DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

Greg Gianforte, Governor | Charles T. Brereton, Director

Medicaid in Montana

FOR MORE INFO CONTACT DPHHS COMMUNICATIONS DIRECTOR JON EBELT AT
JEBELT@MT.GOV OR CALL **(406) 444-0936**

Table of Contents

List of Figures

List of Tables

Medicaid - Authorities

The Montana Medicaid Program is authorized under 53-6-101, Montana Code Annotated, and Article XII, Section XII of the Montana Constitution. The Department of Public Health and Human Services administers the program. Each state Medicaid program is a combination of state plan and waiver authorities, allowing each state to meet the unique needs of their citizens.

State Plan

"The state plan is a formal, written agreement between a state and the federal government, submitted by the single state agency (42 CFR 431.10) and approved by CMS, describing how that state administers its Medicaid program.

The state plan:

- provides assurances that a state will abide by federal rules in order to claim federal matching funds;
- indicates which optional groups, services, or programs the state has chosen to cover or implement; and
- describes the state-specific standards to determine eligibility, methodologies for providers to be reimbursed, and processes to administer the program."

https://www.macpac.gov/subtopic/state-plan/

MACPAC Reference Guide to Federal Medicaid Statute and Regulations

https://www.macpac.gov/reference-guide-to-federal-medicaid-statute-and-regulations/

Waivers

"States seeking additional flexibility can apply to the Secretary of HHS for formal waivers of certain statutory requirements. For example, states can request waivers of provisions requiring service comparability, statewideness, and freedom of choice in order to offer an alternative benefit plan to a subset of Medicaid beneficiaries, to restrict enrollees to a specific network of providers, or to extend coverage to groups beyond those defined in Medicaid law. In exchange for the flexibility offered by waivers, states must meet budgetary criteria and provide regular reports and evaluations to CMS to show that the requirements of the waiver are being met, which are not requirements placed on state plans. Also, unlike most SPAs, waivers require lengthy applications and must be renewed periodically. A state can operate significant portions of its program under waiver authority but must maintain a complete and up-to-date state plan in order to access federal funds."

https://www.macpac.gov/subtopic/state-plan/

Medicaid – A State and Federal Partnership

The Medicaid program is jointly funded by the federal government and states. The federal government reimburses states for a specified percentage of allowable program expenditures depending on the expenditure type.

FMAP

Federal Medicaid funding to states, called the Federal Medical Assistance Percentage (FMAP), is calculated by comparing personal income in each state with the national average.

TABLE 1 - SERVICES FUNDING RATES

Services Funding (SFY 2023)	State Share	Federal Share
Indian & Tribal Health Services		100%
Medicaid Expansion	10%	90%
Family Planning Service	10%	90%
Money Follows the Person	17.89%	82.11%
Breast and Cervical Cancer Program	24.98%	75.02%
Community First Choice (FMAP +6%)	29.77%	70.23%
Standard FMAP	35.77%	64.23%
State Funded	100%	

TABLE 2 - ADMINISTRATION FUNDING RATES

Administration Funding (SFY 2023)	State Share	Federal Share
Systems Development (if pre-approved)	10%	90%
Systems Development	25%	75%
Skilled Medical Personnel	25%	75%
Claims Processing Systems and Operations	25%	75%
Eligibility Determination Systems and Staffing	25%	75%
All Other Administration	50%	50%

Medicaid - Eligibility

Montana Medicaid provides coverage for the following groups/populations:

- Infants and Children
- Subsidized Adoptions, Subsidized Guardianship, and Foster Care
- Pregnant Women
- Low Income Families with Dependent Children
- Low Income Adults
- Low Income Adults with an SDMI
- Aged, Blind/Disabled and/or receiving Supplemental Security Income
- Breast and Cervical Cancer Treatment
- Montana Medicaid for Workers with Disabilities (MWD)
- Medically Needy

More information is available at:

Montana Healthcare Programs – Member Services and

Offices of Public Assistance (OPA)

Medicaid Eligibility – Infants and Children

Newborn Coverage
Children born to women receiving Medicaid (at the time of their child's birth) automatically qualify for Medicaid coverage through the month of their first birthday.

Healthy Montana Kids Plus (HMK Plus)
Provides medically necessary health care coverage for children through the month of their 19th birthday, in families with countable income up to 143% of the Federal Poverty Level (FPL). Montana Medicaid and HMK Plus pay for services that are:

- Provided by a Montana Medicaid/HMK Plus enrolled provider; and
- Within the scope of listed Medicaid/HMK Plus covered services

Subsidized Adoption, Subsidized Guardianship and Foster Care
Children eligible for an adoption or guardianship subsidy through DPHHS automatically qualify for Medicaid coverage. Coverage may continue through the month of the child's 26th birthday. Children placed into licensed foster care homes by the Child and Family Services Division are also Medicaid eligible.

TABLE 3 – 2022 FEDERAL POVERTY LEVELS AND GROSS MONTHLY INCOME

Family Size	Pregnant Women 157% FPL	HMK 261% FPL	Child or HMK Plus 143% FPL
1	$1,778	$2,956	$1,620
2	$2,396	$3,982	$2,182
3	$3,013	$5,009	$2,744
4	$3,631	$6,036	$3,307
Resource Test	No Test	No Test	No Test

Medicaid Eligibility – Low Income Montanans

Low Income Families – Standard Medicaid
Adult members of Montana families whose household countable income is less than 25% FPL are eligible for standard Medicaid.

Low Income Families – Expansion Medicaid
Adult members of Montana families whose household countable income is between than 25% and 138% FPL are eligible for Medicaid Expansion.

Low Income Montanans – Expansion Medicaid
Montanans whose household countable income equal is between than 25% and 138% FPL are eligible for Medicaid Expansion.

Pregnant Women
Medicaid provides temporary medical coverage to eligible pregnant women with countable household income equal to or less than 157% FPL who meet the nonfinancial criteria for Affordable Care Act (ACA) Pregnancy Medicaid. The coverage extends for 60 days beyond the child's birth.

Medicaid Eligibility – Special Populations

Breast and Cervical Cancer Treatment
Individuals who are screened by a Montana Breast and Cervical Health Program (MBCHP) and are subsequently diagnosed with breast and/or cervical cancer or pre-cancer may be eligible for Medicaid.

Qualifying recipients must:

- Have received a breast and/or cervical health screening through the Montana Breast and Cervical Health Program;
- Have been diagnosed with breast and/or cervical cancer or pre-cancer as a result of the screening;
- Not have health insurance or other coverage for breast and/or cervical cancer, including Medicare;
- Not be eligible for any other **Categorically Needy** Medicaid program; and
- Recipients' countable income must be at or below 250% FPL.

Severe and Disabling Mental Illness
Individuals who are assessed by a licensed mental health professional and are subsequently diagnosed with a Severe and Disabling Mental Illness (SDMI) through diagnosis, functional impairment, and duration of illness, may be eligible for the Waiver for Additional Services and Populations:

Qualifying individuals must:

- Have a SDMI;
- Otherwise ineligible for Medicaid;
- Individual must be at least 18 years of age; and
- Have a family income 0-138% of FPL and are eligible for or enrolled in Medicare; or 139-150% of FPL regardless of Medicare status.

Medicaid Eligibility – People with Disabilities

Blind/Disabled

Individuals may be eligible for Medicaid if determined blind or disabled using Social Security criteria, and if their income is within allowable limits and their resources do not exceed $2,000 for an individual or $3,000 for a couple. Income limits for the Aged, Blind, Disabled programs are $794 per month for an individual and $1,191 for a couple.

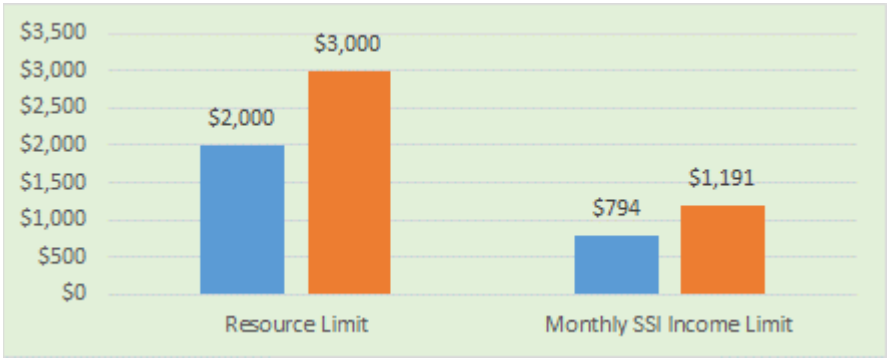
Aged, Blind, or Disabled Recipients of Supplemental Security Income (SSI)

In Montana, any aged, blind, or disabled individual determined eligible for SSI receives Medicaid. This support enables them to receive regular medical attention and maintain their independence.

Montana Medicaid for Workers with Disabilities (MWD)

Allows certain individuals who meet Social Security's disability criteria to receive Medicaid benefits through a cost share. This is based on a sliding scale according to an individual's income. Individuals must be employed (either through an employer or self-employed) to be considered for this program. MWD resource and income standards are significantly higher than many other Medicaid programs: $15,000 for an individual and $30,000 for a couple; while the countable income limit is 250% of the FPL.

FIGURE 1 – 2021 SSI MONTHLY INCOME STANDARDS



For more information, please refer to: [Medical Assistance (MA) Policy Manual]

Medicaid Eligibility – Categorically and Medically Needy

Categorically Needy
Assists individuals with an attribute (disability, pregnant, child, etc.) for which there is a mandatory or optional Medicaid program.

Medically Needy
Assists individuals whose income is too high for Medicaid but would otherwise qualify:

- Provides coverage for the aged, blind, disabled, pregnant women, and children, whose income exceeds the income standards, but have significant medical expenses.
- Individuals may qualify for benefits through a process known as Spend Down:
  - Incurring medical expenses equal to spend down amount;
  - Making a cash payment to the department; or
  - Paying both incurred medical expenses and cash payment.

Table 3 – Limits for Medically Needy SFY 2023

Family Size	Resource Limit	Monthly Income Limit
1	$2,000/$3,000*	$525
2	$3,000	$525
3	$3,000	$658
4	$3,000	$792
5	$3,000	$925
6	$3,000	$1,058
*$2,000 for aged, blind, or disabled individuals, $3,000 for children, pregnant women and for aged, blind, or disabled couples.		

Medicaid Benefits



The Montana Medicaid benefits packages meet federal guidelines. Medicaid benefits are divided into two classes: *mandatory* and *optional*. Federal law requires that adults eligible for Medicaid are entitled to mandatory services, unless waived under Section 1115 of the Social Security Act.

States may elect to cover optional benefits. Montana has chosen to cover several cost-effective optional benefits. The table below provides some examples of mandatory and optional benefits:

Mandatory Benefits	**Optional Benefits**
Physician and Nurse Practitioner Nurse Midwife	Outpatient Drugs
Medical and Surgical Service of a Dentist	Dental and Denturist Services
Laboratory and X-ray	Ambulance
Inpatient Hospital (excluding inpatient services in institutions for mental disease)	Physical and Occupational Therapies and Speech Language Pathology
Outpatient Hospital	Home and Community Based Services
Federally Qualified Health Centers (FQHCs) Rural Health Clinics (RHCs)	Eyeglasses and Optometry
Family Planning	Personal Assistance Services
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	Targeted Case Management
Nursing Home Facility Home Health	Podiatry
Durable Medical Equipment	Community First Choice
Transportation	Hospice
Behavioral Health	

Under federal *Early and Periodic Screening, Diagnosis and Treatment (EPSDT)* regulations, a state must cover all medically necessary services to treat or ameliorate a defect, physical and mental illness, or a condition identified by a screen for individuals under age 21. This is true of whether the service or item is otherwise included in the State Medicaid plan.

Population Specific Supports

The Montana Medicaid program includes additional benefits not available to all members. These supports are available to populations with specific health conditions and/or functional impairments. These benefits are authorized under a combination of the state plan amendments and waiver authorities.

Populations	Population Supports	Forms of Authorization
Aged and Physically Disabled		
	Basic Medicaid	State Plan, 1115 Waiver
	Big Sky Waiver	1915(c) Waiver, 1915(b) Waiver
	Home and Community Based Services - Self Directed	1915(c) Waiver
	Community First Choice Services	State Plan 1915(k)
Developmentally Disabled		
	Basic Medicaid	State Plan, 1115 Waiver
	Home and Community Based Services	1915(c) Waiver
	Home and Community Based Services - Self Directed	1915(c) Waiver
	Community First Choice Services	1915 (k)
Severe and Disabling Mental Illness		
	Basic Medicaid	State Plan, 1115 Waiver
	Home and Community Based Services	1915(c) Waiver, 1915(b) Waiver
	Home and Community Based Services - Self Directed	1915(c) Waiver
	Community First Choice Services	State Plan
	Program for Assertive Community Treatment	State Plan
	HEART Waiver	1115 Waiver
Substance Use Disorder		
	Basic Medicaid	State Plan
	HEART Waiver	1115 Waiver

Waivers – The Basics

- **Section 1915(c) Waivers**
  Also known as Medicaid Home and Community-Based Services (HCBS) waivers, these waivers enable states to pay for alternative medical care and support services, to help people continue living in their homes and/or communities, rather than in an institution (nursing facility, hospital, or Intermediate Care Facility for Individuals with Developmental Disability). States have the option to determine eligibility by the income of the affected individual, instead of the income of the entire family.

- **Section 1115 Waivers**
  Authorizes experimental, pilot, or demonstration projects.

- **Section 1915(b) Waivers**
  Allows states to waive statewideness, comparability of services, and freedom of choice. There are four 1915(b) waivers available:
  - (b)(1) to mandate Medicaid enrollment into managed care
  - (b)(2) to utilize a "central broker"
  - (b)(3) to use cost savings to provide additional services
  - (b)(4) to limit the number of providers for services

- **Section 1135 Waivers**
  In certain circumstances, the Secretary of the Department of Health and Human Services (HHS) using section 1135 of the Social Security Act (SSA) can temporarily modify or waive certain Medicare, Medicaid, CHIP, or Health Insurance Portability and Accountability Act (HIPAA) requirements. During an emergency, sections 1135 or 1812(f) of the SSA allow CMS to issue blanket waivers to help beneficiaries access care. When a blanket waiver is issued, providers don't have to apply for an individual 1135 waiver.

States often combine waivers and state plan authorities to achieve their goals. A 1915(b)/1915(c) or 1115/1915(b) are the most common combinations. Waivers are expected to be cost neutral to the federal government.

