

# **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 health care bills of people who meet certain criteria, including income-based criteria. The federal government and state governments share in the costs of the program.

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.

Until 2014, Medicaid primarily covered children, pregnant women, extremely low-income parents, and elderly, blind, or disabled adults. The Patient Protection and Affordable Care Act, passed in 2010 and commonly referred to as ACA, changed that focus. ACA expanded Medicaid to cover nondisabled, nonpregnant, and childless adults ages 19 to 64 with incomes of up to 138 percent of the federal poverty level, starting in 2014. However, ACA was challenged on a number of fronts. In 2012, the U.S. Supreme Court made the Medicaid expansion provisions optional for states.

In 2015, the Montana Legislature approved Senate Bill 405 to expand Medicaid as allowed under ACA, with some requirements that the new enrollees pay premiums and make copayments for services. By mid-2017, about 227,000 Montanans were receiving Medicaid-funded services, either through the traditional program or as part of the expansion population. That compares to 125,200 in FY 2015,<sup>1</sup> before expansion went into effect.

This briefing paper is designed to provide the Children, Families, Health, and Human Services Interim Committee 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
- potential changes at the federal level.

## **MEDICAID ELIGIBILITY**

Within the broad eligibility guidelines set by the federal government, 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. Montana generally has chosen to keep its eligibility guidelines in sync with or lower than those allowed by federal law. Until passage of SB 405 in 2015, the state had rarely expanded the Medicaid program to cover additional people. Coverage for able-bodied adults was limited to adults with dependent children and a very low 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.

Eligibility is based on a percentage of the federal poverty level, or FPL. The Department of Public Health and Human Services (DPHHS) administers the Medicaid program in Montana and determines whether individuals qualify for participation.

An average of about 125,200 Montanans were enrolled in Montana's traditional Medicaid program each month in state fiscal year 2015, the most recent year for which full enrollment and spending figures are available. About 61% were children.<sup>2</sup> Federal and state spending on medical benefits for totaled about \$1.1 billion that year, before the program was expanded as allowed under ACA.<sup>3</sup>

Enrollment in the traditional Medicaid program stood at about 146,300 in May 2017, the most recent month for which figures are available. Enrollment in the Medicaid expansion program was 80,806 on July 15.

The tables on the following page show:

- the range of eligibility levels for key Medicaid categories;
- the number of Montanans enrolled in each of those categories as of mid-2017; and
- the corresponding income levels allowed for those categories.

### Montana Medicaid Eligibility, 2017

Category	Income as % of FPL	Allowable Assets	Enrollees as of 5/1/17*
Adults with Children	24%	Not Counted	17,609
Aged, Blind, Disabled	Individual: \$735/month Couple: \$1,103/month	Individual: \$2,000 Couple: \$3,000	23,627
Children Under 19	143%	Not Counted	102,001
Pregnant Women	157%	Not Counted	3,022**
Children in Foster Care or Subsidized Adoption	Varies	Foster Care: \$3,000 Sub Adoption: Not Counted	Foster Care: 2,290 Sub Adopt: 3,445 Former Foster: 137
Breast/Cervical Cancer	250%	Not Counted	49
Workers with Disabilities	250%	Individual: \$15,000 Couple: \$30,000	1,165
Medicaid Expansion	138%	Not Counted	80,806***

\* Source: Department of Public Health and Human Services

\*\* Client counts in this category may be duplicate counts and included in other categories.

\*\*\* Medicaid expansion figure reflects enrollment on July 15, 2017.

### Income as a Percentage of the 2017 Federal Poverty Level

Size	Gross Yearly Income					Gross Monthly Income				
	24%	138%	143%	157%	250%	24%	138%	143%	157%	250%
	Parents	Expansion	Children	Pregnant Women	Buy-In	Parents	Expansion	Children	Pregnant Women	Buy-In
1	\$2,894	\$16,643	\$17,246	\$18,934	\$30,150	\$241	\$1,387	\$1,437	\$1,578	\$2,513
2	\$3,898	\$22,411	\$23,223	\$25,497	\$40,600	\$325	\$1,867	\$1,935	\$2,124	\$3,383
3	\$4,901	\$28,180	\$29,201	\$32,059	\$51,050	\$408	\$2,349	\$2,434	\$2,672	\$4,255
4	\$5,904	\$33,948	\$35,178	\$38,622	\$61,500	\$492	\$2,829	\$2,932	\$3,219	\$5,125
5	\$6,907	\$39,716	\$41,155	\$45,185	\$71,950	\$576	\$3,309	\$3,429	\$3,765	\$5,995
6	\$7,910	\$45,485	\$47,133	\$51,747	\$82,400	\$659	\$3,791	\$3,928	\$4,313	\$6,868
7	\$8,914	\$51,253	\$53,110	\$58,310	\$92,850	\$743	\$4,271	\$4,426	\$4,859	\$7,738
8	\$9,917	\$57,022	\$59,088	\$64,872	\$103,300	\$826	\$4,751	\$4,923	\$5,406	\$8,608

