Presentation to the 2019 Health and Human Services Joint Appropriation Subcommittee

Health Resources Division (HRD)

Medicaid and Health Services Branch
Department of Public Health and Human Services

The following topics are covered in this report:

- Overview
- Summary of Major Functions
- Highlights and Accomplishments during the 2019 Biennium
- Funding and FTE Information
- Change Packages

Overview

The HRD mission is *to protect the health and safety of all Montanans* and carries out this mission by administering numerous plans and programs; including Medicaid, Healthy Montana Kids, Medicaid Expansion, and Big Sky Rx. HRD pays for eligible Montanans to receive a wide range of preventive, primary and acute care services from private and public providers. The majority of services in the HRD are funded through Medicaid.

Medicaid is a state-federal partnership that reimburses for medical services for the aged, blind, disabled, children and low-income families. Medicaid services range from hospital, pharmacy, dental, tribal and Indian Health Services, member healthcare assistance programs, durable medical equipment, school-based services and home infusion therapy.

Healthy Montana Kids (HMK) is a state-federal partnership that provides health care coverage to over 30,000 Montana children with family incomes under 261% of the federal poverty level. The coverage is provided through a TPA contract with Blue Cross Blue Shield of Montana and through the agency's fiscal agent, Conduent. HRD administers the HMK pharmacy and dental programs.

Big Sky Rx is a state funded program that helps Montanans, who are at or below 200% of the federal poverty level and who are eligible for the Medicare Part D prescription drug program, pay for their Medicare premium. A related program, PharmAssist, pays for prescription drug counseling by a pharmacist and provides drug information and technical assistance to all Montanans.

Summary of Major Functions

Medicaid Services

The majority of services in the HRD are funded through Medicaid, and cumulatively seek to increase access to timely, affordable and effective health services.

Hospital Services
Hospital Services are provided in Montana through an in-state network of 15 Acute Care Facilities and 46 Critical Access Hospitals across the state. Montana Health Care Programs reimburse for inpatient services, outpatient services and emergency care. Providing these services in Montana supports Montana's healthcare system and helps assure access to health services for all Montanans.

Montana Health Care Programs covers inpatient hospital care outside of the state only in special circumstances. Out-of-state inpatient coverage is limited to services that are: 1) not available in Montana (i.e. transplants); 2) for people who live near the border and normally get their health care in Idaho, Wyoming, North Dakota or South Dakota; and 3) for Montanans who have traveled outside the state and need emergency services. Montana Health Care Programs has 396 enrolled out-of-state hospital facilities.

Physician Program
The physician program includes physician, mid-level practitioners, podiatrists, lab, independent diagnostic treatment clinics, public health clinics and family planning clinics. Medicaid reimbursement for these services includes but is not limited to: office visits, lab tests, x-rays, surgeries, prenatal care, deliveries and anesthesia. The Medicaid provider network includes 14,934 practitioners and clinics. Medicaid reimburses for services utilizing the nationally developed payment methodology, Resource Based Relative Value System (RBRVS), customized to Montana.

Pharmacy Program
The pharmacy program includes 436 pharmacies, with 273 of those in Montana, that provide access to medications throughout Montana. In addition, the program provides and promotes the appropriate use of medications through provider education and pharmacy case management.

HRD contracts with Mountain Pacific Quality Health to develop drug coverage criteria through the implementation of the Drug Use Review Board (DURB). The DURB is comprised of physicians, mid-level providers, and pharmacists from around Montana who develop drug coverage criteria to ensure prescribed medications are appropriate, medically necessary and cost effective. Coverage determinations balance cost effective alternatives, while allowing flexibility based on professional medical decisions.

HRD is also responsible for collecting rebates from drug manufacturers for Medicaid, Medicaid Expansion, and Healthy Montana Kids prescriptions. The drug rebates are collected through the mandated federal rebates, in addition to the rebates required under the Montana Preferred Drug

List (PDL). The rebates reduce the overall cost of the Medicaid program in Montana. On average, rebates average 55.5% of the drug spend.

The ***Big Sky Rx program*** is a state-funded program designed to complement the Medicare Part D drug benefit by providing premium assistance to eligible Montanans. Individuals must have family income at or below 200% of the FPL and be enrolled in Medicare Part D. Big Sky Rx makes a payment of the Part D premium up to $35.80 per month.

