GOVERNOR'S OFFICE OF BUDGET AND PROGRAM PLANNING

Fiscal Note 2027 Biennium

Bill#/Title: **SB0072: Provide presumptive eligibility for Medicaid coverage of home and community-based services**

Primary Sponsor: Mike Yakawich Status: As Amended in Senate Committee

☐ Included in the Executive Budget ☒ Needs to be included in HB 2 ☐ Significant Local Gov Impact

☐ Significant Long-Term Impacts ☒ Technical Concerns ☐ Dedicated Revenue Form Attached

FISCAL SUMMARY

	FY 2026 Difference	FY 2027 Difference	FY 2028 Difference	FY 2029 Difference
Expenditures				
General Fund (01)	$843,712	$498,231	$546,992	$599,323
Federal Special Revenue (03)	$1,412,170	$809,413	$894,810	$985,506
Revenues				
General Fund (01)	$0	$0	$0	$0
Federal Special Revenue (03)	$1,412,170	$809,413	$894,810	$985,506
Net Impact	($843,712)	($498,231)	($546,992)	($599,323)
General Fund Balance				

Description of fiscal impact

SB 72 as amended, provides for presumptive eligibility under the Medicaid program for certain Home and Community Based Services provided under the he Department of Public Health and Human Service's big sky waiver program and community first choice program for persons with physical disabilities and persons who are elderly. This would result in increased benefit costs due to benefit costs being paid sooner for individuals determined eligible for presumptive eligibility.

FISCAL ANALYSIS

Assumptions

Department of Public Health and Human Services (DPHHS/department)

1. The department assumes that 2.06% of the total Medicaid enrollments for these services will be found presumptive eligibility each year (174 of 8,439). This is based on the percentage of Medicaid enrollment in 2024 that had a presumptive eligibility span. The department assumes caseload growth of 1% each year.
2. In FY 2026 the department assumes the 130 individuals currently on the open referral waiting list will be found presumptively eligible. The open referral list is used to track individuals who are applying for the Big Sky Waiver who have met level of care criteria, but who have additional eligibility steps to complete prior to being added to the waiting list, including Medicaid eligibility. As a result, the FY 2026 total members served under this presumptive eligibility is assumed to be 304 (174+130).
3. The department assumes the individual will be on presumptive eligibility for 45 days until a full Medicaid eligibility determination is made. See technical notes for typical application processing timelines.
4. The department assumes a per member per month (PMPM) cost of $4,632 in FY 2026. This assumption is based on current calculated PMPM for individuals receiving these services under Medicaid. The

department assumes an inflationary factor of 3.7%. This is based on the most recently published Consumer Price Index (CPI) for medical services.

The table below shows the fiscal impact for individuals receiving services during the presumptive eligibility time period.

	FY 2026	FY 2027	FY 2028	FY 2029
# of Presumptive Eligible Individuals	304	176	177	179
Caseload Growth		1%	1%	1%
Per Member Per Month Cost	$4,632	$4,803	$4,981	$5,165
Inflation Factor		3.70%	3.70%	3.70%
#Presumptive Eligibility Days	45	45	45	45
Average Presumptive Eligibility Span Cost - 45 days	$6,948	$7,205	$7,472	$7,748
Total Cost	**$2,112,192**	**$1,266,220**	**$1,326,201**	**$1,389,023**
FMAP	**FY 2026**	**FY 2027**	**FY 2028**	**FY 2029**
State Share	38.39%	38.53%	38.53%	38.53%
Federal Share	61.61%	61.47%	61.47%	61.47%
FUNDING				
State Share	$810,871	$487,875	$510,985	$535,191
Federal Share	$1,301,321	$778,345	$815,216	$853,832
Total Cost	**$2,112,192**	**$1,266,220**	**$1,326,201**	**$1,389,023**

5. Changes to the Medicaid Management Information System (MMIS) and ancillary systems including data and reporting and system integration to reflect coding for presumptive Home and Community Based Services would be $71,000 ($125/hour rate for 568 hours).
6. Human and Community Services Division Administrative Costs
   a. Eligibility Activities – There are approximately 130 cases that are currently referred to home and community-based services but have not completed the application process. These cases are assumed to be processed through presumptive eligibility the first year. The estimated annual increase in presumptive coverage cases is 85 cases per year based on assumption 2 (2.06% * 4,140 estimated applications).
   b. The presumptive eligible applicants have a two-step process that takes a total of 1.83 hours per case. The application for presumptive eligibility must be entered into the eligibility system (.33 hours per case), and an application for traditional Medicaid must be determined (1.5 hours per application). All traditional Medicaid cases must be redetermined annually (1.5 hours per case ongoing). Each client service coordinator spends about 70% of their time conducting eligibility determination activities (1,456 hours per year).

