# 2026 Medicaid *in* MONTANA

## How Medicaid Impacts Montana's State Budget, Economy, and Health

MONTANA HEALTHCARE FOUNDATION

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# About This Report

The 2026 Medicaid in Montana report is an annual report commissioned by the Montana Healthcare Foundation and produced by Manatt Health.

Montana Medicaid and the Healthy Montana Kids program – collectively called "Medicaid" in this report – provide Montana residents with low income access to low- or no-cost health insurance. This report provides key statistics and describes the impact of Montana Medicaid on health outcomes, the health care system, and the economy.

The findings in this report are based on an analysis of Medicaid claims data, economic data, and national health care research. The Montana Healthcare Foundation has released Medicaid in Montana reports annually since 2021.

The report's authors would like to thank the Montana Department of Public Health and Human Services (DPHHS) and the Montana Hospital Association for providing data and expertise for this report.

# Medicaid provides Montanans access to health care services that support their health and well-being.

Medicaid covers critical health care services to address the physical and behavioral health needs of Montanans with low incomes. Medicaid provides access to screenings and preventive care, ongoing care for chronic conditions, mental health and substance use disorder (SUD) services, dental services, inpatient hospitalization and emergency services, and long-term services and supports (LTSS).

Medicaid provides health care coverage to individuals who are blind and disabled, women who are pregnant or have breast or cervical cancer, and families with dependent children. In 2015, Montana passed the Health and Economic Livelihood Partnership (HELP) Act, which expanded Medicaid eligibility to include nondisabled, nonelderly adults with incomes up to 133% of the federal poverty level (FPL). In 2025, House Bill 245 made the Medicaid expansion population (referred to as "adults with low income" and "expansion adults" in this report) a permanent Medicaid eligibility group in Montana.

Medicaid is a joint federal-state partnership managed locally by DPHHS and federally by the U.S. Centers for Medicare and Medicaid Services (CMS). DPHHS and CMS agree to a "state plan" that outlines how DPHHS will administer the Medicaid program. The State Plan describes who is eligible for Medicaid, what services they are eligible to receive beyond those minimally required by CMS, and how Medicaid services will be delivered. The State Plan is modified by jointly agreed-to "waivers" of federal requirements. The state and federal governments jointly fund Medicaid.

**Additional background information on Montana's Medicaid program is available in the Montana Healthcare Foundation report 2026 Montana Medicaid Background.**

## Montana’s current Medicaid program improves health outcomes, strengthens the health care system, and brings new federal dollars to Montana.

