MONTANA LEGISLATIVE BRANCH

Legislative Fiscal Division

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MEDICAID 101

DEFINING MEDICAID

Medicaid is public health coverage program that covers health care services for nearly 20.0% of individuals in Montana who meet specific financial eligibility criteria. It was enacted as Title XIX of the Social Security Act of 1965 and is authorized in Title 53 of the Montana Code Annotated.

Medicaid and Medicare

Medicaid and Medicare are the two major nationwide health care programs supported by the federal government. They are sometimes confused because their names are similar, but they are distinct and separate programs. It is possible for a low-income Medicare beneficiary to also be eligible for Medicaid (dual eligibility).

Medicare is:

- Funded entirely by the federal government;
- For citizens over 65 or who meet certain federal disability criteria; and
- Accessible regardless of income.

Medicaid is:

- Funded by both state and federal governments;
- For persons of low-income only; and
- Accessible to all persons regardless of age or disability status.

Medicaid Expansion

Medicaid was expanded by the Affordable Care Act in 2010 to provide healthcare coverage to individuals between the ages of 19-64 earning less than 138% of the federal poverty level (FPL). In 2015, the 64th Montana Legislature passed Medicaid expansion into law through the Montana Health and Economic Livelihood Partnership (HELP) Act (SB 405). Renewed by the 66th legislature, the HELP Act is scheduled to terminate on June 30, 2025.

ELIGIBILITY, ENROLLMENT, AND EXPENDITURES

Eligibility Categories

Although Montana Medicaid is now accessible to all low-income individuals, there are different criteria for eligibility according to a person's life circumstances. Eligibility thresholds are determined according to the current FPL.

Children are eligible if their families earn up to 143.0% of the FPL. Historically, this group has comprised about 62.0% of traditional Medicaid enrollees. When factoring in Medicaid expansion, children account for approximately 37.8% of total Medicaid enrollment. Children may also qualify for coverage under the Children's Health Insurance Program (CHIP), discussed on page 6.

Pregnant women are eligible if they earn up to 157.0% of the FPL. Pregnant women historically account for around 1.0% of the total Medicaid population.

Aged, blind, or disabled people must meet federal Social Security Income (SSI) criteria to be eligible for Medicaid. Aged recipients comprise about 5.9% of enrollees and blind or disabled about 10.5%. Eligible individuals must be:

- over the age of 65, or
- determined to be blind or disabled by the Social Security Administration ***and*** must meet income and assets tests.

Federal Poverty Level (FPL)

The federal poverty level is updated annually, usually in late February or early March. The poverty level is based on family size. The table below shows the 2024 federal poverty level by household size and by various levels.

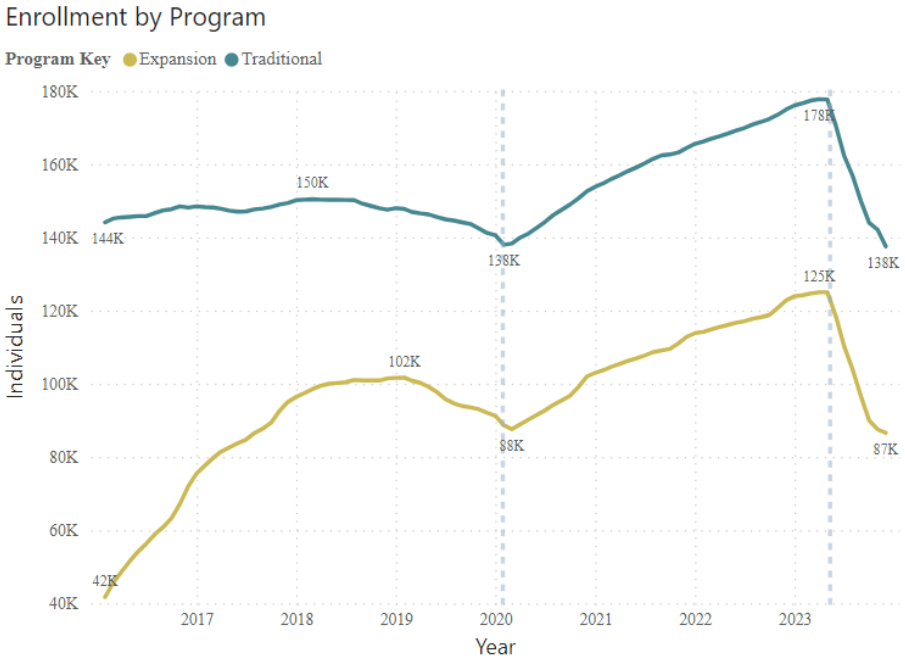
Percent of Poverty by Family Size
Based on 2024 Federal Poverty Guidelines