1915c Waiver –
HCBS for Individuals with Developmental Disabilities

Purpose

Home and Community Based Service (HCBS) waivers authorized under Section 1915(c) of the Social Security Act allow for the payment of home and community-based services to people who would otherwise require institutional care. The **0208 Comprehensive Services Waiver** (HCBS DD Waiver) allows individuals with developmental disabilities to live in their community while decreasing the cost of their health care.

A copy of the current waiver is available at:

1915(c) HCBS 0208 DD Comprehensive Services Waiver for Individuals with Developmental Disabilities

Waiver Participants

In State Fiscal Year (SFY) 2021, an average of 2,370 Montanan's, each month, received services funded by the Comprehensive Services (HCBS) Waiver. The waiver supported successful community living for 2,562 Montanans during SFY 2021. The waiver funds services to Medicaid members of all ages with service plans specific to their individual needs. The waiver includes an option for self-directing the individual care plan.

Services

The waiver offers 32 separate services, provided in a variety of residential and work settings. Waiver participants live in a variety of circumstances, including family homes, group homes, apartments, foster homes and assisted living situations. Work service options covered by this waiver include day supports and activities and supported employment (including individual and group supports). A variety of other services and supports are available, including extended State Plan services.

Cost Plans

The SFY 2021 average cost plan per person is $59,330 per year. The cost plans ranged from $1,289 to $487,555. These costs do not include the cost of Medicaid State Plan services, which are available to all eligible members such as inpatient hospital, physician, pharmacy, durable medical equipment, physical therapy, behavioral health services and speech therapy.

1915c Waiver – HCBS for Individuals Elderly and/or Physically Disabled (Big Sky Waiver)

Purpose

Home and Community Based Service (HCBS) waivers authorized under Section 1915(c) of the Social Security Act allow for the payment of home and community-based services to people who would otherwise require more costly institutional care. The **Big Sky Waiver** (HCBS Waiver), in combination with a 1915(b)(4) waiver, allows members who meet nursing facility level of care to live in their community while decreasing the cost of their health care.

Copies of the current waivers are available at:

1915(b) (4) and 1915(c) Montana Big Sky Waiver

Waiver Participants

Every year approximately 2,700 Montanan's receive Montana Big Sky Waiver services, supporting independent living for the elderly (age 65 and older) and people with physical disabilities. In SFY 2022, an average of 2,115 Montanans received services each month funded by the Big Sky Waiver. Members must be financially eligible for long term care Medicaid and meet the program's nursing facility or hospital level of care requirements. The waiver includes an option for self-directing services under the Big Sky Bonanza program.

Services

The waiver offers several different services including case management, respite, adult residential care (assisted living facilities), private duty nursing for adults, home and vehicle modifications, and specialized medical equipment and supplies not covered by other third parties. Services under the Big Sky Waiver are often partnered with state plan in home support services such as Community First Choice.

1915c Waiver – HCBS for Individuals with SDMI

Purpose

Home and Community Based Service (HCBS) waivers authorized under Section 1915(c) of the Social Security Act allow for the payment of home and community-based services to people who would otherwise require more costly institutional care. The HCBS **SDMI Waiver i**n combination with a 1915(b)(4) waiver, provides Medicaid reimbursement for community-based services for adults with SDMI who meet criteria for nursing home level of care and functional level of impairment.

Copies of the current waivers are available at:

1915(c) Home and Community Based Services (HCBS) SDMI Waiver

Members

Case management services are provided to SDMI waiver members statewide. Case managers assist members in gaining access to Home and Community Based Services, State Plan Services as well as needed medical, behavioral health, social, educational and employment services. In SFY 2022, the SDMI waiver served more than 500 members, with additional members being added to the waiver each month.

Services

A social worker, with a bachelor's level of education, coordinates services through case management to provide services including: adult day health, behavioral intervention assistant, case management, community transition, consultative clinical and therapeutic services, environmental accessibility adaptations, health and wellness, homemaker chore, life coach, meals, non-medical transportation, pain and symptom management, personal assistance service, personal emergency response system, private duty nursing, residential habilitation, respite, specialized medical equipment and supplies, and supported employment. Licensed clinical supervision is provided to all case managers.

1115 Waiver – Waiver for Additional Services and Populations

The Waiver for Additional Services and Populations (WASP) covers three populations:

- Adults with serious and disabling mental illness with incomes from 0-138% FPL or 139-150% FPL, depending on Medicare eligibility;
- Dental treatment services above the Medicaid State Plan cap of $1,125 per individual for people determined categorically eligible as aged, blind or disabled; and
- Non-Expansion Medicaid covered individuals, also known as parent and caretaker relatives (PCR), whose eligibility is based on MAGI. The only benefit this population receives under the WASP is a 12-month continuous eligibility period for their existing Standard Medicaid benefit. This singular benefit will end when the federal public health emergency (PHE) ends.

The waiver is available at: **1115 Waiver for Additional Services and Populations (WASP)**

1115 Waiver – Plan First

The Plan First Waiver is an 1115 waiver with a limited benefit plan. The program covers family planning services such as office visits, contraceptive supplies, laboratory services, and testing and treatment of Sexually Transmitted Diseases (STDs). Women ages 19 through 44 (who are able to bear children and not presently pregnant) with an annual household income up to 211% FPL are eligible. Program is limited to 4,000 women at any given time.

The waiver is available at: **1115 Plan First Waiver – Health Resources Division**

1115 Waiver – Health and Economic Livelihood Program

The Health and Economic Livelihood Program (HELP) waiver was the 1115 waiver covering the Medicaid expansion population in Montana. The waiver ended effective December 31, 2022. The waiver was no longer needed after CMS informed the Department it would not renew the authority to charge premiums coverage to this population effective January 1, 2023.

1115 Waiver – Healing and Ending Addiction through Recovery and Treatment (HEART)

The Healing and Ending Addiction through Recovery and Treatment (HEART) is an 1115 waiver intended to support implementation of the HEART Initiative, which is intended to expand the state's behavioral health continuum of care. This program will provide additional health care services to existing Medicaid beneficiaries, ages 18 to 64 years old with a substance use disorder (SUD) or severe mental illness (SMI). This waiver allows for reimbursement for individuals diagnosed with a SUD receiving treatment in short-term residential and inpatient stays in institutions of mental disease (IMDs). IMDs are institutions of more than 16 beds. Contingent on further approval by the Centers for Medicare and Medicaid Services (CMS), it will also cover the following services: Contingency Management (evidence-based practice that uses positive reinforcement for members receiving stimulant use disorder treatment); tenancy support services; and targeted services for individuals in the Montana State Prisons 30-days prior to discharge/transfer.

The current approved waiver is available at: **1115 HEART Waiver**

1915(b) Waiver – Passport to Health

The Passport to Health is a 1915(b) waiver that allows for care coordination services from a limited number of providers. The program minimizes ineffective or inappropriate medical care to Medicaid and HMK Plus members. The waiver, which involves about 70% of all Montana Medicaid members, has three program components:

Passport to Health

- Primary Care Case Management (PCCM) program.
- Members choose or are assigned a primary care provider, who delivers all medical services or furnishes referrals for other medically necessary care.
- Most Medicaid and HMK Plus eligible individuals are enrolled in this program.

Team Care

- Reduces inappropriate or excessive utilization of health care services, including overutilization of hospital emergency rooms.
- Identifies candidates through referrals from providers, Health Improvement Program care managers, Drug Utilization Review Board, or through claim review.
- Individuals are enrolled for at least 12 months and are required to receive services from one pharmacy and one medical provider.
- Approximately 140 Medicaid and HMK Plus members are enrolled as of December 2022.

Tribal Health Improvement Program (T-HIP)

The Tribal Health Improvement Program (T-HIP) is a historic partnership between the Tribal, State and Federal governments to address factors that contribute to health disparities in the American Indian population. This program has a three-tiered structure, creating a unique opportunity for each Tribe to build and operate health promotion programs and associated activities that are culturally based and relevant to their members and community:

- Services provided under Tier 1 seek to improve the health of members who have chronic illnesses or are at risk of developing serious health conditions through intensive care coordination of individual members. The services in Tier 1 also seek to enhance the communication and coordination link between the member and the Passport primary care provider.
- Tier 2 and Tier 3 address specific health focus areas that contribute to health disparities. Activities generally focus on improving the health of a population rather than individual members. (i.e., obesity prevention program for grade school youth.)

Indian Health Service (IHS) and Tribal Health Activities

Health care delivery is a collaborative effort:

- Indian Health Service (IHS) – (100% federally funded)
- Tribal Health 638 Programs/Departments - (100% federally funded)
- Urban Indian Health Centers – (64.23% federally funded / 35.77% state funded)

Combined in-patient and out-patient services offered at:

- Blackfeet Community Hospital
- Crow/Northern Cheyenne Hospital
- Fort Belknap Hospital
- Confederated Salish-Kootenai Tribes

Out-patient services are also offered at Indian Health Service Units and Tribal Health Programs/Departments:

- Northern Cheyenne Service IHS Unit
- Fort Peck IHS Service Unit
- Blackfeet Tribal Health Department
- Chippewa Cree Tribal Health Department (Rocky Boy Health Center)
- Confederated Salish and Kootenai Tribal Health Department
- Crow Tribal Health Department
- Fort Belknap Tribal Health Department
- Fort Peck Tribal Health Department
- Northern Cheyenne Tribal Health (Northern Cheyenne Board of Health)

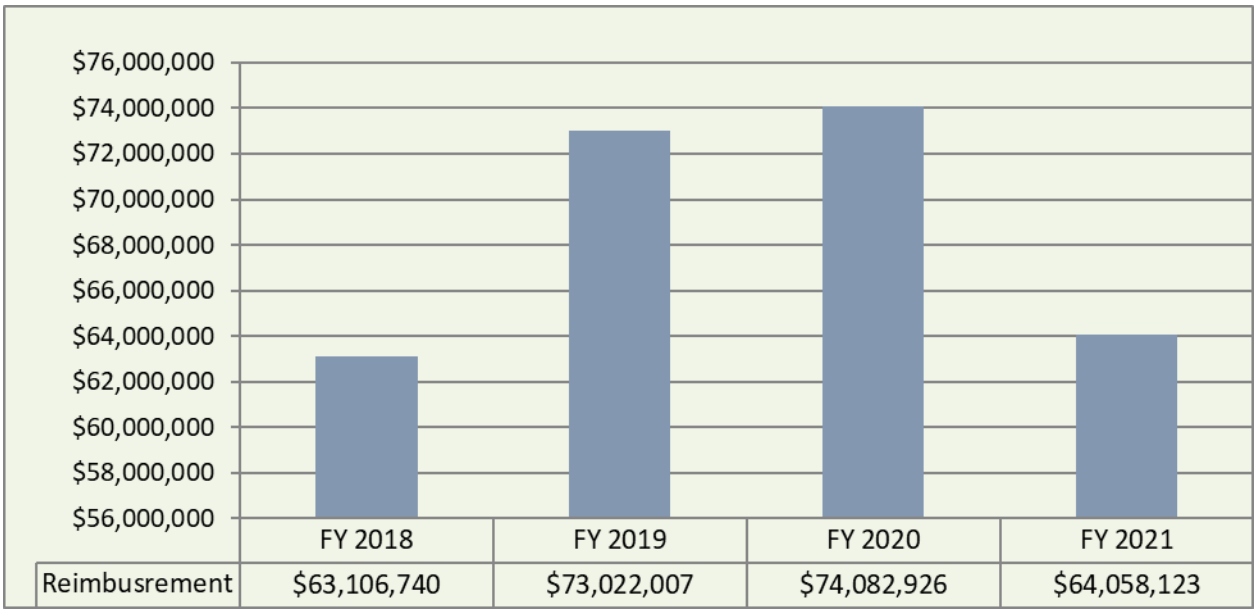
Five major Urban Indian Health Centers provide care to American Indians who reside off a respective Indian reservation:

- Billings Urban Indian Health and Wellness Center
- Helena Indian Alliance
- Indian Family Health Clinic of Great Falls
- Missoula All Nations Health Center
- North American Indian Alliance of Butte

TABLE 4 – AMERICAN INDIAN MEDICAID PAYMENTS

Organization	Location	Eligible Client	Services Provided	Federal Match
Indian Health Service	Reservation	Tribal Member or Descendent	In-patient – Blackfeet, Crow/Northern Cheyenne and Fort Belknap Outpatient – All Reservations – services offered vary	100% Federal Funds
Tribal Health (operating under a 638 compact) or contract	Reservation	Tribal Member or Descendent	Outpatient – services offered vary. Nursing Facility - Blackfeet, Crow	100% Federal Fund
Urban Indian Health Centers	Billings Butte Great Falls Helena Missoula	Tribal Member or Descendent Plus Non-Natives	Outpatient – services offered vary	64.23% Federal Funds/ 35.77% State Funds

Figure 2 – Standard Medicaid Indian Health Service/Tribal Reimbursement by State Fiscal Year



Medicaid Revenue Reports

Every year, DPHHS prepares Medicaid Revenue Reports and discusses them with the Tribal Governing bodies (Tribal Council), the Indian Health Service Units, and the Area Office. Specific information includes Medicaid revenue received, billable services by type, and where payment was sent. The Medicaid Revenue Reports serve as a useful tool for Tribes and IHS, as they compare information and identify opportunities for future billing.

Medicaid Tribal Consultations

DPHHS formally consults with Tribal Governments, Indian Health Service, and the Urban Indian programs on a regular basis, to discuss the Medicaid program and its impact on American Indians and Tribal and urban communities.

Medicaid Administrative Match (MAM)

MAM is a federal reimbursement program for the costs of "administrative activities" that directly support efforts to identify, and/or to enroll individuals in the Medicaid program, or to assist those already enrolled in Medicaid to access benefits. Through MAM, Tribes who have entered into contracts with the State of Montana are reimbursed for allowable administrative costs directly related to the Montana State Medicaid plan or waiver service. The Montana Tribal Cost Allocation Plan gives Tribes a mechanism to seek reimbursement for the Medicaid administrative activities they perform. The program, the first of its kind in the country, began July 1, 2008. The Chippewa Cree Tribe and the Northern Cheyenne Tribe are currently under contract.