Dental and Denture Services
The Medicaid Dental program provides services up to $1,125 per year to Medicaid members (above the age of 20 and not enrolled as Aged, Blind, and Disabled). Diagnostic, preventative, dentures, and anesthesia services are not included in the treatment cap. Members who are age 20 and under or eligible under Aged, Blind and Disabled have no dental benefit limit. Services are provided by dentists, denturists, dental hygienists, and oral surgeons.

Rural Health Clinics and Federally Qualified Health Centers
Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) primarily provide primary care and preventive services. RHCs and FQHCs are in a location designated as a health care professional shortage area or as having a medically-underserved population. These facilities are reimbursed using a prospective payment system (PPS). The PPS rate is a provider specific per-visit payment based on the providers' allowable costs and scope of service.

Tribal and Indian Health Services
Montana Medicaid works in coordination with Tribal Governments, Indian Health Service, and Urban Indian programs to support health care delivery in tribal communities with the goal of building greater health care capacity to serve Montana's American Indians, allowing for better access and culturally-appropriate care. DPHHS formally consults with Tribal Governments, Indian Health Service, and Urban Indian programs on a regular basis, to discuss the Medicaid program and its impact on American Indians, tribal, and urban communities.

Montana Medicaid provides funding for medical services to Medicaid-eligible American Indians through an Indian Health Service (IHS) facility and other approved tribal providers. The Medicaid program acts as the "pass-through" agency for IHS reimbursement, which is 100% funded with federal funds in accordance with federal laws and regulations.

Since 2014, Medicaid has paid IHS and tribal facilities for primary care and the following services: pharmacy, dental, durable medical equipment, laboratory, x-ray, radiology, eyeglasses, and eyeglass dispensing/fitting fee, Substance Use Disorder (SUD), nursing homes, and outpatient surgeries.

Tribal Health Improvement Program (T-HIP)
Health disparities on tribal lands have been a growing concern for the people who reside on Montana's reservations. DPHHS, in partnership with Tribal and Centers for Medicare & Medicaid Services (CMS) created an opportunity for tribes to build and operate health promotion programs and activities that are culturally based and relevant to their membership and community. On March 24, 2017, CMS approved the Tribal Health Improvement Program (T-

HIP) program through the 1915(b) Passport to Health Waiver. The waiver is approved through March 2019.

The T-HIP is a historic partnership between 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 where tier 1 is designed to enhance communication and intensive care coordination of services for members with chronic illnesses or at-risk of these illnesses. Tiers 2 and 3 focus on specific areas of health disparities as defined by each tribe, such as obesity prevention programming for grade school youth.

Five tribes are currently participating in T-HIP; those being Fort Peck, Rocky Boy, Confederated Salish and Kootenai Tribes (CSKT), Fort Belknap and Blackfeet. DPHHS provides payments to tribes for over 15,000 tribal members. Rocky Boy reservation was approved to implement Tier 2 effective December 2018.

Healthy Montana Kids

Montanans created Healthy Montana Kids (HMK) in 2008. The program provides health care coverage to over 30,000 Montana children with family incomes under 261% of the federal poverty level. The coverage is provided through a contract with Blue Cross Blue Shield of Montana.

Coverage includes physician visits; well-child checkups; routine physicals; hospital in-patient and out-patient services; emergency visits; hearing and vision screenings; dental services; prescription drugs and behavioral health services.

Health Resource Division Waivers

State Medicaid programs may request from CMS a waiver(s) of certain federal Medicaid requirements that are found in the Social Security Act. Only certain requirements such as state wideness, freedom of choice, and comparability of eligibility and/or benefits can be waived. Waivers are also limited in that they must always be cost neutral to the federal government.

HRD manages the following waivers:

Passport to Health Section 1915(b) Care Management Waiver Programs
The Passport to Health waiver helps Montanans access and utilize services appropriately. The four components of the waiver promote smart, effective, and efficient use of health care to improve outcomes for our members while reducing costs. Members and providers report satisfaction with these care management programs that reduce costs to Medicaid every year.

- **Passport to Health:** This is the primary care case management program in which about 70% of all Montana Medicaid members are enrolled. A member chooses or is assigned a primary care provider who delivers all medical services or furnishes referrals for other medically-necessary care. Care management offered under the waiver enhances care,

while reducing costs by minimizing ineffective or inappropriate medical care. The waiver is operated in all 56 counties.