Family Size	Annual Household Income			
	100%	138%	143%	157%
1	$15,060	$20,783	$21,536	$23,644
2	20,440	28,207	29,229	32,091
3	25,820	35,632	36,923	40,537
4	31,200	43,056	44,616	48,984
5	36,580	50,480	52,309	57,431
6	41,960	57,905	60,003	65,877
7	47,340	65,329	67,696	74,324
8	52,720	72,754	75,390	82,770

Through Medicaid expansion, all other low-income adults are eligible if they earn up to 138.0% of the FPL. Prior to Montana's adoption of Medicaid expansion, the only eligible adults (other than those falling into the eligibility categories discussed above) were parents earning up to 133.0% of the FPL. Adults account for about 62.2% of total Medicaid enrollment.

Enrollment

Traditional Medicaid enrollment generally changes with population and according to economic conditions. From March of FY 2018 to March of FY 2020, Montana saw a decrease of 9.2% in traditional Medicaid enrollment. This trend was reversed when the federal government declared the COVID-19 Public Health Emergency (PHE). Before the COVID-19 PHE, enrollment was steadily decreasing from its peak enrollment in February 2019. The declaration put a pause on disenrollment from both state Medicaid programs as a condition for receiving additional emergency federal Medicaid funding. The emergency federal Medicaid funding came in the form of an additional 6.2 percentage points on the traditional Federal Medicaid Assistance Percentage (FMAP – see page 5 for further information) granted through the Families First Coronavirus Response Act (2020). Once the PHE officially ended, individuals began to be disenrolled, as required by the federal government, and the additional 6.2 percentage points were phased down to zero.

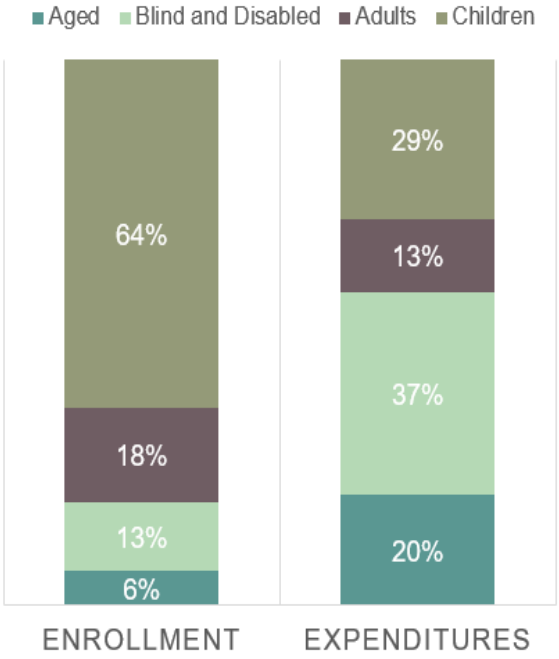


As of December 1, 2023, Montana's Traditional Medicaid enrollment was 137,581 and Medicaid Expansion reported 86,607 enrolled individuals (see above graphic).