Medicaid Eligibility Determination Agreements

The partnerships that exist between DPHHS and the Tribes in Montana are important for delivering quality services in a cost-efficient manner. Since federal law allows, DPHHS has entered into agreements with four Tribes - Chippewa Cree Tribes, Confederated Salish and Kootenai Tribes, Blackfeet Tribe and the Fort Belknap Tribes allowing the Tribes to determine Medicaid eligibility on their respective Indian reservations. This is a collaborative effort and partnership that allows Tribal members to apply for services locally and helps to remove barriers and delays that might otherwise impede tribal members from obtaining Medicaid benefits and proper medical care.

Nursing Facility Reimbursement

The Crow and Blackfeet Tribes nursing homes are reimbursed at 100% federal funds, at a rate higher than non-tribally owned nursing facilities. This rate was negotiated with IHS. Additionally, the CMS-approved state plan has resulted in significant savings to the state general fund.

Standard Medicaid Enrollment and Expenditures

TABLE 5 – SUMMARY OF STANDARD MEDICAID ENROLLED PERSONS FOR SFY 2021

Beneficiary Characteristic	Average Monthly Enrollment: All	Aged	Blind & Disabled	Standard Adults	Standard Children	% of Medicaid Total	% of Montana Population
Total	**145,958**	**8,633**	**18,602**	**25,771**	**92,952**	**100%**	
Age							
0 to 1	5,576	0	26	0	5,550	4%	1%
1 to 5	27,784	0	292	0	27,492	19%	6%
6 to 18	61,838	0	1,928	0	59,910	42%	16%
19 to 20	3,325	0	424	2,901	0	2%	2%
21 to 64	38,099	0	15,229	22,870	0	26%	55%
65 and older	9,336	8,633	703	0	0	6%	20%
	145,958	8,633	18,602	25,771	92,952		
Gender							
Male	67,656	3,087	9,463	7,956	47,150	46%	51%
Female	78,302	5,546	9,139	17,815	45,802	54%	49%
	145,958	8,633	18,602	25,771	92,952		
Race							
White	94,066	6,505	14,336	17,852	55,373	64%	89%
AIAN	31,629	936	2,986	5,392	22,315	22%	7%
Other	2,265	96	236	428	1,505	2%	5%
Unknown *	17,998	1,096	1,044	13,759	2,099		
	145,958	8,633	18,602	25,771	92,952		
Assistance Status							
Medically Needy	88	47	41	0	0	0%	
Categorically Needy	145,870	8,586	18,561	25,771	92,952	100%	
	145,958	8,633	18,602	25,771	92,952		
Medicare Status							
Part A and B	17,640	7,967	8,541	1,131	1	12%	
Part A only	99	33	37	29	0	0%	
Part B only	552	519	32	1	0	0%	
None	127,667	114	9,992	24,610	92,951	87%	
	145,958	8,633	18,602	25,771	92,952		
Medicare Saving Plan (not include d in total)							
QMB Only	5,196	2,797	2,383	16	0		
SLMB - QI Only	5,200	3,367	1,833	0	0		
Other Medicaid Eligibles (not included in total)							
HK Exp (CHIP Funded)	6,472	0	0	0	6,472		
Plan First Waiver	1,327	0	0	1,327	0		

* Individuals that decline to report their race on their Medicaid application are included in the Unknown race category.

Excludes HMK (CHIP) and State Fund Mental Health. For QMB only enrollees Medicaid pays for Medicare premiums, co-insurance, and deductibles. For SLMB - QI only enrollees Medicaid pays for Medicare Premiums.

Figure 3 – Medicaid 2021 Enrollment and Expenditures by Major Aid Categories

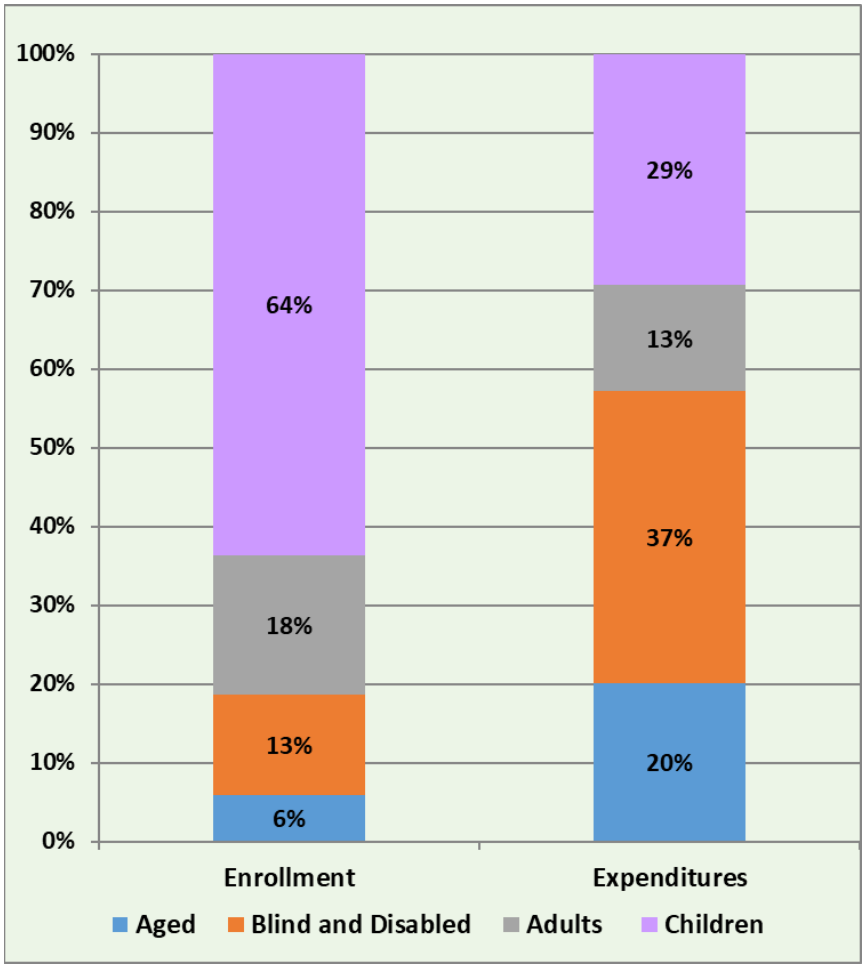


TABLE 6 –ENROLLMENT AND EXPENDITURES BY STANDARD MEDICAID CATEGORY SFY 2021

Aid Category	Average Monthly Enrollment	Percent of Enrollment	Expenditures	Percent of Expenditures
Aged	8,633	6%	$240,896,420	20%
Blind and Disabled	18,602	13%	$447,286,776	37%
Adults	25,771	18%	$160,806,824	13%
Children	92,952	64%	$352,645,571	29%
Total	145,958	100%	$1,201,635,591	100%

Note that the above graphs do not include HMK (CHIP Funded), Expansion, Medicare Savings Plan, or Plan First Waiver clients.

FIGURE 4 – STANDARD MEDICAID ENROLLMENT – ADULTS AND CHILDREN (Excludes Medicare Savings Plan Only)

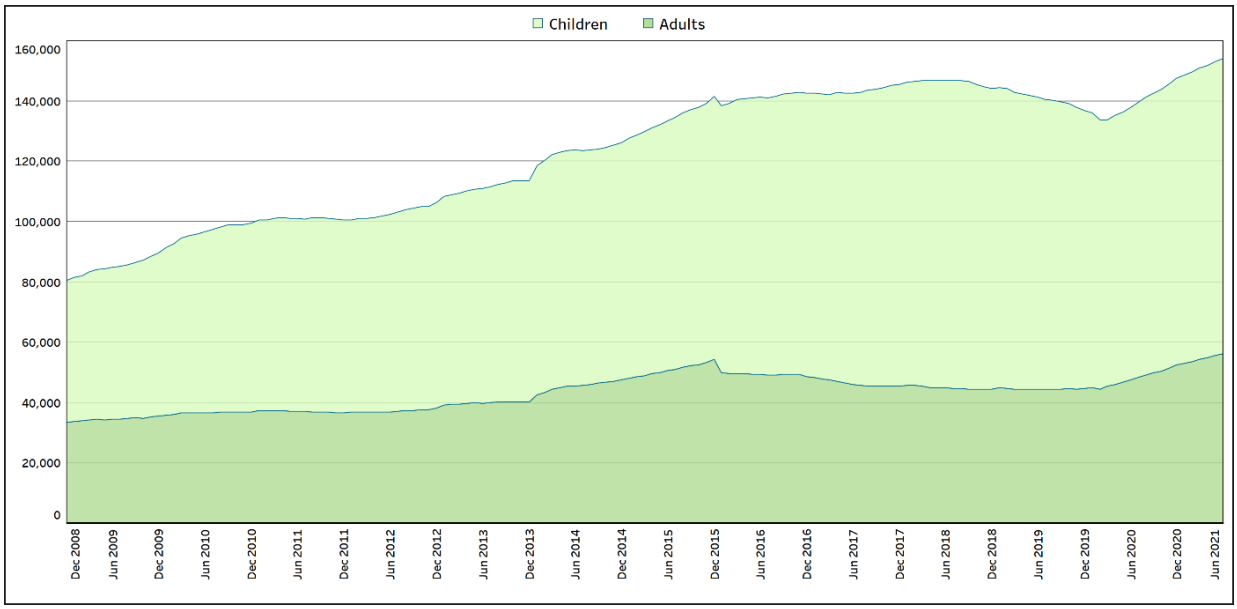


FIGURE 5 – DISABLED MEDICAID ENROLLMENT – ADULTS AND CHILDREN (Excludes Medicare Savings Plan Only)

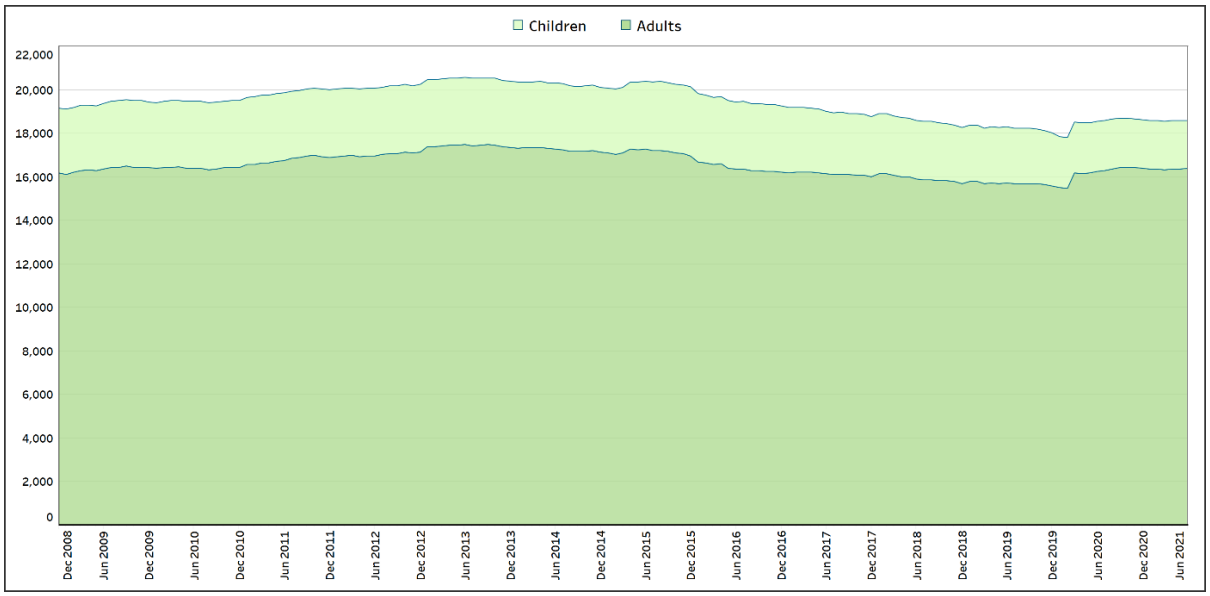


FIGURE 6 – MEDICAID ENROLLMENT – AGE 65 AND OLDER (Excludes Medicare Savings Plan Only)

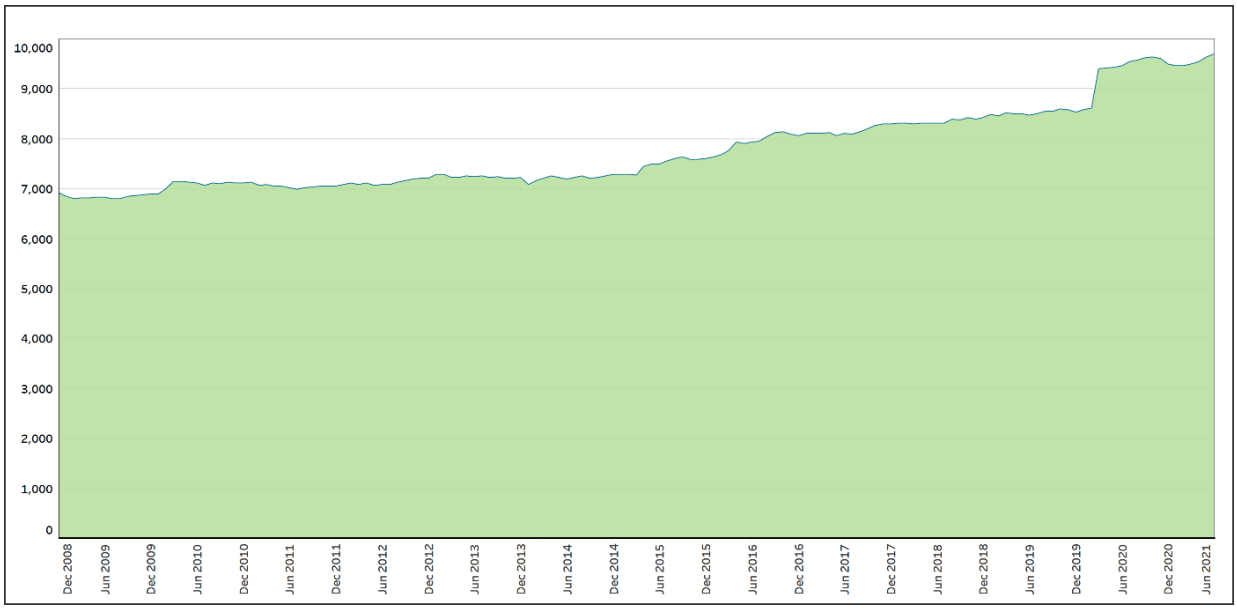


FIGURE 7 – FAMILY MEDICAID ENROLLMENT (EXCLUDES MEDICARE SAVINGS PLAN ONLY)

