PRESENTATION TO THE 2025 HEALTH AND HUMAN SERVICES JOINT APPROPRIATION SUBCOMMITTEE

MEDICAID IN MONTANA

2025

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DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

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MEDICAID – AUTHORITIES

The Montana Medicaid Program is a joint federal-state program authorized under § 53-6-101, Montana Code Annotated (MCA), and Article XII, Section 3 of the Montana Constitution; it is administered under § 53-6-101 *et seq.*, MCA, and in accordance with Title XIX of the Social Security Act, 42 U.S. Code § 1396 *et seq*., for the purpose of providing necessary medical services to eligible Montanans who need medical assistance. The Department of Public Health and Human Services (DPHHS) 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 its citizens.

Medicaid and CHIP Payment and Access Commission (MACPAC) Reference Guide to Federal Medicaid Statute and Regulations:

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

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, provider reimbursement methodologies, and program administration processes."

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

WAIVERS

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

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

MEDICAID – A STATE AND FEDERAL PARTNERSHIP

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

TABLE 1 - SERVICES FUNDING RATES

Services Funding (SFY 2025)	State Share	Federal Share
Indian & Tribal Health Services		100%
Medicaid Expansion	10%	90%
Family Planning Service	10%	90%
Money Follows the Person	18.73%	81.27%
Breast and Cervical Cancer Program	26.07%	73.93%
Community First Choice (FMAP +6%)	31.45%	68.55%
Standard FMAP	37.45%	62.55%
State Funded	100%	

TABLE 2 - ADMINISTRATION FUNDING RATES

Administration Funding (SFY 2025)	State Share	Federal Share
Systems Development (if pre-approved)	10%	90%
Systems Operations & Maintenance	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%

STATE AND FEDERAL SHARES

Medicaid services are funded by a combination of federal, state, and (in some cases) local funds. The federal match rate for most Medicaid services provided to Montanans eligible for the standard benefit plan is derived by comparing the state average per capita income to the national average. Montana's base federal match rate started a noticeable downward trend beginning in SFY23 and is continuing.

TABLE 3 – MONTANA MEDICAID BENEFITS – FEDERAL/STATE MATCHING RATE

State Fiscal Year	2020	2021	2022	2023	2024	2025	2026	2027
Federal Match Rate	64.95%	65.43%	64.96%	64.23%	63.84%	62.55%	61.61%	61.47%
State Match Rate	35.05%	34.57%	35.04%	35.77%	36.16%	37.45%	38.39%	38.53%

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); and
- during the COVID-19 Public Health Emergency 2020-2023.

FIGURE 1 – TRADITIONAL MEDICAID – FEDERAL DOLLAR MATCHING SHARE SFY 2008-2027

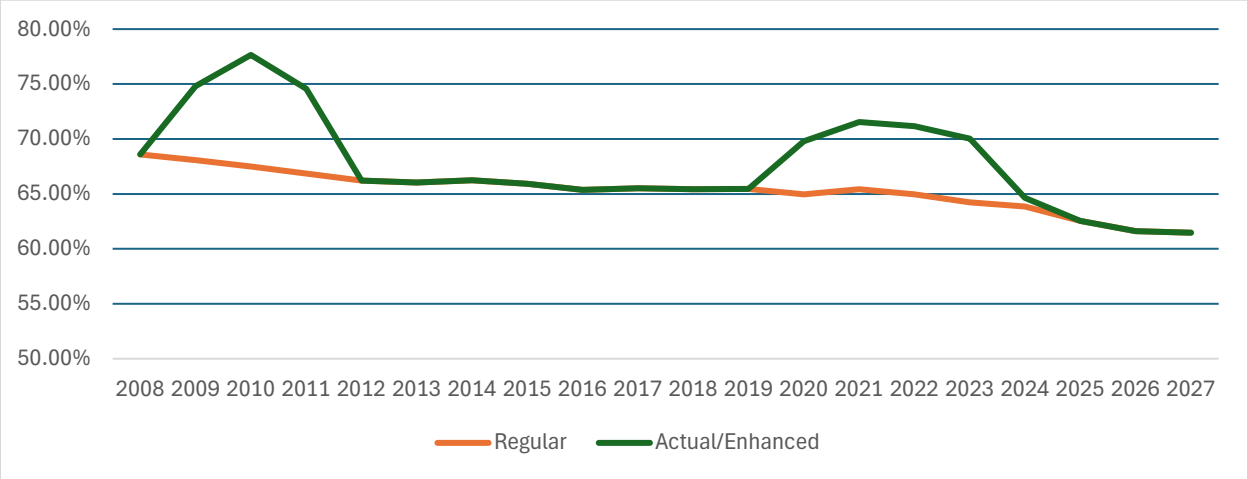


TABLE 4– TRADITIONAL MEDICAID – COMPARISON OF REGULAR VS. ACTUAL/ENHANCED DOLLAR MATCH

State Fiscal Year	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Regular	68.59%	68.08%	67.48%	66.86%	66.21%	66.04%	66.25%	65.92%	65.36%	65.50%
Actual/Enhanced	68.59%	74.80%	77.65%	74.58%	66.21%	66.04%	66.25%	65.92%	65.36%	65.50%
State Fiscal Year	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
Regular	65.42%	65.47%	64.95%	65.43%	64.96%	64.23%	63.84%	62.55%	61.61%	61.47%
Actual/Enhanced	65.42%	65.47%	69.80%	71.55%	71.16%	70.03%	64.63%	62.55%	61.61%	61.47%

MEDICAID - ELIGIBILITY

Montana Medicaid provides coverage for the following groups/populations:

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

More information is available at:

Montana Healthcare Programs – Member Services and Offices of Public Assistance (OPA)

MEDICAID ELIGIBILITY – INFANTS AND CHILDREN

NEWBORN COVERAGE

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

HEALTHY MONTANA KIDS PLUS (HMK PLUS)

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

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

SUBSIDIZED ADOPTION, SUBSIDIZED GUARDIANSHIP AND FOSTER CARE

Children eligible for an adoption or guardianship subsidy through DPHHS automatically qualify for Medicaid coverage. Children placed into licensed foster care homes by the Child and Family Services Division are also Medicaid eligible. Former foster care youth may be eligible through the month of their 26th birthday.

TABLE 5 – 2024 FEDERAL POVERTY LEVELS AND GROSS MONTHLY INCOME

Family Size	Pregnant Women 157% FPL	HMK 261% FPL	Child or HMK Plus 143% FPL
1	$1,970	$3,276	$1,795
2	$2,674	$4,446	$,2,436
3	$3,378	$5,616	$3,077
4	$4,082	$6,786	$3,718
Resource Test	No Test	No Test	No Test

MEDICAID ELIGIBILITY – LOW INCOME MONTANANS

LOW INCOME FAMILIES – STANDARD MEDICAID

Adult members of Montana families whose household countable income is less than 25% FPL are eligible for standard Medicaid. These families must include at least one dependent child.

LOW INCOME MONTANANS – EXPANSION MEDICAID

Montanans whose household countable income equal is between than 0% and 138% FPL are eligible for Medicaid Expansion.

PREGNANT WOMEN

Medicaid provides temporary medical coverage to eligible pregnant women with countable household income equal to or less than 157% FPL who meet the nonfinancial criteria for Affordable Care Act (ACA) Pregnancy Medicaid. The coverage extends for 12 months beyond the conclusion of the pregnancy.

MEDICAID ELIGIBILITY – SPECIAL POPULATIONS

BREAST AND CERVICAL CANCER TREATMENT

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

Qualifying recipients must:

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

SEVERE AND DISABLING MENTAL ILLNESS

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

Qualifying individuals must:

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

MEDICAID ELIGIBILITY – PEOPLE WITH DISABILITIES

BLIND/DISABLED

Individuals may be eligible for Medicaid if determined blind or disabled using Social Security criteria, and if their income is within allowable limits and their resources do not exceed $2,000 for an individual or $3,000 for a couple.

2025 income limits for the Aged, Blind, Disabled programs are $967 per month for an individual and $1,450 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 standards are significantly higher than many other Medicaid programs: $15,000 for an individual and $30,000 for a couple, while the countable income limit is 250% of the FPL.

FIGURE 2 – 2025 SSI MONTHLY INCOME STANDARDS

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

MEDICAID ELIGIBILITY – CATEGORICALLY AND MEDICALLY NEEDY

CATEGORICALLY NEEDY

Assists individuals with an attribute (disability, pregnancy, 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 has significant medical expenses.
- Individuals may qualify for benefits through a process known as Spend Down:
  - Incurring medical expenses equal to spend down amount;
  - Making a cash payment to the department; or
  - Paying both incurred medical expenses and cash payment.

TABLE 6 – LIMITS FOR MEDICALLY NEEDY SFY 2024

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.		

A HISTORY OF MONTANA'S MEDICAID EXPANSION

After the passage of the Affordable Care Act in 2010 and the establishment in 2014 of the federally facilitated Marketplace (FFM), through which eligible Montanans could purchase health insurance with tax credit assistance, a key group of Montanans was left without any source of affordable health coverage. These were the lowest-income Montanans, particularly those without dependent children. The FFM only provided tax credits to individuals at 100-400% FPL, which left most below 100% FPL - $11,770 for an individual or $20,090 for a family of three - without any coverage and in the Medicaid gap. Adult Montanans with dependent children could only qualify for Medicaid if they were extremely poor; for a family of three, their income would need to be less than approximately $6,000 per year.

2015: THE LEGISLATURE PASSES MEDICAID EXPANSION (HELP)

The 2015 Legislature heard testimony from many organizations, providers, and individuals about the need to expand Medicaid eligibility to all of these lowest-income adults. They heard from critical access hospitals, federally qualified health centers (FQHCs), tribes, advocacy organizations, and individuals who needed health care to stay alive but couldn't access it because they were in the Medicaid gap.

Under the leadership of Senator Buttrey and in negotiation with Governor Bullock, the legislature passed SB 405, the Health and Economic Livelihood Partnership (HELP) Act, establishing Medicaid expansion. The bill proposed an innovative approach to expansion, combining premiums and cost-sharing designed to maximize participant payment, a third-party administrator (TPA), and a voluntary workforce program called HELP-Link operated by the Department of Labor. It directed DPHHS to apply for a

federal 1115 demonstration waiver to secure the authority to charge premiums and utilize a TPA. Separately, the bill created a Taxpayer Integrity Fee (TIF), administered by the Department of Revenue.

2016: MEDICAID EXPANSION MEETS Montanans' needs

Newly Medicaid eligible Montanans could apply for coverage that began on January 1, 2016. By the end of 2016, approximately 70,000 Montanans with incomes at or below 138% FPL had applied and been found eligible for coverage.

2017: LEGISLATIVE ADJUSTMENTS

The 2017 Legislature faced budget shortfalls and directed DPHHS to eliminate the TPA as a cost-saving measure in SB 261.

DPHHS ended its contract with the TPA as of January 1, 2018.

2019: THE LEGISLATURE REAUTHORIZES HELP

After reviewing the evidence and outcomes of three years of the HELP Act and Medicaid expansion, the 2019 Legislature voted to renew Medicaid expansion. They passed, and Governor Bullock signed HB 658, the Medicaid Reform and Integrity Act, which authorized the continuation of HELP and directed DPHHS to request federal approval of new community engagement requirements under the 1115 demonstration waiver. These requirements sought to condition eligibility for Medicaid expansion on meeting a prescribed number of hours of work or other approved community activities. The request also included increasing monthly premiums based on the duration of an individual's coverage under Medicaid expansion. Separately, after hearing from providers about the administrative burden of billing members for copayments, the bill directed DPHHS to remove copayments from the Medicaid program. It also amended the qualifications to be subject to the TIF, increasing the number of Montanans assessed that fee.

DPHHS submitted the waiver amendment in August 2019. In December 2020, CMS approved a one-year extension of the waiver as previously approved, not incorporating the requested changes.

2020: COVID-19 AND THE FAMILIES FIRST CORONAVIRUS RESPONSE ACT (FFCRA)

The removal of copayments from Montana Medicaid, as ordered in HB 658, took effect on January 1, 2020.

The Families First Coronavirus Response Act of March 2020 included a provision that temporarily increased states' Medicaid FMAP by 6.2%. As a condition of receiving this increased FMAP, states were required to maintain Medicaid coverage for enrollees through the end of the month in which the federal public health emergency ended. This led to a steady increase across the nation in the number of individuals enrolled in

Medicaid, which peaked in Montana in the spring of 2023 at 324,489 individuals, including 125,035 under Medicaid expansion.

2021: FURTHER LEGISLATIVE CHANGES

The 2021 Legislature passed a budget that explicitly removed funding for 12-month continuous eligibility, which had initially been adopted to reduce churn and associated administrative costs and directed DPHHS to submit an amendment removing the policy from the HELP waiver.