• **Team Care:** This is a program which reduces inappropriate or excessive utilization of healthcare services, including overutilization of hospital emergency rooms. Members are identified for Team Care through claim reviews, provider referrals, and Drug Utilization Review Board referrals, and Health Improvement Program care managers. Individuals are enrolled in Team Care for at least 12 months and are assigned to one pharmacy and one medical provider. Approximately 650 Medicaid and HMK Plus members are currently enrolled in the Team Care program.

• **Nurse First Advice Line:** This is a 24/7 nurse advice line that all Medicaid and HMK Plus members can call for healthcare questions. The advice line is operated by a vendor and through clinically-based algorithms which directs callers to the most appropriate level of care: self-care, provider visit, or emergency department visit. Quality, access to care, and health outcomes are continuously monitored, tracked, and reported.

• **Tribal Health Improvement Program (T-HIP):** This is a historic partnership program that created an opportunity for tribes to build and operate health promotion programs and activities that are relevant to their membership and community.

Section 1115 Plan First Family Planning Waiver
Plan First improves access to family planning services for women age 19-44 whose income is below 211% of federal poverty level. Plan First is intended to reduce unplanned pregnancies and improves birth outcomes by providing a limited set of family planning benefits to eligible Montana women. The plan covers:

- Office visits
- Contraceptive supplies
- Laboratory services
- Testing and treatment of sexually transmitted diseases

Section 1115 Montana Waiver for Additional Services and Populations (WASP)
The 1115 Waiver for Additional Services and Populations (formerly the Basic Medicaid Waiver) is a statewide section 1115 demonstration that was first approved in 1996. This waiver covers up to 3,000 individuals age 18 or older, with serious and disabling mental illness and have income 139-150% of the federal poverty level who do not otherwise qualify for Medicaid. The waiver also covers comprehensive dental treatment services for elderly, blind, and disabled individuals in Medicaid. This allows these individuals to receive treatment beyond the Medicaid State Plan cap of $1,125 per individual.

Highlights and Accomplishments During the 2019 Biennium

In spite of the budget cuts in the 2019 biennium, HRD has continued to move forward with implementing the reductions and maintain existing programs with the limited resources. Despite the challenges faced, HRD was able to make cost-saving improvements to the Medicaid programs and continue to protect the health and safety of vulnerable Montanans with effective and efficient use of limited resources. We made measurable progress towards our division's strategic goals and the measurable outcomes identified in DPHHS's Strategic Plan, with emphasis on promoting health equity and improving population health to increase access to timely, affordable and effective health services, and did so through the following strategies:

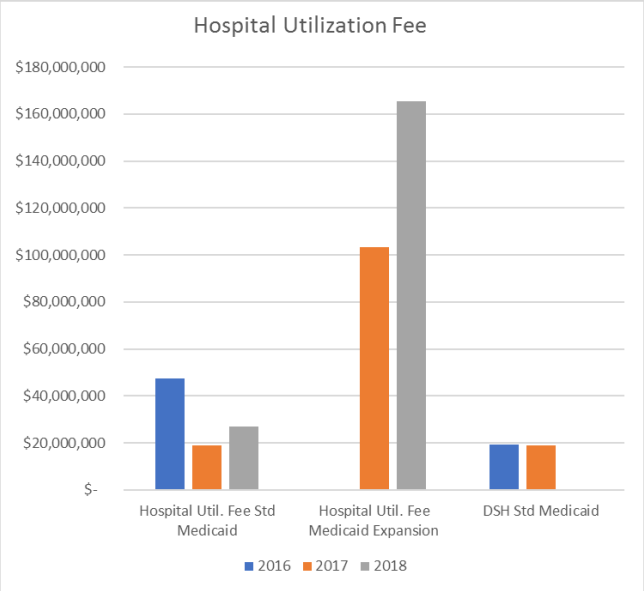
- Implementing efficiency improvements to the Medicaid programs, and
- Working to increase member education to better assist our members in navigating the complex health care system.