## **MEDICAID BENEFITS**

Federal law requires that adults covered by Medicaid receive certain services. Children are eligible for the same services as adults. Children also must be provided any other services that are medically 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**

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

## **PAYMENT FOR SERVICES**

The federal and state governments generally pay for the medical services provided to people in the Medicaid program. Enrollees may be required to pay a small share of the costs. However, federal law limits the maximum they may be charged, and states may allow for lower cost-sharing amounts.

The Montana Medicaid program has established copayments as follows<sup>4</sup>:

- People with incomes at or below 100% of the poverty level pay may be charged \$4 per visit, service, or prescription for most non-hospital services and \$75 per discharge for each inpatient hospital stay.
- People with incomes above 100% of poverty may be charged 10% of the provider's reimbursed amount for most medical services and hospital stays.

Some groups of beneficiaries, such as pregnant women, children, tribal members, and people in hospice care, are exempt from cost-sharing requirements.<sup>5</sup> In all cases, cost-sharing may not, under federal regulation, exceed 5% of a family's income.

The amount the federal government pays for Medicaid costs varies by state and also by whether services are provided to people enrolled in the traditional Medicaid program or in the expanded program authorized by ACA, as described below.

- **Traditional Medicaid Program:** 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 34% of the costs of most health care services, while the federal government pays nearly 66%.

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%.

- **Expansion Population:** ACA created a higher FMAP for individuals covered under the expanded Medicaid program. The federal government paid the full cost of medical services in the first three calendar years the expansion was in effect — 2014 through 2016. That "enhanced" FMAP has been gradually reduced each year since then and is scheduled to level off at 90% in 2020 and beyond. At that point, states will be paying 10% of the costs. The FMAP was 100% in 2016, when Montana's

expansion program began and is 95% right now. It will decrease to 94% in 2018, 93% in 2019, and 90% in 2020. Administrative costs are paid using the same FMAP as the traditional program.

Montana's reimbursement level for the medical costs of expansion enrollees has actually been slightly less than the enhanced FMAP because the state chose to allow what's known as 12-month continuous eligibility for the enrollees. Under that provision, a person can remain in the Medicaid program for a full year even if the person's income increases and exceeds 138% of poverty during that time. In exchange for allowing continuous eligibility, the federal government decided to pay the standard, lower FMAP of about 66% for 2.6% of the medical claims of the expansion group.

### Costs to Montana

The Montana Legislature sets the budget for the traditional Medicaid program when it passes House Bill 2 each session. However, a specific amount is not appropriated for the Medicaid expansion program or for Medicaid enrollees who receive services through the Indian Health Service or a tribal clinic. Instead, those amounts are "statutorily appropriated," meaning that state law gives DPHHS the authority to spend whatever amount is needed to cover the costs without having a specific dollar amount appropriated in HB 2 or another bill.

For the current biennium that began on July 1, 2017, the appropriated or estimated total costs for Medicaid break out as follows<sup>6</sup>:

- \$2.5 billion for the traditional Medicaid program. The amount is appropriated in HB 2, with the state's share of the costs totaling about \$832 million.
- an estimated \$1.1 billion for the costs of the Medicaid expansion program. The state's share of the costs is estimated at nearly \$82.5 million. However, budget cuts triggered under Senate Bill 261, passed by the 2017 Legislature, will eliminate the state's contract with Blue Cross Blue Shield to administer the expansion program. Elimination of the contract is estimated to reduce general fund costs to the program by \$4 million.
- an estimated \$176.9 million for the costs of services provided by the Indian Health Service or through tribal health clinics. There is no general fund cost for these services; the federal government pays 100% of costs provided through IHS and tribal clinics.

## **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 manage costs by deciding which optional services to cover, how much to pay for health care services, and by seeking waivers of various provisions of federal Medicaid law.

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.