In December, CMS approved the removal of expenditure authority for 12-month continuous eligibility and stated it did not intend to renew the authority to charge premiums, as it had determined that premiums can present a barrier to coverage and thus were not likely to promote the objectives of Medicaid. The HELP demonstration would expire on December 31, 2022, and expansion enrollees would be fully covered under the State Plan.

2023-2024: REDETERMINATION

With the end of the FFCRA continuous coverage requirements, DPHHS redetermined eligibility for all Medicaid enrollees, including the 125,000 Medicaid expansion enrollees. At the end of the 10-month redetermination process, 77,398 Montanans remained enrolled under Medicaid expansion.

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 Hospice

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		
	Standard Medicaid	State Plan, 1115 Waiver
	Big Sky Waiver	1915(c) Waiver, 1915(b) Waiver
	Home and Community Based Services - Self Directed	1915(c) Waiver
	Community First Choice Services	State Plan 1915(k)

Developmentally Disabled		
	Standard Medicaid	State Plan, 1115 Waiver
	Home and Community Based Services	1915(c) Waiver
	Home and Community Based Services - Self Directed	1915(c) Waiver
	Community First Choice Services	1915 (k)
Severe and Disabling Mental Illness		
	Standard Medicaid	State Plan, 1115 Waiver
	Home and Community Based Services	1915(c) Waiver, 1915(b) Waiver
	Home and Community Based Services - Self Directed	1915(c) Waiver
	Community First Choice Services	State Plan
	Program for Assertive Community Treatment	State Plan
	HEART Waiver	1115 Waiver
Substance Use Disorder		
	Standard Medicaid	State Plan
	HEART Waiver	1115 Waiver

WAIVER – BASICS

SECTION 1915(C) WAIVERS

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

SECTION 1115 WAIVERS

Authorizes experimental, pilot, or demonstration projects.

SECTION 1915(B) WAIVERS

Allows states to waive state wideness, comparability of services, and freedom of choice. There are four 1915(b) waivers available:

- (b)(1) to mandate Medicaid enrollment into managed care

- (b)(2) to utilize a "central broker"
- (b)(3) to use cost savings to provide additional services
- (b)(4) to limit the number of providers for services

SECTION 1135 WAIVERS

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

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

1915C WAIVER – HCBS FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

PURPOSE

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

A copy of the current waiver is available at:

Comprehensive Services Waiver for Individuals with Developmental Disabilities

WAIVER PARTICIPANTS

In State Fiscal Year (SFY) 2023, an average of 2,254 Montanans each month received services funded by the Comprehensive Services (HCBS) Waiver. The waiver supported successful community living for 2,505 Montanans during SFY 2023. The waiver funds services to Medicaid members of all ages with service plans specific to their individual needs. The waiver includes an option for self-directing the individual care plan.

SERVICES

The waiver offers 32 separate services provided in a variety of residential and work

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

COST PLANS

The SFY 2023 average cost plan per person is $60,995 per year. The cost plans ranged from $1,500 to $515,000. These costs do not include the cost of Medicaid State Plan services, available to all eligible members, such as inpatient hospitals, physicians, pharmacies, durable medical equipment, physical therapy, behavioral health services, and speech therapy.

1915C WAIVER – HCBS FOR INDIVIDUALS ELDERLY AND/OR PHYSICALLY DISABLED (BIG SKY WAIVER)

PURPOSE

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

Copies of the current waivers are available at:

1915(b) (4) and 1915(c)

WAIVER PARTICIPANTS

Approximately 2,700 Montanans annually receive Montana Big Sky Waiver services, supporting independent living for the elderly (age 65 and older) and people with physical disabilities. In SFY 2024, an average of 2,065 Montanans received services each month funded by the Big Sky Waiver. Members must be financially eligible for long term care Medicaid and meet the program's nursing facility or hospital level of care requirements. The waiver includes an option for self-directing services under the Big Sky Bonanza program.

SERVICES

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

1915C WAIVER – HCBS FOR INDIVIDUALS WITH SEVERE AND DISABLING MENTAL ILLNESS

PURPOSE

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

Copies of the current waivers are available at:

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

MEMBERS

Case management services are provided to SDMI waiver members statewide. Case managers assist members in gaining access to Home and Community-Based Services, State Plan Services, and needed medical, behavioral health, social, educational, and employment services. In SFY 2024, the SDMI waiver served more than 550 members, adding additional members each month.

SERVICES

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

1115 WAIVER – WAIVER FOR ADDITIONAL SERVICES AND POPULATIONS

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

- Up to 3,000 adults aged 18 or older with serious and disabling mental illness with incomes from 0-138% FPL or 139- 150% FPL, depending on Medicare eligibility, receive standard Medicaid benefits and
- 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)]

1115 WAIVER – PLAN FIRST

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

The waiver is available at: [1115 Plan First Waiver - Health Resources Division]

1115 WAIVER – HEALING AND ENDING ADDICTION THROUGH RECOVERY AND TREATMENT (HEART)

The Healing and Ending Addiction through Recovery and Treatment (HEART) is an 1115 waiver intended to support the implementation of the HEART Initiative, designed to expand the state's behavioral health continuum of care. This program will provide additional behavioral health care services to existing Medicaid beneficiaries, ages 18 to 64 years old, with a substance use disorder (SUD) or severe mental illness (SMI). In 2022, CMS approved reimbursement for individuals diagnosed with SUD receiving treatment in short-term residential and inpatient stays in institutions of mental disease (IMDs). IMDs are institutions of more than 16 beds. On Feb. 26, 2024, CMS approved contingency management, tenancy supports, and reentry services for individuals leaving state prisons, as requested through the original demonstration waiver. All components of the original waiver request have been approved except the SDMI IMD request, which is contingent on MSH regaining accreditation.

The currently approved waiver is available at: [1115 HEART Waiver.]

1915(B) WAIVER – PASSPORT TO HEALTH

The Passport to Health is a 1915(b) waiver that allows for care coordination services from a limited number of providers. The program minimizes ineffective or inappropriate medical care for Medicaid and HMK Plus members. The waiver, which involves about 70% of all Montana Medicaid members, has two 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, 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 120 Medicaid and HMK Plus members are enrolled as of June 2024.

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 Organizations (UIOs) – (Standard Medicaid FMAP 62.55% federally funded and 35.77% state funded; Medicaid expansion FMAP 90% federally funded and 10% state funded)

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

- Blackfeet Community Hospital
- Crow/Northern Cheyenne Hospital
- Fort Belknap Hospital

Outpatient services are also offered at IHS Units and Tribal Health Programs/Departments:

- Northern Cheyenne IHS Service Unit
- Fort Peck IHS Service Unit
- Little Shell 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)

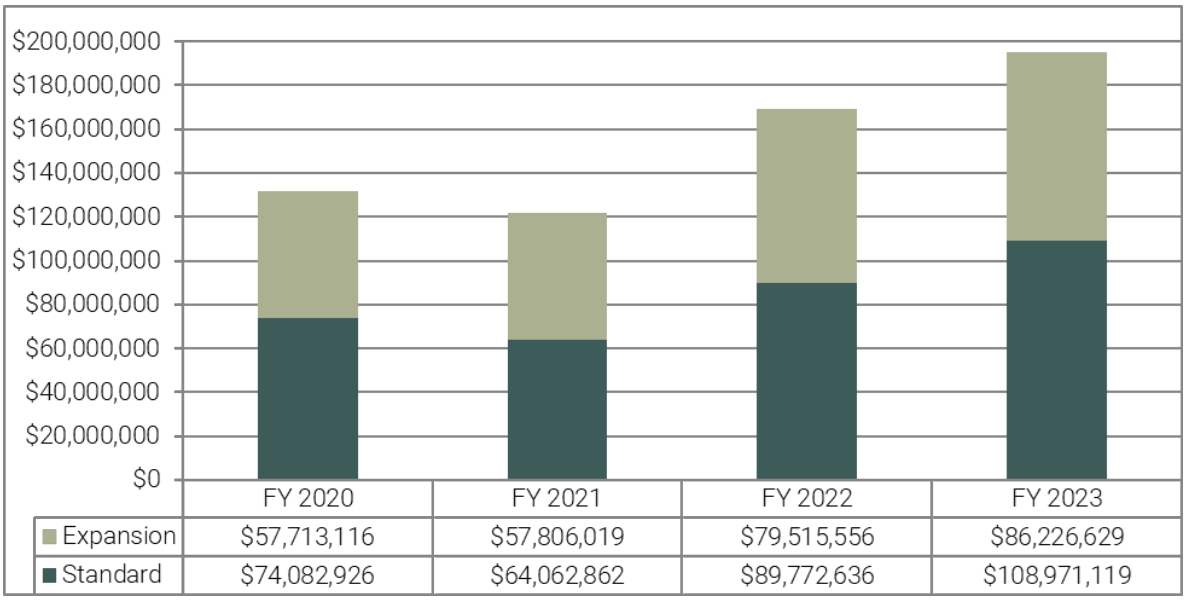
Five UIOs provide care to American Indians and Alaska Natives who reside in urban areas:

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

TABLE 7 – 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 – Northern Cheyenne Service Unit, Fort Peck Service Unit, Little Shell Service Unit– services offered vary	100% Federal Funds
Tribal Health (operating under a 638 compact) or contract	Reservation	Tribes are sovereign and set their own requirements for who is eligible for services.	Outpatient – services offered vary. Nursing Facility - Blackfeet, Crow	100% Federal Fund
Urban Indian Organizations	Billings Butte Great Falls Helena Missoula	Tribal Member or Descendent Plus Non-Natives	Outpatient – services offered vary	Standard 62.55% Federal Funds/ 35.45% State Funds; Medicaid Expansion 90% Federal Funds/ 10% State Funds

FIGURE 3 – MEDICAID INDIAN HEALTH SERVICE/TRIBAL REIMBURSEMENT BY STATE FISCAL YEAR



	FY 2020	FY 2021	FY 2022	FY 2023
Expansion	$57,713,116	$57,806,019	$79,515,556	$86,226,629
Standard	$74,082,926	$64,062,862	$89,772,636	$108,971,119

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. The program structure creates a unique opportunity for each tribe to enhance communication and care coordination with members with chronic illnesses who face a higher risk of disease. T-HIP services are designed to help members maximize the benefits of their medical and other support systems, improve knowledge of their disease and self-management skills, and remove barriers to achieving better health and a better quality of life.

MEDICAID REVENUE REPORTS

Every year, DPHHS prepares Medicaid Revenue Reports and shares them with the tribal governing bodies (tribal councils), tribal health directors, the IHS units, the IHS Billings Area Office, and UIOs. These reports include the Medicaid revenue received, broken down by service provided, the amount received for that service per month, and where the payment was sent. The Medicaid Revenue Reports are useful for tribes, IHS, and Urbans as they compare information and identify opportunities for future billing.

MEDICAID TRIBAL CONSULTATIONS

DPHHS formally consults with tribal governments, IHS, and Urban Organizations on matters related to Medicaid and CHIP having a direct impact on Indian Health Programs and UIOs. Consultations allow DPHHS to seek input on a regular, ongoing basis and to create open communication with our Medicaid partners.

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 that 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 their Medicaid administrative activities. 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 enables 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

There are currently two tribes that own and operate nursing facilities: the Blackfeet Tribe and the Crow Tribe. The Department developed a State Plan Amendment using the tribes' self-determination authority. This CMS approved state plan allowed for a negotiated rate reimbursed at 100% federal funds, resulting in significant savings to the state general fund.

MEDICAID ENROLLMENT AND EXPENDITURES

TABLE 8 – SUMMARY OF MEDICAID ENROLLED PERSONS FOR SFY 2023

Beneficiary Characteristic	Average Monthly Enrollment						% of Medicaid Total	% of Montana Population
		Standard				Expansion		
	All	Aged	Disabled	Adults	Children	Adults		
Total	289,413	8,988	18,367	39,062	101,586	121,410	100%	
Age								
0 to 1	5,376	0	21	0	5,355	0	2%	1%
1 to 5	28,012	0	231	0	27,781	0	10%	5%
6 to 18	70,243	0	1,793	0	68,450	0	24%	16%
19 to 20	9,590	0	443	7,034	0	2,113	3%	2%
21 to 64	166,104	0	14,779	32,028	0	119,297	57%	55%
65 and older	10,088	8,988	1,100	0	0	0	4%	21%
Gender								
Male	136,320	3,255	9,410	13,269	51,652	58,734	47%	51%
Female	153,093	5,733	8,957	25,793	49,934	62,676	53%	49%
Race								
White	198,782	6,887	14,216	27,841	62,439	87,399	69%	89%
AIAN	54,562	1,016	2,922	7,535	23,316	19,773	19%	6%
Other	4,837	109	263	743	1,783	1,939	2%	5%
Unknown *	31,232	976	966	2,943	14,048	12,299	11%	
Assistance Status								
Medically Needy	825	525	300	0	0	0	0%	
Categorically Needy	288,588	8,463	18,067	39,062	101,586	121,410	100%	
Medicare Status								
Part A and B	18,369	8,468	8,690	1,211	0	0	6%	
Part A only	163	45	75	43	0	0	0%	
Part B only	466	383	79	4	0	0	0%	
None	270,415	92	9,523	37,804	101,586	121,410	93%	
Medicare Saving Plan (not included in total)								
QMB Only	4,668	2,640	2,014	14	0	0		
SLMB - QI Only	4,853	3,372	1,481	0	0	0		
Other Medicaid Eligibles (not included in total)								
HK Med Plus	6,842	0	0	0	6,842	0		
Plan First Waiver	1,880	0	0	1,880	0	0		

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

Excludes HMK (CHIP) and State Fund Mental Health. For QMB only enrollees Medicaid pays for Medicare premiums, co-insurance, and deductibles. For SLMB - QI only enrollees Medicaid pays for Medicare Premiums. HK Med Plus are Medicaid clients age 6 to 18 that are funded through CHIP.