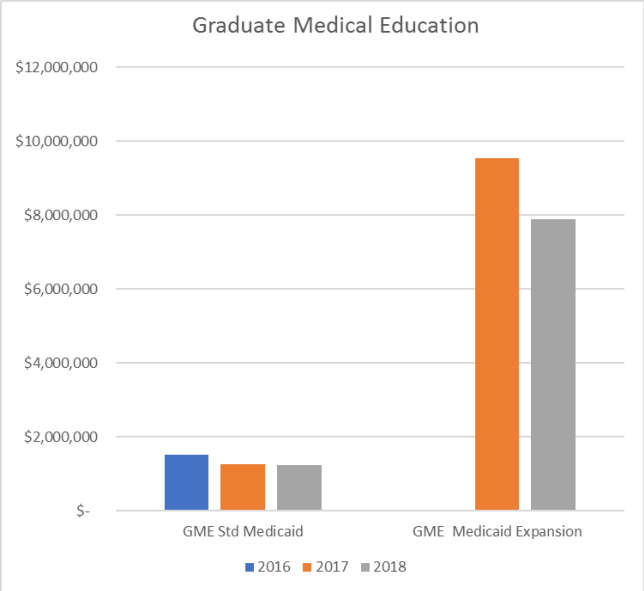
Medicaid Initiatives

Hospital Utilization Fee Funding
Through updates to the Medicaid State Plan Amendments, HRD secured the ability to utilize Medicaid Expansion's Federal Medical Assistance Percentage (FMAP) to increase hospital supplemental payments in 2017 and 2018. The additional funds from leveraging the Expansion FMAP help to assure access to health services from Montana's hospitals.

Expanded the Graduate Medical Education (GME) Program
As of August 1, 2018, the five teaching hospitals in Montana participating in the GME program can now count psychiatry residents and residents who participate in rural rotations as part of their full-time equivalent counts. This program expansion strives to increase access to healthcare in rural locations as well as increase access to much needed behavioral health services. Placing psychiatric residents in rural communities adds to community-based systems of mental health care and develops innovative approaches to needed psychiatric care. HRD also utilizes the increase in the FMAP to increase GME payments to Montana's teaching hospitals.

The below graphs show how Medicaid Expansion has contributed to the significant increase in hospitalization supplemental payments covering hospital utilization fees and the increase in GME payments to Montana's teaching hospitals.





Alternative Payment Methodology for Long-Acting Reversible Contraceptives (LARC)
Historically, Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) providers struggled with providing adequate birth control options to the Montana Health Care Program members. The reimbursement methodology for RHC and FQHC providers made providing LARCs to members a costly, inefficient process. This prompted several facilities to request members to fill the LARC through their pharmacy benefit and return on another day for services. This practice had the potential to discourage members from receiving the LARC. To increase access to LARCs and discourage potential waste through unused products, DPHHS improved the service to be more efficient for members and less costly by allowing Montana Health Care Programs to provide direct reimbursements for the LARC to FQHC and RHC providers starting July 2017, in addition to their standard prospective payment system rate.

Comprehensive Primary Care Plus (CPC+)
Montana Medicaid (along with Blue Cross Blue Shield, Pacific Source and Allegiance Life and Health) was chosen as one of 14 regions nationally to participate in the CPC+ Program in coordination with Medicare. CPC+, the largest-ever initiative of its kind, is a five-year, multi-payer initiative to improve primary care, which is critical to promoting health equity, reducing overall health care costs, and improving population health. It is a national advanced primary care medical home model that aims to strengthen primary care through a regionally-based multi-payer payment reform and care delivery transformation. CPC+ includes two primary care practice tracks with incrementally advanced care delivery requirements and payment options to meet the diverse needs of primary care practices in the United States. Track 2 practices are required to integrate behavioral health services. The care delivery redesign ensures practices in each track have the infrastructure to deliver better care to result in a healthier patient population. The multi-payer payment redesign will give practices greater financial resources and flexibility to make appropriate investments to improve the quality and efficiency of care and reduce unnecessary health care utilization such as emergency room and inpatient hospital utilization. CPC+ provides practices with a robust learning system, as well as actionable patient-level cost

and utilization data feedback, to guide their decision making. CPC+ providers report quality measures annually to DPHHS; 2017 quality measures are currently being compiled and will be reported out to providers. Currently 48 practices participate in Montana Medicaid's CPC+ Program throughout the state and approximately 62,000 Medicaid members including Medicaid expansion members. Participating practices include independent practices and hospital-based practices. All members participating in Medicaid Expansion can partake and will benefit from services provided.