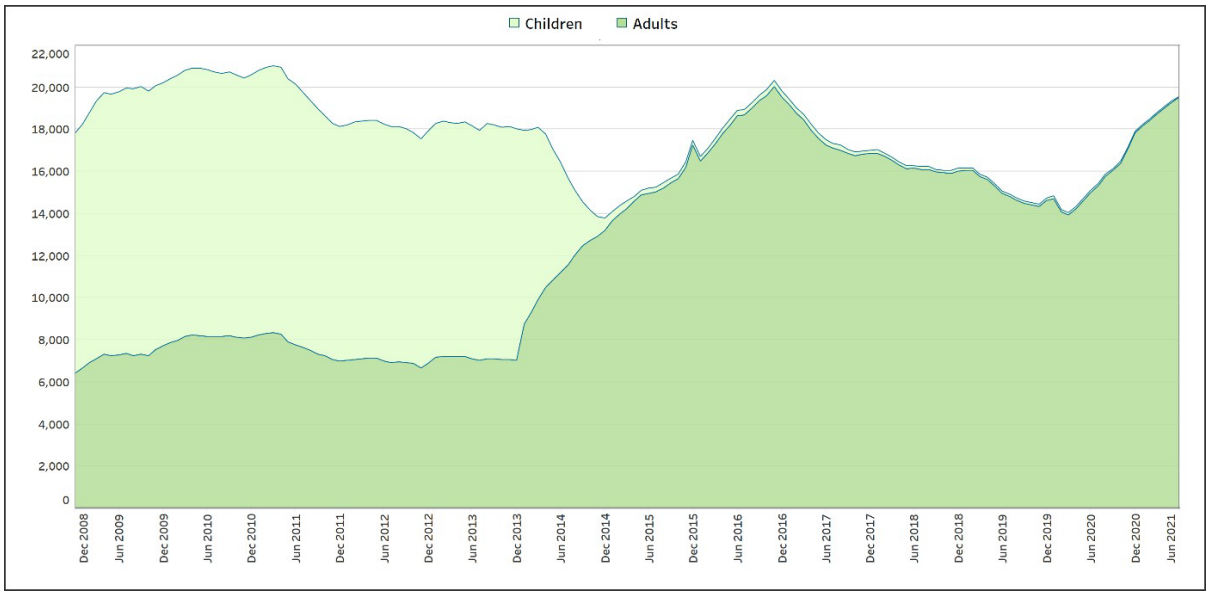


FIGURE 8 – MEDICAID POVERTY CHILD ENROLLMENT (EXCLUDES MEDICARE SAVINGS PLAN ONLY)

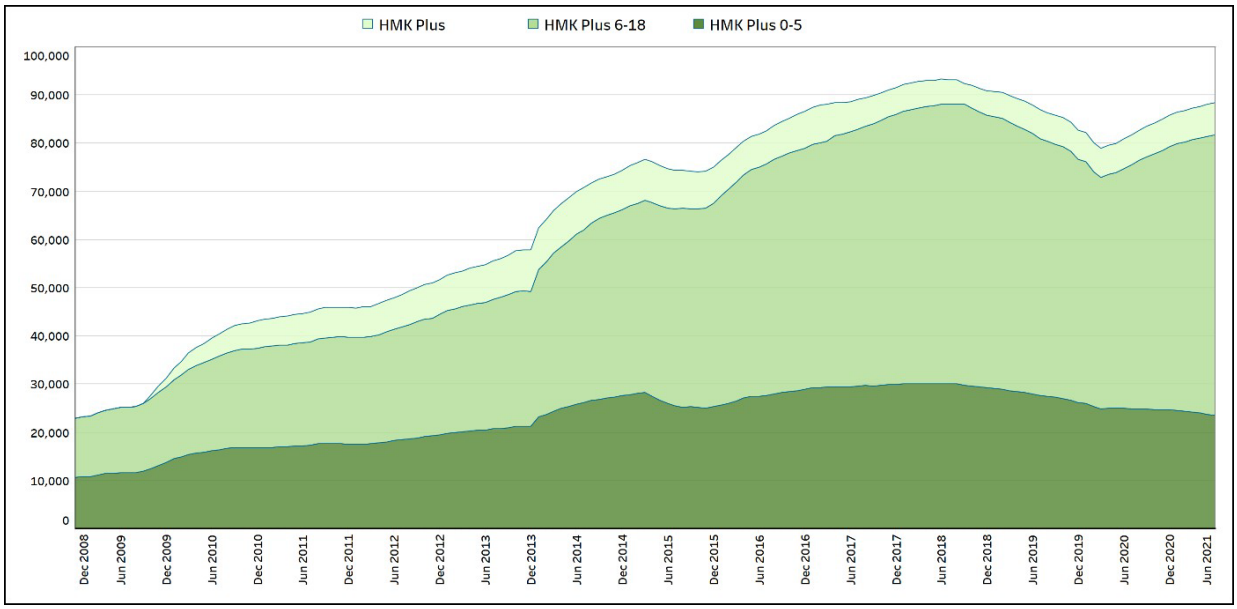


FIGURE 9 – MEDICAID ENROLLMENT – PREGNANT WOMEN AND INFANTS

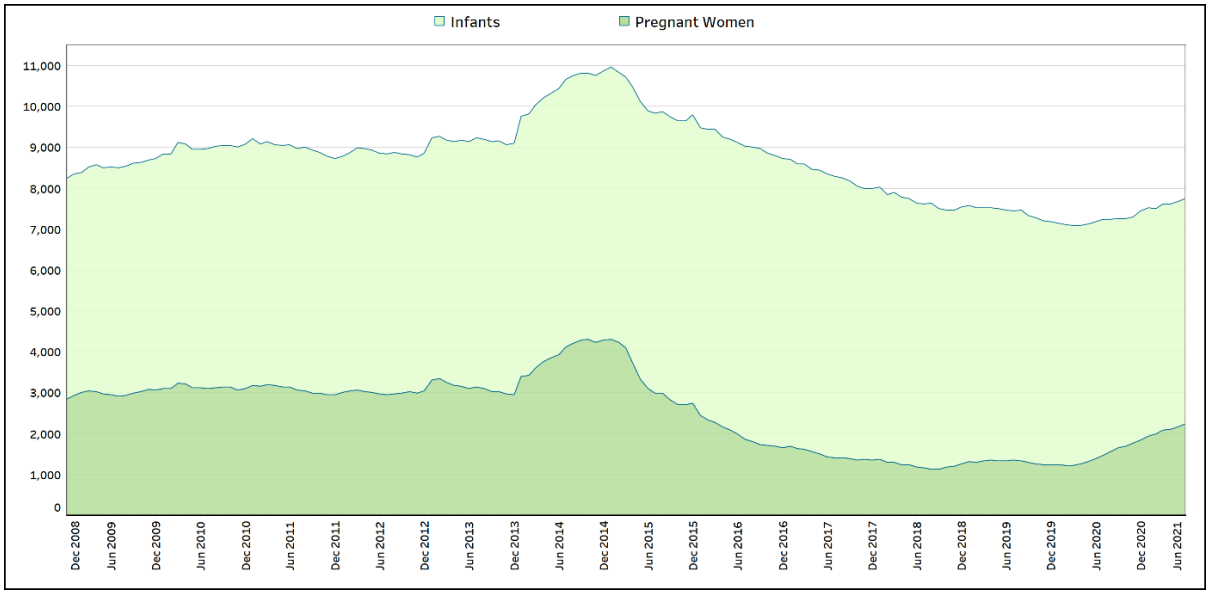


TABLE 7 – STANDARD MEDICAID ENROLLMENT AND EXPENDITURES BY COUNTY SFY 2021

County	County Population 2021	Average Monthly Medicaid Enrollment	Percent on Medicaid	Rank by Percent on Medicaid	Total County Expenditures	Average Expenditure per Enrollee	Rank by Average Expenditure per Enrollee
BEAVERHEAD	9,524	1,057	11%	37	$10,048,214	$9,509	14
BIG HORN	12,957	4,389	34%	2	$27,564,401	$6,280	49
BLAINE	6,980	1,741	25%	5	$14,875,888	$8,545	23
BROADWATER	7,288	599	8%	50	$4,623,724	$7,718	37
CARBON	10,847	1,081	10%	40	$8,507,881	$7,871	29
CARTER	1,428	95	7%	55	$781,981	$8,217	26
CASCADE	84,511	11,969	14%	21	$105,277,018	$8,796	20
CHOUTEAU	5,916	549	9%	44	$5,265,209	$9,591	13
CUSTER	11,916	1,659	14%	24	$17,724,907	$10,682	5
DANIELS	1,686	141	8%	49	$1,427,418	$10,142	8
DAWSON	8,904	1,072	12%	32	$10,855,042	$10,129	9
DEER LODGE	9,491	1,214	13%	29	$13,553,830	$11,161	3
FALLON	3,017	264	9%	46	$2,114,119	$7,995	27
FERGUS	11,617	1,415	12%	31	$15,688,752	$11,090	4
FLATHEAD	108,454	13,903	13%	28	$99,774,945	$7,177	42
GALLATIN	122,713	7,456	6%	56	$46,077,857	$6,180	50
GARFIELD	1,209	203	17%	13	$1,199,260	$5,898	52
GLACIER	13,785	4,564	33%	3	$36,016,713	$7,892	28
GOLDEN VALLEY	831	122	15%	19	$737,900	$6,040	51
GRANITE	3,344	267	8%	52	$2,075,252	$7,775	33
HILL	16,179	3,982	25%	6	$30,039,429	$7,544	40
JEFFERSON	12,470	1,096	9%	45	$11,650,195	$10,635	6
JUDITH BASIN	2,044	232	11%	33	$1,213,480	$5,242	56
LAKE	32,033	6,093	19%	9	$47,349,706	$7,771	34
LEWIS AND CLARK	72,223	8,170	11%	35	$77,166,754	$9,446	15
LIBERTY	1,946	311	16%	16	$2,348,176	$7,563	39
LINCOLN	20,525	3,585	17%	11	$27,370,242	$7,635	38
MADISON	8,917	661	7%	53	$5,150,407	$7,792	32
MCCONE	1,718	144	8%	48	$958,157	$6,635	46
MEAGHER	1,964	329	17%	14	$2,238,219	$6,800	45
MINERAL	4,860	844	17%	12	$4,553,698	$5,394	55
MISSOULA	119,533	13,328	11%	36	$125,067,363	$9,384	16
MUSSELSHELL	4,896	775	16%	17	$6,490,527	$8,376	24
PARK	17,473	1,710	10%	42	$16,032,818	$9,377	17

TABLE 8 – STANDARD MEDICAID ENROLLMENT AND EXPENDITURES BY COUNTY SFY 2021 (CONTINUED)

County	County Population 2021	Average Monthly Medicaid Enrollment	Percent on Medicaid	Rank by Percent on Medicaid	Total County Expenditures	Average Expenditure per Enrollee	Rank by Average Expenditure per Enrollee
PETROLEUM	519	54	10%	39	$357,111	$6,583	47
PHILLIPS	4,192	782	19%	10	$7,133,905	$9,122	18
PONDERA	5,994	1,375	23%	7	$10,629,787	$7,730	36
POWDER RIVER	1,702	119	7%	54	$939,405	$7,867	30
POWELL	6,999	792	11%	34	$8,364,056	$10,560	7
PRAIRIE	1,091	141	13%	27	$1,415,987	$10,078	11
RAVALLI	45,959	5,849	13%	30	$45,613,815	$7,799	31
RICHLAND	11,283	1,208	11%	38	$10,363,181	$8,581	22
ROOSEVELT	10,821	3,723	34%	1	$32,871,167	$8,830	19
ROSEBUD	8,124	2,219	27%	4	$15,887,774	$7,160	43
SANDERS	12,959	2,068	16%	15	$17,939,189	$8,673	21
SHERIDAN	3,527	338	10%	43	$2,800,071	$8,290	25
SILVER BOW	35,411	5,384	15%	18	$53,042,789	$9,851	12
STILLWATER	9,044	901	10%	41	$6,224,090	$6,911	44
SWEET GRASS	3,723	299	8%	51	$1,937,637	$6,473	48
TETON	6,269	876	14%	23	$6,378,452	$7,282	41
TOOLE	5,011	681	14%	25	$9,698,083	$14,248	2
TREASURE	768	108	14%	22	$601,572	$5,579	54
VALLEY	7,537	1,073	14%	20	$10,845,817	$10,112	10
WHEATLAND	2,059	434	21%	8	$2,552,733	$5,880	53
WIBAUX	934	79	8%	47	$1,225,408	$15,577	1
YELLOWSTONE	167,146	22,331	13%	26	$172,807,102	$7,738	35
Other / Institution		107			$186,979		
Sub Total	**1,104,271**	**145,958**	**13%**		**$1,201,635,591**	**$8,233**	
Plan First		1,327			$211,866	$160	
QMB Only		5,196			$17,000,724	$3,272	
SLMB - QI Only		5,200			$8,782,410	$1,689	
Grand Total	**1,104,271**	**157,681**	**14%**		**1,227,630,591**	**$7,786**	

Population estimates as of 2021. Columns may not sum to total due to rounding.

Excludes HMK (CHIP) and State Fund Mental Health. For QMB only enrollees, Medicaid pays for Medicare Premiums, co-insurance, and deductibles. For SLMB - QI only enrollees, Medicaid pays for Medicare Premiums.