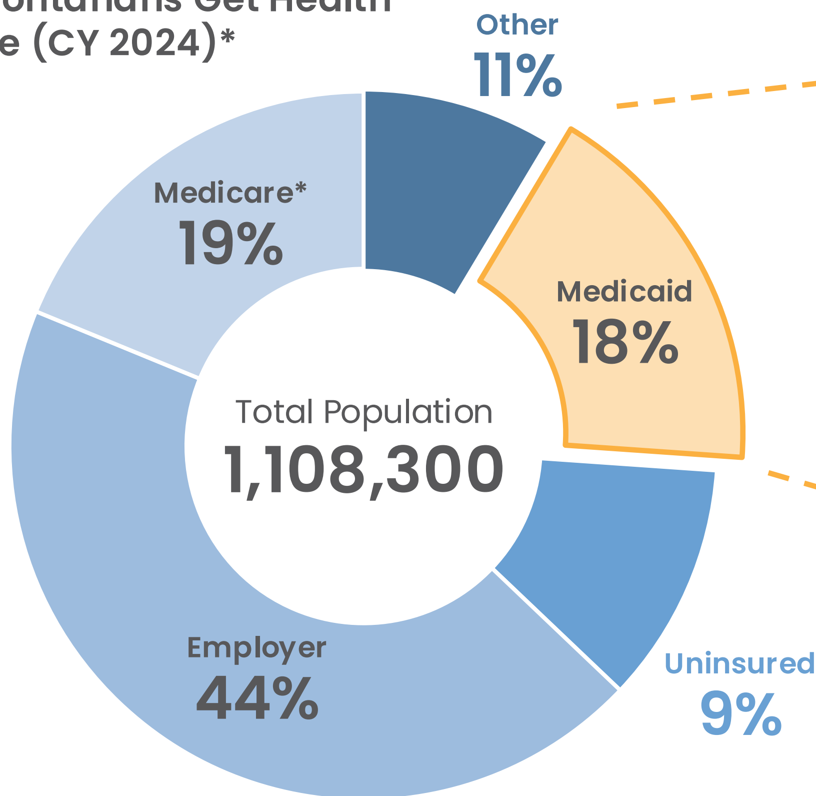
- Medicaid provides health care coverage to more than one of every five Montanans, including two of every five children (page 7).
- Medicaid enrollment declined in 2024 and 2025 after Montana and other states completed eligibility redeterminations following the end of the COVID-19 public health emergency (page 8).
- Almost three-quarters of adults with Medicaid coverage (72%) are in the labor force or attend school (page 12).
- Medicaid is a critical source of coverage for the American Indian and Alaskan Native (AI/AN) population. The AI/AN population comprises 6.4% of the state’s population and 21% of the Medicaid expansion population (page 46).
- Medicaid is a critical source of coverage for Montanans with a behavioral health condition. More than one-thirds of Montana Medicaid members have a behavioral health diagnosis (page 19).
- The use of preventive services decreased in 2024 compared to 2023 as enrollment declined. However, the proportion of adults and children who receive a wellness exam was higher in 2024 than any other year in the past decade (pages 15- 17).
- In Montana, average per-member Medicaid spending increased across all eligibility groups between 2022 and 2024, consistent with national trends and provider rate increases in Montana (pages 24-26).
- Decreased use of the emergency department (ED) by adults covered through Medicaid expansion members suggests that Medicaid improves health outcomes. During their first year of enrollment, 18,872 adults with low income enrolled in Medicaid for at least three years had at least one ED visit. By their third year of enrollment, 16,833 of those members visited the ED, a decline of 10.8% (page 34).

# Medicaid Enrollment

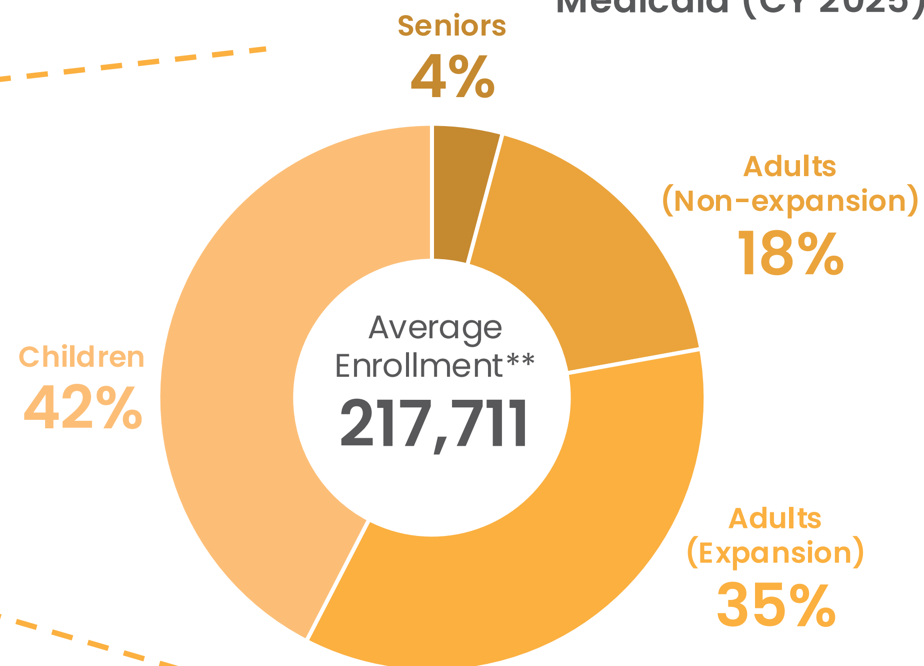
# Medicaid provides health insurance to nearly one in five Montanans.

Nearly one in five Montanans (18%) were enrolled in Medicaid in 2024, similar to national rates (20%). Two in every five Medicaid members in Montana (42%) are under the age of 18.

