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Medicaid – The Basics

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.”

macpac.gov/subtopic/state-plan/

MACPAC Reference
Guide to Federal
Medicaid Statute and
Regulations

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.”

macpac.gov/subtopic/state-plan/

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 program expenditures depending on the expenditure type. A list of various matching percentages is listed below:

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.

Montana's FMAP is approximately 65 percent.

TABLE 1 SERVICES FUNDING RATES

Services Funding (SFY 2019)	State Share	Federal Share
Indian & Tribal Health Services		100%
Medicaid Expansion	7%	93%
Family Planning Service	10%	90%
Breast and Cervical Cancer Program	24%	76%
Community First Choice (FMAP +6%)	29%	71%
Standard FMAP	35%	65%
State Funded	100%	

TABLE 2 ADMINISTRATION FUNDING RATES

Administration Funding (SFY 2019)	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%

Goals and Objectives:

1. Promote health equity and improve population health
 - 1.1. Decrease health disparities
 - 1.1.1. Reduce the number of uninsured people
 - 1.1.2. Improve health outcomes by emphasizing primary care
 - 1.1.3. Improve access to services for underserved and vulnerable populations
 - 1.2. Increase access to timely, affordable and effective health services
 - 1.2.1. Assure the integrity and accountability of the Medicaid health care delivery System
 - 1.3. Strengthen prevention efforts to promote health and well-being
 - 1.3.1. Promote appropriate utilization of preventive and other necessary services
 - 1.3.2. Support integrated behavioral health into primary care
 - 1.3.3. Support children's mental health rehabilitative programs in order to reduce the impact of or ameliorate adult mental illness.
 - 1.4. Improve public health system capacity
2. Strengthen the economic and social well-being of Montanans across the lifespan
 - 2.1. Encourage individual and family stability
 - 2.1.1. Reduce the number of uninsured people
 - 2.1.2. Support outpatient behavioral health treatment programs, including in-home services.
 - 2.2. Support individuals' ability to work and be self-sufficient
 - 2.2.1. Reduce the number of uninsured people
 - 2.2.2. Support outpatient behavioral health treatment programs
 - 2.3. Maximize the opportunity for independence, well-being, and health among older adults, people with disabilities, and their families and caregivers
 - 2.3.1. Provide community-based services as an alternative to institutional care
 - 2.3.2. Support respite services
 - 2.3.3. Provide increased support to familial caregivers through life span respite voucher program.
 - 2.3.4. Increase educational efforts to encourage early planning for in home supports prior to age 65
3. Ensure all children and youth achieve their highest potential

- 3.1. Improve birth outcomes for mothers and babies
 - 3.1.1. Support integrated behavioral health into prenatal care
 - 3.1.2. Promote early prenatal care
 - 3.2. Support the developmental needs of children and youth
 - 3.2.1. Support integrated behavioral health into primary care
 - 3.2.2. Promote child well visits and screenings
 - 3.3. Increase access to high quality care and education
 - 3.3.1. Support school-based services including behavioral and primary care services
 - 3.4. Promote safe, stable, and nurturing relationships and environments
- 4. Effectively engage stakeholders
 - 4.1. Enhance and expand engagement with clients
 - 4.1.1. Provide member education in the most effective manner for the member
 - 4.1.2. Engage in productive dialogue with providers.
 - 4.2. Enhance collaboration with tribal agencies and organizations services American Indians
 - 4.3. Engage additional stakeholders essential to program and service delivery
 - 5. Ensure core business services are efficient, innovative and transparent
 - 5.1. Increase use of effective planning, evaluation, and management principles across the Department
 - 5.2. Strengthen coordination and collaboration across branches, divisions, and programs
 - 5.2.1. Increase cross division, cross agency collaboration to reduce duplication of processes.
 - 5.3. Enhance use of financial resources
 - 5.3.1. Ensure cost effectiveness in the delivery of health care services by using efficient management practices and maximizing revenue opportunities
 - 5.3.2. Implement measures that will reduce the growth in Medicaid expenditures while improving services
 - 5.4. Optimize information technology investments to improve process efficiency and enable innovation

Medicaid Eligibility

Montana Medicaid provides coverage for the following groups/populations:

- Children and Infants
- Subsidized Adoptions, Subsidized Guardianship, and Foster Care
- Pregnant Women
- 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](#)

[Offices of Public Assistance \(OPA\)](#)

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

Medically Needy – By the Numbers

TABLE 3 –LIMITS FOR MEDICALLY NEEDED SFY 2017

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.

TABLE 4 - MEDICALLY NEEDED MONTHLY ENROLLMENT

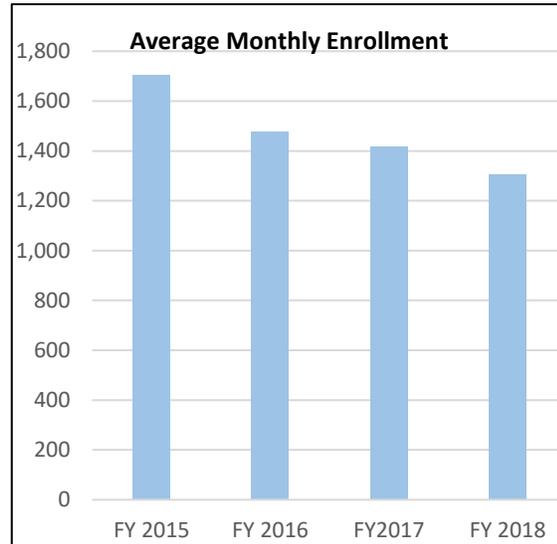
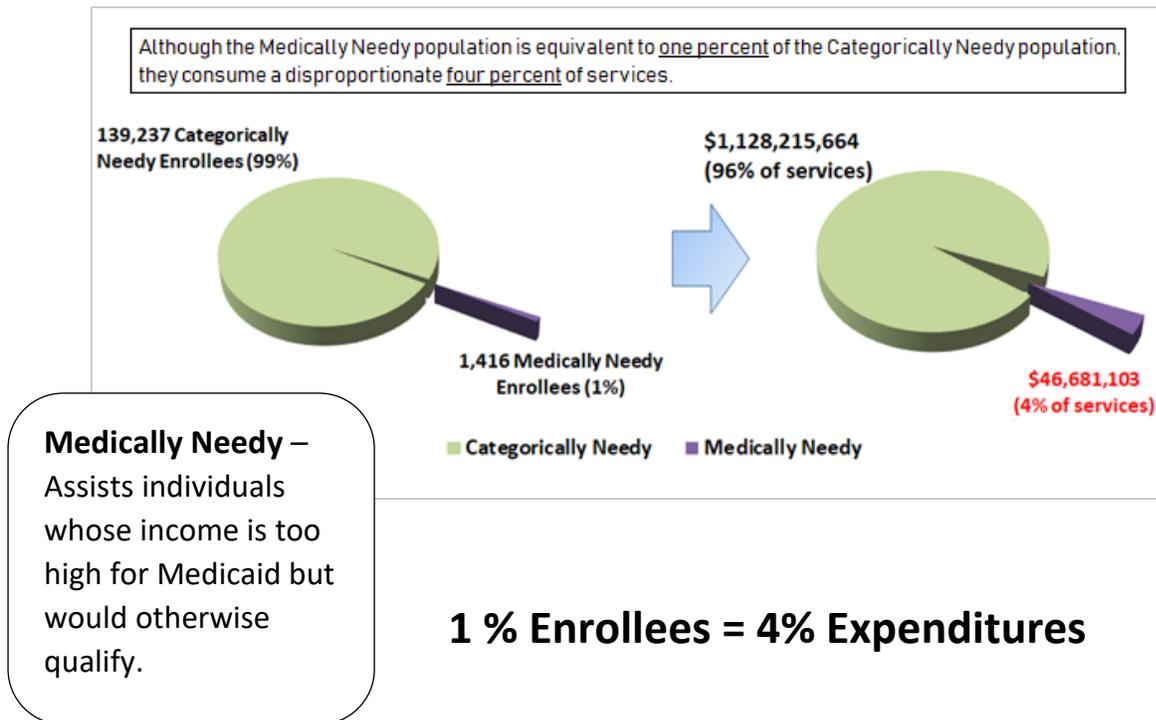


FIGURE 1 – 2017 AVERAGE MONTHLY ENROLLMENT AND EXPENDITURES – CATEGORICALLY NEEDED AND MEDICALLY NEEDED



Medicaid Eligibility - Children



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
- Within the scope of listed Medicaid/HMK Plus covered services



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.



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 5 – 2016 FEDERAL POVERTY LEVELS AND GROSS MONTHLY INCOME

Family Size	Pregnant Women 157% FPL	HMK 261%FPL	Child or HMK Plus 143% FPL
1	\$1,578	\$2,623	\$1,437
2	\$2,125	\$3,532	\$1,935
3	\$2,672	\$4,441	\$2,433
4	\$3,219	\$5,351	\$2,932
Resource Test	No Test	No Test	No Test

Families may be responsible for copayments, depending on their income level and specific services. Some members are exempt from copayments. Please refer to the [Montana Medicaid and Healthy Montana Kids \(HMK\) Plus website](#) for lists of standard benefits, copayments, exceptions, and other information.

Medicaid Eligibility - Women



Pregnant Women

Medicaid provides temporary medical coverage to eligible pregnant women with countable income equal to or less than 157% FPL. The coverage extends for 60 days beyond the child's birth.

Pregnant women may qualify for Medicaid if:

- They meet the nonfinancial criteria for Affordable Care Act (ACA) Pregnancy Medicaid, and
- Household income does not exceed 157% of the federal poverty level standard.



Plan First

Medicaid provides limited family planning services to a limited number of low-income women.

- Covers family planning services such as office visits, contraceptive supplies, laboratory services, and testing and treatment of Sexually Transmitted Diseases (STDs)
- Eligibility is open to women ages 19 through 44 (who are able to bear children and not presently pregnant) with an annual household income up to 211% FPL
 - o Program is limited to 4,000 women at any given time

For more information, please refer to:

[Offices of Public Assistance \(OPA\) \(Phone: 1-888-706-1535\)](#)

[Family Medicaid Program Policy Manual](#)

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 through diagnosis, functional impairment, and duration of illness, may be eligible for the Waiver for Additional Services and Populations:

Qualifying individuals must:

- Have a Severe and Disabling Mental Illness
- 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.

For more information, please refer to:

[ACA/Family Medicaid Table of Standards: Breast & Cervical Cancer Treatment-Income](#)

[Offices of Public Assistance \(OPA\) \(Phone: 1-888-706-1535\)](#)

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 \$2000 for an individual or \$3000 for a couple. Income limits for the Aged, Blind, Disabled programs are \$735 per month for an individual and \$1103 for a couple.