Enrollment vs. Expenditures

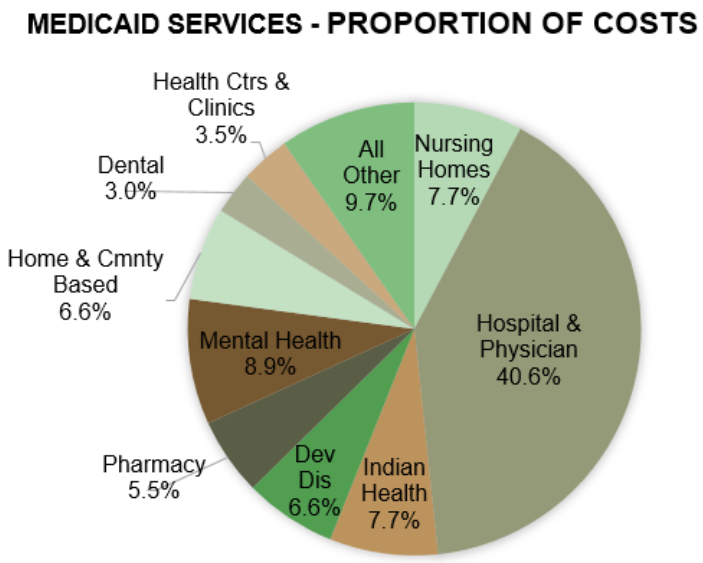
The below chart shows the approximate percentage of persons eligible for traditional Medicaid services compared to the percentage of total cost by major type of eligibility in FY 2021.

Total and average expenditures vary across eligibility groups. Low-income children comprise the largest share of Medicaid enrollees, but this group incurs a relatively small amount of total expenditures. Conversely, aged recipients account for the smallest percentage of enrollees, but account for approximately four times that percentage of expenditures. Disabled or blind recipients incur almost three times their proportion of enrollment in expenditures. While low-income parents and pregnant women have historically had expenditures in line with their proportion of enrollment.



WHAT SERVICES DOES MEDICAID PAY FOR?

Medicaid benefits comprise over a quarter of all funds in the general appropriations act (HB 2) at nearly $5,013 million for the 2025 biennium budget. This includes approximately 21.0% of total general fund appropriations and 52.8% of total federal fund appropriations. Medicaid cost increases are tied to changes in enrollment, advances in medical technology and pharmaceuticals, provider rate increases authorized by the legislature, and expansions of services or eligibility.



Major expenditures include hospital and physician services (40.6% of the total Medicaid services budget), nursing facilities (7.7%), home and community-based services (6.6%), mental health services (8.9%), Indian and Tribal Health Services (7.7%), and developmental disabilities services (6.6%). The remaining 21.9% is made up of several smaller service categories.

Medicaid Program Characteristics

All states administer a Medicaid program. Once a state opts to participate, it must abide by federal criteria which establish services and eligibility categories that a state must include in its Medicaid plan. With federal approval, a state may opt toprovide additional services or require alternative eligibility criteria.

Other federal criteria include:

- 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, and
- Once a person meets eligibility criteria, they are entitled to receive services

The table to the right displays the benefits provided under Montana's Medicaid program.

Services Covered by Montana Medicaid	
Federally Mandated	Optional
Inpatient Hospital Services	Prescription drugs
Outpatient Hospital Services	Clinic services
Early and Periodic Screening, Disagnostic and Treatment (EPSDT) Services for children	Physical, occupational, and speech therapy
Nursing Facility Services	Podiatry services
Home health services	Optometry and eyeglass services
Physician services	Dentistry and denturist services
Rural health clinic services	Private duty nursing services
Federally qualified health center services	Personal care services
Laboratory an X-ray services	Hospice care services
Family planning serivces	Targeted case management
Nurse midwife services	Mental health services
Certified pediatric and family nurse practitioner services	Home and community-based services
	Community first choice option
Freestanding birth center services	
Transportation to medical care	
Tobacco cessation counseling for pregnant women	

Medicaid Waivers

In general, a state needs a waiver of federal regulations to bypass compliance with any of the criteria required by Medicaid law. Medicaid waivers are designed to give states flexibility for multiple purposes including:

- Testing expanded eligibility and/or coverage options
- Developing managed care plans to improve quality, cost control, utilization, performance, and client outcomes
- Providing home and community-based services to keep clients out of institutional settings

A waiver must be cost-neutral to the federal government, meaning that the federal share of Medicaid costs cannot increase under a waiver. States are liable for any cost increase if a waiver program is not cost-neutral.