Waivers must be approved by the federal government. They 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 Section 1115 research and demonstration waiver to expand Medicaid as allowed under ACA while also charging premiums and establishing an alternate benefit package for people who participate in the expansion program;
- a 1915(b) waiver to allow the state to require expansion enrollees to use a provider network established by a third-party administrator;

- a 1915(b) waiver known as the Passport to Health waiver, which has multiple components designed to help people obtain and use the most appropriate medical service and to manage their care. Most Medicaid members are enrolled in the primary case management program in which a designated primary care provider either delivers all medical care or makes referrals for medically necessary care that must be provided by another health care provider.
- 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 for people who otherwise may be placed in a nursing home or hospital but instead are cared for in their homes and communities.
- 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 298 people.
- a Section 1115 waiver to cover family planning services for up to 4,000 women ages 19 through 44 who have an annual income of up to 211% of poverty; and
- a Section 1115 waiver that provides up to 3,000 mentally ill adults with incomes of 139% to 150% of poverty with Medicaid coverage if they are not otherwise eligible for Medicaid. The waiver also provides 12-month continuous eligibility for all non-expansion individuals whose eligibility is based on modified adjusted gross income without an asset test and standardizes the benefit packages for different types of enrollees.

## **THE ISSUES AHEAD**

Recent proposals in Congress to repeal or replace ACA called for substantial changes to the Medicaid program. In addition to phasing out or changing policies related to the Medicaid expansion, the proposals sought to limit federal spending on the traditional Medicaid program to a defined amount of money. That would change the current funding approach, in which the federal government pays its established share of all Medicaid costs that are incurred.

Various pieces of federal legislation have focused on two alternatives to the current funding mechanism — block grants or per-capita spending.

Under a block grant program, each state would receive a finite amount of federal funds to pay for Medicaid costs. The amount would be based on the amount of money the state had spent on its program in a base year and would increase by a specific percentage each fiscal

year. If the federal funds, along with the state matching funds, didn'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 suggested giving states more flexibility in establishing their own program guidelines, as well.

Under a per-capita spending plan, each state's federal allocation would be based on the amount of money that was spent on Medicaid enrollees in a specific, base year. Different bills have proposed breaking the per-capita spending down by different types of enrollee groups, such as the disabled, pregnant women, and children. The amount of federal funding would increase each year by a certain percentage. As with a block grant scenario, if the combined federal and state funding didn't cover the state's costs, the state would need to appropriate additional money for the program or reduce Medicaid spending.

Depending on whether Congress revisits these ideas in the coming months, Montana policymakers in both the executive branch and the Legislature may need to make significant decisions related to the Medicaid program in future years.

## Endnotes

1. "The Montana Medicaid Program: Report to the 2017 Legislature," *Department of Public Health and Human Services*, Jan. 9, 2017, P. 9.

2. Ibid.

3. Ibid.

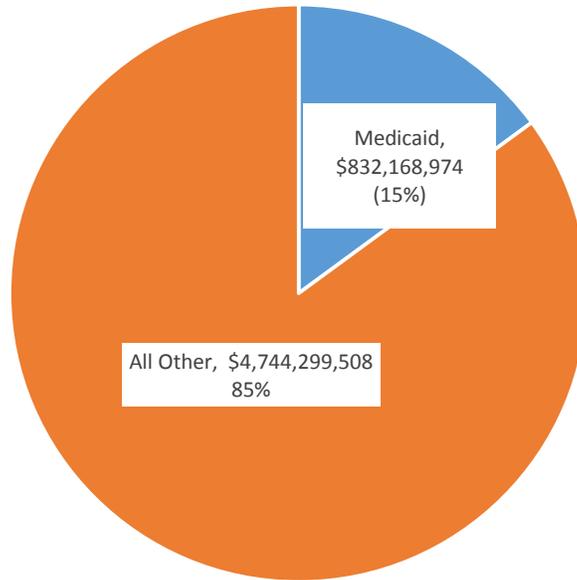
4. "Recipient Requirements, Cost Sharing," 37.85.204, Administrative Rules of Montana.

5. Ibid.

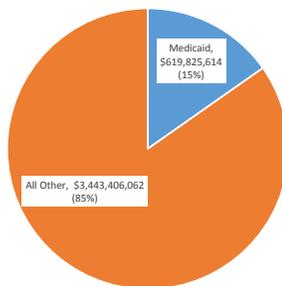
6. Legislative Fiscal Division.

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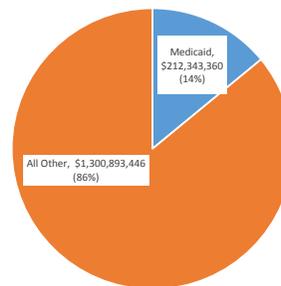
Total 2019 Biennium Appropriations Medicaid Services Compared to All HB2 Appropriations  
 (\$5.6 Billion Total State Funds)



General Fund 2019 Biennium Appropriations Medicaid Services Compared to All HB2 Appropriations  
 (\$4.1 Billion Total General Fund)



State Special Revenue 2019 Biennium Appropriations Medicaid Services Compared to All HB2 Appropriations  
 (\$1.5 Billion Total State Special Revenue)



Source: Legislative Fiscal Division