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

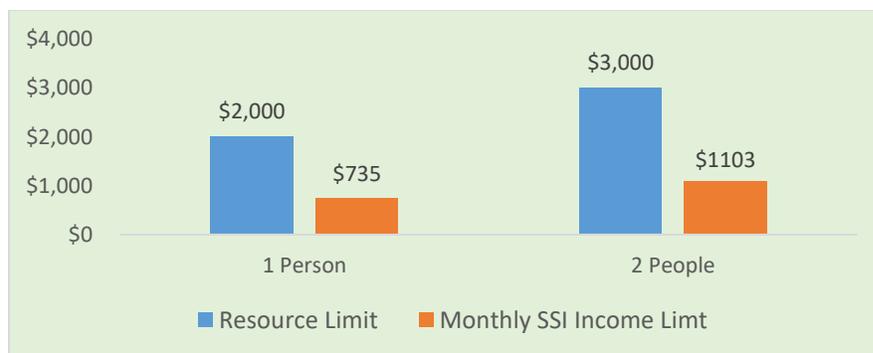
In Montana, any aged, blind, or disabled individual determined eligible for SSI receives Medicaid. This support enables them to receive regular medical attention and maintain their independence.



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 Federal Poverty Level (FPL).

FIGURE 2 – 2017 SSI MONTHLY INCOME STANDARDS



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

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

- Physician and Nurse Practitioner
- Nurse Midwife
- Medical and Surgical Service of a Dentist
- Laboratory and X-ray
- Inpatient Hospital (excluding inpatient services in institutions for mental disease)
- Outpatient Hospital
- Federally Qualified Health Centers (FQHCs)
- Rural Health Clinics (RHCs)
- Family Planning
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
- Nursing Home Facility
- Home Health
- Durable Medical Equipment
- Transportation
- Behavioral Health

Optional Benefits

- Outpatient Drugs
- Dental and Denturist Services
- Ambulance
- Physical and Occupational Therapies and Speech Language Pathology
- Home and Community Based Services
- Eyeglasses and Optometry
- Personal Assistance Services
- Targeted Case Management
- Podiatry
- Community First Choice

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.

Waivers – The Basics

- 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 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

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.

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
	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
Developmentally Disabled		
	Basic Medicaid	State Plan
	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
Severe and Disabling Mental Illness		
	Basic Medicaid	State Plan
	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

Waivers – HCBS 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 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 - Developmental Services Division](#)

Waiver Participants

Approximately 2,700 Montanan's with developmental disabilities receive services under the 0208 Comprehensive Services (HCBS) Waiver. 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. Effective June 30, 2017 there were 1524 people on the 0208 Comprehensive Waiver waiting list. The average number of days waiting was 611.

Services

The waiver offers 30 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 average cost plan per person is \$49,485 per year. The cost plans range from \$1,594 to \$434,687. These costs do not include the cost of Medicaid State Plan services, which are available to all eligible members. Examples of services that are available under the Medicaid State Plan include physician, pharmacy, durable medical equipment, occupational therapy, physical therapy, behavioral health services and speech therapy

Waivers – HCBS Individuals for Aged and Physically Disabled

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 a 1915(b)(4) waiver, to allows nursing home level members to live in their community while decreasing the cost of their health care.

Waiver Participants

Every year approximately 2,500 Montanan’s receive Montana Big Sky Waiver services, supporting independent living for the elderly (age 65 and older) and people with physical disabilities. Members must be financially eligible for 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 a number of different services including but not limited to: 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.

Waiver slots

The Big Sky Waiver slots costs do not include the cost of Medicaid State Plan services, which are available to eligible Medicaid members. Examples of services that are available under the Medicaid State Plan include physician, pharmacy, durable medical equipment, occupational therapy, physical therapy, behavioral health services and speech therapy

Copies of the current waivers are available at:

[1915\(b\) \(4\) and 1915\(c\) Montana Big Sky Waiver – Senior and Long-Term Care Division](#)

Waivers – HCBS 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 SDMI HCBS Waiver provides Medicaid reimbursement for community-based services for adults with SDMI who meet criteria for nursing home level of care. This waiver is partnered with a 1915(b)(4) waiver to deliver services statewide via a limited number of case management providers.

Copies of the current waivers are available at:

[1915\(c\) Home and Community Based Services \(HCBS\) SDMI Waiver - Addictive and Mental Disorders Division](#)

Members

The waiver's 357 slots are distributed among two contractors that provide case management services statewide. Partners in Home Care provides case management services in Mineral, Missoula and Ravalli Counties; Benefis Spectrum Medical provides case management services for the remainder of the state.

Services

A registered nurse and a social worker coordinate services through case management to provide services including: adult day health, case management, community transition, consultative clinical and therapeutic services, environmental accessibility adaptations, habilitation aide, health and wellness, homemaker, homemaker chore, life coach, meals, non-medical transportation, pain and symptom management, peer support, personal assistance attendant, personal emergency response system, prevocational services, private duty nursing, residential habilitation, respite, specialized medical equipment and supplies, specially trained attendants, and supported employment.

Waiver – Waiver for Additional Services and Populations (WASP)

Formerly known as the Basic Waiver, this waiver has evolved and is now known as the *Section 1115 Montana Waiver for Additional Services and Populations (WASP)*.

- Covers adults with serious and disabling mental illness between 139-150% FPL who do not otherwise qualify for Medicaid
- Covers dental treatment services above the Medicaid State Plan cap of \$1,125 per individual for people determined categorically eligible as Aged, Blind or Disabled

The waiver is available at: [1115 Waiver for Additional Services and Populations \(WASP\) – Health Resources and Addictive and Mental Disorders Divisions](#)

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). Eligibility is open to women ages 19 through 44 (who are able to bear children and not presently pregnant) with an annual household income up to 211% FPL. Program is limited to 4,000 women at any given time.

The waiver is available at: [1115 Plan First Waiver – Health Resources Division](#)

Waiver – Children’s Autism (Services moved to State Plan)

- CMS approved the Concurrent 1915(b)(4) Autism Waiver on December 21, 2016. This waiver is specific to the autism evaluation and utilization review contract. The Department is planning on reviewing this component of the Autism State Plan amendment to determine the need for the independent evaluation.
- CMS originally approved the 1915(c) Children’s Autism Waiver (CAW) on January 1, 2009 to serve Montana children ages 15 months through 7 years old with autism and adaptive behavior deficits. The CAW was renewed with an effective date of January 1, 2017, to phase-out and allow the children who were enrolled to complete the maximum three years of services.
- There were 50 children enrolled at the time of the renewal on January 1, 2017
- As of January 1, 2019, 8 children continue to be enrolled in the CAW with the last child phasing out by July 2019, at which time the CAW will terminate
- CMS approved the following CAW services: Respite, Waiver Funded Children’s Case Management (WCCM), Transportation, Environmental Modifications, and Individual Goods and Services
- Program Design and Monitoring and Children’s Autism Training services continue to be available to children enrolled in the CAW
- Children who exit the CAW can have an Early, Periodic Screening and Treatment application submitted to determine medical necessity for autism state plan services. Children may also be eligible to receive Occupational Therapy, Speech Therapy, Physical Therapy, and other Medicaid services

[1915\(b\)\(4\) and 1915\(c\) Home and Community Based Services \(HCBS\) Children’s Autism Waiver - Developmental Services Division](#) –

The Children's Autism Waiver is scheduled to end June 30, 2019. Autism treatment is now offered as a state plan service and will serve more individuals up to age 21 with autism.

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 percent of all Montana Medicaid members, has four 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 650 Medicaid and HMK Plus members are currently enrolled

- **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.)

Nurse First Advice Line

- 24/7 Nurse Advice Line, available to all Medicaid and HMK Plus members
- Clinically-based algorithms (vendor provided) direct callers to the most appropriate level of care: self-care, provider visit, or emergency department visit
- Continuously monitors quality, access to care, and health outcomes among members and providers, reducing Medicaid costs

TABLE 6 – SUMMARY OF MEDICAID ENROLLED PERSONS FOR SFY 2017

Beneficiary Characteristic	Average Monthly Enrollment					% of Medicaid Total	% of Montana Population
	All	Aged	Blind & Disabled	Adults	Children		
Total	140,653	7,596	19,235	22,463	91,359	100%	
Age							
0 to 1	7,052	0	41	0	7,011	5%	1%
1 to 5	29,593	0	445	0	29,148	21%	6%
6 to 18	57,727	0	2,527	0	55,200	41%	16%
19 to 20	1,628	0	415	1,213	0	1%	3%
21 to 64	36,669	0	15,419	21,250	0	26%	55%
65 and older	7,984	7,596	388	0	0	6%	19%
	140,653	7,596	19,235	22,463	91,359		
Gender							
Male	64,486	2,550	9,687	6,086	46,163	46%	50%
Female	76,167	5,046	9,548	16,377	45,196	54%	50%
	140,653	7,596	19,235	22,463	91,359		
Race							
White	93,235	5,932	15,002	14,798	57,503	67%	92%
American Indian	29,873	831	3,079	5,482	20,481	21%	4%
Other	17,545	833	1,154	2,183	13,375	12%	4%
	140,653	7,596	19,235	22,463	91,359		
Assistance Status*							
Medically Needy	1,416	846	570	0	0	1%	
Categorically Needy	139,237	6,750	18,665	22,463	91,359	99%	
	140,653	7,596	19,235	22,463	91,359		
Medicare Status							
Part A and B	16,152	7,016	7,994	1,138	4	12%	
Part A only	82	22	34	26	0	0%	
Part B only	494	474	20	0	0	0%	
None	123,925	84	11,187	21,299	91,355	88%	
	140,653	7,596	19,235	22,463	91,359		
Medicare Saving Plan (not included in total)							
QMB Only	5,247	2,527	2,720	0	0		
SLMB - QI Only	5,082	5,082	0	0	0		
Other Medicaid Eligibles (not included in total)							
HK Exp (CHIP Funded)	7,046	0	0	0	7,046		
Plan First Waiver	1,941	0	0	1,941	0		

* Medically Needy clients are responsible for their medical bills each month until they have incurred enough medical expenses equal to the difference between their countable income and the Medically Needy income level.

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.

The column in the above chart “% of Montana Population” shows the percentage of Montana population for specific beneficiary characteristics. For example, 50% of Montana’s population is female, but 54% of the total Medicaid population in Montana is female.