Patient Centered Medical Home (PCMH)
In June 2018, DPHHS expanded the PCMH program to 23 sites and includes any practice that is certified through the National Committee for Quality Assurance (NCQA). In 2014, the PCMH program was started with five pilot locations project. The PCMH now covers 39,000 Medicaid members including Medicaid Expansion members. PMCH is designed to improve health care by transforming how primary care is standardized and delivered. The current PCMH program has been transformed to model the CPC+ program for practices that do not qualify for the CPC+ program and have received PCMH recognition from the NCQA. The model is centered on the following core principles:

- Comprehensive health care directed by the patient's personal provider;
- Team-based, ongoing patient-centered care;

- Care coordination across the health system using information technology;
- Enhanced access through expanded hours, new communication methods, or alternative visits;

- Quality and safety through evidence-based medicine, quality improvement, and performance measurement;

- Value-based payment that recognizes alternative visits, care coordination, health information technology, enhanced communication, and risk-based population stratification.

Complex Care Management (CCM)
Launched in October 2018, the CCM program partners with FQHCs that are also PCMHs to provide up to six months of in-home intensive case management to patients with complex chronic conditions who are high utilizers of emergency departments and/or hospitals. Clients eligible for CCM must have two or more chronic conditions, be enrolled in the FQHC's PCMH, and voluntarily agree to intensive case management services. They must also have had either two or more ER visits in the past 60 days or two or more inpatient hospital stays for the same reason in the past six months. FQHCs operating a CCM program assemble teams comprised of a nurse and a licensed behavioral health professional or para-professional with behavioral health training. CCM staff must have field experience working with very vulnerable and complex patients. CCM teams primarily meet face-to-face with the member, providing in-home support to improve the health of members with high utilization by focusing on both medical and non-medical factors that may be impacting the member's health.

Clinical Pharmacist Practitioner Program
The Clinical Pharmacist Practitioner program was established and approved by CMS in July 2017. As part of this new program, the clinical pharmacist practitioner provides collaborative practice drug therapy management ensuring cost effective and therapeutically appropriate prescription drug therapy. To participate in the program, the clinical pharmacist must enroll in the Montana Healthcare Programs and have a collaborative practice agreement with a medical practitioner. The clinical pharmacist manages a member's drug therapy by providing face-to-face, direct care offered through employment, or contract within the physical practice of a medical practitioner or facility. Members who have at least one chronic condition needing at least one maintenance medication are eligible for collaborative practice drug therapy management services.

Montana Perinatal Behavioral Health Initiative
In September 2018, DPHHS in partnership with the Montana Healthcare Foundation, was awarded a five-year HRSA grant to implement the Montana Perinatal Behavioral Health Initiative. The initiative will implement an integrated behavioral health model into obstetric practices throughout the state. This model aims to improve access to timely care, build health system capacity, and improve health outcomes for Montana's pregnant and postpartum mothers experiencing behavioral health issues and their children.

The project will focus on supporting providers in rural and underserved regions throughout the state; and thereby, will extend access to behavioral health screening and effective early intervention to pregnant and postpartum women statewide. The initiative will help practices implement a coordinated team of primary care providers, behavioral health providers, and care coordinators, as well as peer supports. Teams will be located on site to support effective warm handoffs between obstetric and behavioral health providers. Telehealth resources will be used in four ways:

- To provide psychiatric consultation to obstetric/behavioral health teams, when needed;
- To provide initial behavioral health assessment and consultation in regions that have not yet established a local integrated care team;
- Provide monthly rounds between local teams and behavioral health specialists, fetal medicine specialists, and neonatologists; and
- Provide monthly provider trainings on areas pertinent to the local providers.

Newborn Caregiver Depression Screening
In July 2017, we implemented Newborn Caregiver Depression Screening protocols to address the negative health consequences that result for both the caregiver and the newborn when the caregiver is experiencing depression. If the caregiver's depression persists, it can negatively affect bonding, which is critical to healthy development. For these reasons, Montana Medicaid encourages and pays for providers to screen all newborn caregivers for depression during the

child wellness visit at week 1 and month 1, 2, 4, 6 and 9-months of age. This screening will allow for the provider to screen the child's caretaker for depression and make a referral for follow-up treatment. Consistent screening is an effective means of identifying women and other direct caregivers, with or at-risk for postpartum depression.