Montana Waivers

- The Plan First Waiver is used to provide family planning services such as office visits, contraceptive supplies, laboratory services, and testing and teatment of sexually transmitted infections
- The Passport to Health Waiver has four components intended to help members access and utilize services appropriately:
- a primary care case management program
- term care for individuals identified with inappropriate or excessive utilization of health services
- the *Health Improvement Program* for enhanced primary care case management, and
- *Nurse First*, a 24/7 nurse line available to all Medicaid clients
- Finally, Montana has multiple waivers to serve various populations in home and community-based settings. These include the Big Sky Waiver (elderly and physically disabled), the Severe and Disabling Mental Illness waiver (SDMI), and the 0208 waiver for the Developmentally Disabled

For additional information on Medicaid waivers and those currently approved in Montana, click here.

MEDICAID FUNDING

States must share in the cost of Medicaid. The amount of the cost covered by the federal government depends on the type of expenditure. Furthermore, match rates can vary year to year based on state per-capita-income. Varying rates are tied to the federal medical assistance percentage (FMAP) discussed in the box to the right. The general federal contributions are as follows:

- Administrative and operating costs (e.g.: staff, rent, travel, supplies): generally 50.0%
- General benefits (services): FMAP
- Indian Health Service providers: 100.0%; and
- Information system design and build: 90.0%.

Federal Medical Assistance Percentage (FMAP)

The FMAP is the federal contribution to most Medicaid services as well as foster care services (Title IV-E of the Social Security Act), some child care services, and for the Children's Health Insurance Program (CHIP).

The rate is based on per capita state income compared to national per capita income over the most recent three years. Montana's FMAP is generally around 1/3 state and 2/3 federal.

A 1.0% change in the match rate (from 33.0% to 34.0%, for example) causes state spending to change by about $9.0 to $10.0 million per year.

Healthy Montana Kids (Children's Medicaid and the Children's Health Insurance Program)

Healthy Montana Kids was a Montana ballot citizen initiative passed in the fall of 2008. This program provides health coverage for all low-income children in Montana through either Medicaid or the Children's Health Insurance Program (CHIP). The chart below illustrates the eligibility requirements for each program as well as the funding source for services.

Healthy Montana Kids Program Funding				
HMK Plus (Medicaid Coverage)			HMK (CHIP Coverage)	
	0%-100% FPL	101%-143% FPL	143%-261% FPL	
Ages 0-6	Medicaid Funding	Medicaid Funding	CHIP Funding	Ages 0-6
Ages 6-18	Medicaid Funding	CHIP Funding	CHIP Funding	Ages 6-18

Children receiving coverage under Medicaid have services reimbursed at the current FMAP, just as all other Medicaid recipients. Those covered under the CHIP program receive services reimbursed under an enhanced match rate. Historically, the state's contribution for services under the CHIP program has been lower than its contribution under the general FMAP, though still upwards of 20.0%. The ACA increased the federal share of CHIP expenditures by 22.5% effective October 1, 2015. This reduced Montana's share of CHIP expenditures to about 1.3%. In February 2018 CHIP was reauthorized by congress through 2027; however, the ACA-based federal match for CHIP expired September 30, 2019, at which point it returned to the pre-ACA enhanced FMAP. The state share for CHIP incrementally increased to 25.3% in FY 2024 and will reach an estimated 26.3% in FY 2025.

HOW THE LEGISLATURE CAN INFLUENCE MEDICAID

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

The legislature may:

- Change which optional services are covered by the Medicaid program for certain eligibility groups
- Alter eligibility levels for certain groups, and

- Change provider reimbursement levels and methodologies

If the legislature wishes to seek approval to waive certain federal requirements governing Medicaid, it can do so in many different areas of the program. While some options to reduce expenditures appear straightforward, there can be unintended consequences for some actions that need to be considered, such as shifts to higher cost services.

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).