FIGURE 3 – MEDICAID 2017 ENROLLMENT AND EXPENDITURES BY MAJOR AID CATEGORIES

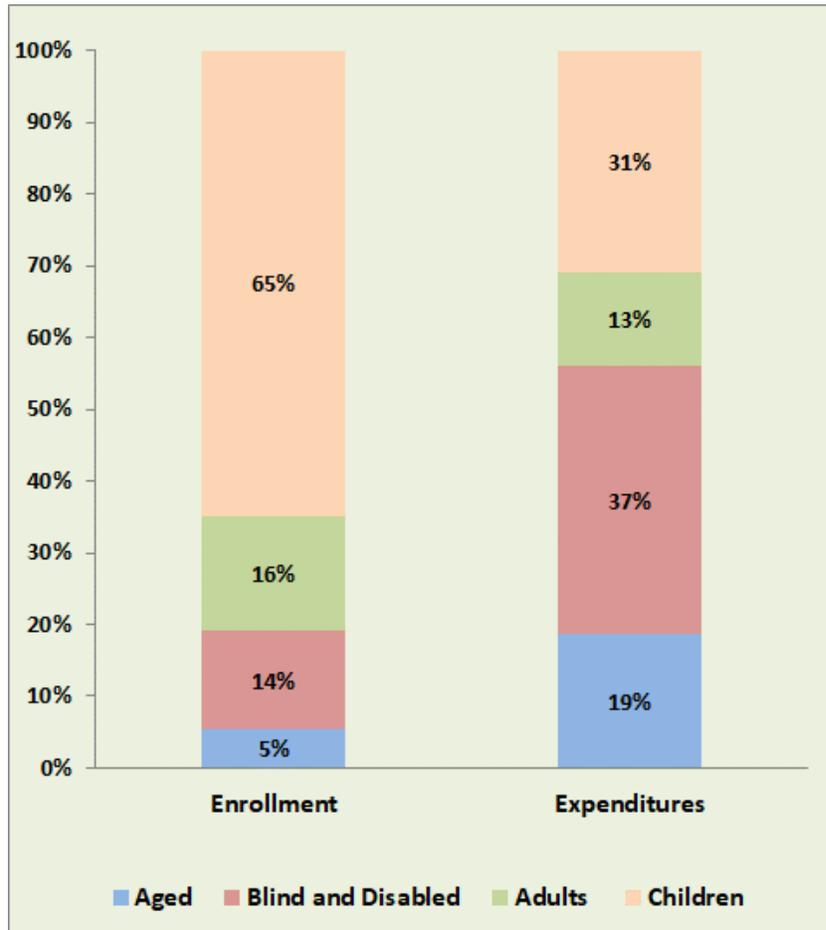


TABLE 7 –ENROLLMENT AND EXPENDITURES BY MAJOR AID CATEGORY SFY 2017

<u>Aid Category</u>	<u>Average Monthly Enrollment</u>	<u>Percent of Enrollment</u>	<u>Expenditures</u>	<u>Percent of Expenditures</u>
Aged	7,596	5%	\$218,354,832	19%
Blind and Disabled	19,235	14%	\$441,404,409	37%
Adults	22,463	16%	\$152,659,082	13%
Children	91,359	65%	\$362,478,444	31%
Total	140,653	100%	\$1,174,896,767	100%

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

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

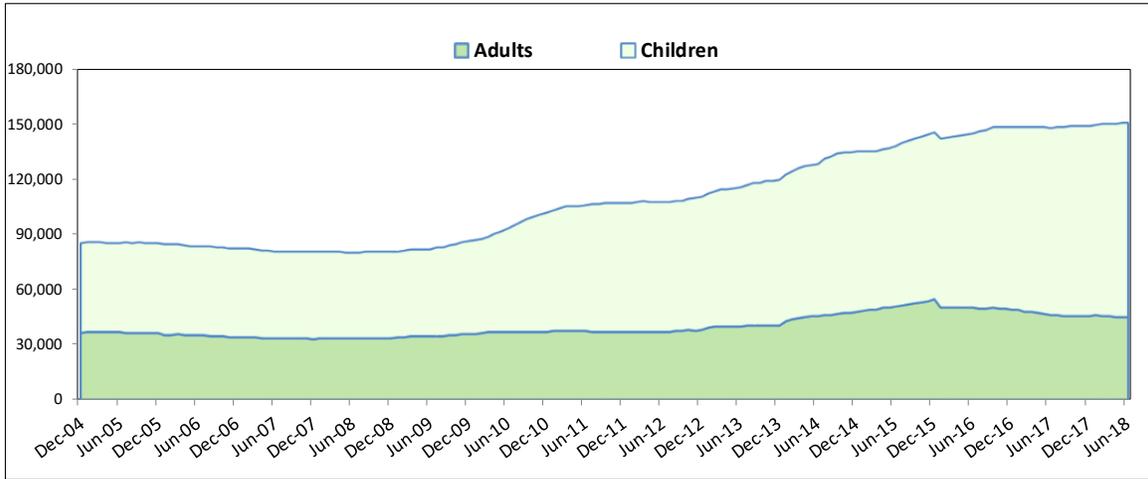


FIGURE 5 – DISABLED MEDICAID ENROLLMENT – ADULTS AND CHILDREN (Excludes Medicare Savings Plan Only)

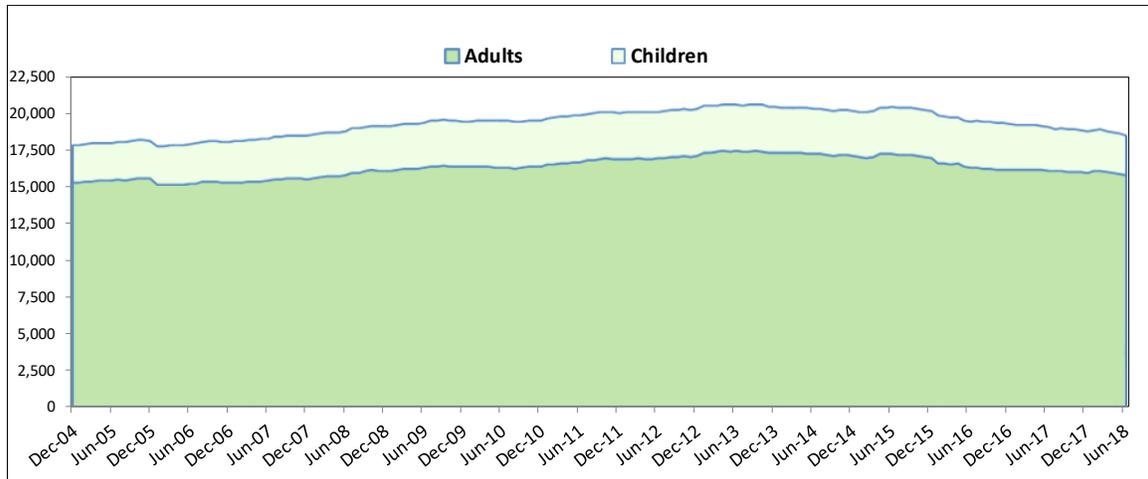


FIGURE 6 – MEDICAID ENROLLMENT – AGE 65 AND OLDER (EXCLUDES MEDICARE SAVINGS PLAN ONLY)

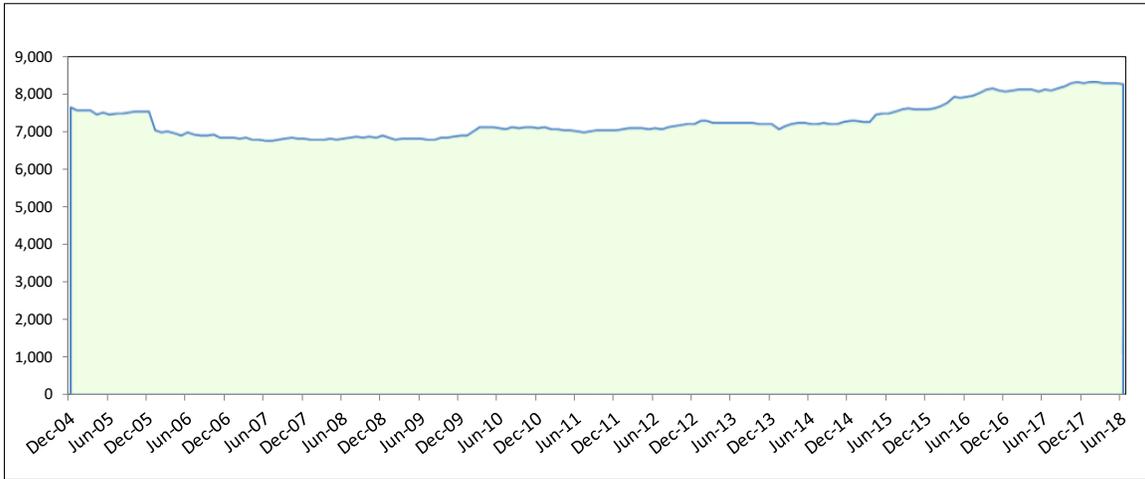


FIGURE 7 – FAMILY MEDICAID ENROLLMENT (EXCLUDES MEDICARE SAVINGS PLAN ONLY)

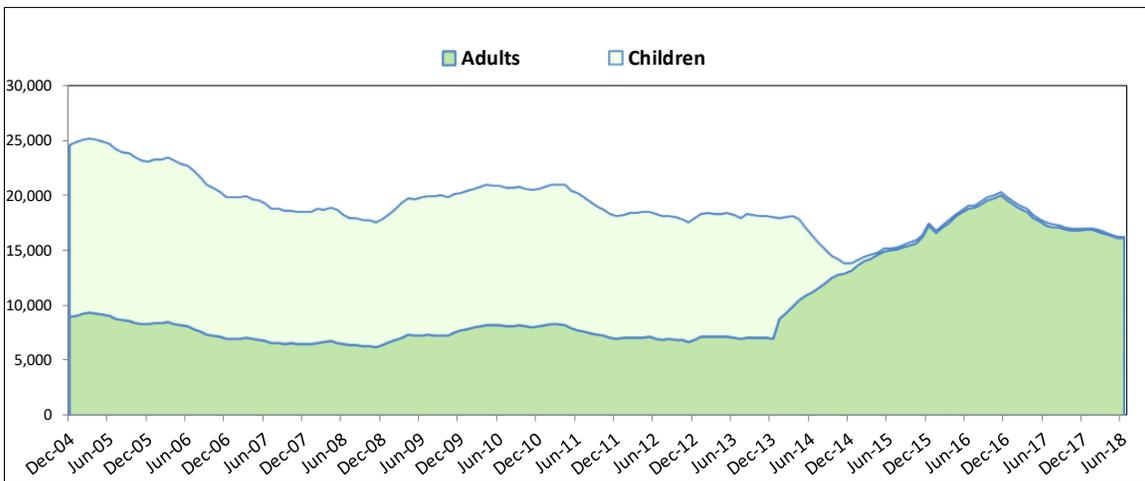


FIGURE 8 – MEDICAID POVERTY CHILD ENROLLMENT (EXCLUDES MEDICARE SAVINGS PLAN ONLY)