FIGURE 10 – STANDARD MEDICAID EXPENSES – SFY 2021

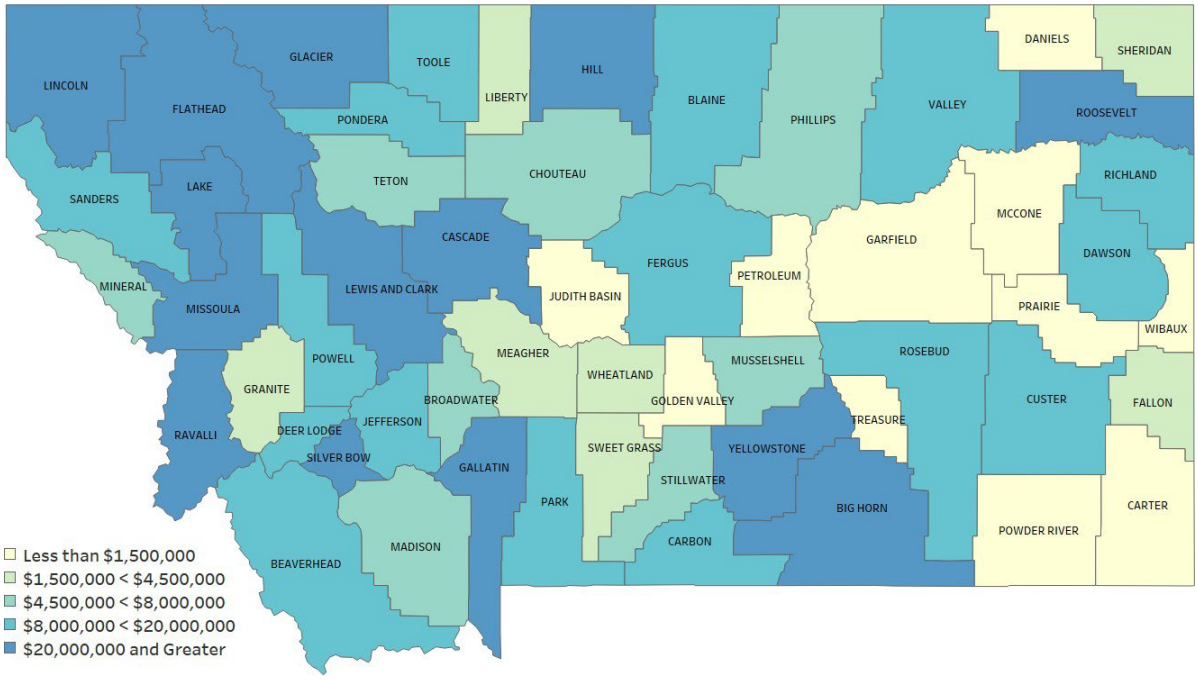


Figure 11 – Standard Medicaid: Average Monthly Enrollment – SFY 2021

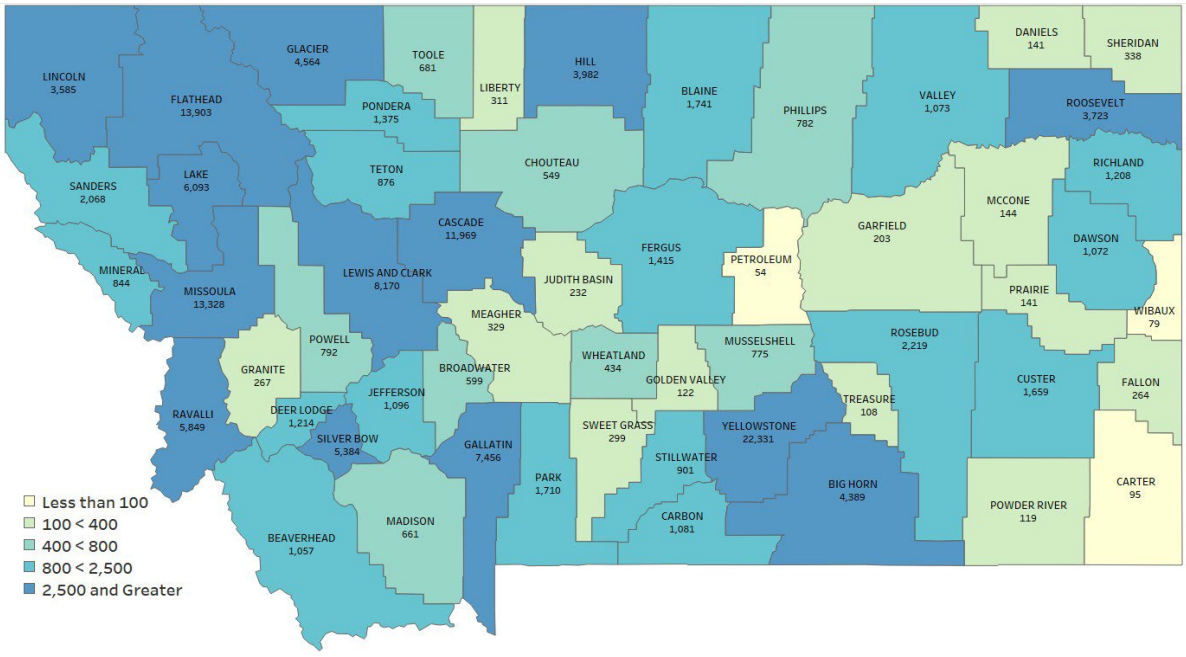


FIGURE 12 – STANDARD MEDICAID: AVERAGE EXPENDITURE PER ENROLLEE – SFY 2021

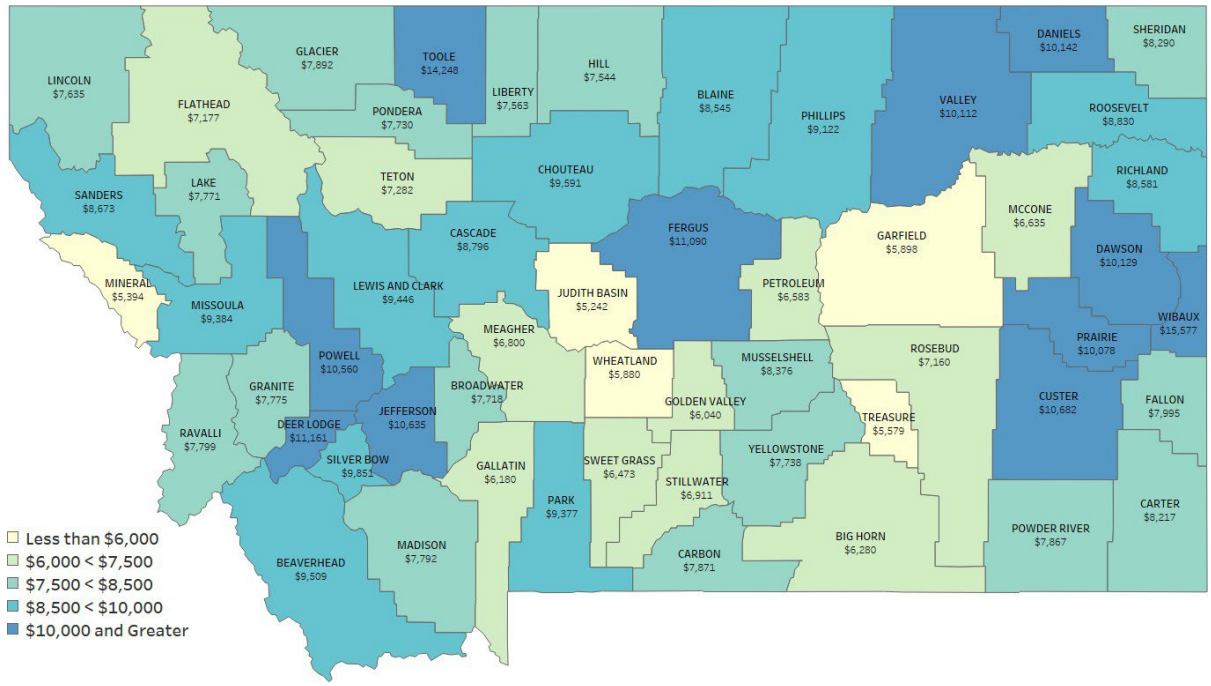
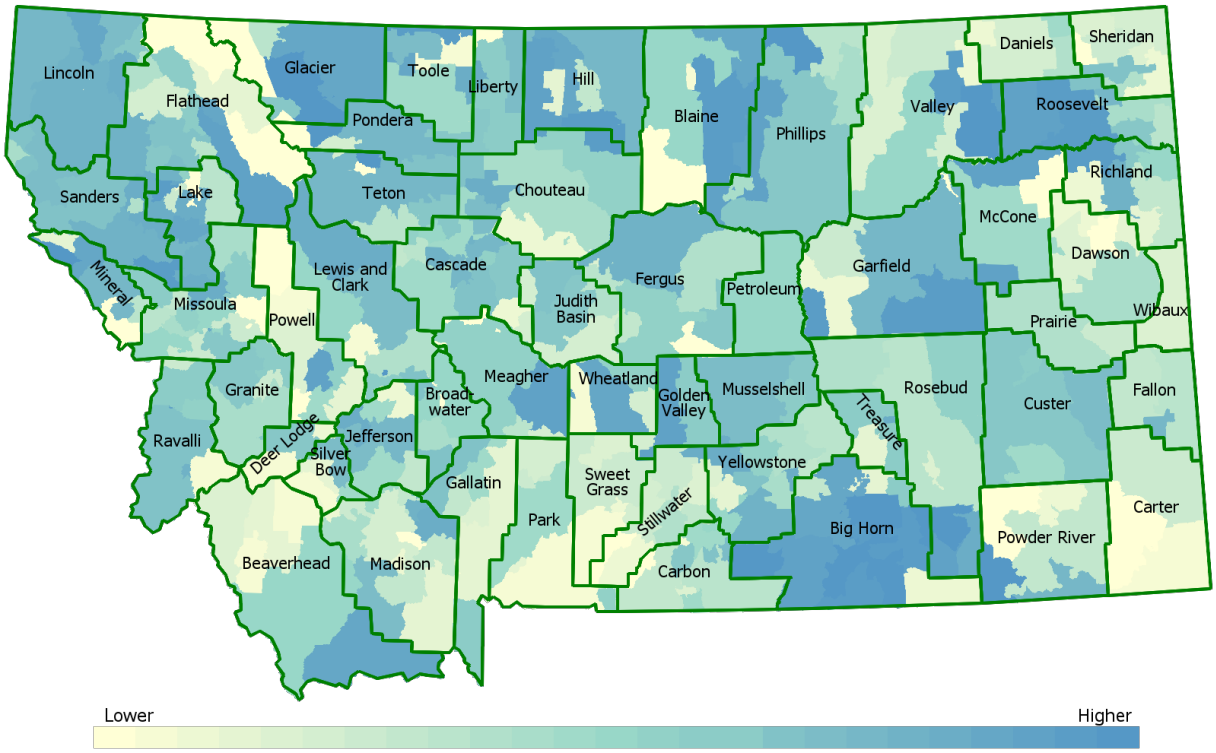


FIGURE 13 – STANDARD MEDICAID ENROLLMENT BY PERCENT OF POPULATION



Montana Medicaid Benefit-Related Expenditures

The following series of Medicaid expenditure data only includes benefit-related expenditures. It does *not* include administrative activity costs. Benefit-related expenditures for Hospital Utilization Fee distributions, Medicaid Buy-in, Intergovernmental Transfers (IGT), Pharmacy Rebates, Part-D Pharmacy Clawback, and Institutional Reimbursements for Medicaid, Third Party Liability (TPL), and Medically Needy offsets are included. These are non-audited expenditures on a date of service basis.

Table 9 – Standard Medicaid Benefit Expenditures by Category

Categories	FY 2018	FY 2019	FY 2020	FY 2021
Hospital Services	$ 222,902,134	$ 203,431,168	$ 239,935,498	$ 255,602,748
Physician and Professional Services	81,110,490	90,809,454	85,816,853	92,203,931
Pharmacy and Rebates	56,104,493	57,944,282	58,310,924	60,099,939
Dental	44,425,371	43,563,335	40,148,262	48,065,700
Health Centers and Clinics	24,686,520	26,739,156	34,471,277	33,200,310
Medical Equipment and Supplies	16,029,184	15,561,465	18,003,077	21,514,904
Laboratory and Imaging Services	5,572,098	5,111,552	4,784,195	6,850,324
Medical Transportation	9,232,544	8,736,124	8,687,516	7,812,994
Other Services	2,204,585	2,295,052	2,241,981	2,029,278
Nursing Facility	167,496,591	176,562,401	177,972,379	160,680,778
Home and Community Based - Other Service	4,720,456	6,547,868	6,188,666	4,794,509
Home and Community Based - CFC	-	-	-	-
Home and Community Based - Big Sky Waiv	39,376,098	36,416,471	40,280,154	53,101,449
Care and Case Management	22,786,286	14,775,313	14,534,884	16,765,881
Substance Use Disorder Services	2,641,497	2,242,075	2,949,955	3,175,807
Mental Health Services	121,768,506	117,642,772	120,203,229	126,326,122
Home and Community Based - SDMI Waiver	5,286,642	5,691,953	6,291,500	12,914,335
Mental Health Services - HIFA Waiver	6,931,491	6,907,089	7,676,380	7,202,432
Developmental Disability Services	2,674,046	224,855	285,200	645,713
Home and Community Based - DD Waiver	114,975,108	123,386,149	128,562,147	128,029,734
Indian and Tribal Health Services	63,106,740	73,022,007	74,082,926	64,058,123
School Based - Physical Health	5,830,269	5,785,626	4,226,096	4,414,947
School Based - Mental Health	33,605,456	34,544,405	25,035,863	19,981,903
Medicare Buy-In	43,122,324	44,598,918	46,829,969	50,070,053
Total	$ 1,096,588,929	$ 1,102,539,490	$ 1,147,518,931	$ 1,179,541,916

Figure 14 – Standard Medicaid Benefit Expenditures by Category: FY 2018 to FY 2021