Breast Pump Coverage
Beginning in February 2018, HRD secured a Breast Pump sole source contract, which offers double Electric Breast pumps to members who are at least 28 weeks' gestation or are currently breastfeeding. An abundance of research has proven the wide ranging, long-term benefits of breast feeding for both mothers and babies. In 2011, the Surgeon General released a report indicating a 32% higher risk of childhood obesity and 64% higher risk of type 2 diabetes for children who were not breastfed. It also reports a 56% higher risk of sudden infant death syndrome in children who were not breastfed. Additionally, the report found a 4% higher risk of breast cancer and a 27% higher risk of ovarian cancer in women who have never breastfed. To promote breast feeding, Medicaid covers prenatal lactation group classes, lactation services in outpatient hospitals, and postnatal one-on-one lactation consultations. The breast pumps are shipped directly to a member's home to increase access.

Durable Medical Equipment Process Improvements
In October 2017, HRD removed prior authorization requirements for prosthetic devices, and Bi-level Positive Airway Pressure devices (BiPAPs) which reduced administrative burden on prescribers and durable medical equipment (DME) providers. Medicaid updated our claims processing procedures in July 2018 to ensure Medicaid reimbursement matched Medicare DME pricing for rural areas.

Member Education Initiatives

Navigating the health care system can be confusing and time consuming. Thus, HRD is working on the following ways to assist our members in obtaining the information and the understanding they need to effectively utilize the health care system:

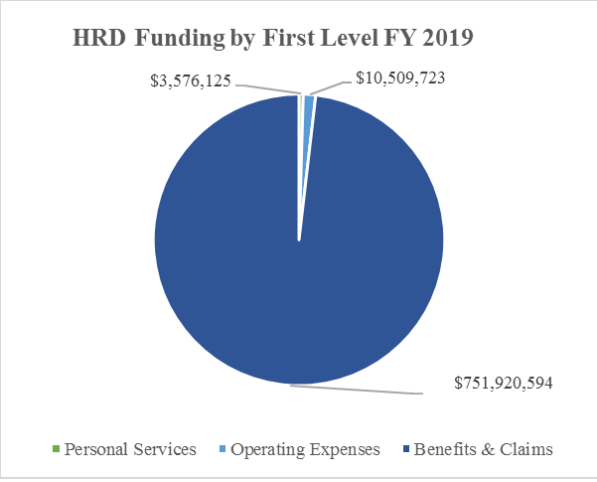
- Publish a quarterly member newsletter to provide members with information on using their benefits;

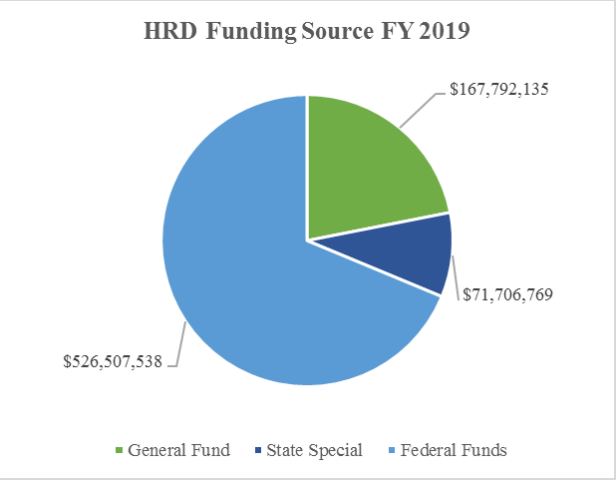
- Issue member notices and postcard mailings to notify members of significant benefit changes and where they can find member information (member guide, newsletters, notices, presentations, etc.), and

- Provide child wellness schedule magnets and annual mailings on the member's birthday as a reminder to get their annual wellness visit.

Funding & FTE Information

Health Resources Divsion	FY 2019 Budget	FY 2020 Request	FY 2021 Request
FTE	51.62	51.62	51.62
Personal Services	$3,576,125	$4,097,544	$4,094,627
Operating Expenses	$10,509,723	$11,028,532	$11,028,575
Benefits & Claims	$751,920,594	$717,096,856	$773,429,780
TOTAL COSTS	$766,006,442	$732,222,932	$ 788,552,982
	FY 2019 Budget	**FY 2020 Request**	**FY 2021 Request**
General Fund	$167,792,135	$175,921,135	$193,163,701
State Special	$71,706,769	$80,915,753	$93,644,698
Federal Funds	$526,507,538	$475,386,044	$501,744,583
TOTAL Funds	$766,006,442	$732,222,932	$788,552,982





Change Packages

Present Law Adjustments:

SWPL - 1 - Personal Services

The budget includes $521,419 in FY 2020 and $518,502 in FY 2021 to annualize various personal services costs including FY 2019 statewide pay plan, benefit rate adjustments, longevity adjustments related to incumbents in each position at the time of the snapshot, and vacancy savings.