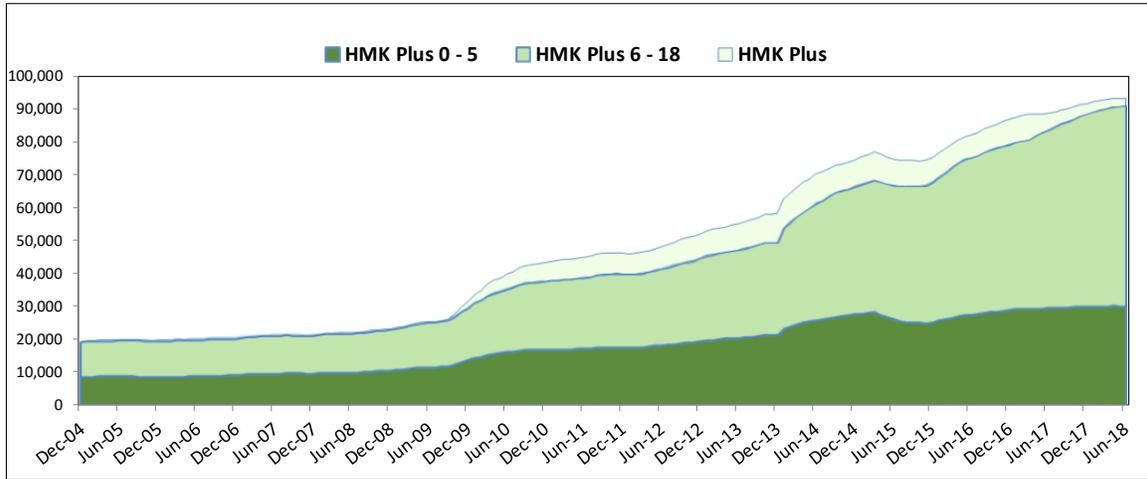
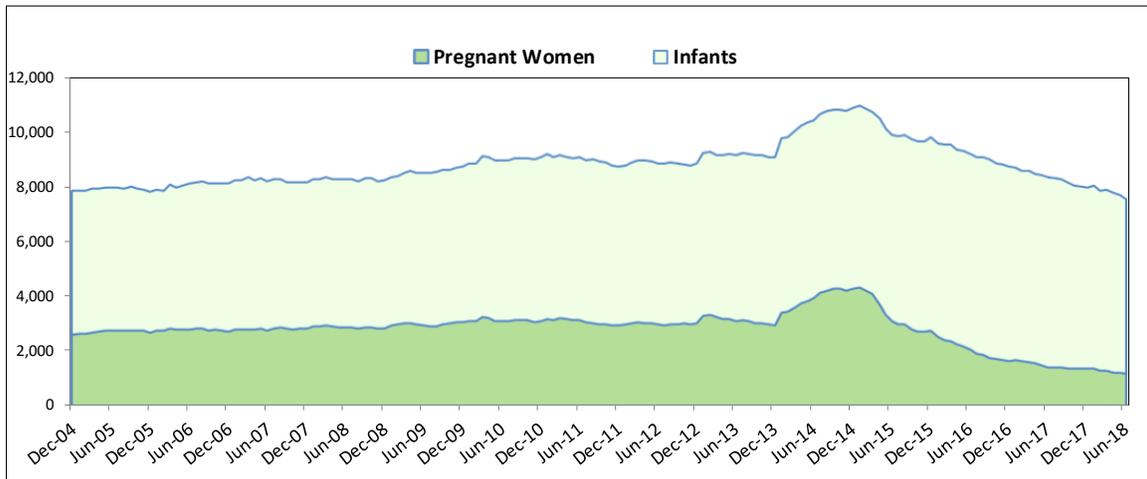


FIGURE 9 – MEDICAID ENROLLMENT – PREGNANT WOMEN AND INFANTS



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 – (65% federally funded / 35% 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)

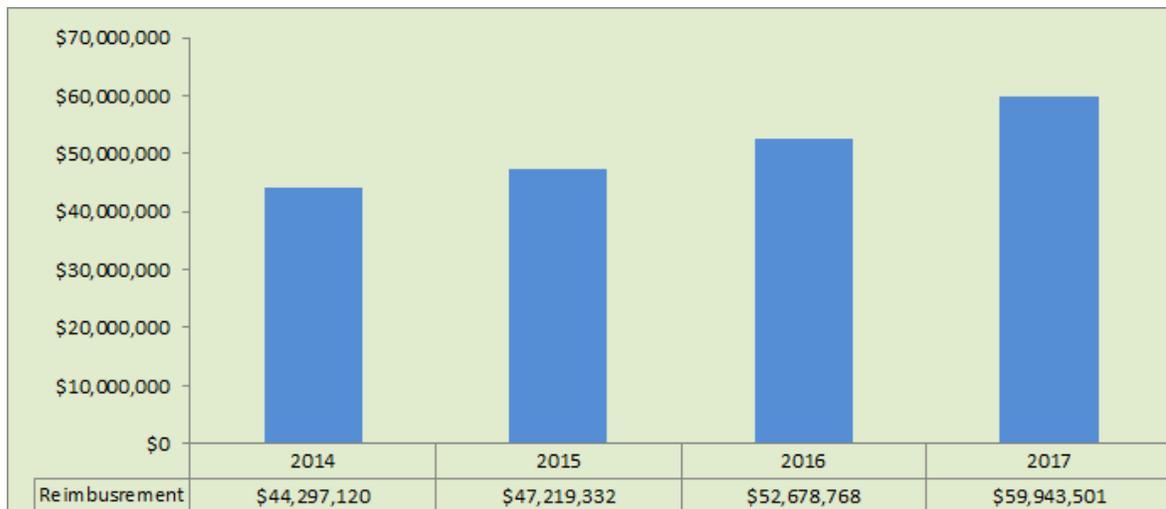
Five major Urban Indian Health Centers provide care to American Indians who reside off a respective Indian reservation:

- [Billings Urban Indian Health and Wellness Center](#)
- [Helena Indian Alliance](#)
- [Indian Family Health Clinic of Great Falls](#)
- [Missoula Urban Indian Health Center](#)
- [North American Indian Alliance of Butte](#)

TABLE 8 – 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	65% Federal Funds/ 35% State Funds

Figure 10 – 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

DPHHS and the Crow and Blackfeet Tribes negotiated a new payment rate that substantially increased reimbursement for Tribally-owned nursing facilities. This re-financing initiative made the nursing homes eligible for 100% federal match for the majority of their patients. This CMS-approved state plan has resulted in significant savings to the state general fund.

Medicaid Enrollment and Expenditures

TABLE 9 – ENROLLMENT AND EXPENDITURES BY COUNTY SFY 2017

County	County Population 7/1/2017	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	9,300	1,007	11%	34	\$10,120,953	\$10,051	10
BIG HORN	13,171	4,304	33%	3	\$32,779,285	\$7,615	40
BLAINE	6,613	1,710	26%	4	\$13,059,240	\$7,637	37
BROADWATER	5,852	554	9%	39	\$4,816,194	\$8,692	22
CARBON	10,544	903	9%	49	\$6,884,899	\$7,628	38
CARTER	1,205	105	9%	45	\$752,840	\$7,187	45
CASCADE	80,492	11,883	15%	20	\$105,189,571	\$8,852	20
CHOUTEAU	5,683	489	9%	48	\$3,035,030	\$6,209	53
CUSTER	11,554	1,546	13%	23	\$15,500,159	\$10,028	11
DANIELS	1,712	126	7%	51	\$1,165,972	\$9,260	19
DAWSON	8,823	912	10%	37	\$9,716,480	\$10,651	6
DEER LODGE	8,976	1,280	14%	21	\$15,090,371	\$11,790	4
FALLON	2,966	282	10%	38	\$1,944,515	\$6,900	49
FERGUS	11,130	1,372	12%	28	\$14,277,895	\$10,404	8
FLATHEAD	98,577	13,075	13%	24	\$94,882,357	\$7,257	44
GALLATIN	106,275	7,085	7%	55	\$42,042,562	\$5,934	54
GARFIELD	1,275	133	10%	36	\$1,332,866	\$10,053	9
GLACIER	13,446	4,652	35%	1	\$37,468,615	\$8,055	28
GOLDEN VALLEY	810	148	18%	11	\$744,279	\$5,020	56
GRANITE	3,310	287	9%	46	\$2,231,057	\$7,769	35
HILL	16,229	3,882	24%	6	\$30,597,189	\$7,881	32
JEFFERSON	11,722	1,052	9%	41	\$13,377,050	\$12,720	2
JUDITH BASIN	1,933	173	9%	42	\$1,276,103	\$7,362	42
LAKE	29,842	6,145	21%	8	\$49,690,346	\$8,086	26
LEWIS AND CLARK	66,808	8,039	12%	29	\$62,352,965	\$7,756	36
LIBERTY	2,392	260	11%	32	\$1,868,058	\$7,185	46
LINCOLN	19,163	3,374	18%	13	\$26,565,474	\$7,873	33
MADISON	8,059	560	7%	53	\$4,458,654	\$7,963	30
MCCONE	1,694	146	9%	47	\$762,591	\$5,220	55
MEAGHER	1,825	348	19%	10	\$2,538,342	\$7,294	43
MINERAL	4,194	638	15%	16	\$4,532,679	\$7,100	47
MISSOULA	115,770	13,718	12%	30	\$137,070,874	\$9,992	12
MUSSELSHELL	4,573	763	17%	14	\$7,328,578	\$9,611	17
PARK	16,120	1,734	11%	35	\$15,216,208	\$8,775	21

TABLE 10 – ENROLLMENT AND EXPENDITURES BY COUNTY SFY 2017 (CONTINUED)

County	County Population 7/1/2017	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	516	33	6%	56	\$233,961	\$7,036	48
PHILLIPS	4,060	736	18%	12	\$5,938,855	\$8,071	27
PONDERA	5,875	1,305	22%	7	\$10,208,290	\$7,823	34
POWDER RIVER	1,727	125	7%	52	\$1,484,683	\$11,862	3
POWELL	6,698	771	12%	31	\$7,601,314	\$9,859	15
PRAIRIE	1,093	119	11%	33	\$1,155,737	\$9,739	16
RAVALLI	41,957	5,564	13%	25	\$44,139,907	\$7,933	31
RICHLAND	10,882	1,024	9%	40	\$7,550,001	\$7,372	41
ROOSEVELT	10,940	3,697	34%	2	\$36,926,933	\$9,988	13
ROSEBUD	9,116	2,289	25%	5	\$17,436,342	\$7,619	39
SANDERS	11,544	1,869	16%	15	\$15,870,524	\$8,491	23
SHERIDAN	3,420	304	9%	43	\$2,525,671	\$8,320	24
SILVER BOW	34,109	5,173	15%	17	\$51,346,977	\$9,925	14
STILLWATER	9,285	819	9%	44	\$5,302,454	\$6,477	50
SWEET GRASS	3,638	251	7%	54	\$2,324,372	\$9,270	18
TETON	5,998	899	15%	19	\$5,798,483	\$6,449	51
TOOLE	4,816	615	13%	27	\$5,031,388	\$8,182	25
TREASURE	669	94	14%	22	\$991,122	\$10,516	7
VALLEY	7,327	1,103	15%	18	\$12,091,393	\$10,963	5
WHEATLAND	2,110	412	20%	9	\$2,608,075	\$6,337	52
WIBAUX	1,005	76	8%	50	\$1,279,960	\$16,786	1
YELLOWSTONE	156,717	20,589	13%	26	\$165,059,268	\$8,017	29
Other / Institution		100			\$1,320,807		
Sub Total	1,035,540	140,653	14%		\$1,174,896,767	\$8,353	
Plan First		1,941			\$1,133,055	\$584	
QMB Only		5,247			\$15,848,344	\$3,021	
SLMB - QI Only		5,082			\$7,994,513	\$1,573	
Grand Total	1,035,540	152,923	15%		1,199,872,679	\$7,846	

Population estimates as of July 1, 2017. 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 11 – TOTAL MEDICAID EXPENSES – SFY 2017

