



MONTANA LEGISLATIVE BRANCH

Legislative Fiscal Division

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MEDICAID 101

WHAT IS MEDICAID?

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.

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. 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; and
- Accessible regardless of income.

Medicaid is:

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

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 has increased by over 80% in the last five years, 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, expanded eligibility; and
- 2015: the Montana legislature passed Medicaid expansion under the ACA, making it accessible to a broader range of low-income Montanans.

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 federal poverty level (FPL).

Children are eligible if their families make up to 143% of the FPL. Historically, this group has comprised about 62% of Medicaid enrollees. Additional children qualify for coverage under the Children’s Health Insurance Program (CHIP) discussed beginning on page 4.

Pregnant women are eligible if they make up to 157% of the FPL. In combination with low-income parents, pregnant women made up about 12% of Medicaid enrollees prior to expansion.

Aged, blind, or disabled people must meet federal Social Security Income (SSI) criteria. Historically, aged recipients have comprised about 7% of enrollees and blind or disabled about 19%. 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 2018 federal poverty level by household size and by various levels.

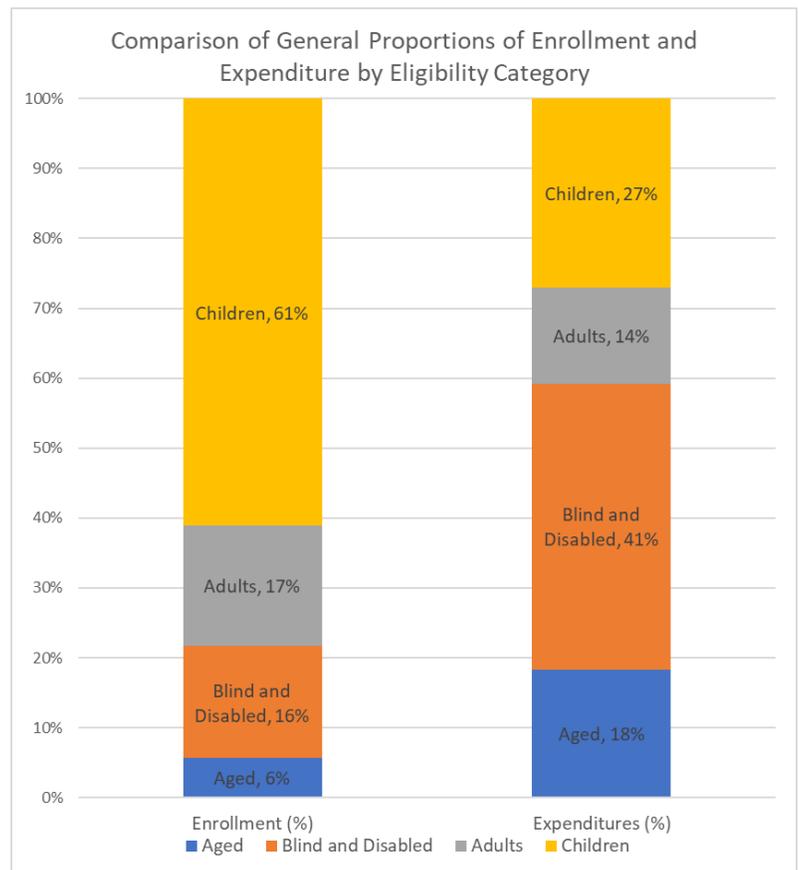
Percent of Poverty by Family Size Based on 2018 Federal Poverty Guidelines				
Family Size	Annual Household Income			
	100%	138%	143%	157%
1	\$12,140	\$16,753	\$17,360	\$19,060
2	16,460	22,715	23,538	25,842
3	20,780	28,676	29,715	32,625
4	25,100	34,638	35,893	39,407
5	29,420	40,600	42,071	46,189
6	33,740	46,561	48,248	52,972
7	38,060	52,523	54,426	59,754
8	42,380	58,484	60,603	66,537

