waiver that provides limited support services to developmentally disabled individuals who live in their own homes.
- an HCBS waiver for people who otherwise may be placed in a nursing facility or hospital but instead are cared for in their homes and communities.
- an HCBS waiver that allows more flexibility and choice than the HCBS waiver for the elderly.
- an HCBS waiver for community-based services for individuals 18 years of age or older who have a severe disabling mental illness and meet the criteria for nursing home level of care. Services are limited to 155 people in the Billings, Great Falls, Missoula, and Butte areas.
- a five-year HCBS waiver that allows youth who are 6 to 17 years of age and who are diagnosed with a serious emotional disturbance to obtain services in their home communities rather than a psychiatric in-patient setting.
- a Section 1115 waiver that provides mentally ill individuals who are 21 to 64 years of age with basic Medicaid benefits and also provides basic services to up to 800 individuals with schizophrenia or bipolar disorder who previously were eligible for the Mental Health Services Plan, which is funded solely with state general fund dollars.

THE ISSUES AHEAD

Medicaid programs across the nation are facing a host of issues related to current costs as well as the planned expansion of Medicaid under the Patient Protection and Affordable Care Act (PPACA), passed by Congress in 2010.

Nationally, about 64.4 million people were enrolled in Medicaid for all or part of federal fiscal year 2009; nearly half were children.⁵ The combined costs to the federal government and the states of paying for health care services totaled \$360.3 billion that year.⁶

PPACA will require states to expand their Medicaid programs in 2014 to cover all individuals who are under 65 years of age and who have modified adjusted gross incomes, as defined in the federal tax code, under 138% of the federal poverty level. In April 2010 — when 96,500 Montanans were covered by the Medicaid program — DPHHS estimated that the expansion could add another 82,000 Montanans to Medicaid by 2019.⁷

PPACA calls for the federal government to pay the full costs of covering the newly eligible individuals for the first three years that the expansion is in place, through 2016. After that, states will gradually assume a portion of the costs, up to a maximum of 10% in 2020 and beyond.

Two other factors also are putting pressure on state Medicaid programs:

- the economic recession has resulted in a higher number of people qualifying for and obtaining Medicaid benefits; and
- PPACA prevented states from significantly changing their Medicaid eligibility requirements or standards after passage of the law. If they do, they will lose their federal Medicaid dollars.

As Medicaid costs to the federal government increase, Congress, as well, is starting to discuss options for reducing the costs.

Concerns at both the state and federal level have prompted policy makers to propose some new ideas for Medicaid and to take a closer look at existing options.

New proposals under discussion include:

- using a blended FMAP rate for the current Medicaid program, the expanded Medicaid population to be covered under PPACA, and the Children's Health Insurance Program (CHIP). As currently established, the Medicaid and CHIP programs have different FMAPs, and PPACA proposes a third matching rate for the expanded Medicaid population. Montana's current Medicaid FMAP is 66.81%, while the FMAP for CHIP is 76.77%, and the FMAP for the expanded Medicaid population would be 100% from 2014 through 2016. A blended rate would apply to all state Medicaid and CHIP expenditures except administrative costs. The change could reduce the amount of federal funds for these programs, shifting costs to the states.
- making Medicaid a block grant program, rather than an entitlement program. Under a block grant program, the state would receive a finite amount of money from the federal government to pay for Medicaid costs. If that money, along with the state matching funds, doesn't cover projected costs, the state would need to reduce costs or increase the amount of state funds spent on the program. Steps to reduce costs typically would involve changing eligibility guidelines, reducing services covered by the program, and/or reducing provider rates. Some block grant proposals have suggested giving states more flexibility in establishing their own program guidelines, as well.

Some states also are more closely examining existing options, including:

- using managed care to control costs by contracting with one or more companies that would administer the program. A managed care program typically provides the company with a pre-determined amount of money for each Medicaid enrollee, and the company then manages the overall costs of the program through contracts with providers and pre-authorization of services that enrollees receive.

- contracting with private companies to operate some portions of the Medicaid program. Not all aspects of the Medicaid program can be operated by a private company, but states have explored options for contracting out some services.
- creating "medical homes" for Medicaid beneficiaries, where a primary physician oversees medical care and coordinates with other health care professionals to ensure that necessary services are provided in an efficient and cost-effective manner.