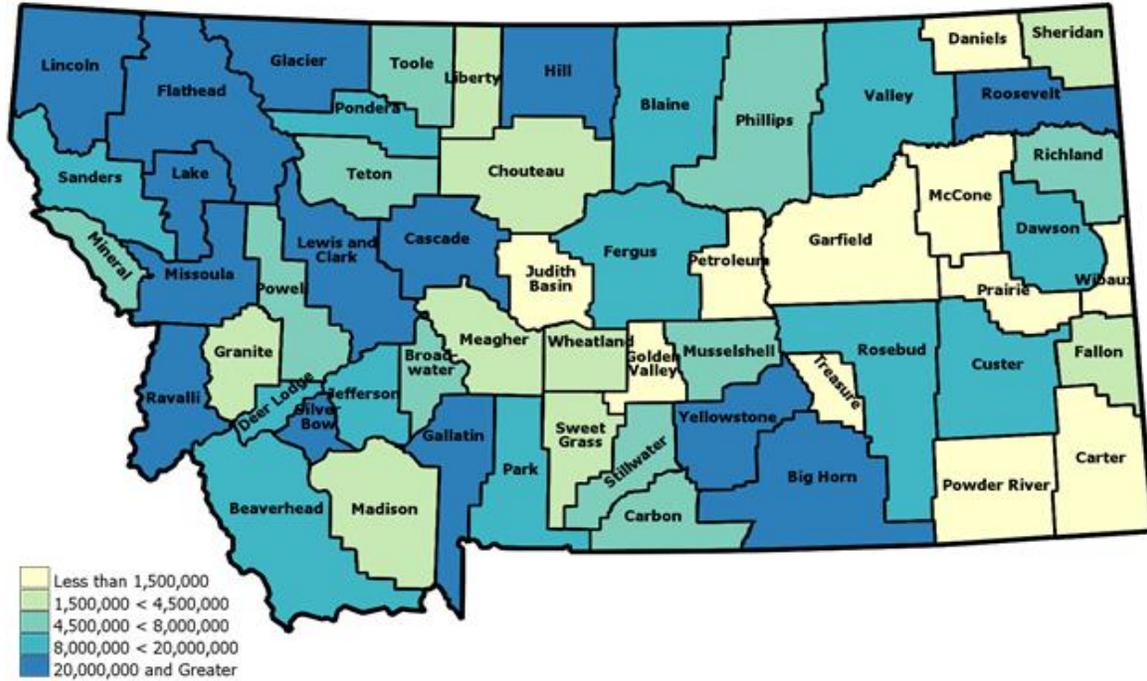


Figure 12 – Medicaid: Average Monthly Enrollment – SFY 2017

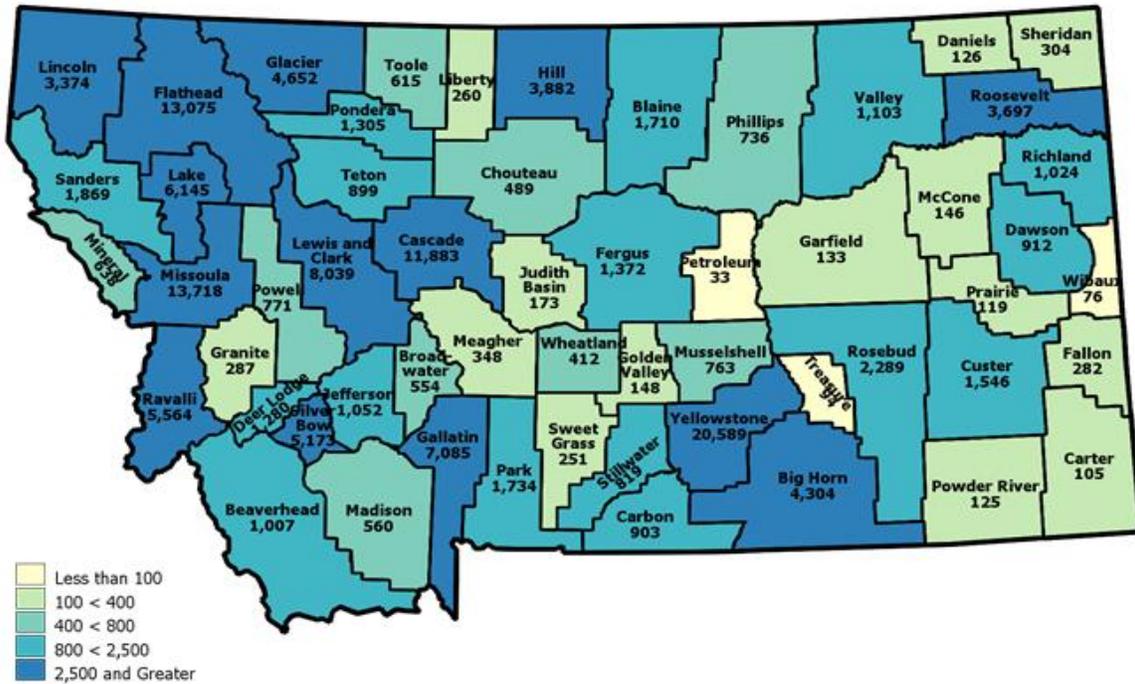


FIGURE 15 – MEDICAID BENEFIT EXPENDITURES BY CATEGORY: FY 2014 TO FY 2017

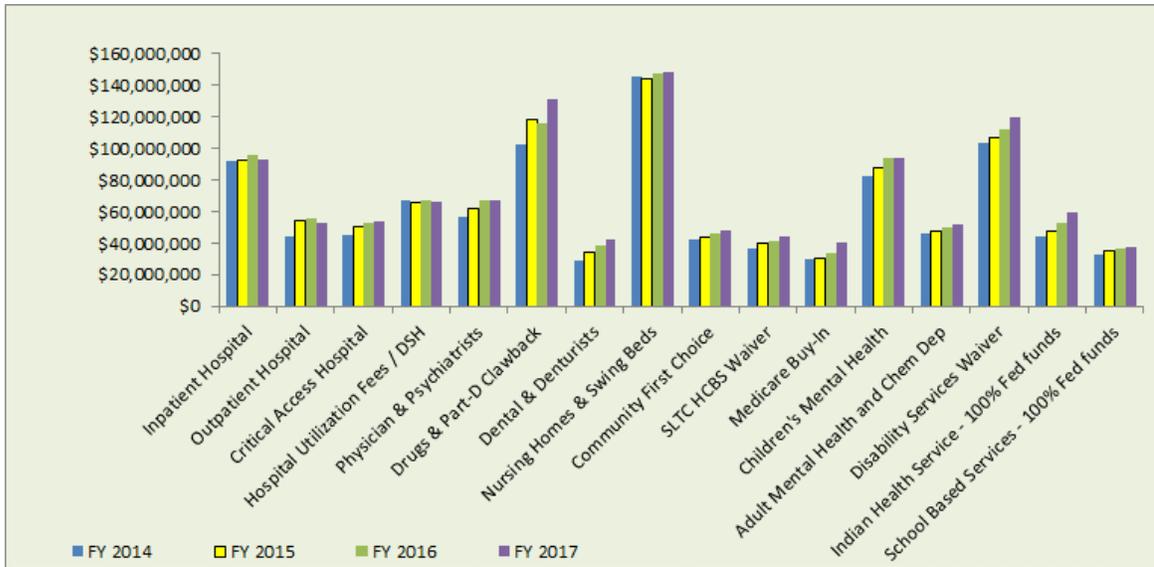
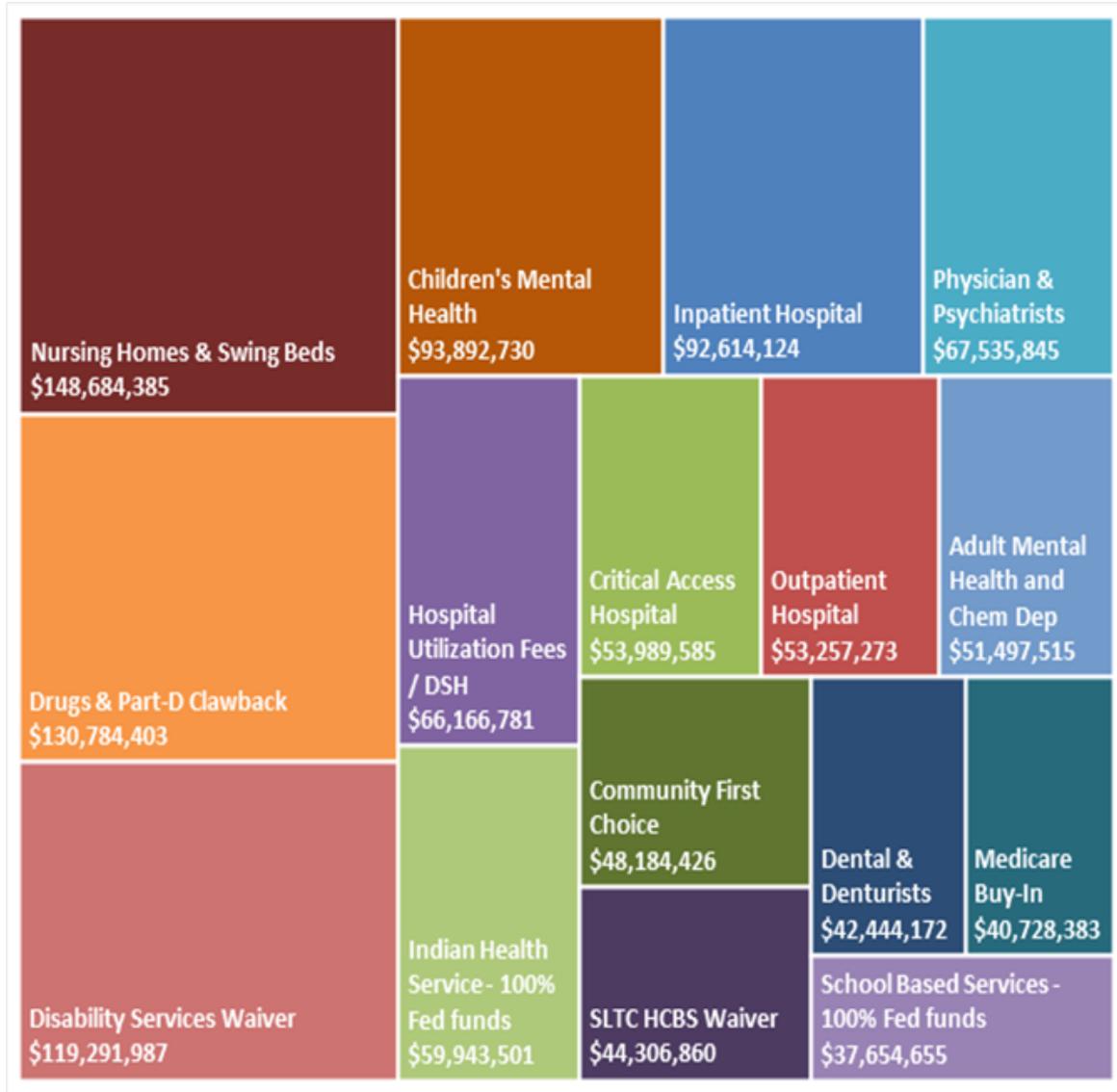


