MONTANA LEGISLATIVE BRANCH

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TRADITIONAL MEDICAID

WHAT IS TRADITIONAL MEDICAID?

Traditional Medicaid is a federal and state program that pays for health care services for individuals 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. Traditional Medicaid does not include the Medicaid expansion program, which started in Montana in CY 2016 as a result of the Montana Health and Economic Livelihood Partnership (HELP) Act, SB 405 (2015).

Medicaid and Medicare

Medicaid and Medicare are the two major nationwide health care programs supported by the federal government. Because their names are similar, they are sometimes confused but they are distinct and separate programs. A low-income Medicare beneficiary may 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
- Accessible regardless of income

Medicaid is:

- Funded by both state and federal governments
- Accessible to all persons regardless of age or disability status (post-expansion)
- For persons of low-income only

Medicaid was expanded by the Affordable Care Act in 2010. In 2015, the 64th Montana Legislature passed Medicaid expansion into law through the HELP Act. For further information regarding Medicaid expansion, click here.

WHO IS ELIGIBLE?

Enrollment and Eligibility

Without program changes or eligibility expansion, Medicaid enrollment generally changes with population and according to economic conditions. Medicaid enrollment increased by almost 80.0% between FY 2013 and FY 2018, and this increase can be partially attributed to some specific events.

- 2009: a citizen initiative called Healthy Montana Kids went into effect; this expanded coverage for children as well as launching a targeted enrollment campaign to reach eligible families
- 2010 and 2011: effects of the recession impacted social assistance programs leading to increased enrollment
- 2013: the Affordable Care Act (ACA) was implemented and expanded eligibility
- 2015: the Montana legislature passed Medicaid expansion under the ACA, making it accessible to a broader range of low-income Montanans

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 during the COVID-19 public health emergency (PHE). The federal PHE declaration put a pause on disenrollment from state Medicaid programs as a condition for receiving additional emergency federal Medicaid funding (through the Families First Coronavirus Response Act - FFCRA). The emergency federal Medicaid funding came in the form of an additional 6.2 percentage point increase on the current state Federal Medicaid Assistance Percentage (FMAP – see page 5 for further information) granted through FFCRA. Until the PHE is officially ended, individuals can only be disenrolled if they move out of state or request disenrollment.

Eligibility Categories

Although Montana Medicaid is now accessible to all low-income individuals, there are different criteria for eligibility according to individual circumstances. Eligibility thresholds are determined according to the current federal poverty level (FPL).

Children are eligible if their families make up to 143.0% of the FPL. Historically, this group has comprised about 62.0% of Medicaid enrollees. Currently that percentage has risen to around 63.8% due to the COVID-19 PHE and the inability of the state to disenroll participants. When factoring in Medicaid Expansion, children account for around 37.8% of total Medicaid and Medicaid Expansion enrollment. Additionally, children may qualify for coverage under the Children's Health Insurance Program (CHIP) discussed on page 5.

Pregnant women are eligible if they make up to 157.0% of the FPL. Currently, pregnant women account for around 0.5% of the total Medicaid and Medicaid Expansion population.

Aged, blind, or disabled people must meet federal Social Security Income (SSI) criteria. 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 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 2022 federal poverty level by household size and by various levels.

Percent of FPL by Family Size
Based on 2022 Federal Poverty Guidelines

Family size	Annual Household Income			
	100%	138%	143%	261%
1	$13,590	$18,754	$19,434	$35,470
2	18,310	25,268	26,183	47,789
3	23,030	31,781	32,933	60,108
4	27,750	38,295	39,683	72,428
5	32,470	44,809	46,432	84,747
6	37,190	51,322	53,182	97,066
7	41,910	57,836	59,931	109,385
8	46,630	64,349	66,681	121,704

All other low-income adults are eligible if they make up to 138.0% of the FPL. Prior to Medicaid expansion, the only eligible adults (other than those falling into the eligibility categories discussed above) were parents making up to 133.0% of the FPL. Adults account for about 62.2% of total Medicaid and Medicaid Expansion enrollment.

Enrollment vs. Expenditures

The adjacent graph shows the approximate percentage of eligibility type in Medicaid compared to the percentage of total cost by major type of eligibility in FY 2019.

As the chart on the right shows, the expenditures incurred by an eligibility group are not necessarily in line with its enrollment levels. 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. Low-income parents and pregnant women have historically had expenditures in line with their proportion of enrollment.

