GOVERNOR'S OFFICE OF BUDGET AND PROGRAM PLANNING

Fiscal Note 2027 Biennium

Bill#/Title: **SB0523.01: Revise reimbursement for medicaid services**

Primary Sponsor: Christopher Pope Status: As Introduced

☐ 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)	$14,359,449	$30,663,358	$47,122,415	$64,374,166
Federal Special Revenue (03)	$38,369,365	$82,397,867	$126,608,326	$172,936,001
Revenues				
General Fund (01)	$0	$0	$0	$0
Federal Special Revenue (03)	$38,369,365	$82,397,867	$126,608,326	$172,936,001
Net Impact	($14,359,449)	($30,663,358)	($47,122,415)	($64,374,166)
General Fund Balance				

Description of fiscal impact

SB 523 mandates reimbursement rates for services covered by the Montana Medicaid program be increased annually by a minimum of the consumer price index for those services. This will increase benefit expenditures under the Montana Medicaid program.

FISCAL ANALYSIS

Assumptions

Department of Public Health and Human Services (department)

1. The department will annually increase the reimbursement rate to providers of all Medicaid covered services by a minimum of the consumer price index (CPI) for those services each year beginning in FY 2026 with the exception of physicians that already have a statutorily required rate adjustments under 53-6-125 MCA. For purposes of the fiscal note, the department utilized the annual average CPI for medical services over the past five years (2.86%). This increase will compound over time resulting in a realized increase in rates as compared to current rates of 5.8018% in FY 2027, 8.8277% in FY 2028, and 11.9402% in FY 2029.
2. To calculate the fiscal impact, the department utilized its projected caseload for traditional Medicaid and Medicaid expansion in FY 2026 and FY 2027 and then applied the average CPI increase (2.86%) each year, with the only exclusion being providers that fall under the existing provisions of 53-6-125 MCA and critical access hospitals (see technical note 1(b)). For FY 2028 and FY 2029, the department applied a 1% annual caseload growth factor to the FY 2027 caseload projection.
3. The following Federal Medical Assistance Percentage (FMAP) rates were used: Standard Medicaid FMAP for SFY 2026 - 38.39% general fund, 61.61% federal funds ~ SFY 2027 to 2029 - 38.53% general fund, 61.47% federal funds; Standard Community First Choice FMAP for SFY 2026 – 32.3S9% general fund, 67.61% federal funds ~ SFY 2027 to 2029 to 32.53% general fund, 67.47% federal funds; Expansion

Medicaid FMAP - SFY 2026 to 2029 – 10% general fund, 90% federal funds; Expansion Community First Choice FMAP - SFY 2026 to 2029 – 4% general fund, 96% federal funds.

Fiscal Analysis Table

Department of Public Health and Human Services

	FY 2026 Difference	FY 2027 Difference	FY 2028 Difference	FY 2029 Difference
Fiscal Impact				
Expenditures				
Benefits	$52,728,814	$113,061,225	$173,730,741	$237,310,167
TOTAL Expenditures	**$52,728,814**	**$113,061,225**	**$173,730,741**	**$237,310,167**
Funding of Expenditures				
General Fund (01)	$14,359,449	$30,663,358	$47,122,415	$64,374,166
Federal Special Revenue (03)	$38,369,365	$82,397,867	$126,608,326	$172,936,001
TOTAL Funding of Expenditures	**$52,728,814**	**$113,061,225**	**$173,730,741**	**$237,310,167**
Revenues				
Federal Special Revenue (03)	$38,369,365	$82,397,867	$126,608,326	$172,936,001
TOTAL Revenues	**$38,369,365**	**$82,397,867**	**$126,608,326**	**$172,936,001**
Net Impact to Fund Balance (Revenue minus Funding of Expenditures)				
General Fund (01)	($14,359,449)	($30,663,358)	($47,122,415)	($64,374,166)
Federal Special Revenue (03)	$0	$0	$0	$0

Technical Concerns

1. In addition to providers who receive a statutory rate increase under existing 53-6-125 MCA, many other Medicaid rate adjustments are made annually based on different payment methodologies utilized by Medicaid. These different methodologies are outlined below:
2. Ambulatory Surgical Center Services, Durable Medical Equipment (DME), laboratory services, and physician administered drugs rates are tied to the Medicare fee schedules.
3. Critical Access Hospitals are cost settled annually at 101% of cost.
4. Pharmacy reimbursement has two pricing components: professional dispensing fee and the allowed drug ingredient cost. 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. Montana Medicaid utilizes an average acquisition cost (AAC) methodology to establish an allowed drug ingredient cost.
5. Federally Qualified Health Centers, Rural Health Clinics and Urban Indian Organizations rates 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.
6. Indian Health Service (IHS)/Tribal 638 provider rates are required to utilize the All-Inclusive Rate (AIR) published annually in the federal register.
7. A mandatory increase of provider rates without exceptions could put the department at risk of exceeding applicable upper payment limits. Many Medicaid services are reimbursed at rates equal to Medicare, which serves as the upper payment limit for these services. A mandated increase could push reimbursement rates above these limits, resulting in non-compliance with federal regulations. For example, federal upper payment limits require the Medicaid durable medical equipment program to reimburse at or below 100% of

the Medicare rate. If the department exceeds the upper payment limit, the state would be responsible for the expenditures above this limit.

8. SB 523 directs the department to include in provider contracts a cost-of-living increase to covered service reimbursement. Medicaid rates are not incorporated into a provider contract, rather rates are set through administrative rule in accordance with the direction given in 53-6-113, MCA.
9. Section 1 of HB 585 creates a statutory rate increase, similar to 53-6-125, MCA, for physical therapists, occupational therapists, and speech-language pathologists. If HB 585 passes, its increase would be in addition to the increase in SB 523.

Sponsor's Initials	Date	Budget Director's Initials	Date
			3/4/2025