## Where Montanans Get Health Coverage (CY 2024)*



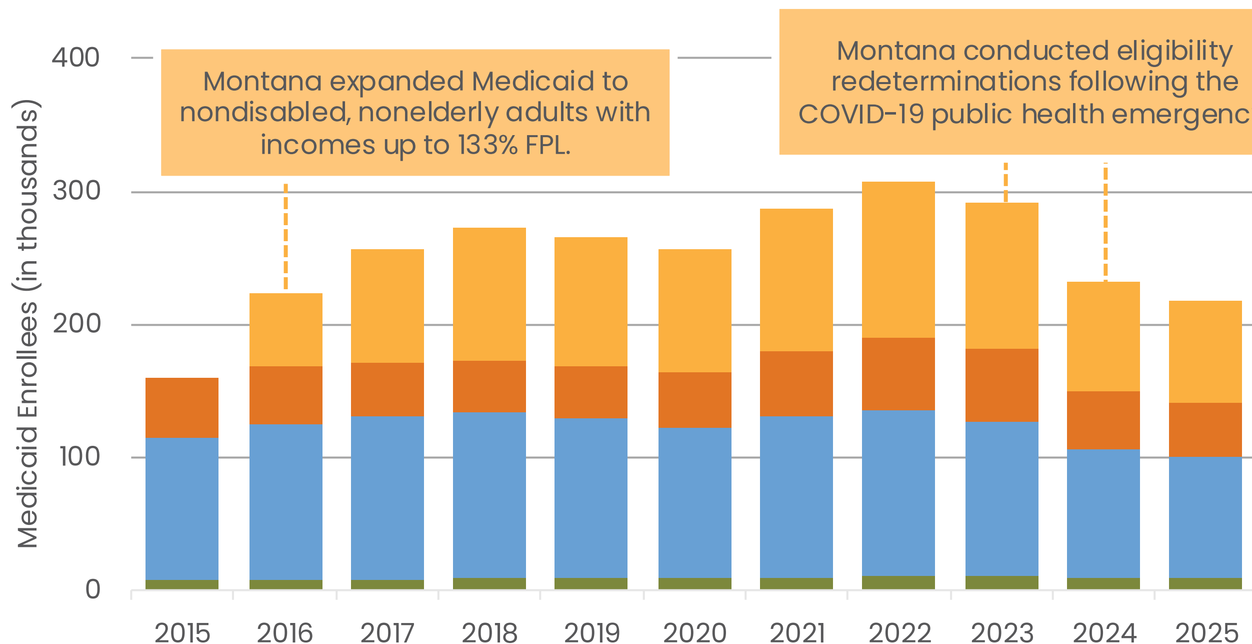

## Who is Enrolled in Medicaid (CY 2025)




*The count of individuals with Medicare excludes those who report having both Medicare and Medicaid coverage, also known as "dual-eligibles." "Other" includes those covered under the military or Veterans Administration and individuals and families who purchased or are covered as a dependent by non-group insurance.
**Average monthly enrollment from Jan-Jun 2025. Totals include individuals enrolled in traditional Medicaid, Medicaid expansion, CHIP, and Healthy Kids Expansion.

# Medicaid enrollment in 2025 was at its lowest level since before Montana expanded Medicaid in 2016.

## Average Montana Medicaid Enrollment (CY 2015-2025)




| | Enrollment (2025)* | | Change (2024-25) | |
|---|---|---|---|---|
| | Total | Share | Total Change | Percent Change |
| **Total** | **217,711** | - | **-14,162** | **-6.1%** |
| **Adults (Expansion)** | **76,766** | 35% | -5,248 | -6.4% |
| **Adults (Non-expansion)** | **40,056** | 18% | -3,867 | -8.8% |
| **Children** | **91,872** | 42% | -5,020 | -5.2% |
| **Seniors**** | **9,016** | 4% | -27 | -0.3% |