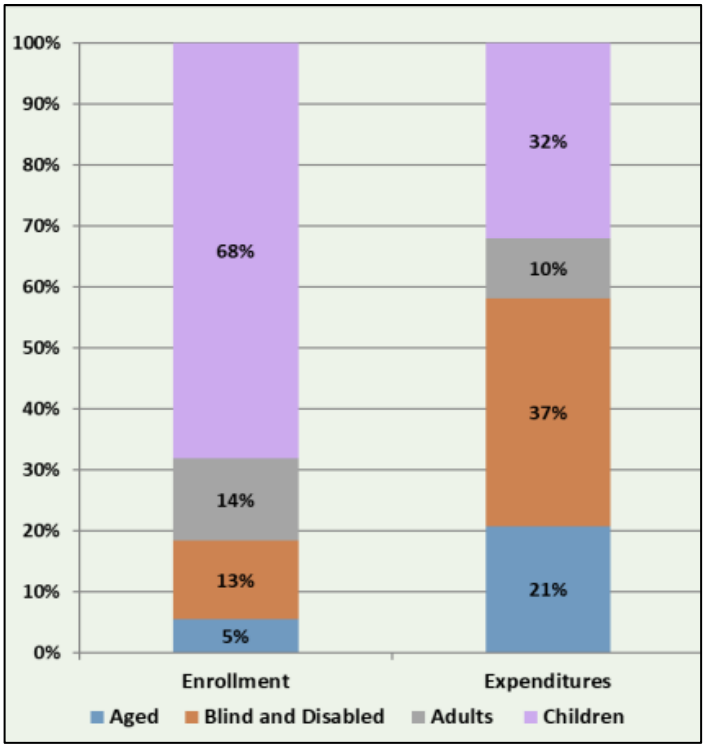


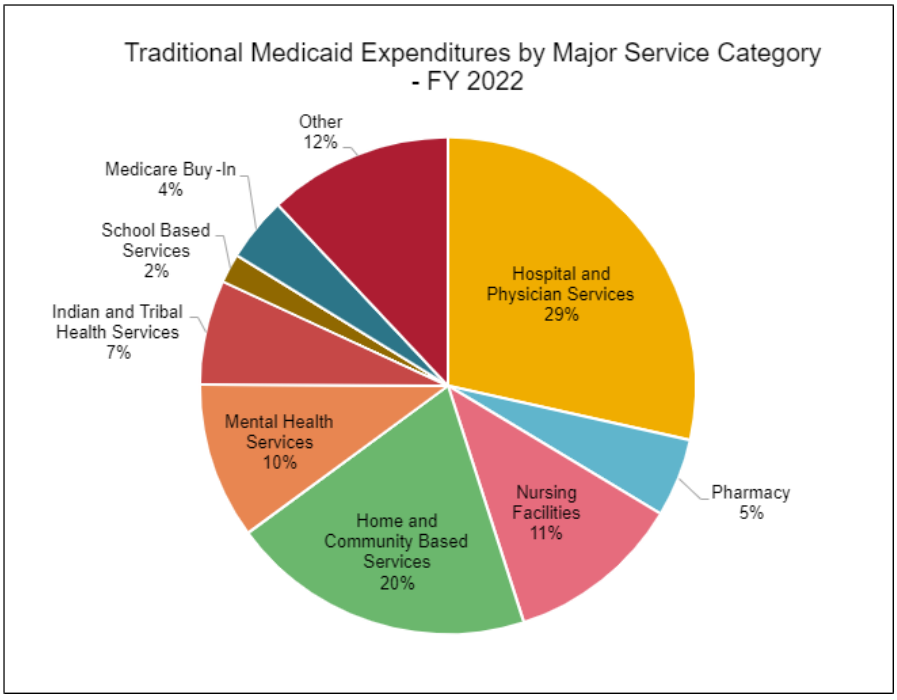
Chart from DPHHS "Medicaid in Montana" report, 2021

WHAT SERVICES DOES MEDICAID PAY FOR?

Traditional Medicaid benefits comprise nearly one-fifth of all funds in the general appropriations act (HB 2) at over $2.5 billion in the 2023 biennium budget. Medicaid provides a significant source of funding for medical services provided in the state of Montana.

Medicaid cost increases are tied to advances in medical technology and pharmaceuticals, provider rate increases authorized by the legislature, expansions of services or eligibility, and increased utilization.

Major expenditures include hospital and physician services (28.5% of the total Medicaid services budget), nursing facilities (11.4%), home and community-based services (19.9%), mental health services (10.2%), Indian and tribal health services (6.8%), and pharmacy services (5.1%). The remaining 18.1% is made up of many smaller services.



Medicaid Program Characteristics

All states administer a Medicaid program. Once a state opts to participate, it must abide by federal criteria. The adjacent table displays the benefits provided under Montana's Medicaid program.

Federal criteria establish:

1. Mandatory services and categories of eligibility that a state must include in its state Medicaid plan
2. Optional services and eligibility that a state can add at its discretion

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
- Once a person meets eligibility criteria, he or she is entitled to receive services

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	

What is a Medicaid Waiver?

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 the increased federal share of costs if a waiver program is not cost neutral.

Montana Waivers

Montana has multiple Medicaid waivers in addition to the HELP Act waiver (Medicaid expansion). Some examples include the Plan First Waiver, used to provide family planning services such as office visits, contraceptive supplies, laboratory services, and testing and teatment of sexually transmitted diseases. The Passport to Health Waiver has four components intended to help members access and utilize services appropriately. Components include 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 Mediaid 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.

HOW IS MEDICAID FUNDED?

States must share in the cost of Medicaid. The amount of the cost covered by the federal government varies based on type of expenditure, and some match rates vary year-to-year based on average state per capita income in comparison to the rest of the country. 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 Services and school-based services, 100.0%
- Information Technology, 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 childcare 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 $12.0 to $13.0 million per year.

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

Healthy Montana Kids was a 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 25.1% in FY 2023 and will reach an estimated 25.2% in FY 2024.

How Can the Legislature Influence Medicaid?

The legislature has several options to influence 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
- Change provider reimbursement levels and methodologies

If the legislature wishes to seek federal 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 cost 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).