Fiscal Year	General Fund	State Special	Federal	Total Request
FY 2020	$163,588	$105,742	$252,089	$521,419
FY 2021	$162,097	$107,254	$249,151	$518,502
Biennium Total	$325,685	$212,996	$501,240	$1,039,921

SWPL - 3 - Inflation/Deflation

This change package includes an increase of $179 in FY 2020 and $222 in FY 2021 to reflect budgetary changes generated from the application of inflation to specific expenditure accounts. Affected amounts include those associated with the statewide Motor Pool operated by the Department of Transportation.

Fiscal Year	General Fund	State Special	Federal	Total Request
FY 2020	$89	$0	$90	$179
FY 2021	$111	$0	$111	$222
Biennium Total	$200	$0	$201	$401

PL - 11991 - Medicaid Core - Health Resources Division

This present law adjustment for caseload growth in the Health Resources Division covers the increase in the number of eligible individuals, utilization, acuity levels, and cost per service for medical care. This change package requests $45,907,016 in total funds. The biennial funding is $15,386,413 in general fund, $523,140 in state special revenue, and $29,997,463 in federal funds.

Fiscal Year	General Fund	State Special	Federal	Total Request
FY 2020	$585,765	$232,727	$1,531,022	$2,349,514
FY 2021	$14,800,649	$290,413	$28,466,440	$43,557,502
Biennium Total	$15,386,414	$523,140	$29,997,462	$45,907,016

PL - 11992 - Medicaid Core HUF & GME - Health Resources Division
This present law adjustment for hospital utilization fee in the Health Resources Division covers utilization, acuity levels, and cost per service for medical care. This change package requests a reduction of $58,278,622 in total funds. The biennial funding is a reduction of $1,468,107 in state special revenue, and reduction of $56,810,515 in federal funds.

Fiscal Year	General Fund	State Special	Federal	Total Request
FY 2020	$0	($341,489)	($28,238,695)	($28,580,184)
FY 2021	$0	($1,126,618)	($28,571,820)	($29,698,438)
Biennium Total	$0	($1,468,107)	($56,810,515)	($58,278,622)

PL - 11993 - HMK Other Caseload - Health Resources Division
This present law adjustment for caseload growth in the Health Resources Division covers the adjustment in the number of eligible individuals, utilization, acuity levels, and cost per service for medical care. This change package requests a reduction of $25,001,489 in total funds. The biennial funding is a reduction of $3,523,750 in state special revenue, and a reduction of $21,477,739 in federal funds.

Fiscal Year	General Fund	State Special	Federal	Total Request
FY 2020	$0	($1,516,817)	($14,040,281)	($15,557,098)
FY 2021	$0	($2,006,933)	($7,437,458)	($9,444,391)
Biennium Total	$0	($3,523,750)	($21,477,739)	($25,001,489)

PL - 11994 - Medicaid Federal Services - Health Resources Division
This present law adjustment is necessary to maintain existing services for the Medicaid School Based Services program in the Health Resources Division. The change package requests total funds of $1,914,122 for the biennium, with a federal fund amount of $503,407 in FY 2020 and $1,410,715 in FY 2021.

Fiscal Year	General Fund	State Special	Federal	Total Request
FY 2020	$0	$0	$503,407	$503,407
FY 2021	$0	$0	$1,410,715	$1,410,715
Biennium Total	$0	$0	$1,914,122	$1,914,122

PL - 11995 - Medicaid Other Services - Health Resources Division
This present law adjustment is necessary to maintain existing services for the Medicaid Clawback program in the Health Resources Division. The change package requests total funds of $8,745,303 for the biennium, with an increase in the general fund amount of $3,511,782 in FY 2020 and $5,233,521 in FY 2021.

Fiscal Year	General Fund	State Special	Federal	Total Request
FY 2020	$3,511,782	$0	$0	$3,511,782
FY 2021	$5,233,521	$0	$0	$5,233,521
Biennium Total	$8,745,303	$0	$0	$8,745,303

PL - 11996 - Medicaid Ben Core FMAP - Health Resources Division
This present law adjustment is necessary to maintain existing services for the Medicaid programs in the Health Resources Division. The change package requests a general fund increase of $2,723,424 in FY 2020 and $1,566,071 in FY 2021 with offsetting federal funds for each year. The total cost for the program does not change.