Expenditure Assumptions	**FY 2026**	**FY 2027**	**FY 2028**	**FY 2029**
New Presumptive Applications	215	300	385	470
Hours to Process	1.83	1.83	1.83	1.83
Redeterminations		215	300	358
Hours to Process		1.5	1.5	1.5
Total hours needed per year (Total Cases x Hours)	394	873	1,156	1,399
Additional FTE	0.5	0.5	0.75	1

Office of the Secretary of State

7. This bill requires the Office of the Secretary of State to notify each federally recognized tribal government in Montana. While there may be a minimal fiscal impact, the Office of the Secretary of State will absorb the costs associated with implementing this bill within its existing operating budget.

Fiscal Analysis Table

Department of Public Health and Human Services

	FY 2026 Difference	FY 2027 Difference	FY 2028 Difference	FY 2029 Difference
Fiscal Impact				
FTE	0.50	0.50	0.75	1.00
TOTAL Fiscal Impact	**0.50**	**0.50**	**0.75**	**1.00**
Expenditures				
Personal Services	$40,087	$40,217	$60,585	$80,370
Operating Expenses	$103,603	$1,207	$2,493	$3,236
Benefits	$2,112,192	$1,266,220	$1,378,724	$1,501,223
TOTAL Expenditures	**$2,255,882**	**$1,307,644**	**$1,441,802**	**$1,584,829**
Funding of Expenditures				
General Fund (01)	$843,712	$498,231	$546,992	$599,323
Federal Special Revenue (03)	$1,412,170	$809,413	$894,810	$985,506
TOTAL Funding of Expenditures	**$2,255,882**	**$1,307,644**	**$1,441,802**	**$1,584,829**
Revenues				
Federal Special Revenue (03)	$1,412,170	$809,413	$894,810	$985,506
TOTAL Revenues	**$1,412,170**	**$809,413**	**$894,810**	**$985,506**
Net Impact to Fund Balance (Revenue minus Funding of Expenditures)				
General Fund (01)	($843,712)	($498,231)	($546,992)	($599,323)
Federal Special Revenue (03)	$0	$0	$0	$0

Technical Concerns

1. If it is determined that an 1115 waiver is needed for implementation of SB 72, DPHHS will submit the waiver to be approved by the Centers for Medicare & Medicaid service (CMS) by September 30, 2025. As a result, implementation would likely take effect on January 1, 2026. This would result in only six months of costs in FY 2026. DPHHS also would incur estimates contract costs of $205,000 for the CMS required independent evaluations of the 1115 waiver.
2. The Big Sky Waiver (BSW) is not an entitlement program, and applicants are placed on a waitlist. Applicants are scored with the waitlist criteria tool based on their assessed needs. Applicants with the highest score will receive the next available slot in their care category. Presumptive eligibility may decrease the amount of time it takes an individual to get added to the BSW waitlist, but it may not have an impact on the amount of time it takes someone to get screened into a BSW slot.
3. Presumptive eligibility coverage is addressed in federal regulations under 42 CFR 435.1100 – 1110. The eligible groups covered in the bill (elderly individuals and individuals with physical disabilities) are not referenced in these federal regulations. Additionally, the entities listed under Section 1(2)(a)(ii) of the bill as being authorized to perform presumptive eligibility determinations appears to exceed what is permitted under the federal regulations. DPHHS believes implementation of the presumptive eligibility process set forth in the bill will require approval from CMS through a state plan amendment and/or waiver amendment.
4. Section 1 (5) limits coverage to the date a determination is made or the end of the month following the month of the presumptive eligibility, whichever is earlier. Some cases allow for an eligibility determination within 90 days due to specific circumstances. This could require presumptive eligibility services to end prior

to an eligibility determination that is made within typical allowable timelines. This will also require DPHHS to prioritize these cases and may extend processing time for non-presumptive traditional Medicaid applications.

5. Traditional Medicaid cases require some individuals to have a monthly cost for Medicaid coverage through a "spend down". It is unclear in the bill if a client is responsible for the "spend down" during the months for which they were presumed eligible and received services.

Sponsor's Initials	Date	Budget Director's Initials	Date
			2/3/2025