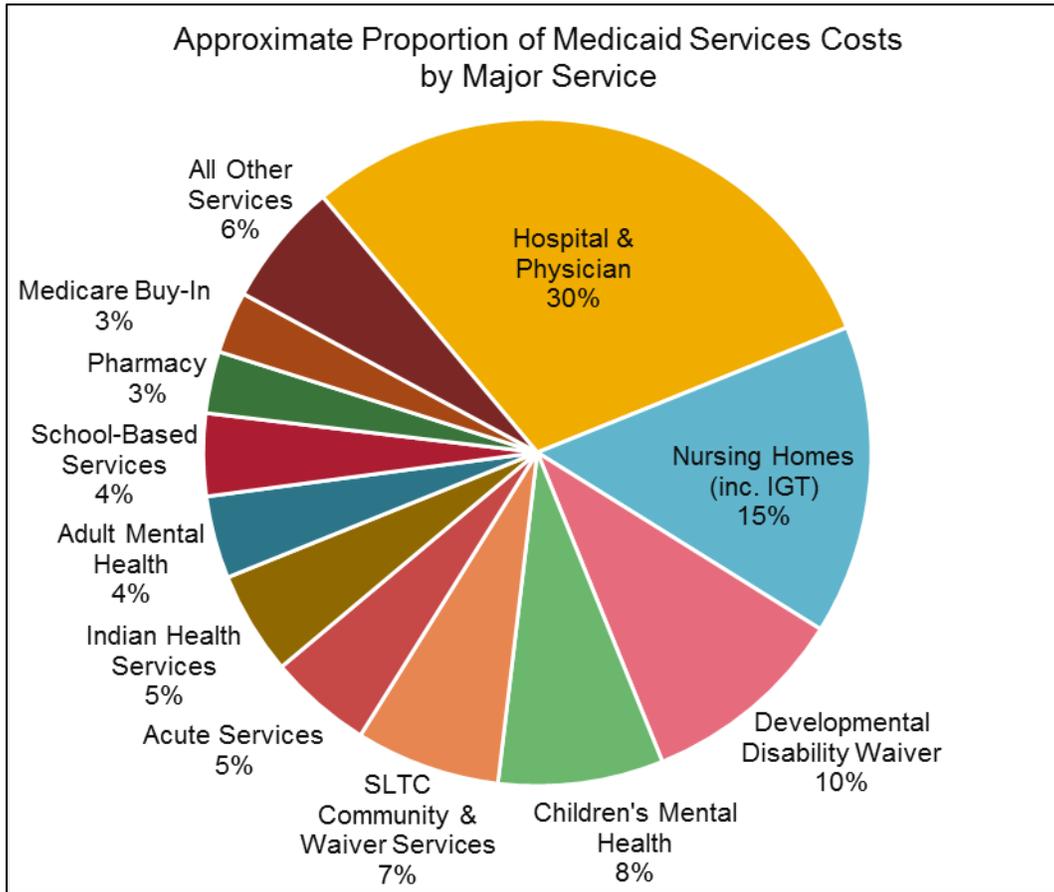
All other low-income adults are eligible if they make up to 138% of the FPL. Prior to Medicaid expansion, the only eligible adults (other than those falling into the eligibility categories discussed above) were parents making up to 33% of the FPL. Information on the proportion of enrollees in this group post-expansion, and how that affects the proportions of the other categories, is not yet available.

Enrollment vs. Expenditures

The adjacent graph shows the approximate percentage in recent years of persons eligible for Medicaid services compared to the percentage of total cost by major type of eligibility. This chart will change as data becomes available regarding the recent Medicaid expansion.

As the chart on the right shows, the expenditures incurred by an eligibility group are not necessarily in line with its enrollment. 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 three times that percentage of expenditures. Disabled or blind recipients incur about 2.5 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 over \$2,500 million for the biennium. This includes about 15% of total general fund appropriations and around 40% of total federal fund appropriations. 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, and expansions of services or eligibility.

Major expenditures include hospital and physician services (30% of the total Medicaid services budget), nursing home services (15%), community based services for the developmentally disabled (10%), children's mental health services (8%), and home and community based services for seniors and individuals requiring long-term care (7%). The remaining 30% is made up by many smaller services.

Services Covered by Montana Medicaid	
Federally Mandated	Optional
Inpatient Hospital Services	Prescription drugs
Outpatient Hospital Services	Clinic services
Early and Periodic Screening, Diagnostic 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 dentist services
Rural health clinic services	Private duty nursing services
Federally qualified health center services	Personal care services
Laboratory and X-ray services	Hospice care services
Family planning services	Targeted case management
Nurse midwife services	Mental health services
Certified pediatric and family nurse practitioner services	Home and community-based services
Freestanding birth center services	Community first choice option
Transportation to medical care	
Tobacco cessation counseling for pregnant women	

Medicaid Program Characteristics

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

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.

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

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 state plans. For instance, Montana received two waivers for Medicaid expansion (SB 405) passed by the 2015 Legislature: one limiting freedom of choice through establishment of a third-party administrator and the other establishing co-payments for medical expenses.

Medicaid waivers are designed for multiple purposes to give states flexibility 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 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. Some examples include the Plan First Waiver, used to provide family planning services such as office visits, contraceptive supplies, laboratory services, and testing and treatment of STD's. 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, a 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 (Developmentally Disabled).

Additional information about Medicaid waivers can be found in the Medicaid waiver brochure [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 how well a state's economy is doing 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:

- o Administrative and operating costs (e.g.: staff, rent, travel, supplies): generally 50%;
- o General benefits (services): FMAP;
- o Indian Health Services and School-based services: 100%; and
- o Information Technology: 90%.

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.

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% change in the match rate (from 33% to 34%, for example) causes state spending to change by about \$9.0 to \$10.0 million per year.

Healthy Montana Kids Program Funding				
HMK Plus (Medicaid Coverage)			HMK (CHIP Coverage)	
	0% - 100% FPL	101% - 133% FPL	133% - 250% 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%. The ACA increased the federal share of CHIP expenditures by 23% effective October 1, 2015. This reduced Montana's share of CHIP expenditures to about 1%. In February 2018 CHIP was reauthorized by congress through 2027. However, the ACA based federal match for CHIP will expire September 30, 2019, at which point it will return to the pre-ACA enhanced FMAP. The state share for CHIP will incrementally increase to an estimated 9.7% during FY 2020 and 21.1% in FY 2021.

HOW CAN THE LEGISLATURE INFLUENCE MEDICAID?

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

- o 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 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 fairly straight forward, 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](#)).