These options and others are likely to be scrutinized by federal and state officials in the coming months and years, as both the states and the federal government look at ways to control health care costs, including Medicaid costs.

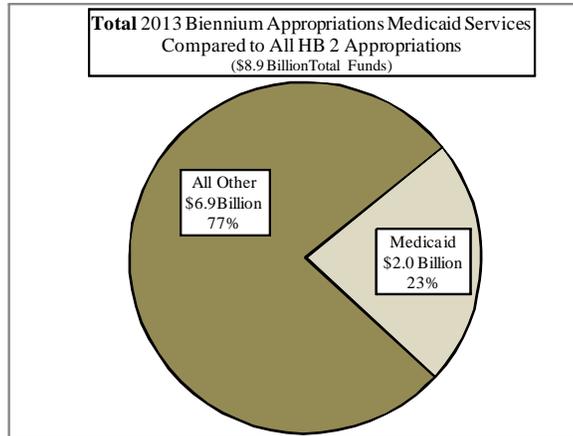
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Endnotes

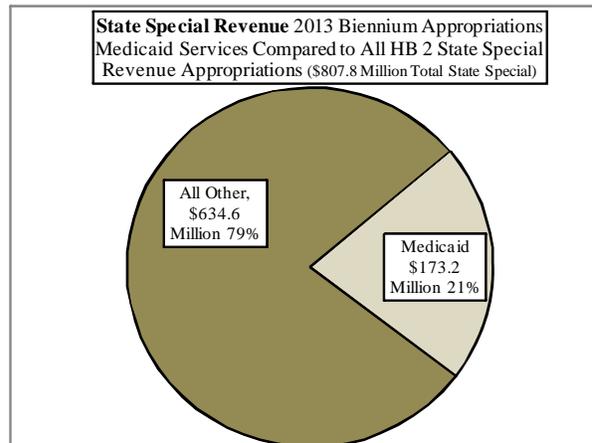
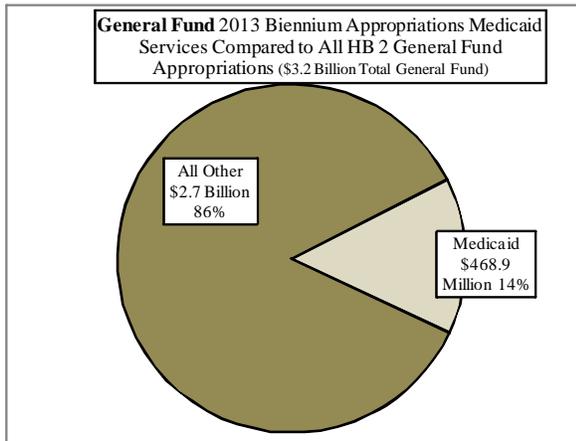
1. "The Montana Medicaid Program: Report to the 2011 Legislature," *Department of Public Health and Human Services*, Dec. 22, 2010, P. 8.
2. Ibid, P. 25.
3. "Recipient Requirements, Cost Sharing," 37.85.204, *Administrative Rules of Montana*.
4. Source: Legislative Fiscal Division, based on appropriations made by the 2011 Legislature.
5. "Medicaid and CHIP enrollment," Table I.16, *2010 CMS Statistics*, Centers for Medicare and Medicaid, available at www.cms.gov/ResearchGenInfo/02_CMSStatistics.asp, accessed July 28, 2011.
6. "Medicaid/type of service," Table III.8, *2011 CMS Statistics*, Centers for Medicare and Medicaid, available at www.cms.gov/ResearchGenInfo/02_CMSStatistics.asp, accessed July 28, 2011.
7. "Montana and Major Components of Federal Health Care Reform," *Department of Public Health and Human Services*, April 19, 2010, P. 5.

MONTANA MEDICAID BUDGET 2013 Biennium

The table below shows the total amount appropriated for the state's Medicaid program as compared to all other programs funded by House Bill 2 for the biennium beginning July 1, 2011, and ending June 30, 2013.



The tables below show the amount of general fund and state special revenue funds appropriated for the state's Medicaid program as compared to all other programs funded by House Bill 2 for the biennium beginning July 1, 2011, and ending June 30, 2013.



Source: Legislative Fiscal Division