Table 11 – Medicaid Benefit Expenditures by Category

Categories	Medicaid Expenditures			
	FY 2014	FY 2015	FY 2016	FY 2017
Inpatient Hospital	\$ 92,062,103	\$ 92,454,888	\$ 96,304,834	\$ 92,614,124
Outpatient Hospital	44,150,457	54,314,511	55,591,464	53,257,273
Critical Access Hospital	44,833,368	50,578,797	53,006,737	53,989,585
Hospital Utilization Fees / DSH	67,251,332	66,179,993	66,755,614	66,166,781
Other Hospital and Clinical Services	23,746,552	27,078,552	29,627,112	31,139,898
Physician & Psychiatrists	56,589,893	61,626,404	67,085,080	67,535,845
Other Practitioners	19,179,326	21,379,440	23,500,794	25,659,127
Other Managed Care Services	11,020,874	11,464,186	12,151,779	13,585,370
Drugs & Part-D Clawback	102,554,496	118,370,773	115,707,266	130,784,403
Drug Rebates	(50,938,420)	(59,638,452)	(68,080,561)	(76,157,830)
Dental & Denturists	29,054,247	33,697,779	38,420,739	42,444,172
Durable Medical Equipment	14,785,273	14,633,945	15,112,677	15,945,651
Other Acute Services	3,158,315	3,524,033	3,842,420	4,675,055
Nursing Homes & Swing Beds	145,667,404	143,875,938	147,378,878	148,684,385
Nursing Home IGT	14,247,724	15,833,725	12,527,238	14,150,700
Community First Choice	41,980,800	44,044,729	45,696,741	48,184,426
Other SLTC Home Based Services	4,212,169	4,230,689	3,600,025	3,706,911
SLTC HCBS Waiver	36,786,236	39,670,949	41,195,948	44,306,860
Medicare Buy-In	30,266,987	30,444,789	33,275,829	40,728,383
Children's Mental Health	82,721,345	87,284,066	94,143,937	93,892,730
Adult Mental Health and Chem Dep	46,095,022	47,195,521	49,728,845	51,497,515
HIFA Waiver	9,755,145	18,333,805	18,378,211	7,116,889
Disability Services Waiver	103,305,690	106,923,045	111,784,498	119,291,987
Indian Health Service - 100% Fed funds	44,297,120	47,219,332	52,678,768	59,943,501
School Based Services - 100% Fed funds	33,047,616	34,700,046	36,251,879	37,654,655
MDC & ICF Facilities - 100% Fed funds	11,930,684	11,746,182	11,512,162	9,074,285
Total	\$ 1,061,761,758	\$ 1,127,167,665	\$ 1,167,178,913	\$ 1,199,872,679

FIGURE 16 –MEDICAID BENEFIT EXPENDITURES SFY 2017



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), Medicare Savings Plan, or Plan First Waiver clients and expenditures.

FIGURE 17 – HISTORY OF EXPENDITURES AND ENROLLMENT

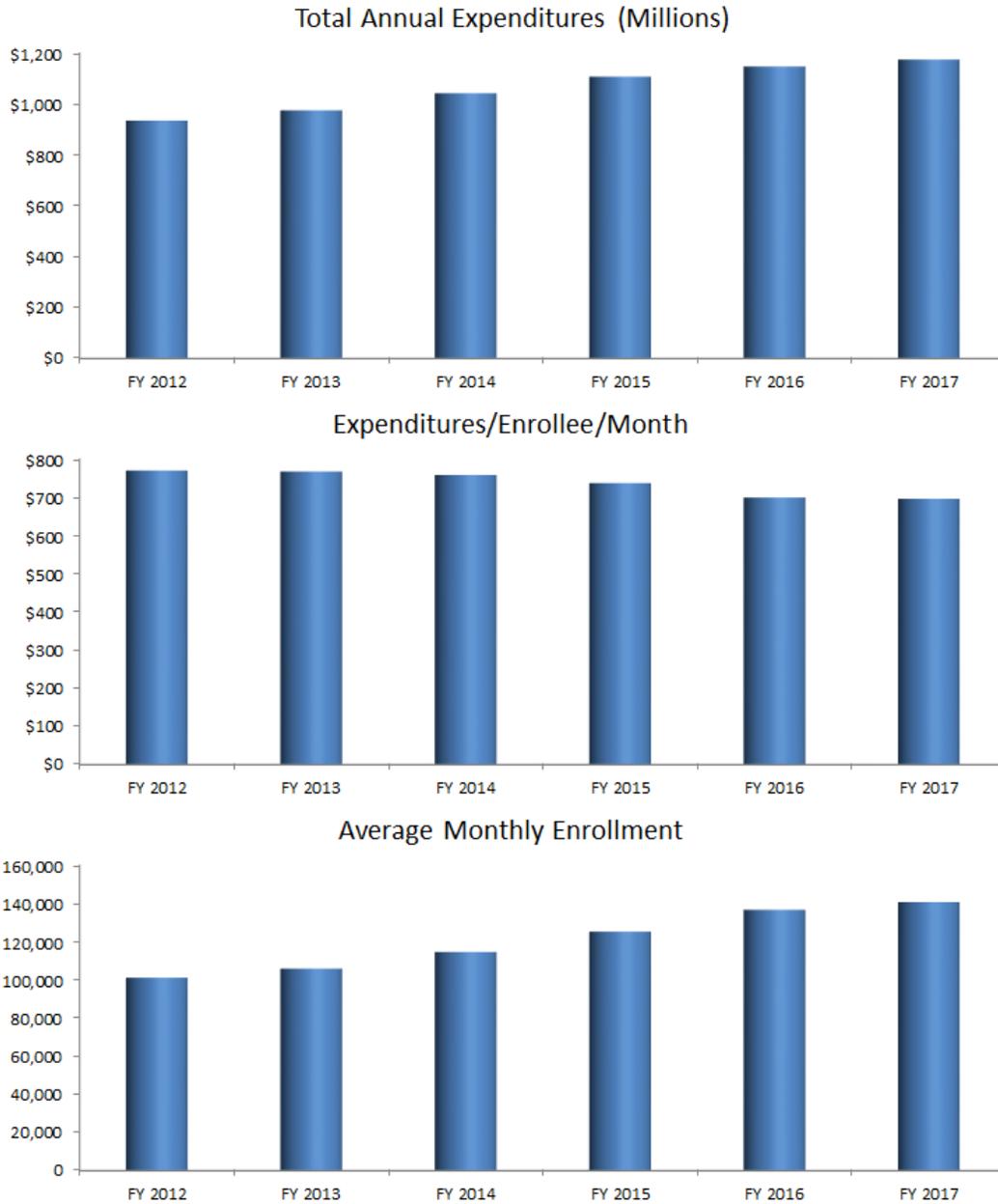


Table 12 – Medicaid Average per Month Enrollment

		State Fiscal Year					
Age	Category	2012	2013	2014	2015	2016	2017
< 1	Blind/Disabled	64	51	32	34	34	41
< 1	Child	5,817	5,848	6,241	6,584	6,984	7,011
1 to 5	Blind/Disabled	601	573	552	494	482	445
1 to 5	Child	22,526	23,850	25,431	25,760	27,697	29,148
6 to 18	Blind/Disabled	2,442	2,472	2,464	2,496	2,614	2,527
6 to 18	Child	32,928	35,839	40,421	44,174	50,102	55,200
19 to 20	Blind/Disabled	518	509	499	478	430	415
19 to 20	Adult	1,034	970	981	1,309	1,376	1,213
21 to 64	Blind/Disabled	16,247	16,541	16,628	16,372	16,019	15,419
21 to 64	Adult	11,858	11,932	14,024	20,183	23,214	21,250
65 +	Aged	6,917	7,030	7,002	7,033	7,344	7,596
65 +	Blind/Disabled	170	204	229	289	367	388
Total		101,122	105,820	114,502	125,207	136,664	140,653
All	Plan First	15	1,317	2,837	2,259	2,398	1,941
All	QMB	3,802	4,200	4,765	4,911	4,797	5,247
All	SLMB - QI	3,640	3,970	4,216	4,421	4,760	5,082
Total	All Medicaid	108,579	115,307	126,320	136,798	148,619	152,923
6 to 18	HK Med Plus	6,305	7,343	8,601	8,314	7,415	7,046
Total	All Categories	114,883	122,650	134,922	145,113	156,034	159,969

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 13 – Medicaid Monthly Reimbursement – Per Member

		State Fiscal Year					
<u>Age</u>	<u>Category</u>	<u>2012</u>	<u>2013</u>	<u>2014</u>	<u>2015</u>	<u>2016</u>	<u>2017</u>
<1	Blind/Disabled	\$4,982	\$4,461	\$4,999	\$5,665	\$4,774	\$7,429
<1	Child	\$648	\$763	\$777	\$702	\$707	\$850
1 to 5	Blind/Disabled	\$1,707	\$1,651	\$1,680	\$1,755	\$1,807	\$1,784
1 to 5	Child	\$155	\$162	\$168	\$177	\$179	\$189
6 to 18	Blind/Disabled	\$1,903	\$2,028	\$2,110	\$2,128	\$2,126	\$2,081
6 to 18	Child	\$325	\$329	\$340	\$340	\$338	\$340
19 to 20	Blind/Disabled	\$1,430	\$1,260	\$1,514	\$1,635	\$1,437	\$1,386
19 to 20	Adult	\$699	\$748	\$707	\$616	\$622	\$538
21 to 64	Blind/Disabled	\$1,719	\$1,748	\$1,806	\$1,925	\$1,889	\$1,893
21 to 64	Adult	\$622	\$640	\$655	\$579	\$566	\$568
65 +	Aged	\$2,452	\$2,387	\$2,395	\$2,362	\$2,293	\$2,396
65 +	Blind/Disabled	\$1,147	\$1,139	\$1,181	\$1,153	\$1,287	\$1,713
Total		\$770	\$768	\$758	\$737	\$699	\$696
All	Plan First	\$79	\$63	\$48	\$49	\$55	\$49
All	QMB	\$220	\$215	\$221	\$218	\$224	\$252
All	SLMB - QI	\$114	\$108	\$105	\$101	\$98	\$131
Total	All Medicaid	\$729	\$717	\$700	\$687	\$654	\$654
6 to 18	HK Med Plus	\$213	\$231	\$238	\$232	\$240	\$250
Total	All Categories	\$701	\$688	\$671	\$661	\$635	\$636

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 14 – Medicaid Reimbursement Totals – All Demographic Groups