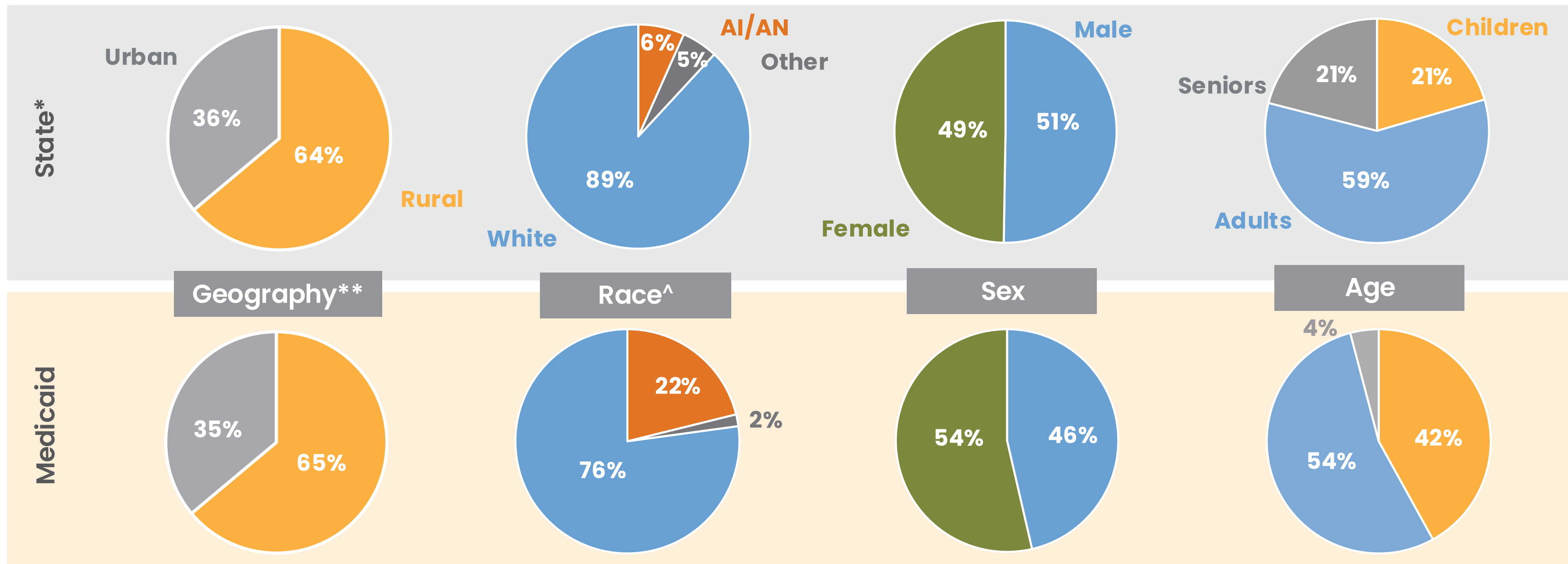
Medicaid enrollment has fluctuated over the past decade due to federal and state program changes. After Montana expanded Medicaid to include adults with low income in 2016, enrollment grew to approximately 273,000 people in 2018, before decreasing in 2019 and 2020. In 2021 and 2022, enrollment increased as Montana, like other states, maintained continuous coverage for Medicaid members during the COVID-19 public health emergency. In March 2023, Montana resumed eligibility redeterminations, resulting in enrollment declines of 30% between the 2022 peak and 2025 (-90,692 members). Montana's Medicaid enrollment was approximately 217,000 in 2025, the lowest level since before 2016.

*Average annual enrollment from January-June 2025. Totals include individuals enrolled in traditional Medicaid, Medicaid expansion, CHIP, and Healthy Kids Expansion.
**Primarily includes seniors dually enrolled in Medicare and Medicaid; there are also individuals who are dually enrolled in other age groups.

Data & Sources

# Medicaid provides health care coverage to Montanans across geographies and to Montanans of all races and ethnicities, sexes, and ages.

## Medicaid Demographics in Comparison with State Demographics (CY 2025)




*State demographic data only available for 2024. Numbers may not total to 100% due to rounding.

**Rural/urban definitions are from the University of Washington Rural Health Research Center's RUCA Census data crosswalk.

^ The race demographics category excludes approximately 25,000 members did not report their race. Reporting assumes individuals in the "Unknown" race category are distributed normally across race categories.

The demographics of the Medicaid population are largely representative of Montana's state population. Medicaid is a critical source of coverage for the AI/AN population, which comprise 6.4% of the state's population and 22% of its Medicaid enrollment. Medicaid is also essential for children and youth: children make up 21% of Montana's state population, but 42% of its Medicaid population.