Fiscal Year	General Fund	State Special	Federal	Total Request
FY 2020	$2,723,424	$0	($2,723,424)	$0
FY 2021	$1,566,071	$0	($1,566,071)	$0
Biennium Total	$4,289,495	$0	($4,289,495)	$0

PL - 11997 - HMK FMAP - Health Resources Division
This present law adjustment is necessary to maintain existing services for the Healthy Montana Kids program in the Health Resources Division. The change package requests an increase in state special funds of $10,708,378 in FY 2020 and $24,548,061 in FY 2021 with offsetting federal fund adjustment for each year. The total cost for the program does not change.

Fiscal Year	General Fund	State Special	Federal	Total Request
FY 2020	$0	$10,708,378	($10,708,378)	$0
FY 2021	$0	$24,548,061	($24,548,061)	$0
Biennium Total	$0	$35,256,439	($35,256,439)	$0

PL - 6 - Medicaid funds switch from enhanced FMAP to traditional FMAP
This change package addresses the general and federal fund impact of transferring eligible members from expanded Medicaid to traditional Medicaid FMAP in the Health Resources Division due to the sunset of the HELP Act. Total funds for the request is $112,222,989 including biennial funding of $37,624,136 in general fund.

Fiscal Year	General Fund	State Special	Federal	Total Request
FY 2020	$18,725,226	$0	$37,008,577	$55,733,803
FY 2021	$18,898,910	$0	$37,590,276	$56,489,186
Biennium Total	$37,624,136	$0	$74,598,853	$112,222,989

New Proposals:

NP - 11989 - PRI Medicaid Core - Health Resources Division
This new proposal requests a 0.91% provider rate increase in FY 2020 and a 1.83% increase in FY 2021 Medicaid Core programs in the Health Resources Division. This percentage increase in rates is the same percentage applied in the Executive Budget to K-12 Schools, Office of Public Defender providers, and Correction services providers. This change package requests $13,612,647 in total funds over the biennium and $4,753,469 in general fund.

Fiscal Year	General Fund	State Special	Federal	Total Request
FY 2020	$1,144,352	$0	$2,118,683	$3,263,035
FY 2021	$3,609,117	$0	$6,740,495	$10,349,612
Biennium Total	$4,753,469	$0	$8,859,178	$13,612,647

NP - 11990 - PRI - Non-Medicaid - Health Resources Division
This new proposal requests a 0.91% provider rate increase in FY 2020 and a 1.83% increase in FY 2021 Non-Medicaid programs (Healthy Montana Kids) in the Health Resources Division. This percentage increase in rates is the same percentage applied in the Executive Budget to K-12 Schools, Office of Public Defender providers, and Correction services providers. This change package requests $823,732 in total funds over the biennium.

Fiscal Year	General Fund	State Special	Federal	Total Request
FY 2020	$0	$20,444	$183,993	$204,437
FY 2021	$0	$125,752	$493,543	$619,295
Biennium Total	$0	$146,196	$677,536	$823,732

NP - 11999 - Realign State Special for HMK FMAP - Health Resources Division
This new proposal is necessary to maintain existing services for the Healthy Montana Kids program in the Health Resources Division. The change package requests an increase in I-149 state special funds of $5,000,000 in FY 2020 and $10,000,000 in FY 2021 with an offsetting adjustment in I-146 state special funds for each year. The total cost for the program does not change. This change package is contingent upon the passage and approval of LC # Tobacco Tax.

Fiscal Year	General Fund	State Special	Federal	Total Request
FY 2020	$0	$0	$0	$0
FY 2021	$0	$0	$0	$0
Biennium Total	$0	$0	$0	$0

NP - 7 - Medicaid fund switch from traditional FMAP to enhanced FMAP
This change package addresses the general and federal fund impact of transferring eligible members from traditional Medicaid to expanded Medicaid FMAP in the Health Resources Division. The total fund reduction requested is $112,222,989, including a biennial fund reduction of $37,624,136 in general fund. This change package is contingent upon the passage and approval of LC #_____.

Fiscal Year	General Fund	State Special	Federal	Total Request
FY 2020	($18,725,226)	$0	($37,008,577)	($55,733,803)
FY 2021	($18,898,910)	$0	($37,590,276)	($56,489,186)
Biennium Total	($37,624,136)	$0	($74,598,853)	($112,222,989)