FIGURE 4 – MEDICAID 2023 ENROLLMENT AND EXPENDITURES BY MAJOR AID CATEGORIES

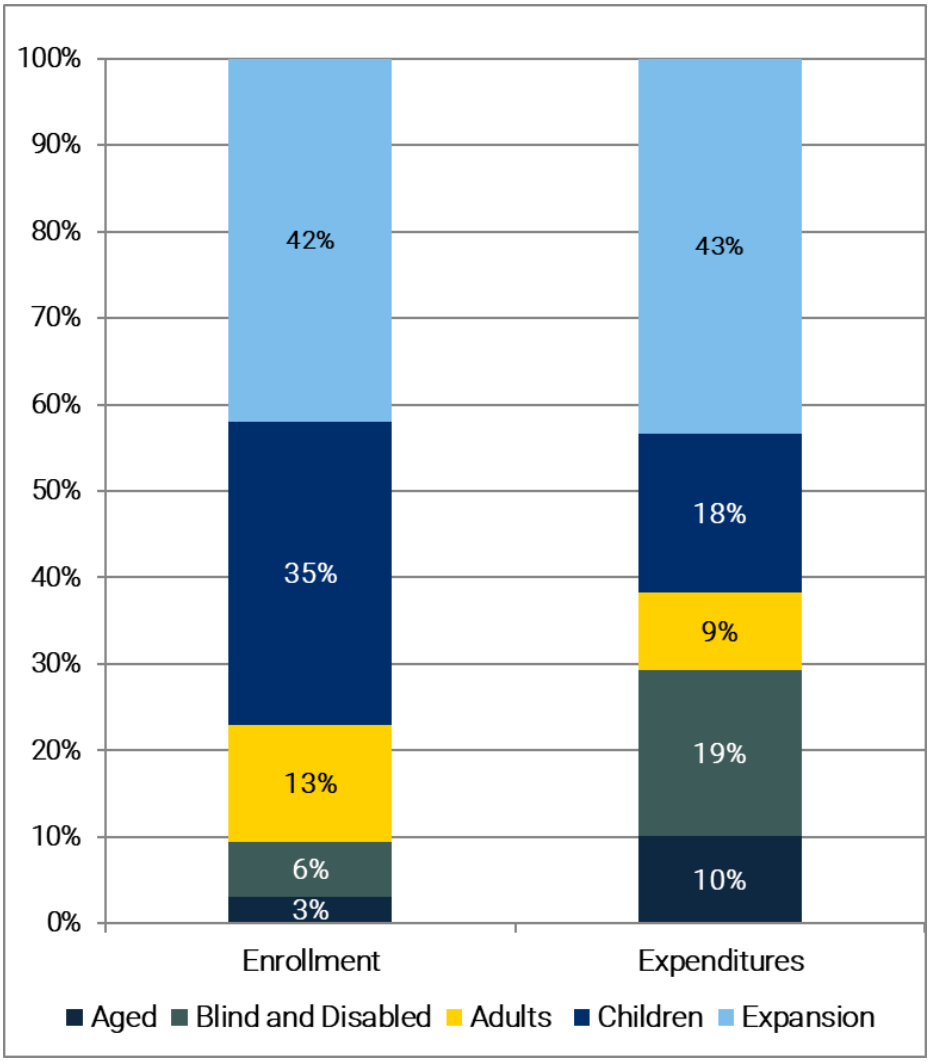


TABLE 9 –ENROLLMENT AND EXPENDITURES BY STANDARD MEDICAID CATEGORY SFY 2023

Aid Category	Average Monthly Enrollment	Percent of Enrollment	Expenditures	Percent of Expenditures
Aged	8,988	3%	$ 239,973,752	10%
Blind and Disabled	18,367	6%	458,743,237	19%
Adults	39,062	13%	215,470,909	9%
Children	101,586	35%	436,778,031	18%
Expansion	121,410	42%	1,035,066,628	43%
Total	289,413	100%	$ 2,386,032,556	100%

FIGURE 5 – STANDARD MEDICAID ENROLLMENT – ADULTS AND CHILDREN (EXCLUDES MEDICARE SAVINGS PLAN ONLY)

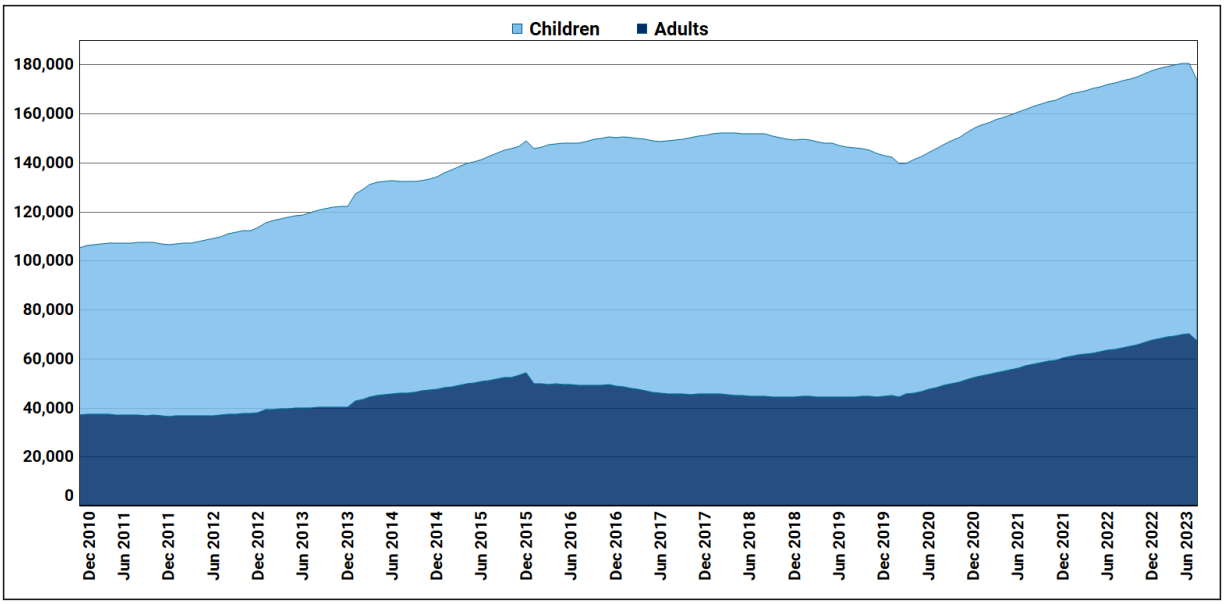


FIGURE 6 – DISABLED MEDICAID ENROLLMENT – ADULTS AND CHILDREN (EXCLUDES MEDICARE SAVINGS PLAN ONLY)

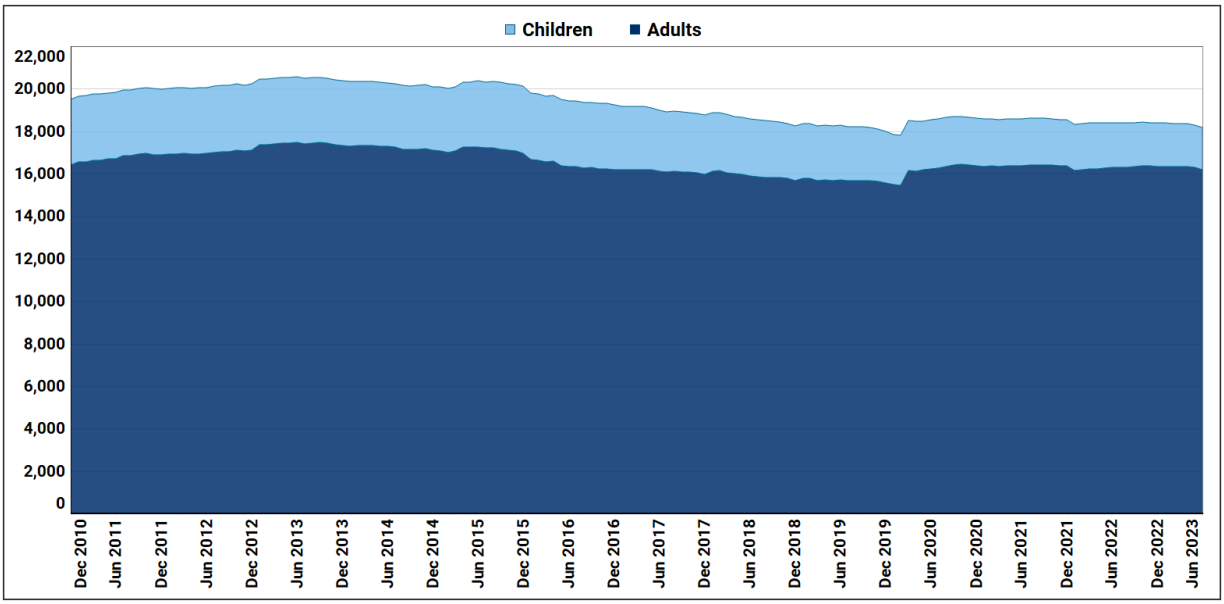


FIGURE 7 – MEDICAID ENROLLMENT – AGE 65 AND OLDER (EXCLUDES MEDICARE SAVINGS PLAN ONLY)

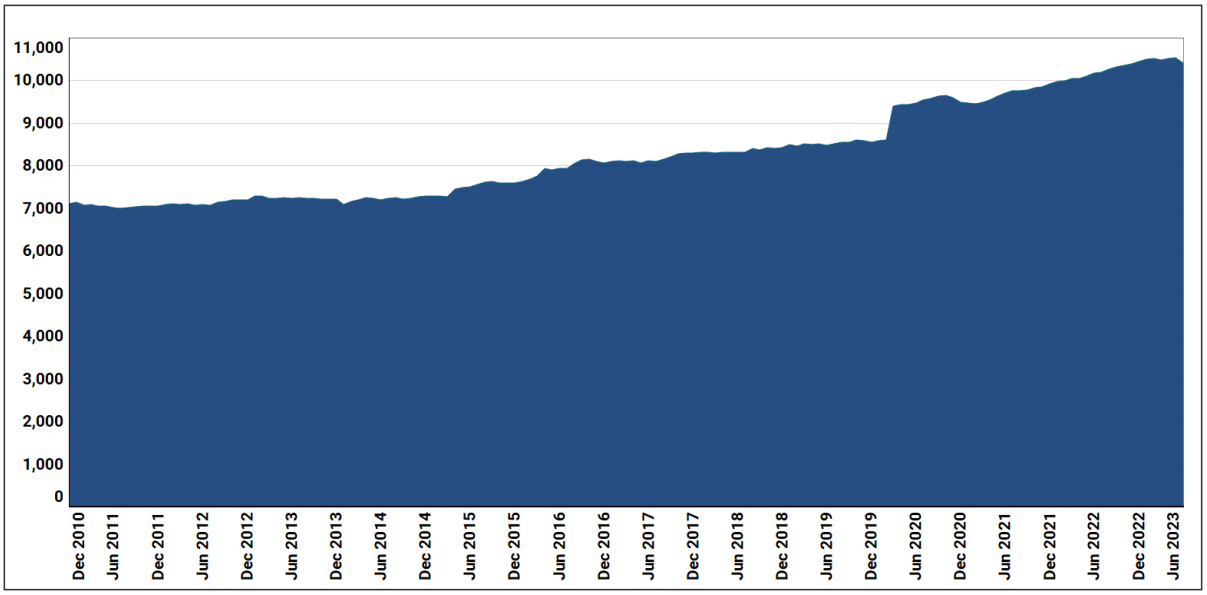


FIGURE 8 – FAMILY MEDICAID ENROLLMENT (EXCLUDES MEDICARE SAVINGS PLAN ONLY)