		State Fiscal Year					
Age	Category	2012	2013	2014	2015	2016	2017
<1	Blind/Disabled	\$3,816,049	\$2,707,645	\$1,919,630	\$2,288,694	\$1,947,610	\$3,617,857
<1	Child	\$45,217,841	\$53,530,545	\$58,163,825	\$55,439,615	\$59,247,893	\$71,523,750
1 to 5	Blind/Disabled	\$12,312,734	\$11,358,224	\$11,124,531	\$10,403,754	\$10,450,506	\$9,522,175
1 to 5	Child	\$41,981,651	\$46,416,135	\$51,170,368	\$54,666,886	\$59,651,551	\$66,009,972
6 to 18	Blind/Disabled	\$55,763,097	\$60,167,988	\$62,410,235	\$63,743,267	\$66,704,988	\$63,094,078
6 to 18	Child	\$128,539,327	\$141,403,304	\$164,888,348	\$180,309,958	\$202,913,571	\$224,944,722
19 to 20	Blind/Disabled	\$8,882,442	\$7,690,675	\$9,072,714	\$9,373,833	\$7,409,035	\$6,903,268
19 to 20	Adult	\$8,679,801	\$8,715,253	\$8,325,571	\$9,676,923	\$10,271,409	\$7,826,730
21 to 64	Blind/Disabled	\$335,087,554	\$347,017,658	\$360,449,143	\$378,267,849	\$363,029,440	\$350,280,729
21 to 64	Adult	\$88,474,628	\$91,593,882	\$110,162,121	\$140,132,243	\$157,703,103	\$144,832,352
65 +	Aged	\$203,525,133	\$201,363,751	\$201,260,691	\$199,322,445	\$202,120,220	\$218,354,832
65 +	Blind/Disabled	\$2,338,288	\$2,794,441	\$3,240,767	\$4,003,391	\$5,675,049	\$7,986,302
Total		\$934,618,544	\$974,759,502	\$1,042,187,943	\$1,107,628,858	\$1,147,124,375	\$1,174,896,767
All	Plan First	\$14,437	\$996,323	\$1,629,761	\$1,330,502	\$1,575,608	\$1,133,055
All	QMB	\$10,035,260	\$10,817,891	\$12,631,175	\$12,858,935	\$12,897,649	\$15,848,344
All	SLMB - QI	\$4,985,681	\$5,155,917	\$5,324,640	\$5,353,250	\$5,600,031	\$7,994,513
Total	All Medicaid	\$949,639,486	\$991,729,633	\$1,061,773,520	\$1,127,171,545	\$1,167,197,663	\$1,199,872,679
6 to 18	HK Med Plus	\$16,147,030	\$20,350,579	\$24,569,976	\$23,149,585	\$21,312,570	\$21,172,539
Total	All Categories	\$965,786,515	\$1,012,080,212	\$1,086,343,496	\$1,150,321,130	\$1,188,510,233	\$1,221,045,218

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.

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 2017, Medicaid service providers received reimbursements, resulting in over \$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 15 – COMPARISON OF PAPER AND ELECTRONIC CLAIMS PROCESSED (2016)

Claim Type	Number Processed	Percentage of Total
Paper	724,436	5%
Electronic	13,764,279	95%
Total	14,488,715	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(APR-DRG)** 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 policy-making, without yielding control of costs; rate is adjusted annually

Price-Based Reimbursement System

- Reimburses nursing facilities under a case mix, price-based system
- Assigns each nursing facility specific rate, set through annual public process
- Facility payments comprised of two components, operating component (including capital), and direct resident care component
- Facilities receive standard per diem rate (80% of the statewide price); remaining 20% of statewide price represents direct resident care component of the rate and is acuity adjusted using the minimum data set (MDS)

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 uses Medicare fee-for-service rates and per-encounter payment systems for some programs. Areas covered under such payment programs include: Durable Medical Equipment, [Ambulatory Surgical Centers \(ASCs\)](#), and FQHCs.

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 (LARC)
- Promising Pregnancy Care (PPC)
- School Based Services

Physician/Mid-Level Practitioner

- Nurse Advice Line
- 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

Transportation

Eyeglasses

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)
- Long Term Care Insurance
- Prior Authorization
- Intergovernmental Fund Transfer
- Nursing Facility Transitions

Third Party Liability

- Medicare Buy-In and Medicare Savings Program

Health Outcome Initiatives

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

Lactation Services

- Provides reimbursement for lactation services in outpatient hospitals
- Provides participants with access to a prenatal lactation group class and post-natal one-on-one lactation consultations

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

Nurse Advice Line

- Provides toll free, confidential advice line to all Medicaid and HMK Plus members

- Registered nurses triage caller symptoms and guide callers to obtain care in appropriate settings (self-care, physician, or urgent or emergent care)

Team Care

- Medicaid members with a history of over-utilizing Medicaid services are required to participate (program currently has approximately 650 participants)
- Team Care members are managed by a team consisting of a Passport to Health primary care provider, one pharmacy, the Nurse Advice Line, 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

Patient-Centered Medical Home

- Provides Medicaid and HMK Plus members with comprehensive, coordinated approach to primary care
- Primary care providers (PCPs) receive additional reimbursement for each member enrolled for providing enhanced services, reporting quality measures, and supporting comprehensive infrastructure

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

Hospital

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

Transportation

- Provides assistance with obtaining medically necessary transportation services (requires prior authorization)

Eyeglasses

- Reduces eyeglass cost significantly through bulk contract purchasing

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 50% of Medicaid pharmacy expenditures (\$76.1 million in FY 2017)

Average Acquisition Cost (AAC)

- Replaces the estimated acquisition cost reimbursement methodology; now 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

- DPHHS renegotiated payment rate with the Crow and Blackfoot Tribes, substantially increasing reimbursement for tribally-owned nursing facilities
- Majority of tribal nursing home patients became eligible for 100% federal match
- Annual savings of \$1 million/year to each Tribe; savings of \$600,000/year to state

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 in the Montana Developmental Center transitioning to the community; persons with complex needs (including traumatic brain injury), Severe Disabling Mental Illness (SDMI), physical disabilities, and/or elders in nursing homes; and individuals aged 18-21 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 2019

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

Long Term Care Insurance

- Helps defray Medicaid costs (once partnership policies are utilized)
- An institutionalized/waiver individual or spouse who purchased a Qualified Long Term Care Partnership (LTC) policy or converted a previously-existing LTC policy to a Qualified LTC Partnership policy on or after July 1, 2009 may protect resources equal to the insurance benefits received from the policy.
- Asset protection through LTC Partnership is available only after Qualified LTC Partnership policy lifetime limits have fully exhausted LTC services for the Medicaid applicant or spouse. The amount of assets protected will be equal to the insurance benefits paid

Prior Authorization – Prior authorization for most community-based services

Intergovernmental Fund Transfer

- Participating counties pay a fee that is matched with federal funds, which are redistributed to at-risk nursing facilities
- Important component of nursing home reimbursement

Nursing Facility Transitions

- Helps provide services in the least-restrictive setting to nursing facility residents transitioning into community
- Dollars for services (money-follows-the-person) approach helps to rebalance long term care system; reduces costs
- In SFY 2017, the program helped transition into the community 37 nursing facility residents, who were also on the HCBS Big Sky Waiver wait list

Third Party Liability (TPL)

- Identifies third parties liable for payment of Medicaid member medical costs (Medicare, private health insurance, auto accident policies, and workers' compensation)
- Includes recovery for payments made for certain long-term services from the estates of members who have passed away
- In SFY17, Montana cost avoided \$195.9 million in Medicaid payments

Medicare Buy-In and Medicare Savings Program

- Medicare Buy-In designates Medicare the primary payer for Medicare and Medicaid "full" dual eligible recipients, resulting in major cost savings
- Medicare Part-B premiums are paid directly to CMS for certain recipients
- Medicare Part-A premiums are paid for Medicaid enrollees receiving Supplemental Security Income SSI payments, who become entitled to Medicare at age 65
- Medicare Savings Program provides Medicare Buy-in benefits to people with Medicare who are not eligible for full Medicaid services, but have limited income and assets:
 - . Qualified Medicare Beneficiary (QMB) – Covers both Medicare Part A and B premiums and some co-payments and deductibles
 - . Specified Low Medicare Beneficiary (SLMB) – Covers Medicare Part-B premium only
 - . Qualified Individual (QI-1) – Covers Medicare Part-B premium through 100% federal dollars

All three categories automatically entitle the enrollee to Low Income Subsidy (LIS) or "Extra Help" status for the Medicare Prescription Drug Plan (Part-D).

- Due to the cost efficiency of having Medicare as the first payer, a concerted effort is ongoing to ensure that anyone meeting the eligibility criteria is enrolled.

For more information, please refer to:

<https://www.medicare.gov/your-medicare-costs/get-help-paying-costs/medicare-savings-programs>

Program and Payment Integrity Activities

- 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.
- Two state programs help protect the state Medicaid program:
 - . DPHHS Quality Assurance Division – Responsible for insuring proper payment and recovering misspent funds
 - . Attorney General’s Medicaid Fraud Control Unit (MFCU) – Responsible for investigating and ensuring prosecution of Medicaid fraud
- At the federal level, CMS and the Office of Inspector General (OIG) of the Department of Health and Human Services oversee state program and payment integrity activities
- Two federal audit contractors:
 - . PERM operates on a cycle, evaluating states every 3 years. Montana’s PERM cycle reviewed claims from FFY2017. Results are pending from CMS
 - . Montana currently has a waiver from CMS for the requirement to have a RAC. We are in the process of looking for a contractor.
- Results of Medicaid Cost Containment 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)

Expenditure Analysis

Medicaid services are funded by a combination of federal, state, and (in some cases) local funds. The federal match rate for Medicaid services is derived by comparing the state average per capita income to the national average. For example, in State Fiscal Year 2018, for every Medicaid dollar, the federal share was 65.42 cents, and the Montana state share was 34.58 cents.

TABLE 16 – MONTANA MEDICAID BENEFITS – FEDERAL/STATE MATCHING RATE

State Fiscal Year	2014	2015	2016	2017	2018	2019	2020	2021
Federal Match Rate	66.25%	65.92%	65.36%	65.50%	65.42%	65.51%	65.54%	65.78%
State Match Rate	33.75%	34.08%	34.64%	34.50%	34.58%	34.49%	34.46%	34.22%

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 during the recession period 2009-2012, as part of the American Recovery and Reinvestment Act (ARRA).

FIGURE 18 – TRADITIONAL MEDICAID – FEDERAL DOLLAR MATCHING SHARE – FY 2004-2021

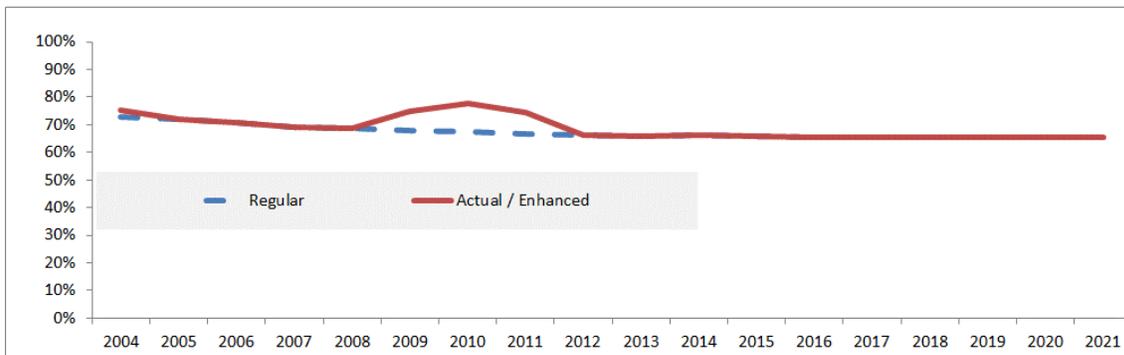


TABLE 17 – TRADITIONAL MEDICAID – COMPARISON OF REGULAR VS. ACTUAL/ENHANCED DOLLAR MATCH

State Fiscal Year	2004	2005	2006	2007	2008	2009	2010	2011	2012
Regular	72.81%	71.96%	70.66%	69.29%	68.59%	68.08%	67.48%	66.86%	66.21%
Actual / Enhanced	75.36%	71.96%	70.66%	69.29%	68.59%	74.80%	77.65%	74.58%	66.21%
State Fiscal Year	2013	2014	2015	2016	2017	2018	2019	2020	2021
Regular	66.04%	66.25%	65.92%	65.36%	65.50%	65.42%	65.51%	65.54%	65.78%
Actual / Enhanced	66.04%	66.25%	65.92%	65.36%	65.50%	65.42%	65.51%	65.54%	65.78%

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. Data for SFYs 2018 to 2021 are the Governor’s budgeted amounts and/or estimates.