# Medicaid provides health care coverage for people in Montana's urban centers and rural regions.

## Medicaid Enrollment as Percent of Population by County (CY 2025)

Lincoln 24.2%
Flathead 18.3%
Glacier 43.4%
Toole 26.7%
Liberty 27.8%
Hill 34%
Blaine 32.1%
Phillips 26.6%
Valley 22.1%
Daniels 14.5%
Sheridan 14.4%
Roosevelt 45.7%
Pondera 35.7%
Sanders 20.5%
Lake 24.4%
Teton 22%
Chouteau 17.7%
McCone 13.4%
Richland 14.6%
Mineral 26.3%
Missoula 17.2%
Lewis and Clark 15.8%
Cascade 21.6%
Judith Basin 17.3%
Fergus 18.3%
Petroleum 17.4%
Garfield 23.2%
Dawson 17.7%
Prairie 19.9%
Wibaux 14.5%
Granite 13.2%
Powell 21.7%
Meagher 23.8%
Wheatland 34.5%
Golden Valley 38.1%
Musselshell 22.5%
Rosebud 33.1%
Fallon 13.1%
Ravalli 18%
Deer Lodge 21.2%
Silver Bow 22.6%
Broadwater 10.9%
Jefferson 13.5%
Treasure 21.6%
Custer 21.1%
Gallatin 9.5%
Sweet Grass 12.5%
Stillwater 12.6%
Yellowstone 19.3%
Beaverhead 16.5%
Madison 10.5%
Park 14.2%
Carbon 14.3%
Big Horn 40.5%
Powder River 12.6%
Carter 12.6%

>35%
25-35%
15-25%
<15%

## Counties With Highest Medicaid Enrollment as a Proportion of Population (CY 2025)

| County | Population* | Medicaid (est.) |
|---|---|---|
| Roosevelt County | 10,197 | 45.7% |
| Glacier County | 13,503 | 43.4% |
| Big Horn County | 12,796 | 40.5% |
| Golden Valley County | 863 | 38.1% |
| Pondera County | 6,078 | 35.7% |
| Wheatland County | 2,058 | 34.5% |
| Hill County | 16,065 | 34.0% |
| Rosebud County | 8,194 | 33.1% |
| Blaine County | 6,903 | 32.1% |
| Liberty County | 1,934 | 27.8% |

*Population data only available for 2023.

# Nearly three quarters of adult Medicaid members are in the labor force or attend school.

## Employment Status of Adult Medicaid Members Ages 19-64*

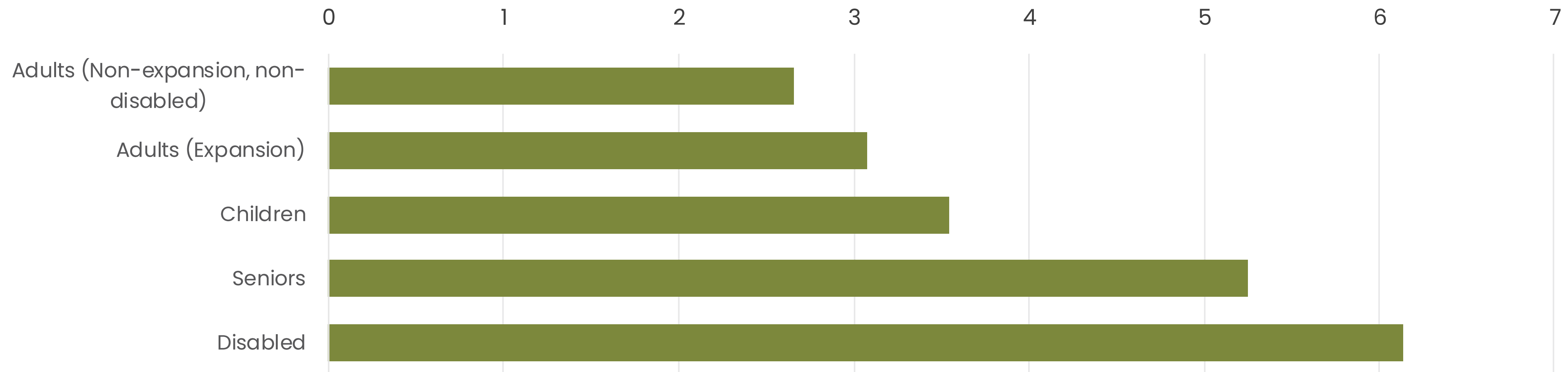
| Share | Category |
|---|---|
| 65% | IN LABOR FORCE |
| 13% | POTENTIAL CAREGIVER** |
| 7% | STUDENT |
| 10% | DISABLED |
| 6% | OTHER |