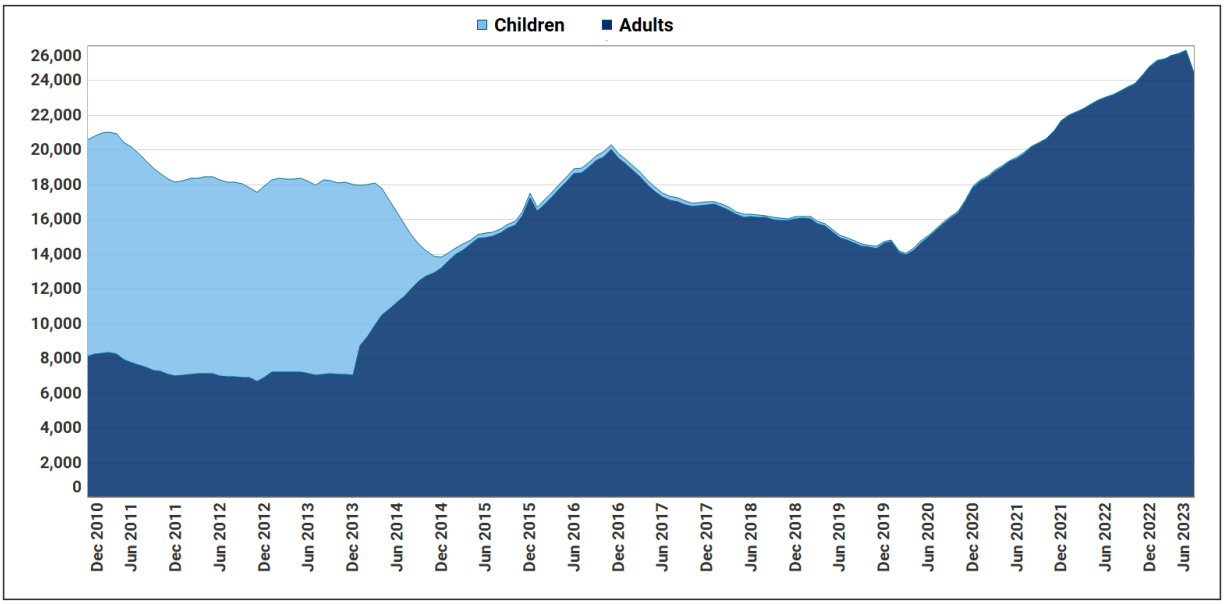


FIGURE 9 – MEDICAID POVERTY CHILD ENROLLMENT (EXCLUDES MEDICARE SAVINGS PLAN ONLY)

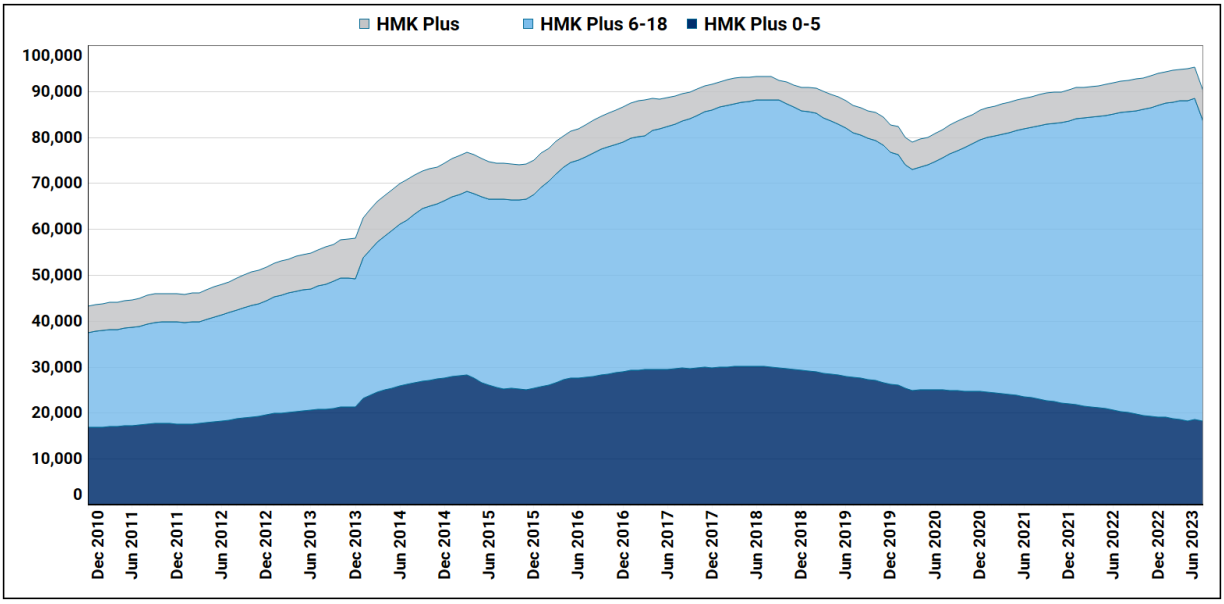


FIGURE 10 – MEDICAID ENROLLMENT – PREGNANT WOMEN AND INFANTS

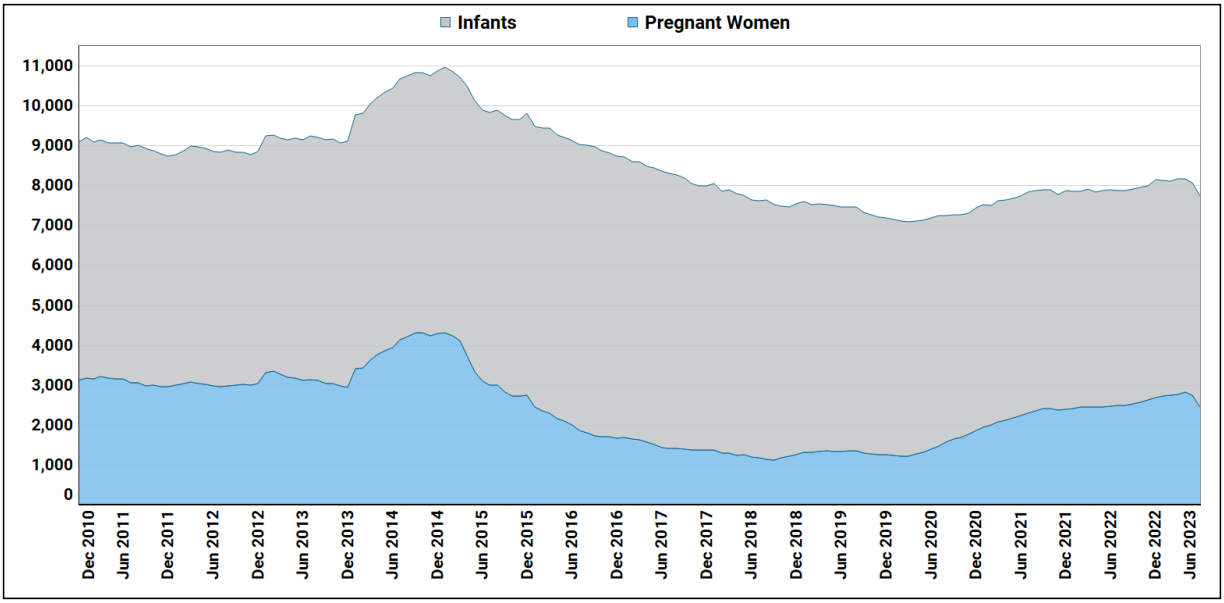


FIGURE 11 – MEDICAID EXPANSION ENROLLMENT

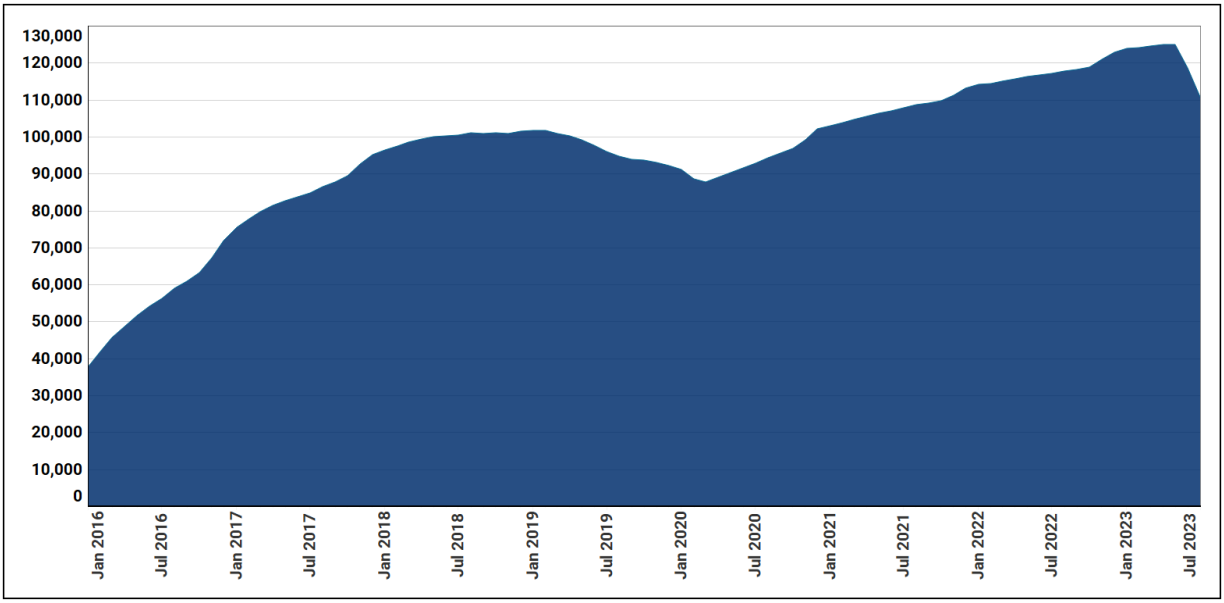


TABLE 10 – MEDICAID ENROLLMENT AND EXPENDITURES BY COUNTY SFY 2023

County	Population	Average Monthly Medicaid Enrollment		Percent on Medicaid	Rank by Percent on Medicaid	Total County Expenditures	
		Standard	Expansion			Standard	Expansion
BEAVERHEAD	9,885	1,273	932	22%	34	10,913,696	8,757,787
BIG HORN	12,751	4,587	2,398	55%	3	36,215,139	34,733,791
BLAINE	6,899	1,849	891	40%	8	19,286,657	13,071,000
BROADWATER	8,032	705	460	15%	53	4,477,352	3,792,392
CARBON	11,419	1,288	1,014	20%	40	7,668,398	7,751,901
CARTER	1,418	104	73	12%	56	779,236	486,397
CASCADE	84,900	13,737	9,428	27%	22	119,154,293	82,715,526
CHOUTEAU	5,847	660	468	19%	42	6,285,548	4,642,607
CUSTER	11,985	1,923	1,160	26%	27	19,717,936	10,003,614
DANIELS	1,633	179	126	19%	43	1,698,841	1,555,487
DAWSON	8,810	1,320	741	23%	32	12,978,940	7,225,347
DEER LODGE	9,673	1,442	1,204	27%	21	16,175,678	9,226,433
FALLON	2,994	338	188	18%	47	2,304,975	1,886,727
FERGUS	11,772	1,696	1,043	23%	33	17,191,199	7,992,610
FLATHEAD	113,679	16,412	11,819	25%	29	106,651,597	92,701,101
GALLATIN	126,409	8,899	8,640	14%	55	48,195,287	47,673,904
GARFIELD	1,211	229	93	27%	23	1,276,695	591,374
GLACIER	13,609	4,970	3,094	59%	1	50,231,252	45,331,758
GOLDEN VALLEY	835	200	152	42%	6	890,969	837,993
GRANITE	3,595	350	269	17%	48	2,475,074	2,370,057
HILL	16,276	4,436	2,638	43%	5	37,458,309	27,879,253
JEFFERSON	13,048	1,383	910	18%	46	14,696,174	6,683,801
JUDITH BASIN	2,093	271	194	22%	35	1,157,594	1,236,639
LAKE	33,338	6,807	4,427	34%	11	51,704,661	44,609,559
LEWIS AND CLARK	75,011	9,441	6,784	22%	37	83,914,068	55,387,574
LIBERTY	1,974	359	237	30%	16	2,670,312	1,916,868
LINCOLN	21,895	4,214	2,844	32%	13	29,879,861	23,743,443
MADISON	9,521	803	566	14%	54	5,589,129	4,446,643
MCCONE	1,676	155	105	16%	51	998,022	878,184
MEAGHER	2,071	385	273	32%	14	2,240,045	2,500,298
MINERAL	5,090	1,012	691	33%	12	5,106,599	5,133,882
MISSOULA	121,849	14,924	14,045	24%	31	137,556,713	95,189,517
MUSSELSHELL	5,308	944	620	29%	18	7,578,859	5,317,906
PARK	17,903	1,948	1,832	21%	38	15,876,122	15,691,009