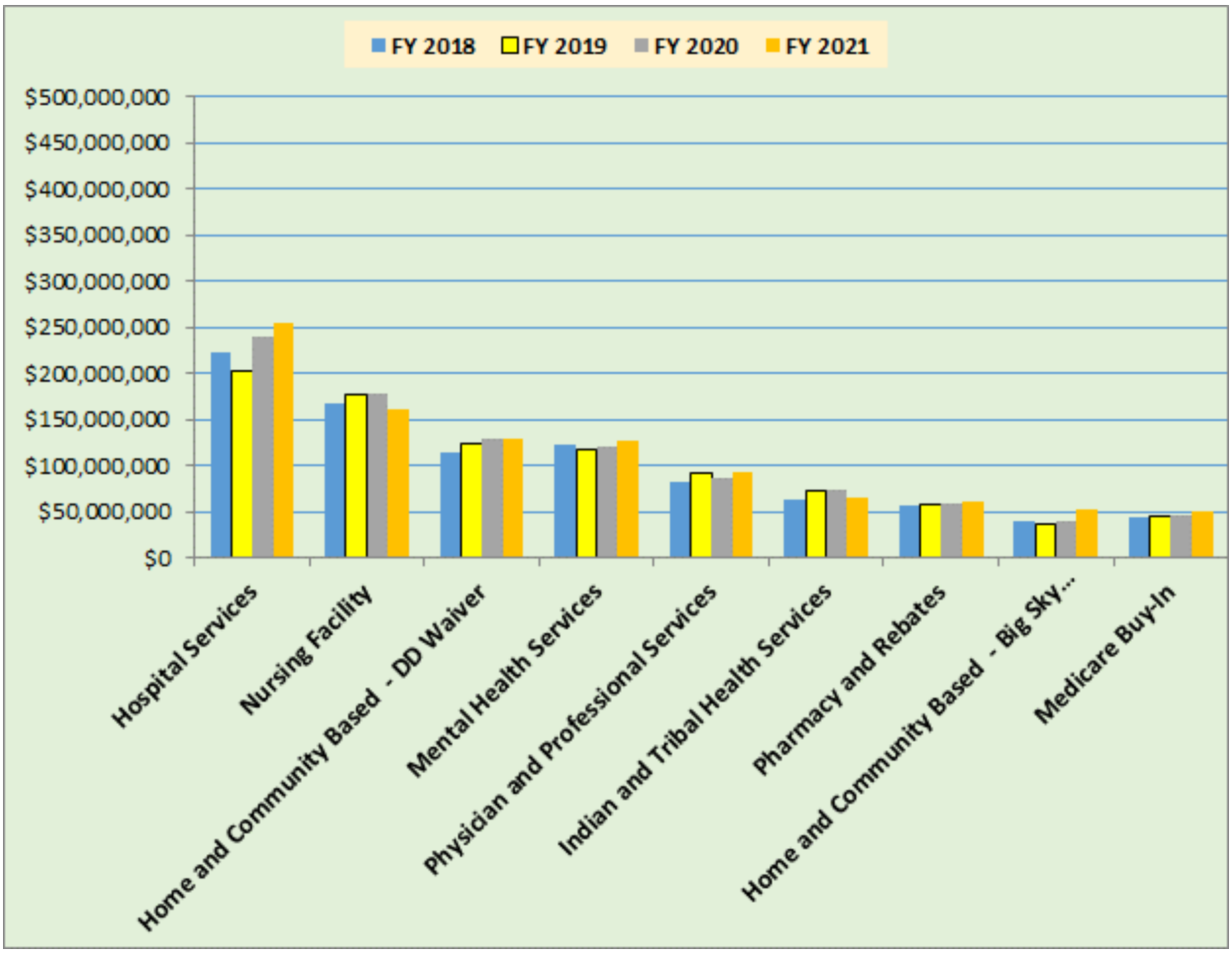


FIGURE 15 –STANDARD MEDICAID BENEFIT EXPENDITURES SFY 2021

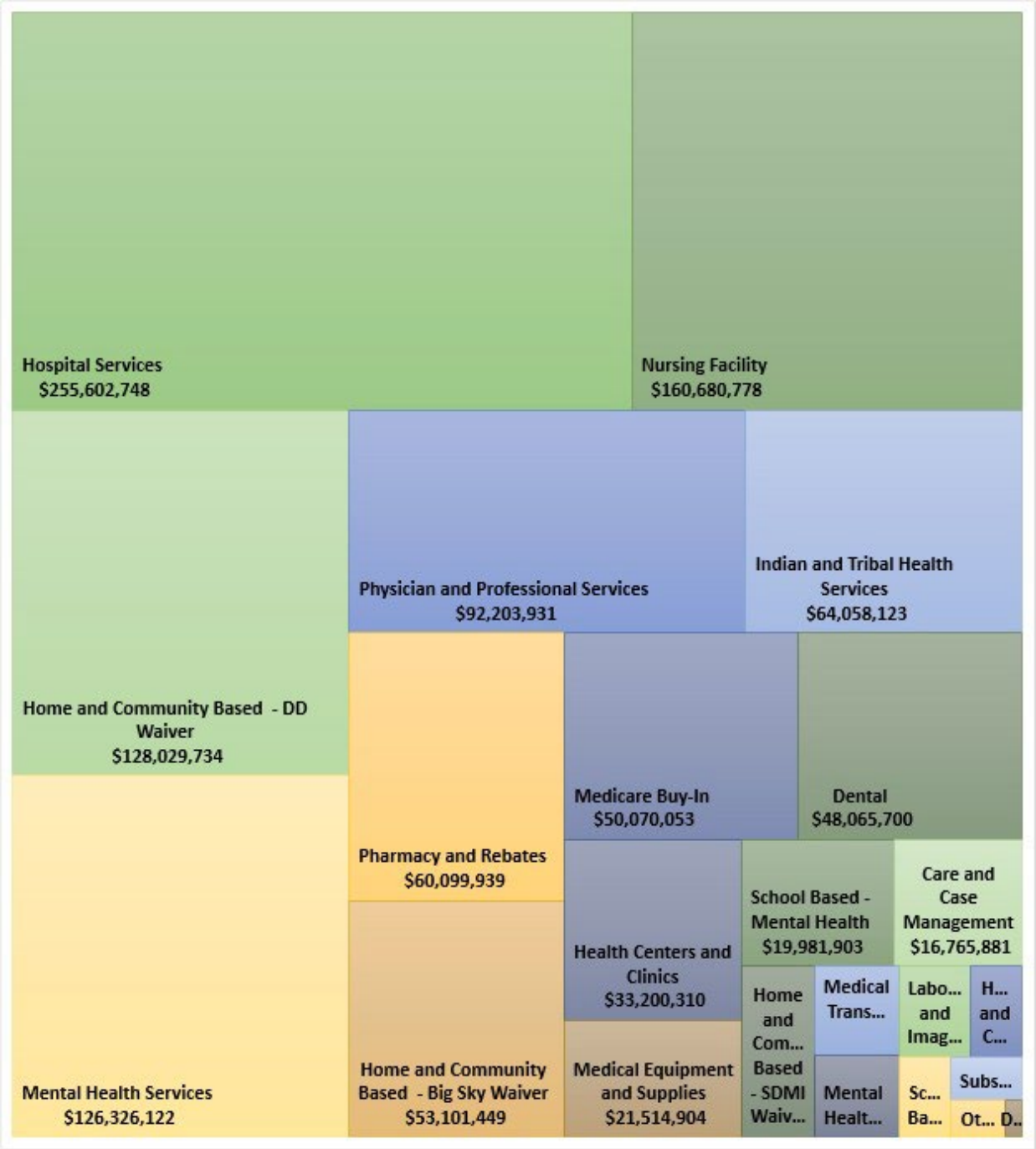
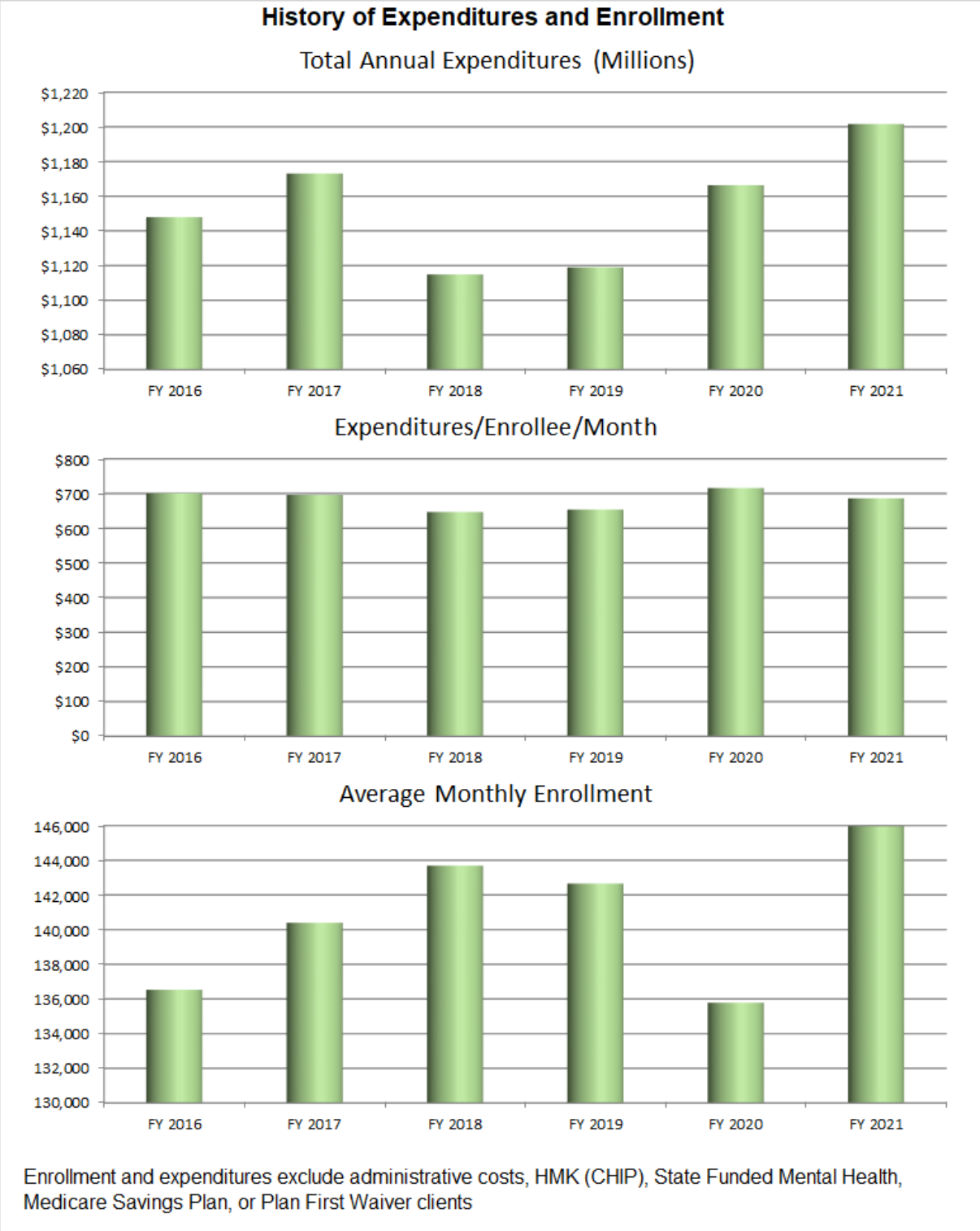


FIGURE 16 – HISTORY OF EXPENDITURES AND ENROLLMENT



Enrollment and expenditures exclude administrative costs, HMK (CHIP), State Funded Mental Health, Medicare Savings Plan, or Plan First Waiver clients

The following charts and tables show the average monthly per-member reimbursement for various age groups and Medicaid eligibility categories. This calculation merges claims and eligibility data, ensuring client enrollment and reimbursement are counted in the same category and the updated enrollment information takes precedence over the claim information. Graphs do not include HMK (CHIP) and state funded mental health expenditures.

Table 10 – Standard Medicaid Average per Month Enrollment

		State Fiscal Year					
Age	**Category**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**
< 1	Blind/Disabled	34	41	47	38	26	26
< 1	Child	6,984	7,012	6,599	6,235	5,910	5,550
1 to 5	Blind/Disabled	482	445	368	363	351	292
1 to 5	Child	27,698	29,144	30,192	29,634	27,003	27,492
6 to 18	Blind/Disabled	2,614	2,529	2,350	2,200	2,042	1,928
6 to 18	Child	50,102	55,037	60,447	61,243	56,781	59,910
19 to 20	Blind/Disabled	430	415	421	408	405	424
19 to 20	Adult	1,369	1,209	1,264	1,395	1,244	2,902
21 to 64	Blind/Disabled	16,011	15,408	15,185	14,899	14,884	15,230
21 to 64	Adult	23,099	21,184	18,699	17,984	18,470	22,870
65 +	Aged	7,343	7,585	7,674	7,811	8,162	8,633
65 +	Blind/Disabled	367	388	437	447	501	703
Total		**136,534**	**140,396**	**143,685**	**142,656**	**135,779**	**145,958**
All	Plan First	2,370	1,884	1,637	1,528	1,426	1,327
All	QMB	4,793	5,202	5,660	5,823	5,690	5,196
All	SLMB - QI	4,755	5,064	5,250	5,384	5,421	5,200
Total	**Traditional**	**148,452**	**152,546**	**156,232**	**155,390**	**148,317**	**157,681**
6 to 18	HK Med Plus	7,415	7,215	5,590	5,253	6,021	6,472
Total	**All Categories**	**155,867**	**159,761**	**161,822**	**160,644**	**154,338**	**164,154**

Categories may not sum to totals due to rounding. For QMB only enrollees, Medicaid pays for Medicare Premiums, co-insurance, and deductibles. For SLMB - QI only enrollees, Medicaid pays for Medicare Premiums. HK Med Plus are Medicaid clients age 6 to 18 that are funded through CHIP. Plan First clients receive a limited benefit for family planning services.

Table 11 – Standard Medicaid Monthly Reimbursement – Per Member

Age	Category	2016	2017	2018	2019	2020	2021
< 1	Blind/Disabled	$4,776		$10,669		$5,947	$4,885
< 1	Child	$711		$733		$774	$854
1 to 5	Blind/Disabled	$1,822	$1,794	$2,052	$2,424	$1,825	$1,717
1 to 5	Child	$184	$186	$186	$190	$194	$176
6 to 18	Blind/Disabled	$2,119	$2,075	$2,024	$2,146	$1,550	$1,598
6 to 18	Child	$342	$338	$321	$324	$345	$331
19 to 20	Blind/Disabled	$1,381	$1,424	$1,341	$1,418	$1,778	$1,585
19 to 20	Adult	$618	$523	$386	$388	$495	$381
21 to 64	Blind/Disabled	$1,850	$1,920	$1,833	$1,871	$2,020	$2,021
21 to 64	Adult	$557	$556	$479	$476	$544	$538
65 +	Aged	$2,380	$2,401	$2,408	$2,512	$2,533	$2,325
65 +	Blind/Disabled	$1,305	$1,732	$1,653	$1,567	$3,331	$3,006
Total		**$701**	**$696**	**$647**	**$654**	**$716**	**$686**
All	Plan First	$26	$19	$15	$13	$13	$13
All	QMB	$224	$239	$253	$266	$276	$273
All	SLMB - QI	$98	$125	$129	$134	$142	$141
Total	**Traditional**	**$655**	**$653**	**$608**	**$615**	**$671**	**$649**
6 to 18	HK Med Plus	$222	$222	$184	$235	$248	$238
Total	**All Categories**	**$634**	**$634**	**$594**	**$602**	**$655**	**$633**

For QMB only enrollees, Medicaid pays for Medicare Premiums, co-insurance, and deductibles. For SLMB - QI only enrollees, Medicaid pays for Medicare Premiums. HK Med Plus are Medicaid clients age 6 to 18 that are funded through CHIP. Plan First clients receive a limited benefit for family planning services.