FIGURE 19 – MONTANA MEDICAID – BENEFIT-RELATED EXPENDITURES

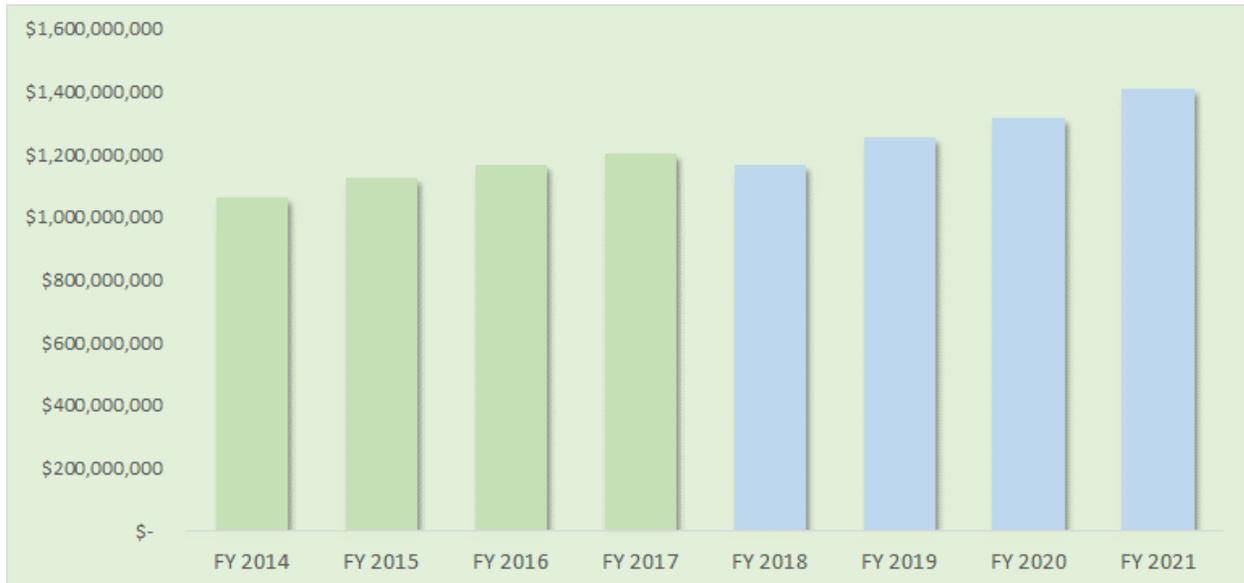


FIGURE 20 – MONTANA MEDICAID – BUDGETED FEDERAL AND STATE FUNDS

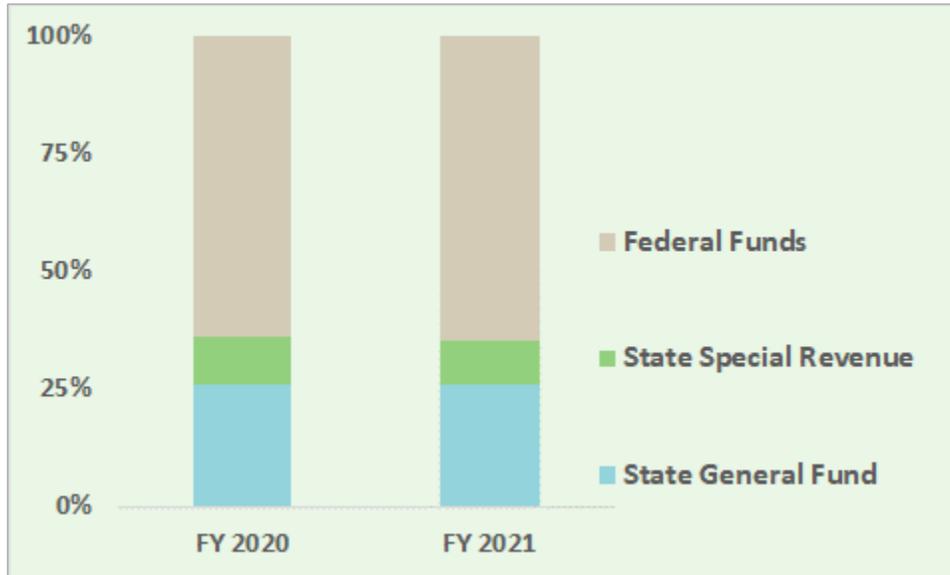


FIGURE 21 – BENEFIT EXPENDITURE BY CATEGORY – FY 2018 – 2021

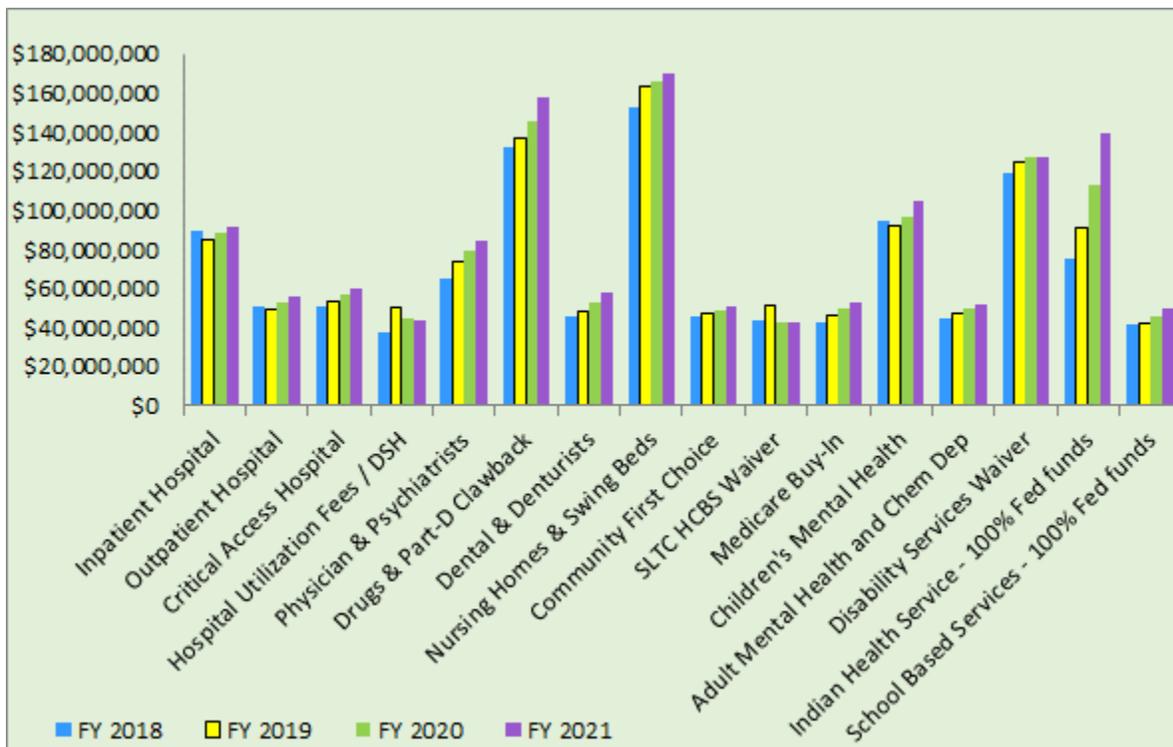


TABLE 18 – MONTANA MEDICAID – PROJECTED EXPENDITURES BY CATEGORY

Categories	Projected Medicaid Expenditures			
	FY 2018	FY 2019	FY 2020	FY 2021
Inpatient Hospital	\$ 89,972,613	\$ 85,069,867	\$ 88,259,987	\$ 91,569,736
Outpatient Hospital	51,088,373	49,496,031	52,777,618	56,276,774
Critical Access Hospital	50,413,213	53,371,858	56,478,100	59,765,125
Hospital Utilization Fees / DSH	37,626,683	49,870,020	45,097,567	44,010,322
Other Hospital and Clinical Services	32,810,690	33,949,603	38,432,196	43,584,011
Physician & Psychiatrists	64,694,323	73,564,199	79,028,700	84,919,223
Other Practitioners	28,075,124	30,771,235	34,621,227	38,988,550
Other Managed Care Services	12,612,789	8,549,809	8,853,052	9,176,453
Drugs & Part-D Clawback	131,854,821	136,679,011	145,982,677	157,802,653
Drug Rebates	(88,640,513)	(73,277,611)	(78,875,243)	(84,484,269)
Dental & Denturists	45,322,015	47,880,772	52,595,894	57,786,736
Durable Medical Equipment	15,853,586	15,283,291	17,139,055	18,227,385
Other Acute Services	7,146,191	6,543,808	7,676,592	9,014,424
Nursing Homes & Swing Beds	152,950,280	162,920,493	165,686,244	170,180,099
Nursing Home IGT	11,255,701	11,255,701	13,821,339	13,821,339
Community First Choice	46,153,636	46,885,973	48,879,941	50,977,266
Other SLTC Home Based Services	3,420,501	5,127,982	4,778,776	4,935,412
SLTC HCBS Waiver	43,491,172	51,763,873	42,919,755	42,919,755
Medicare Buy-In	43,122,324	46,280,436	49,322,189	52,563,960
Children's Mental Health	94,247,378	92,116,052	96,434,146	104,420,136
Adult Mental Health and Chem Dep	44,257,178	47,546,288	49,840,133	52,265,743
HIFA Waiver	7,149,683	6,968,713	6,968,713	6,968,713
Disability Services Waiver	118,894,728	124,638,598	126,997,958	127,102,083
Indian Health Service - 100% Fed funds	74,823,244	91,253,528	112,862,283	139,377,202
School Based Services - 100% Fed funds	41,560,617	42,336,752	46,106,279	50,223,755
MDC & ICF Facilities - 100% Fed funds	7,842,317	5,062,601	5,083,794	5,083,794
Total	\$ 1,167,998,667	\$ 1,251,908,881	\$ 1,317,768,970	\$ 1,407,476,381

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. An ICF is licensed and monitored by DPHHS.

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)

BCBSMT – Blue Cross Blue Shield of Montana

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)

HIFA: Health Insurance Flexibility and Accountability HCBS: Home and Community Based Services

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

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

QMB – Qualified Medicare Beneficiary