TABLE 11 – MEDICAID ENROLLMENT AND EXPENDITURES BY COUNTY SFY 2023

County	Population	Average Monthly Medicaid Enrollment		Percent on Medicaid	Rank by Percent on Medicaid	Total County Expenditures	
		Standard	Expansion			Standard	Expansion
PETROLEUM	554	53	36	16%	50	$263,155	$238,602
PHILLIPS	4,249	924	519	34%	10	6,929,992	5,790,400
PONDERA	6,125	1,506	976	41%	7	13,440,306	10,550,660
POWDER RIVER	1,743	156	101	15%	52	1,111,992	731,980
POWELL	7,133	951	1,143	29%	19	7,987,988	7,081,662
PRAIRIE	1,112	167	80	22%	36	1,530,584	836,840
RAVALLI	47,738	6,638	5,080	25%	30	48,348,530	38,764,276
RICHLAND	11,173	1,451	830	20%	39	11,709,460	9,148,195
ROOSEVELT	10,319	3,871	2,133	58%	2	39,477,098	33,108,030
ROSEBUD	8,160	2,427	1,255	45%	4	19,919,451	14,900,021
SANDERS	13,684	2,433	1,676	30%	17	19,266,591	12,065,078
SHERIDAN	3,498	443	251	20%	41	3,846,350	2,205,883
SILVER BOW	36,360	5,958	5,097	30%	15	57,304,870	41,325,338
STILLWATER	9,173	1,059	609	18%	45	5,896,729	3,916,946
SWEET GRASS	3,763	388	255	17%	49	2,171,050	1,735,614
TETON	6,430	1,001	669	26%	25	6,780,446	4,574,332
TOOLE	5,133	840	662	29%	20	7,485,692	4,619,531
TREASURE	772	130	66	25%	28	586,752	508,646
VALLEY	7,474	1,265	671	26%	26	13,965,680	7,125,538
WHEATLAND	2,057	488	311	39%	9	3,030,181	2,959,480
WIBAUX	910	115	54	19%	44	1,436,042	599,495
YELLOWSTONE	170,843	26,149	18,366	26%	24	196,795,965	157,955,276
Other / Unknown		349	212			685,791	362,420
Sub Total	**1,132,812**	**168,003**	**121,410**	**26%**		**$1,350,965,928**	**$1,035,066,628**
Plan First		1,880				170,049	
QMB Only		4,668				16,889,300	
SLMB - QI Only		4,853				9,656,088	
HK (CHIP Funded)		6,842				23,130,858	
Grand Total	**1,132,812**	**186,246**	**121,410**	**27%**		**$1,400,812,223**	**$1,035,066,628**

Population estimates as 2023. 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 12 – MEDICAID EXPENSES – SFY 2023

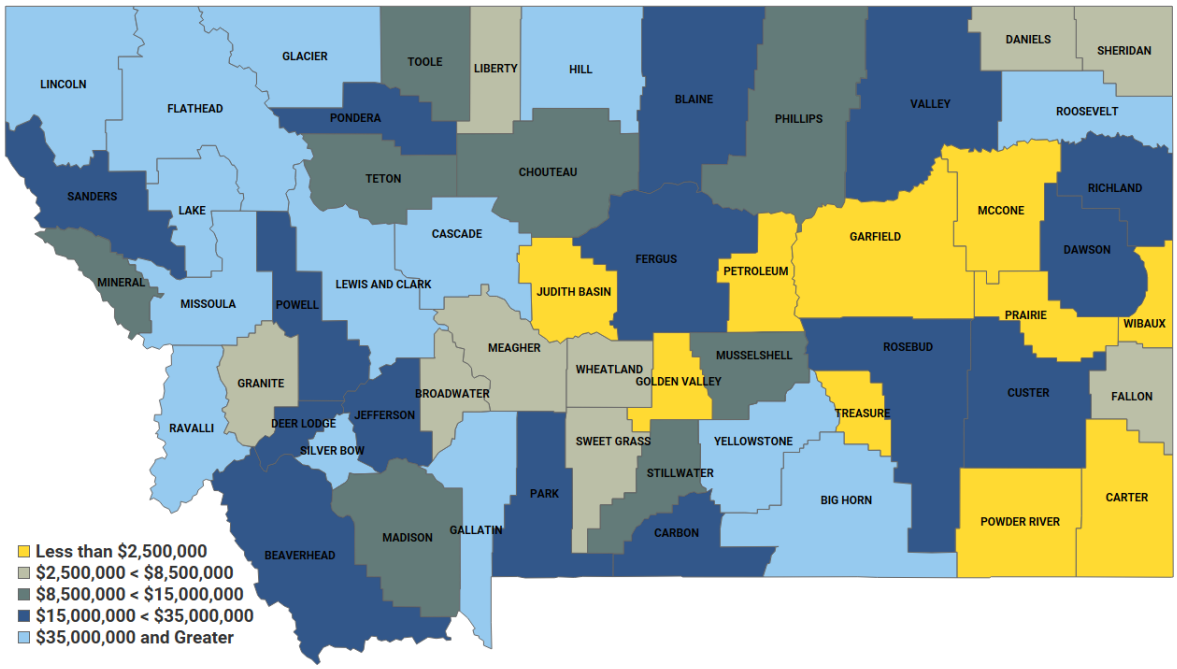


FIGURE 13 – MEDICAID: AVERAGE MONTHLY ENROLLMENT – SFY 2023

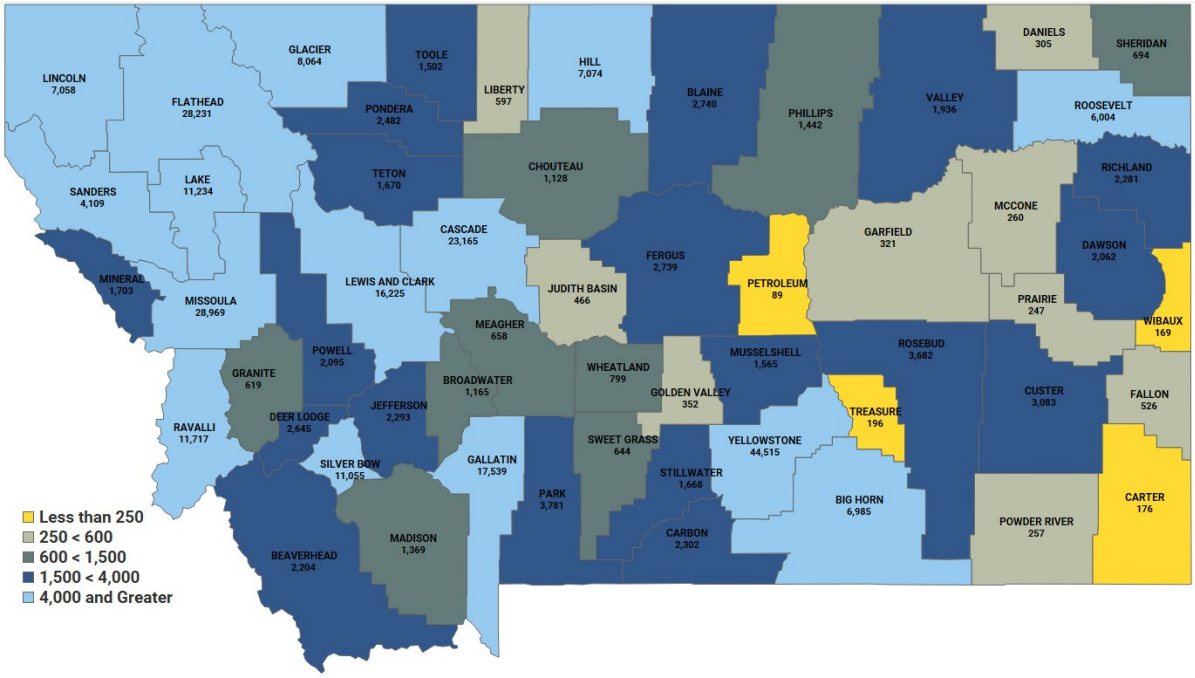


FIGURE 14 – MEDICAID: AVERAGE EXPENDITURE PER ENROLLEE – SFY 2023

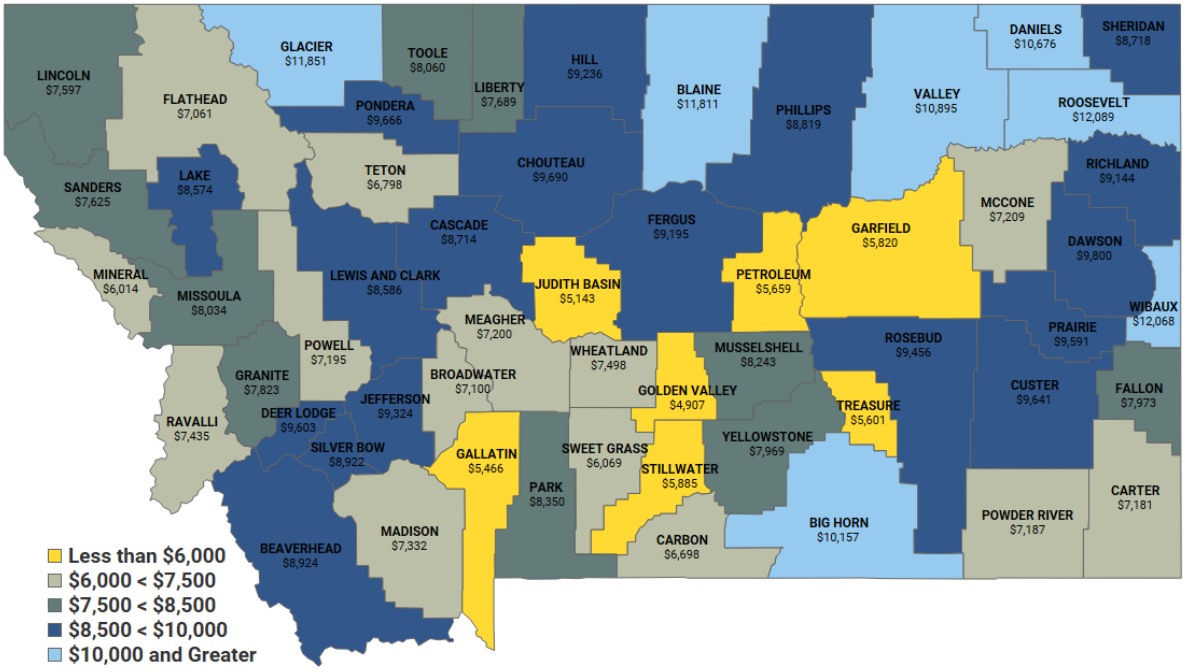
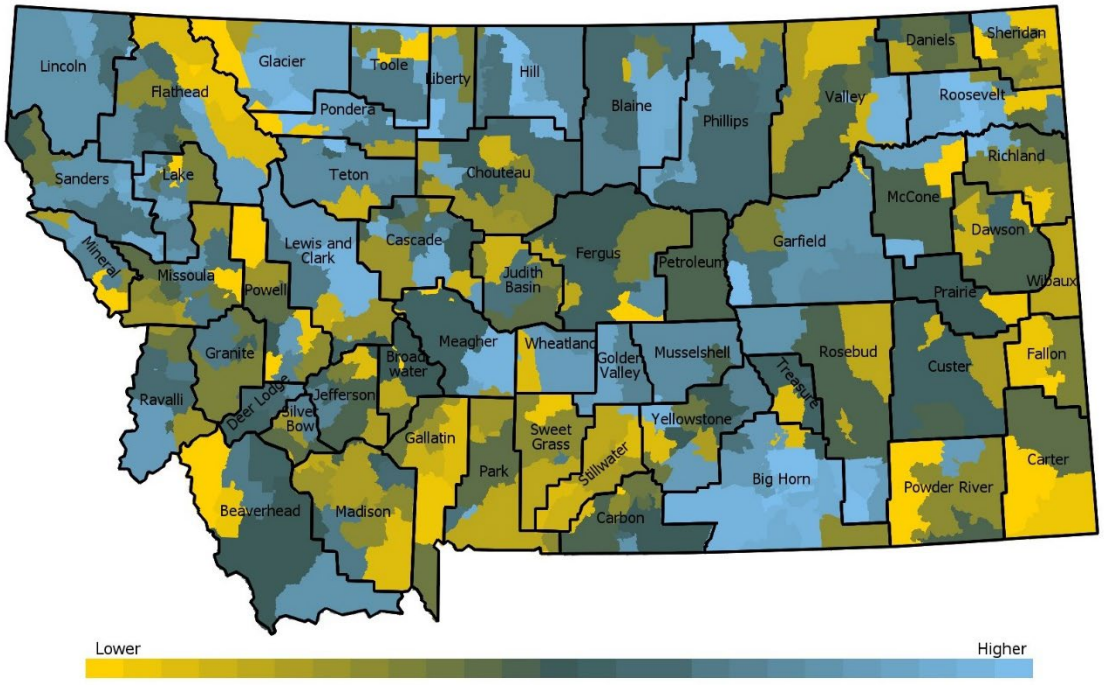