Table 12 – Standard Medicaid Reimbursement Totals – All Demographic Groups

		State Fiscal Year					
Age	**Category**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**
< 1	Blind/Disabled	$1,948,773	$3,653,371	$6,070,381	$1,694,395	$1,849,492	$1,509,350
< 1	Child	$59,572,350	$71,062,262	$58,034,289	$49,997,713	$54,919,332	$56,908,167
1 to 5	Blind/Disabled	$10,537,413	$9,575,913	$9,071,013	$10,552,182	$7,682,948	$6,010,327
1 to 5	Child	$61,040,627	$65,139,960	$67,409,471	$67,541,800	$63,009,286	$58,021,030
6 to 18	Blind/Disabled	$66,464,313	$62,982,766	$57,072,536	$56,652,111	$37,965,477	$36,972,981
6 to 18	Child	$205,761,662	$223,190,140	$232,609,282	$238,045,227	$235,195,192	$237,716,375
19 to 20	Blind/Disabled	$7,117,740	$7,093,206	$6,779,626	$6,935,332	$8,647,784	$8,056,826
19 to 20	Adult	$10,159,371	$7,586,447	$5,861,263	$6,493,642	$7,388,947	$13,265,676
21 to 64	Blind/Disabled	$355,358,700	$355,001,107	$334,050,703	$334,475,310	$360,780,356	$369,377,313
21 to 64	Adult	$154,491,283	$141,212,201	$107,512,666	$102,725,758	$120,682,499	$147,541,148
65 +	Aged	$209,736,755	$218,538,070	$221,748,788	$235,424,504	$248,131,625	$240,896,420
65 +	Blind/Disabled	$5,753,613	$8,073,225	$8,672,889	$8,398,152	$20,028,106	$25,359,979
Total		**$1,147,942,600**	**$1,173,108,668**	**$1,114,892,907**	**$1,118,936,126**	**$1,166,281,046**	**$1,201,635,591**
All	Plan First	$744,926	$436,856	$302,557	$246,193	$215,087	$211,866
All	QMB	$12,882,791	$14,936,078	$17,187,583	$18,583,828	$18,841,721	$17,000,724
All	SLMB - QI	$5,618,331	$7,605,415	$8,155,693	$8,676,687	$9,214,055	$8,782,410
Total	**Traditional**	**$1,166,443,722**	**$1,196,087,017**	**$1,140,538,740**	**$1,146,442,834**	**$1,194,551,909**	**$1,227,630,591**
6 to 18	HK Med Plus	$19,726,828	$19,223,664	$12,331,026	$14,818,857	$17,928,450	$18,474,250
Total	**All Categories**	**$1,186,170,550**	**$1,215,310,681**	**$1,152,869,767**	**$1,161,261,691**	**$1,212,480,359**	**$1,246,104,841**

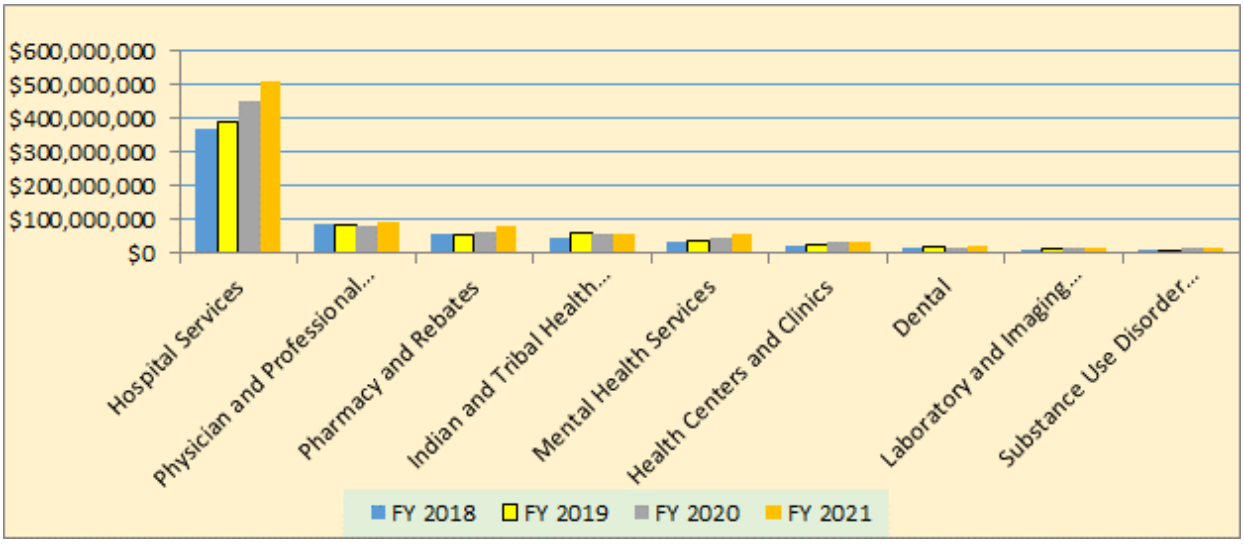
Categories may not sum to totals due to rounding. For QMB only enrollees, Medicaid pays for Medicare Premiums, co-insurance, and deductibles. For SLMB - QI only enrollees, Medicaid pays for Medicare Premiums. HK Med Plus are Medicaid clients age 6 to 18 that are funded through CHIP. Plan First clients receive a limited benefit for family planning services.

Medicaid Expansion Expenditures

Table 13 - Medicaid Expansion Benefit Expenditures by Category

Categories	FY 2018	FY 2019	FY 2020	FY 2021
Hospital Services	368,035,428	$ 391,234,817	$ 451,260,939	$ 511,365,991
Physician and Professional Services	85,085,512	85,826,443	83,410,487	95,664,056
Pharmacy and Rebates	55,189,572	54,770,150	65,322,889	82,794,356
Dental	18,874,345	17,011,449	17,436,161	20,387,484
Health Centers and Clinics	21,524,341	26,116,959	35,242,251	36,172,965
Medical Equipment and Supplies	6,288,234	6,408,126	7,497,715	9,764,515
Laboratory and Imaging Services	11,703,315	13,116,178	13,574,537	19,014,192
Medical Transportation	5,133,882	5,538,940	5,825,363	6,782,160
Other Services	694,568	845,833	935,919	1,192,612
Nursing Facility	6,319,377	6,965,196	6,469,241	7,069,892
Home and Community Based - Other Services	1,336,138	1,282,363	1,655,535	1,511,347
Home and Community Based - CFC	-	-	-	-
Home and Community Based - Big Sky Waiver	36,671	32,758	50,996	122,063
Care and Case Management	7,776,055	6,489,633	5,898,899	6,527,284
Substance Use Disorder Services	9,281,684	9,144,610	13,498,199	13,829,626
Mental Health Services	31,663,801	36,220,673	43,728,102	56,025,275
Home and Community Based - SDMI Waiver	19,338	7,805	27,898	80,759
Indian and Tribal Health Services	46,468,706	60,257,360	57,713,116	57,806,137
Total	$ 675,430,967	$ 721,269,293	$ 809,548,247	$ 926,110,714

Figure 17 –Medicaid Expansion Benefit Expenditures by Category: FY 2018 to FY 2021



Providers

Medicaid provides services through a network of private and public providers, including clinics, hospitals, nursing facilities, physicians, nurse practitioners, physician assistants, community health centers, tribal health, and the Indian Health Service (IHS). Montana Medicaid providers predominately live and work in communities across the state and serve as major employers. In SFY 2021, Standard Medicaid service providers received reimbursements, resulting in over $1.1 billion flowing into Montana's economy.

Examples of services offered by providers (either directly or indirectly) include:

- Primary care
- Preventive care
- Health maintenance
- Treatment of illness and injury
- Coordinating access to specialty care
- Providing or arranging for child checkups; children's healthcare (EPSDT)services, lead screenings, and immunizations

For more information, please refer to:

Montana Healthcare Programs Provider Information

DPHHS Provider Search

Claims Processing

DPHHS currently contracts with Conduent to process claims for reimbursement. Conduent meets the rigorous requirements established by CMS to be a Medicaid fiscal agent.

TABLE 14 – COMPARISON OF PAPER AND ELECTRONIC CLAIMS PROCESSED (2021)

Claim Type	Number Processed	Percentage of Total
Paper	511,980	4%
Electronic	12,287,524	96%
Total	12,799,504	100%

DPHHS is working to replace the State's aging legacy Medicaid Management Information System (MMIS). The Montana Program for Automating and Transforming Healthcare (MPATH) will support the receipt, adjudication, editing, pricing, and payment of health care claims. The configurable module will also process service authorizations, third-party insurance liability, and calculate member liabilities (including cost share and cost share coordination) between multiple payers.

Payment Methodologies

The Montana Medicaid Program payment rate methodologies include:

Reimbursement Systems for Hospitals – Determines provider pay rates by examining cost, utilization, relative value, etc. Consists of the following reimbursement systems:

- **All Patient Refined-Diagnosis Related Grouper (APR-DRG) Charge Cap System** Establishes payment rates for inpatient services at certain hospitals.
- Ambulatory Payment Classification – Establishes outpatient payment rates.
- Cost-based reimbursement for Critical Access Hospitals (CAH) – Limited service hospitals designed to provide essential services to rural communities.

Resource Based Relative Value System (RBRVS)

- Reimburses physicians and other providers who bill on CMS-1500 forms with an adaption of Medicare's RBRVS.
- System developed by CMS, the American Medical Association (AMA), and non-physician provider associations.
- Determines reimbursement based on service value, relative to other services.
- Benefits Montana with ongoing investment in research and policymaking, without yielding control of costs; rate is adjusted annually.

Rate + Quality System

- Two component rate methodology – Flat rate with a quality rate component.
- The Flat Rate Component is the same per diem rate for all nursing facilities and is set or adjusted through a public Administrative Rules of Montana process.
- The Quality Component is based on 5-Star rating system for nursing facility services calculated by the Centers for Medicare/Medicaid Services. It is set for each facility based on their average 5-star ratings for staffing and quality. Facilities with an average of 3-5 stars receive a quality component payment.

Fee-for-Service – Fees established for specific products/services

- Pharmacy services are one of the major services reimbursed.
- Pharmacies receive a professional dispensing fee for each prescription, plus the cost of the ingredient.

Medicaid Cost Containment Measures

Medicaid containment measures reduce costs and improve the efficiency of the program:

Healthy Outcome Initiatives
- Early/Elective Inductions and Cesarean Sections
- Long Acting Reversible Contraceptives
- Promising Pregnancy Care (PPC)
- School Based Services

Physician/Mid-Level Practitioner
- Team Care
- Passport to Health
- Comprehensive Primary Care Plus (CPC+)

Hospital
- Out-of-State Inpatient Hospitals
- All Patient Refined-Diagnosis Related Grouper (APR-DRG) Charge Cap

Pharmacy
- Prior Authorization
- Drug Utilization Review
- Over-the-Counter Drug Coverage
- Mandatory Generic Substitution
- Dispensing Restrictions
- Preferred Drug List and Supplemental Rebates
- Drug Rebate Collection
- Average Acquisition Cost (AAC)
- HMK and Pharmacy Processed through MMIS

Long-Term Care
- Tribal Nursing Facility Rates
- Money Follows the Person (MFP)
- Community First Choice (CFC**)Error! Reference source not found.**
- Prior Authorization
- Intergovernmental Fund Transfer

Third Party Liability
- Medicare Buy-In and Medicare Savings Program
- Health Insurance Premium Payment Program (HIPP)
- Coordination of Benefits

Early/Elective Inductions and Cesarean Sections

- Reduces reimbursement for non-medically necessary inductions, prior to 39 weeks.
- Reduces reimbursements for non-medically necessary cesarean deliveries at any gestational age.

Long Acting Reversible Contraceptives (LARC)

- Allows hospitals to bill separately for LARC, inserted at the time of delivery.
- Reduces unplanned pregnancies.

Promising Pregnancy Care (PPC)

- Consists of 10 group-driven classroom sessions; improves pregnancy. knowledge, readiness for labor, satisfaction with care, and breastfeeding initiation rates.
- Reduces deliveries of pre-term infants.

School Based Services

- Provides federal Medicaid match for services previously provided by school districts.
- Allows children to receive additional needed services such as mental health care and speech therapy at no additional cost to the school district.
- Office of Public Instruction certifies fund matching for Medicaid reimbursed services, as part of each participating child's Individualized Education Plan.

Physician/Mid-Level Practitioner

Team Care

- Medicaid members with a history of over-utilizing Medicaid services are required to participate (program currently has approximately 140 participants).
- Team Care members are managed by a team consisting of a Passport to Health primary care provider, one pharmacy, and DPHHS staff.

Passport to Health

- Primary Case Management Program was implemented to reduce medical costs and improves quality of care.
- Members choose primary care provider, who performs/provides referrals for care.

Comprehensive Primary Care Plus (CPC+)

- Provides practices with a robust learning system and actionable patient-level cost and utilization data feedback, to guide their decision making.
- Results in better delivery of medical care and healthier population.

Hospitals

Out-of-State Inpatient Hospitals

- Requires prior authorization for all inpatient hospital services out-of-state.
- Promotes utilization of available health resources in-state.

All Patient Refined-Diagnosis Related Grouper (APR-DRG) Charge Cap

- Reimburses hospitals in the APR-DRG system the lesser of billed charges, or APR-DRG rate.

Pharmacy

Prior Authorization (PA)

- Requires mandatory advance approval of certain medications before they are dispensed, for any medically accepted indication.
- Process is handled either at the Drug PA unit or through the pharmacy claims processing program.

Drug Utilization Review

- Prospective and retrospective review of drug use to ensure proper utilization.

Over-the-Counter Drug Coverage

- Provides cost-effective alternative to higher-priced federal legend drugs (when prescribed by a physician).

Mandatory Generic Substitution

- Requires pharmacies to dispense generic forms of prescribed drugs.

Dispensing Restrictions

- Restricts quantities per prescription and number of refills.

Preferred Drug List and Supplemental Rebates

- Medicaid's Drug Utilization Review Board/Formulary Committee selects drugs in various classes of medications.
- Extensive review of medications yields best value to Medicaid program, including increased supplemental rebates.

Drug Rebate Collection

- Dedicated staff review rebate programs and conduct claim/invoice audits, prior to invoicing pharmaceutical manufacturers.
- Reduces disputes with manufacturers, resulting in more timely payment.
- Drug rebates constitute over 72% of Standard Medicaid pharmacy expenditures ($94 million in FY 2021).