FIGURE 15 – MEDICAID ENROLLMENT BY PERCENT OF POPULATION



MONTANA MEDICAID BENEFIT – RELATED EXPENDITURES

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

TABLE 12 – BENEFIT EXPENDITURES BY CATEGORY (STANDARD MEDICAID)

Categories	FY 2020	FY 2021	FY 2022	FY 2023
Hospital Services	$ 239,935,498	$ 256,914,739	$ 272,133,940	$ 296,982,027
Physician and Professional Services	85,816,853	92,218,394	107,158,092	114,658,032
Pharmacy and Rebates	58,300,287	62,106,654	66,491,748	67,389,580
Dental	40,148,262	48,059,714	52,774,226	55,425,572
Health Centers and Clinics	34,476,484	34,967,936	39,505,187	43,784,043
Medical Equipment and Supplies	18,003,077	21,545,459	23,390,131	25,452,420
Laboratory and Imaging Services	4,784,195	6,850,085	6,951,606	6,869,754
Medical Transportation	8,687,516	7,810,328	8,992,138	9,440,257
Other Services	2,241,981	2,020,315	2,193,957	2,587,654
Nursing Facility	177,972,379	160,647,033	151,750,194	146,642,703
Home and Community Based - Other Services	6,188,666	4,797,068	4,508,349	3,936,880
Home and Community Based - CFC	47,032,978	48,079,208	49,103,604	49,212,046
Home and Community Based - Big Sky Waiver	40,280,154	53,005,770	57,167,158	57,844,521
Care and Case Management	14,534,884	16,765,911	16,734,376	17,575,244
Substance Use Disorder Services	2,949,955	3,151,047	3,876,237	4,155,670
Mental Health Services	120,178,136	126,347,963	124,064,291	128,737,576
Home and Community Based - SDMI Waiver	6,291,500	12,911,103	15,376,910	18,538,488
Mental Health Services - HIFA Waiver	7,676,380	7,205,950	6,995,412	6,740,858
Developmental Disability Services	285,200	646,522	1,144,790	1,666,601
Home and Community Based - DD Waiver	128,945,129	129,164,590	127,991,212	132,344,299
Indian and Tribal Health Services	74,082,926	64,062,862	89,772,636	108,971,119
School Based - Physical Health	4,227,431	4,414,947	5,090,273	4,945,537
School Based - Mental Health	25,042,572	19,981,903	19,717,067	15,631,320
Medicare Buy-In	46,829,969	50,070,053	54,650,799	58,149,164
Standard Total	$ 1,194,912,411	$ 1,233,745,554	$ 1,307,534,333	$ 1,377,681,365

TABLE 13 – BENEFIT EXPENDITURES BY CATEGORY (MEDICAID EXPANSION)

Categories	FY 2020	FY 2021	FY 2022	FY 2023
Hospital Services	$ 451,260,939	$ 512,249,055	$ 535,466,027	$ 526,212,770
Physician and Professional Services	83,410,487	95,664,580	105,534,825	106,300,364
Pharmacy and Rebates	65,322,889	82,789,335	100,987,858	102,514,478
Dental	17,436,161	20,384,696	20,788,876	21,152,129
Health Centers and Clinics	35,242,251	38,523,241	40,474,485	43,495,167
Medical Equipment and Supplies	7,497,715	9,763,441	12,188,265	14,392,437
Laboratory and Imaging Services	13,574,537	19,014,196	18,325,960	20,149,248
Medical Transportation	5,825,363	6,782,160	8,179,231	8,181,066
Other Services	935,919	1,192,506	1,041,711	839,023
Nursing Facility	6,469,241	7,069,892	6,988,263	8,347,415
Home and Community Based - Other Services	1,655,535	1,502,870	1,814,067	1,364,075
Home and Community Based - CFC	1,347,545	1,886,811	2,959,568	3,291,054
Home and Community Based - Big Sky Waiver	50,996	122,063	167,853	156,607
Care and Case Management	5,898,899	6,527,257	6,652,531	7,404,938
Substance Use Disorder Services	13,498,199	13,805,650	16,294,558	15,286,956
Mental Health Services	43,508,585	55,823,973	61,607,692	69,670,818
Home and Community Based - SDMI Waiver	27,898	80,759	133,232	81,455
Indian and Tribal Health Services	57,713,116	57,806,019	79,515,556	86,226,629
Expansion Total	$ 810,676,274	$ 930,988,505	$ 1,019,120,555	$ 1,035,066,628

FIGURE 16A – STANDARD MEDICAID BENEFIT EXPENDITURES BY CATEGORY: FY 2020 TO FY 2023

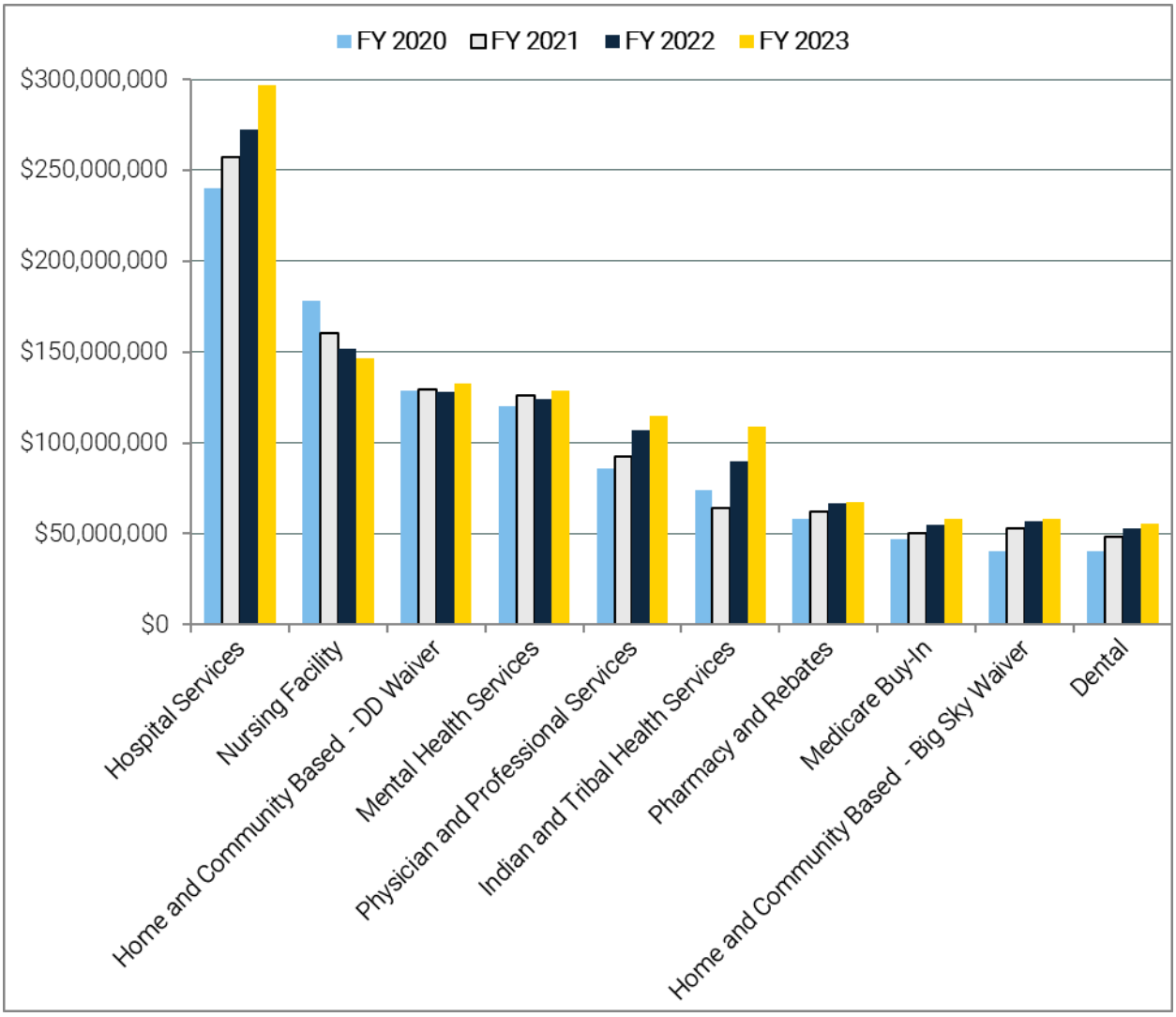


FIGURE 16B – EXPANSION MEDICAID BENEFIT EXPENDITURES BY CATEGORY: FY 2020 TO FY 2023

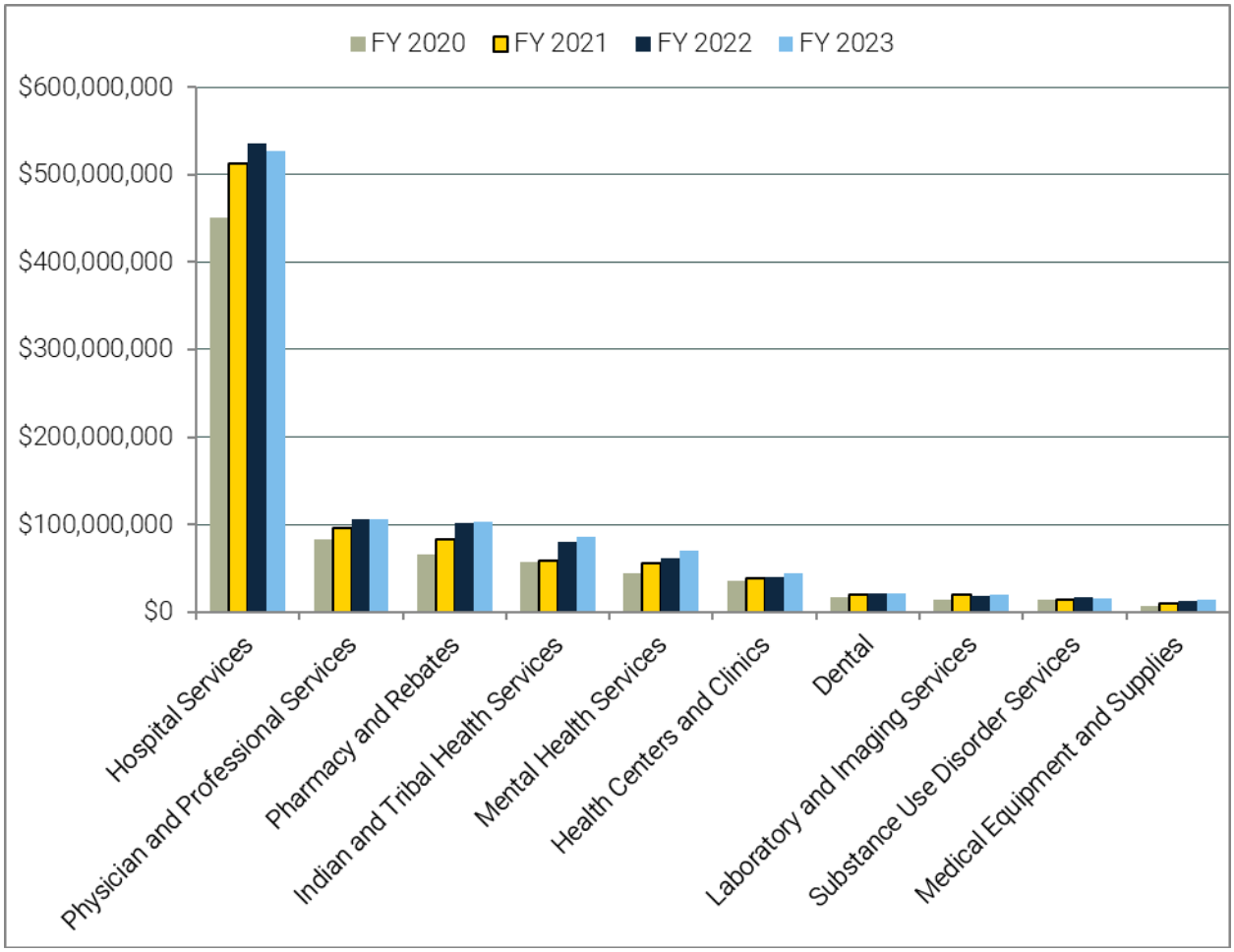


FIGURE 17 –MEDICAID BENEFIT EXPENDITURES SFY 2023

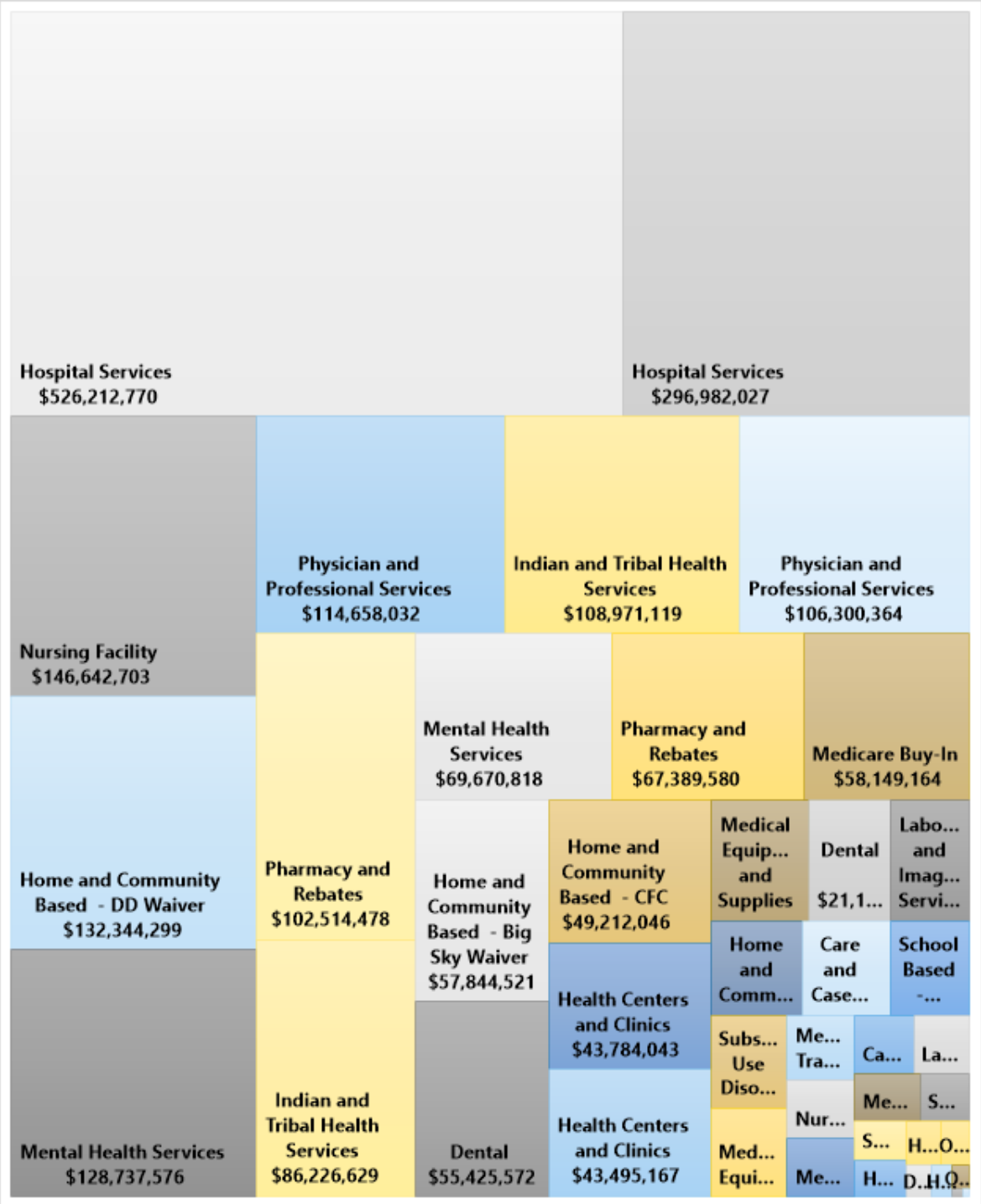
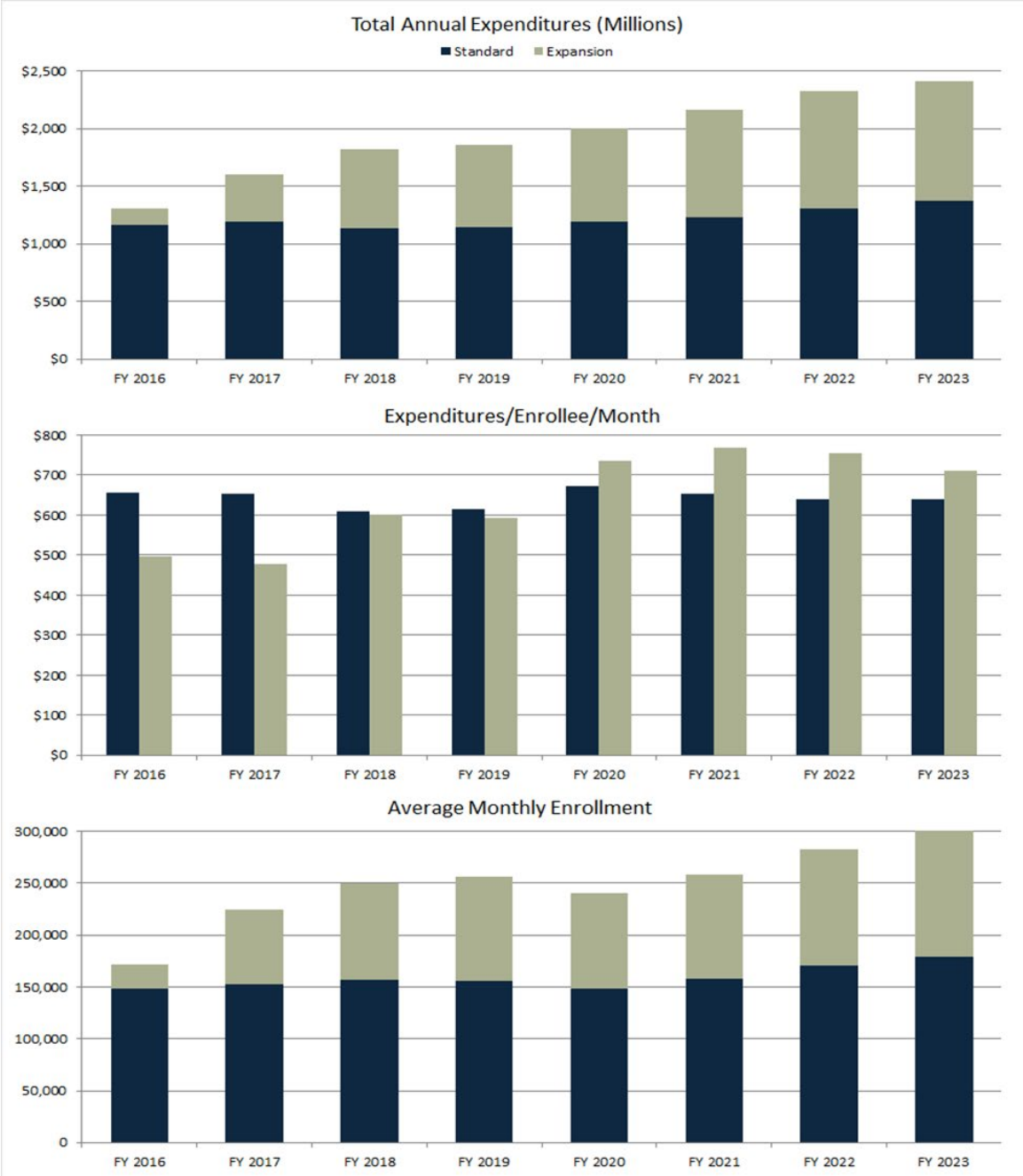


FIGURE 18 – HISTORY OF EXPENDITURES AND ENROLLMENT



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

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

TABLE 14 – MEDICAID AVERAGE PER MONTH ENROLLMENT

		State Fiscal Year					
Age	Category	2018	2019	2020	2021	2022	2023
< 1	Blind/Disabled	47	38	26	26	29	21
< 1	Child	6,599	6,235	5,910	5,551	5,420	5,355
1 to 5	Blind/Disabled	368	363	351	292	250	231
1 to 5	Child	30,192	29,634	27,004	27,498	28,080	27,781
6 to 18	Blind/Disabled	2,350	2,200	2,043	1,929	1,890	1,793
6 to 18	Child	60,447	61,243	56,781	59,913	64,888	68,450
19 to 20	Blind/Disabled	421	408	405	425	431	443
19 to 20	Adult	1,264	1,395	1,244	2,902	5,533	7,034
21 to 64	Blind/Disabled	15,185	14,899	14,886	15,234	14,990	14,779
21 to 64	Adult	18,699	17,984	18,471	22,872	27,473	32,028
65 +	Aged	7,674	7,811	8,162	8,632	8,779	8,988
65 +	Blind/Disabled	437	447	501	704	890	1,099
Total		**143,685**	**142,656**	**135,785**	**145,976**	**158,653**	**168,003**
All	Plan First	1,637	1,528	1,426	1,327	1,646	1,880
All	QMB	5,660	5,823	5,689	5,194	4,934	4,668
All	SLMB - QI	5,250	5,384	5,421	5,200	5,035	4,853
Total	**Standard**	**156,232**	**155,390**	**148,321**	**157,697**	**170,268**	**179,404**
All	Expansion	94,023	100,591	91,781	100,901	112,625	121,410
Total	**All Medicaid**	**250,255**	**255,981**	**240,102**	**258,597**	**282,893**	**300,813**
6 to 18	HK Med Plus	5,590	5,253	6,022	6,473	6,732	6,842
Total	All Categories	255,845	261,234	246,123	265,070	289,625	307,655

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 15 – MEDICAID MONTHLY REIMBURSEMENT – PER MEMBER

		State Fiscal Year					
Age	Category	2018	2019				2023
< 1	Blind/Disabled	$11,221	$3,815	$6,054	$4,985	$2,725	$7,030
< 1	Child	733	668	774	856	887	1,013
1 to 5	Blind/Disabled	2,091	2,422	1,833	1,734	1,543	1,546
1 to 5	Child	186	190	194	176	231	255
6 to 18	Blind/Disabled	2,039	2,149	1,538	1,578	1,671	1,582
6 to 18	Child	321	324	345	332	338	349
19 to 20	Blind/Disabled	1,317	1,376	1,801	1,626	1,662	1,858
19 to 20	Adult	386	388	490	383	331	322
21 to 64	Blind/Disabled	1,832	1,880	2,026	2,048	2,051	2,101
21 to 64	Adult	479	475	544	542	511	490
65 +	Aged	2,402	2,497	2,525	2,312	2,279	2,225
65 +	Blind/Disabled	1,664	1,577	3,380	3,042	2,899	2,733
Total		**$647**	**$654**	**$716**	**$690**	**$673**	**$670**
All	Plan First	15	13	13	13	9	8
All	QMB	253	266	275	272	287	302
All	SLMB - QI	129	134	141	139	153	166
Total	**Standard**	**$608**	**$615**	**$671**	**$652**	**$640**	**$640**
All	Expansion	600	593	736	769	754	710
Total	**All Medicaid**	**$605**	**$606**	**$696**	**$698**	**$685**	**$668**
6 to 18	HK Med Plus	184	235	248	238	269	282
Total	**All Categories**	**$596**	**$599**	**$685**	**$686**	**$676**	**$660**

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 16 – MEDICAID REIMBURSEMENT TOTALS – ALL DEMOGRAPHIC GROUPS

		State Fiscal Year					
Age	Category	2018	2019				2023
< 1	Blind/Disabled	$6,384,796	$1,716,802	$1,882,748	$1,540,389	$945,660	$1,806,759
< 1	Child	58,044,342	50,004,440	54,881,535	56,994,701	57,674,458	65,077,002
1 to 5	Blind/Disabled	9,240,856	10,541,594	7,717,371	6,069,346	4,635,266	4,291,459
1 to 5	Child	67,407,169	67,538,431	63,014,867	58,206,083	77,859,793	85,009,492
6 to 18	Blind/Disabled	57,505,299	56,738,789	37,698,693	36,530,828	37,887,527	34,026,225
6 to 18	Child	232,594,799	238,064,793	235,165,020	238,682,275	262,999,142	286,691,537
19 to 20	Blind/Disabled	6,661,807	6,727,186	8,759,248	8,284,516	8,591,485	9,886,985
19 to 20	Adult	5,861,172	6,495,333	7,313,779	13,349,605	21,971,823	27,146,051
21 to 64	Blind/Disabled	333,832,720	336,063,025	361,994,899	374,348,935	368,950,615	372,686,389
21 to 64	Adult	107,425,221	102,584,368	120,645,169	148,719,588	168,498,577	188,324,858
65 +	Aged	221,180,826	234,015,307	247,355,097	239,518,335	240,093,254	239,973,752
65 +	Blind/Disabled	8,731,587	8,453,341	20,324,374	25,691,345	30,974,970	36,045,421
Total		**$1,114,870,592**	**$1,118,943,409**	**$1,166,752,799**	**$1,207,935,945**	**$1,281,082,571**	**$1,350,965,928**
All	Plan First	302,557	246,193	215,087	211,866	170,741	170,049
All	QMB	17,209,819	18,585,937	18,758,655	16,922,062	17,018,999	16,889,300
All	SLMB - QI	8,155,772	8,667,296	9,185,871	8,675,682	9,262,022	9,656,088
Total	**Standard**	**$1,140,538,740**	**$1,146,442,834**	**$1,194,912,411**	**$1,233,745,554**	**$1,307,534,333**	**$1,377,681,365**
All	Expansion	676,691,517	715,383,808	810,676,274	930,988,505	1,019,120,555	1,035,066,628
Total	**All Medicaid**	**1,817,230,257**	**1,861,826,642**	**2,005,588,685**	**2,164,734,059**	**2,326,654,888**	**2,412,747,993**
6 to 18	HK Med Plus	12,328,564	14,841,267	17,926,611	18,468,036	21,750,755	23,130,858
Total	All Categories	$1,829,558,821	$1,876,667,909	$2,023,515,296	$2,183,202,094	$2,348,405,644	$2,435,878,852

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 IHS. Montana Medicaid providers predominately live and work in communities across the state and serve as major employers. In SFY 2021, Standard Medicaid service providers received reimbursements, resulting in over $1.1 billion flowing into Montana's economy.