Average Acquisition Cost (AAC)

- Sets drug ingredient reimbursement as close to actual acquisition as possible.
- Bases acquisition cost on drug invoice data collected from wholesalers and Montana pharmacy providers.

HMK and Pharmacy Processed through MMIS

- Provides consistent prescription drug formulary for children who change eligibility between HMK Plus and HMK.
- Results in continuity of care and decreased drug changes.

Long-Term Care

Tribal Nursing Facility Rates

- Majority of tribal nursing home patients became eligible for 100% federal match

  Annual savings of $2.6 million of general fund when all 87 beds are full.

Money Follows the Person (MFP)

- CMS-awarded demonstration grant helps pay for services to people who already receive Medicaid funded care in an institutional setting and wish to move into certain types of community settings.
- Targets persons with complex needs (including traumatic brain injury), SDMI, physical disabilities, and/or elders in nursing homes; and individuals aged 18-21 or over 64 in the Montana State Hospital.
- All waiver and demonstration services receive an enhanced Federal Medical Assistance Percentage (FMAP) rate for Medicaid benefits for a period of 365 days of service; at day 366, a participant is served under a HCBS waiver at regular FMAP.
- Grant funding will continue through the Q1 of calendar year 2025.

Community First Choice (CFC)

- Covers home and community-based attendant services and supports to assist members with activities of daily living, instrumental activities of daily living, health-related related tasks, and related support services.
- Incentivizes with a permanent 6% increase in the federal share of Medicaid's cost (the FMAP rate) for CFC services.

Prior Authorization – Prior authorization is required for all Big Sky Waiver services. A nursing facility level of care determination is required for Community First Choice, Big Sky Waiver and all nursing facility services.

Intergovernmental Fund Transfer - Counties that own a nursing facility pay a fee that is matched with federal funds, which are redistributed to at-county facilities at a higher rate for the non-county facilities.

Third Party Liability (TPL)

- Identifies, verifies, and maintains primary health care insurance policies in the Medicaid recipient eligibility files to ensure Medicaid is the payor of last resort.
- Identifies third parties liable for payment of Medicaid member medical services and recovers costs of those services paid by Medicaid. (Medicare, private health insurance, auto accident policies, and workers' compensation).
- Cost avoids spending of Medicaid funds through the Health Insurance Premium Payment and Medicare Buy-In programs, by paying for cost-effective primary group health or Medicare policy premiums.

Medicare Buy-In and Medicare Savings Program

- Medicare Buy-In designates Medicare as the primary payer for Medicare and Medicaid dually eligible recipients. As a result of the major cost savings, a concerted effort is ongoing to ensure that anyone meeting eligibility criteria is enrolled.
- Medicare Part-A premiums are paid for Medicaid enrollees receiving Supplemental Security Income SSI payments, who become entitled to Medicare at age 65.
- Medicare Part-B premiums are paid for Medicaid recipients eligible for one of the Medicare Savings Program; Qualified Medicare Beneficiary (QMB), Specified Low Medicare Beneficiary (SLMB), and Qualified Individual (QI).
- QMB, SLMB, and QI enrollees are automatically entitled to Low Income Subsidy (LIS) or "Extra Help" status for the Medicare Prescription Drug Plan (Part-D).

Program and Payment Integrity Activities

- Two state programs help protect the state Medicaid program:
    - **DPHHS Office of Inspector General** – Responsible for ensuring proper payment and recovering misspent funds; and
    - **Attorney General's Medicaid Fraud Control Unit (MFCU)** – Responsible for investigating and ensuring the prosecution of Medicaid fraud.
- Medicaid Management Information System (MMIS) scans for fraud and billing errors and stops payment when irregularities are detected.
- Medicaid coordinates with efforts to identify, recover and prevent inappropriate provider billings and payments.
- **Federal Audit Requirements:**
    - Payment Error Rate Measurement (PERM) operates on a cycle, evaluating states every 3 years. Montana's most recent PERM cycle, Reporting Year (RY) 2021, reviewed claims paid during SFY 2020.
    - Medicaid Eligibility Quality Control (MEQC) program is required by CMS to ensure that Montana Medicaid and CHIP eligibility is determined correctly, recipients are placed in the correct eligibility category, and the related expenses are paid at the correct Federal Medical Assistance Percentages (FMAPs). MEQC reviews began in calendar year (CY) 2021.
    - Montana current has a waiver from CMS for the requirement to have a Recovery Audit Contractor (RAC).
- **Results of Medicaid Cost Containment\Recovery Measures:**
    - Clarification/streamlining of Medicaid policies, rules, and billing procedures
    - Increased payment integrity, recovery of inappropriately billed payments, and avoidance of future losses
    - Education of providers, regarding proper billing practices
    - Termination of some providers from participation in the Medicaid program
    - Referrals to the Attorney General's Medicaid Fraud Control Unit (MFCU)
    - Recovery of Medicaid payments made for Nursing Home and Home & Community Based services by placing TEFRA liens on real property.

- Recovery of Medicaid payments made on behalf of Medicaid recipients that pass away aged 55 and older, through the submission of a creditor's claims in the recipient's probated estate.
- In SFY21, Montana cost avoided $242.4 million, and recovered $12.5 million of Medicaid payments.
- In SFY22, Montana cost avoided $257.8 million, and recovered $10.7 million of Medicaid payments

State and Federal Shares

Medicaid services are funded by a combination of federal, state, and (in some cases) local funds. The federal match rate, for most Medicaid services provided to Montanan's eligible for the standard benefit plan, is derived by comparing the state average per capita income to the national average.

TABLE 15 – MONTANA MEDICAID BENEFITS – FEDERAL/STATE MATCHING RATE

State Fiscal Year	2018	2019	2020	2021	2022	2023	2024	2025
Federal Match Rate	65.42%	65.47%	64.95%	65.43%	64.96%	64.23%	63.96%	64.08%
State Match Rate	34.58%	34.53%	35.05%	34.57%	35.04%	35.77%	36.04%	35.92%

The chart below details the amount of matching federal dollars for each state dollar spent on traditional Medicaid benefits, as determined by the Federal Medical Assistance Percentage (FMAP).

This rate was temporarily increased:

1) during the recession period 2009-2012, as part of the American Recovery and Reinvestment Act (ARRA); and
2) during the COVID19 Public Health Emergency 2020-2023.

FIGURE 18 – TRADITIONAL MEDICAID – FEDERAL DOLLAR MATCHING SHARE – SFY 2006-2025

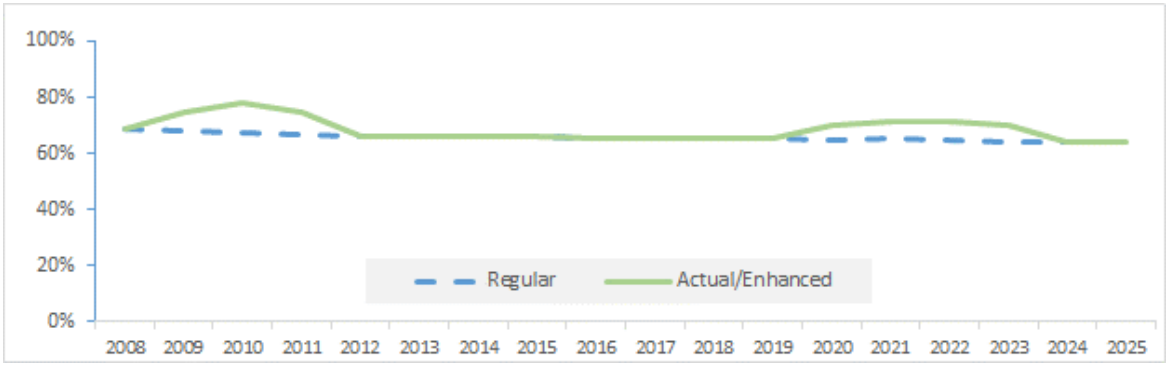


TABLE 16 – TRADITIONAL MEDICAID – COMPARISON OF REGULAR VS. ACTUAL/ENHANCED DOLLAR MATCH

State Fiscal Year	2008	2009	2010	2011	2012	2013	2014	2015	2016
Regular	68.59%	68.08%	67.48%	66.86%	66.21%	66.04%	66.25%	65.92%	65.36%
Actual/Enhanced	68.59%	74.80%	77.65%	74.58%	66.21%	66.04%	66.25%	65.92%	65.36%

State Fiscal Year	2017	2018	2019	2020	2021	2022	2023	2024	2025
Regular	65.50%	65.42%	65.47%	64.95%	65.43%	64.96%	64.23%	63.96%	64.08%
Actual/Enhanced	65.50%	65.42%	65.47%	69.80%	71.55%	71.16%	70.03%	63.96%	64.08%

Glossary

All Patient Refined Diagnosis Related Group (APR-DRG) – The Diagnosis Related Groups (DRGs) are a patient classification scheme which provides a means of relating the type of patients a hospital treats (i.e., its case mix) to the costs incurred by the hospital. There are currently three major versions of the DRG in use: basic DRGs, All Patient DRGs, and All Patient Refined DRGs. The basic DRGs are used by the Centers for Medicare and Medicaid Services (CMS) for hospital payment for Medicare beneficiaries. The All Patient DRGs (AP-DRGs) are an expansion of the basic DRGs to be more representative of non-Medicare populations such as pediatric patients. The All Patient Refined DRGs (APR-DRG) incorporate severity of illness subclasses into the AP-DRGs.

Ambulatory Surgical Centers (ASC) – ASCs, also known as outpatient surgery centers or same day surgery centers, are health care facilities where surgical procedures not requiring an overnight hospital stay are performed. Such surgery is commonly less complicated than that requiring hospitalization.

Care Managers – Care managers are employees of insurance companies who review and approve or disapprove procedures or surgeries before they occur. Decisions of the care managers are meant to control costs for the insurance company and alert consumers that a particular procedure will or will not be covered by their health insurance plans.

Categorically Needy – Refers to an individual with an attribute (disability, pregnant, child, etc.) for which there is a mandatory or optional Medicaid program.

Centers for Medicare and Medicaid Services (CMS) – CMS is part of the federal Department of Health and Human Services (HHS). CMS oversees the following programs: Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Health Insurance Marketplace. Part of this agency's responsibilities includes monitoring health outcomes and cost control in health insurance funded by the federal government.

Comparability – 1902(a)(10)(B) — A Medicaid-covered benefit generally must be provided in the same amount, duration, and scope to all enrollees. Waivers of comparability allow states to limit an enhanced benefit package to a targeted group of persons identified as needing it most and to limit the number of participants to implement a demonstration on a smaller scale.

Critical Access Hospitals (CAH) – Limited service hospitals designed to provide essential services to rural communities.

Fee-for-Service – A method in which doctors and other health care providers are paid for each service performed. Examples of services include tests and office visits.

Freedom of Choice – 1902(a)(23) — All beneficiaries must be permitted to choose a health care provider from among any of those participating in Medicaid. Freedom of choice waivers are typically used to allow implementation of managed care programs or better management of service delivery.

Intermediate Care Facility (ICF) – A residential medical facility, known in federal regulations as a nursing facility, that provides health-related services above the level of room and board, and is certified and recognized under State law as a provider of such medical services. Residents must be admitted by a physician and continuously remain under a physician's care. Montana does not have an ICF, an out of state facility is used as needed.

Spend Down – A process by which a person may subtract medical expenses (cost of medical care, equipment, and supplies, health insurance premiums and copayments, and prescription and over-the-counter medications) from their income to become Medicaid eligible. The Medicaid program may review an applicant's medical expenses (not paid by Medicare or other insurance) usually over a six-month period (A spouse's income and medical expenses are also calculated). The expenses are calculated whether or not the applicant has actually paid them for any given month.

Statewideness – 1902(a)(1) — Statute dictates that a state Medicaid program cannot exclude enrollees or providers because of where they live or work in the state. A waiver of "statewideness" can limit the geographic area in which a state is testing a new program, facilitate a phased-in implementation of a program, or reduce state expenditures by limiting eligible participants. Waivers allow states to target waivers to areas of the state where the need is greatest, or where certain types of providers are available.

Acronyms

AAC – Average Acquisition Cost

AMA – American Medical Association

AMDD – Addictive and Mental Disorders Division

APR-DRG – All Patient Refined-Diagnosis Related Grouper (APR-DRG)

BSW – Big Sky Waiver

CAH – Critical Access Hospitals

CAW – Children's Autism Waiver

CFC – Community First Choice

CMS – Centers for Medicare and Medicaid Services

CSCT – Comprehensive School and Community Treatment

DD – Developmental Disabilities

DPHHS – Department of Public Health and Human Services

DRG – Diagnosis Related Group

DSD – Developmental Services Division

FQHC – Federally Qualified Health Centers

FMAP – Federal Medical Assistance Percentage (the Federal reimbursement percentage for approved medical services)

FPL – Federal Poverty Level

FQHC – Federal Qualified Health Center

FY – Fiscal Year (state FY is July 1—June 30; federal FY is October 1—September 30)

HCBS – Home and Community Based Services

HIFA – Health Insurance Flexibility and Accountability

HELP Act – Health and Economic Livelihood Partnership

HMK – Healthy Montana Kids (HMK) is the largest provider of health care coverage for children in the State of Montana. HMK covers children through Medicaid and CHIP funding.

HMK Plus – The Medicaid portion of HMK is referred to as Healthy Montana Kids Plus.

IHS – Indian Health Service IGT – Inter Governmental Transfers

LARC – Long Acting Reversible Contraceptives

LTC – Qualified Long Term Care Partnership

MFCU – (Attorney General's) Medicaid Fraud Control Unit

MFP – Money Follows the Person

MMIS – Medicaid Management Information System

MWD – Montana Medicaid for Workers with Disabilities

OIG – Office of Inspector General

PA – Prior Authorization

PERM – Payment Error Rate Measurement

PCMH – Patient-Centered Medical Home

PPC – Promising Pregnancy Care

PCP – Primary Care Provider

QI – Qualifying Individual

QMB – Qualified Medicare Beneficiary

RAC – Recovery Audit Contractors

RBRVS – Resource-Based Relative Value Scale

RHC – Rural Health Clinic

SDMI – Severe and Disabling Mental Illness

SFY – State Fiscal Year (July 1—June 30)

SLMB – Specified Low-Income Medicare Beneficiary

SMAC – State Maximum Allowable Cost

SSI – Supplemental Security Income

SPA – State Plan Amendment

TPA – Third Party Administrator

TPL – Third Party Liability