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

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

For more information, please refer to:

- Montana Healthcare Programs Provider Information
- DPHHS Provider Search

CLAIMS PROCESSING

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

TABLE 17– COMPARISON OF PAPER AND ELECTRONIC CLAIMS PROCESSED (SFY 2024)

Claim Type	Number Processed	Percentage of Total
Paper	564,467	3.7%
Electronic	14,857,368	96.3%
Total	15,421,835	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:

RATE + QUALITY SYSTEM

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

PROFESSIONAL SERVICES REIMBURSEMENT

Professional services are services rendered by, but not limited to, physicians, mid-level practitioners, podiatrists, psychiatrists, physical therapists, occupational therapists, speech pathologists, optometrists, audiologists, licensed psychologists, licensed clinical social workers, licensed professional counselors, and dentists. Montana Medicaid utilizes two relative value reimbursement methodologies for professional services: the Resource Based Relative Value Scale (RBRVS) and Relative Value for Dentists (RVD). These methodologies establish rates based on the relative value of services to all other services.

RBRVS

Medicare utilizes the RBRVS reimbursement methodology for establishing the Medicare Physicians Fee Schedule. This methodology assigns a relative value unit (RVU) to a service or procedure relative to all services and procedures. RVUs account for physician work, practice expenses, and malpractice expenses.

The RBRVS rate is calculated by multiplying the RVU by the Montana Medicaid conversion factor and any applicable policy adjustor and/or provider rate of reimbursement. Montana Medicaid has four conversion factors: physician services, allied health, mental health, and anesthesia.

RVD

This methodology is similar to RBRVS methodology as dental services are assigned RVDs based on national surveys of physicians and dentists. The dental service rate is calculated by multiplying the assigned RVD by the Montana Medicaid dental conversion factor.

HOSPITAL SERVICES REIMBURSEMENT

Montana Medicaid has two types of hospital providers: critical access hospitals (CAH) and prospective payment system hospitals. Each with its own reimbursement methodology.

Critical Access Hospitals

Inpatient and Outpatient CAH services are reimbursed utilizing a cost-based reimbursement methodology. CAH hospital claims are priced by multiplying a hospital's submitted charges by their cost-to-charge ratio. Annually CAHs are cost settled to 101% of their cost.

Prospective Payment System Hospitals

There are two reimbursement methodologies for PPS hospitals. Inpatient services are priced under the 3M All Patient Refined Diagnosis Related Groups (APR-DRG) payment methodology. Outpatient services are reimbursed under the Outpatient Prospective Payment System (OPPS) reimbursement methodology.

APR-DRG

This methodology is a classification system that utilizes diagnosis codes, surgical procedure codes, member demographics, and length of stay to assign an APR-DRG and case severity.

The APR-DRG rate is calculated by multiplying the APR-DRG weights by the Montana Medicaid base rate and any applicable policy adjustor. Montana Medicaid has four base rates based on facility type: Center of Excellence (COE), Long Term Acute Care (LTAC), Inpatient Rehabilitation Facility (IRF), and all other IPPS hospitals.

OPPS

This methodology utilizes the Medicare Ambulatory Payment Classifications (APC), the Medicare Outpatient Code Editor (OCE), and a Montana Medicaid OPPS conversion factor to price outpatient PPS hospital claims. The OCE is a program that provides claims editing, APC assignment, and service bundling logic.

FEE SCHEDULE SERVICES REIMBURSEMENT

Various Medicaid covered services are reimbursed at 100% of the published Medicare rate. These services include:

- Ambulatory Surgical Center Services,
- Durable Medical Equipment, Prosthetics, Orthotics and Supplies,
- Laboratory Services, and
- Physician Administered Drugs.

PHARMACY REIMBURSEMENT

Pharmacy reimbursement has two pricing components: professional dispensing fee and the allowed drug ingredient cost.

Professional Dispensing Fee

Annually enrolled pharmacy providers complete the Dispensing Fee Survey. Results from this survey are used to calculate a pharmacy provider's cost to dispense and annual prescription volume. Based on the survey results, a pharmacy is assigned a professional dispensing fee that is the lower of their calculated cost to dispense or the maximum dispensing fee for their assigned prescription volume tier.

Allowed Drug Ingredient Cost

Montana Medicaid utilizes an average acquisition cost (AAC) methodology to establish an allowed drug ingredient cost. The AAC rate is calculated based on direct pharmacy survey, wholesale survey, and other relevant cost information. For drugs that do not have an AAC rate, the allowed ingredient is the lower of the published wholesale acquisition cost rate or the federal upper limit rate.

ENCOUNTER-BASED RATES

Dialysis clinics, FQHCs, RHCs, UIOs, and IHS/Tribal 638 providers are reimbursed utilizing encounter-based reimbursement methodologies.

Dialysis Clinics

The Montana Medicaid dialysis composite rate is state-set. The rate is to cover all services provided for a single date of service.

FQHC, RHC, and UIO

Per encounter rates for these providers are set utilizing Medicare cost reports. The rate is increased annually by the Medicare Economic Index. Medicare cost reports are reviewed, and the encounter rate may be updated based on a provider's requested change in scope of service.

IHS / Tribal 638 services

IHS/Tribal 638 providers are 100% federally funded, for a majority of IHS / Tribal 638 services, Montana Medicaid is required to utilize the All-Inclusive Rate (AIR) published annually in the federal register.

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

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

Long-Acting Reversible Contraceptives (LARC)

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

Promising Pregnancy Care (PPC)

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

School Based Services

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

PHYSICIAN/MID-LEVEL

Practitioner Team Care

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

Passport to Health

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

Comprehensive Primary Care Plus (CPC+) and Patient Centered Medical Home (PCMH)

- 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 a healthier population.

HOSPITALS

Out-of-State Inpatient Hospitals

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

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

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

PHARMACY

Prior Authorization (PA)

- Requires mandatory advance approval of certain medications before they are dispensed for any medically accepted indication.
- Process is handled 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 a 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 the best value to the Medicaid program, including increased supplemental rebates.

Drug Rebate Collection

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

Average Acquisition Cost (AAC)

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

HMK and Pharmacy Processed through MMIS

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

LONG-TERM CARE

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 community settings.
- Targets persons with complex needs (including traumatic brain injury), SDMI, physical disabilities, and/or elders in nursing homes, and individuals aged 18-21 or over 64 in the Montana State Hospital.
- All waiver and demonstration services receive an enhanced Federal Medical Assistance Percentage (FMAP) rate for Medicaid benefits for a period of 365 days of service; on day 366, a participant is served under an HCBS waiver at regular FMAP.
- Grant funding will continue through calendar year 2027.

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 tasks, and related support services.
- Incentivizes with a permanent 6% increase in the federal share of Medicaid's cost (the FMAP rate) for CFC services.

Prior Authorization

- Prior authorization is required for all Big Sky Waiver services. A nursing facility level of care determination is required for Community First Choice, Big Sky Waiver, and all nursing facility services.
- Prior authorization is required for all 0208 Comprehensive Waiver services. An ICF/IID level of care determination is required for all 0208 Comprehensive Waiver services.

Big Sky Waiver/Community First Choice Quality Assurance Recovery

- Senior Long Term Care Division staff regularly conduct quality assurance (QA) reviews. Recoveries are a method of remediation when BSW quality assurance staff discover services have been provided outside the scope of BSW and/or CFC/PAS program and an overpayment has occurred.

Intergovernmental Fund Transfer

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

THIRD PARTY LIABILITY (TPL)

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

Payment and Medicare Buy-In programs by paying for cost-effective primary group or individual health plans or Medicare policy premiums.

Medicare Buy-In and Medicare Savings Program

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

PROGRAM AND PAYMENT INTEGRITY ACTIVITIES

Two state programs help protect the state Medicaid program:

- **DPHHS Office of Inspector General** – Responsible for ensuring proper payment and recovering misspent funds; and
- **Department of Justice (DOJ) Medicaid Fraud Control Unit (MFCU)** – Responsible for investigating and ensuring the prosecution of Medicaid fraud.

Medicaid Management Information System (MMIS) reviews for inaccuracies, billing errors and denies claim payments when irregularities are detected. Medicaid coordinates with efforts to identify, recover and prevent inappropriate provider billings and payments.

Federal Audit Requirements:

- Payment Error Rate Measurement (PERM) operates on a cycle, evaluating states every 3 years. Montana's most recent PERM cycle, Reporting Year (RY) 2024, reviewed claims paid during SFY23.
- Medicaid Eligibility Quality Control (MEQC) program is required by CMS to ensure that Montana Medicaid and CHIP eligibility is determined correctly, recipients are placed in the correct eligibility category, and the related expenses are paid at the correct Federal Medical Assistance Percentages (FMAPs). MEQC operates in conjunction with the PERM cycle, reporting to CMS every third calendar year. Montana's next report to CMS will be for reviews conducted during calendar year 2024.
- Montana currently has a waiver from CMS for the requirement to have a Recovery Audit Contractor (RAC).

Results of Medicaid Cost Containment\Recovery Measures:

- Clarification/streamlining of Medicaid policies, rules, and billing procedures
- Increased payment integrity, recovery of inappropriately billed payments, and avoidance of future losses
- Education of providers regarding proper billing practices
- Termination of some providers from participation in the Medicaid program
- Referrals to the Department of Justice (DOJ) Medicaid Fraud Control Unit (MFCU)
- Recovery of Medicaid payments made for Nursing Home and Home & Community Based services by placing TEFRA liens on real property.
- Recovery of Medicaid payments made on behalf of Medicaid recipients who pass away aged 55 and older through the submission of a creditor's claims in the recipient's probated estate.
- In SFY23, Montana cost avoided $292.4 million and recovered $14.3 million of Medicaid payments.
- In SFY24, Montana cost avoided $272.2 million and recovered $12.4 million of Medicaid payments

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.

ACRONYMS

AAC – Average Acquisition Cost

AMA – American Medical Association

AMDD – Addictive and Mental Disorders Division

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

BSW – Big Sky Waiver

CAH – Critical Access Hospitals

CAW – Children's Autism Waiver

CFC – Community First Choice

CMS – Centers for Medicare and Medicaid Services

CSCT – Comprehensive School and Community Treatment

DD – Developmental Disabilities

DPHHS – Department of Public Health and Human Services

DRG – Diagnosis Related Group

DSD – Developmental Services Division

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

FPL – Federal Poverty Level

FQHC – Federally Qualified Health Center

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

HCBS – Home and Community Based Services

HELP Act – Health and Economic Livelihood Partnership

HIFA – Health Insurance Flexibility and Accountability

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.

IGT – Inter Governmental Transfers

IHS – Indian Health Service
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

PCMH – Patient-Centered Medical Home PCP – Primary Care Provider

PERM – Payment Error Rate Measurement

PPC – Promising Pregnancy Care

QI – Qualifying Individual

QMB – Qualified Medicare

Beneficiary RAC – Recovery Audit Contractors

RBRVS – Resource-Based Relative Value Scale

RHC – Rural Health Clinic

SDMI – Severe and Disabling Mental Illness

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

SLMB – Specified Low-Income Medicare Beneficiary

SMAC – State Maximum Allowable Cost

SPA – State Plan Amendment

SSI – Supplemental Security Income

TPA – Third Party Administrator

TPL – Third Party Liability