- **72% are in the labor force (working full-time, part-time, or looking for work) or attend school**
- **23% may support caregiving or are disabled**
- **6% are not in the labor force and do not fall into any other category**

In Montana, data consistently show that nearly three-quarters of adults with Medicaid coverage (72%) are in the labor force or attend school. An additional 23% of Medicaid members are caregivers or disabled. Many Medicaid members are employed in low-wage, seasonal, or "gig" industries and do not have access to health insurance through their employer. Medicaid supports workers by offering stable health care coverage. For example, 39% of personal care aides, 32% of cooks, 20% of construction laborers, and 25% of childcare workers in Montana are enrolled in Medicaid.^

*Analysis of American Community Survey microdata obtained from IPUMS-USA. Population includes all Montana adults (19-64) with Medicaid coverage who are non-institutionalized and who do not report SSI income or SS income and Medicare coverage from year 2019, 2021-2023. Numbers may not total to 100% due to rounding. The findings from this analysis are consistent with state reporting that indicates 72% of Medicaid expansion adults are employed.
**Potential caregiver includes those who live with someone under 18 or with an adult with a disability.
^Analysis of CPS-ACS data for 2016-2023.

# Medicaid provides a stable source of coverage for seniors and individuals with disabilities, while providing children and adults shorter-term coverage.




Medicaid provides Montanans with low incomes access to the care that supports better health and addresses illnesses and injuries that can limit workforce participation. People with chronic medical needs like seniors and people with disabilities tend to be on Medicaid longer than adults who may enroll in Medicaid for a short time while they are pregnant or before they find permanent employment or alternative sources of coverage. This holds true in Montana, where 59% of adults with low income were enrolled in Medicaid for under three years.

*This analysis is inclusive of 2016-2024 data. The continuous coverage requirement in place from March 2020 through March 2023 resulted in longer enrollment periods for Medicaid members. Categories are mutually exclusive.

# Access to Care

# Medicaid Coverage

**Medicaid coverage facilitates access to screening and preventive services, early diagnosis and treatment, leading to improved health outcomes.**

## Screening

Medicaid coverage facilitates **access to screening and preventive services.**

## Diagnosis

Access to screenings and preventive services results in **early diagnosis for physical and behavioral health conditions.**

## Treatment

Early diagnosis facilitates **early and more effective treatment** of conditions that require attention.

## A Healthier Montana

Early treatment **improves health outcomes** and fewer avoidable emergency visits and hospitalizations.

## Medicaid members have access to screenings and preventive care.

Access to preventive services is a crucial driver of long-term health and well-being. Screenings and preventive services including dental care help catch issues early, support early treatment, and avoid the need for more intensive and costly care in the future.

In 2024, 58,800 Montana Medicaid members received a wellness exam, including 39% of children (37,433) and 17% of adults (20,839). Medicaid also supported dental preventive services in 2024 such as exams and cleanings for more than 112,000 Montanans, including for nearly 70% of enrolled children (67,642).

### Preventive Service Utilization (CY 2024)

| Service | Children | Adults* | Seniors** | Total |
|---|---|---|---|---|
| **Preventive/Wellness Exams** | 37,433 | 20,839 | 528 | 58,800 |
| **Physical and Behavioral Health Screenings^** | | | | |
| Alcohol Abuse Screening | 34 | 1,456 | 16 | 1,506 |
| Breast Cancer Screening | n/a | 5,644 | 144 | 5,788 |
| Cervical Cancer Screening | 17 | 8,451 | 17 | 8,485 |
| Cholesterol Screening | 2,524 | 26,109 | 744 | 29,377 |
| Colorectal Cancer Screening | 1,234 | 11,681 | 365 | 13,280 |
| Diabetes Screening | 2,875 | 26,224 | 857 | 29,956 |
| Hepatitis B Screening | 186 | 4,409 | 45 | 4,640 |
| Hepatitis C Screening | 392 | 9,006 | 39 | 9,437 |
| Sexually Transmitted Disease Screening | 1,475 | 14,989 | 24 | 16,488 |
| Tobacco Use Counseling & Interventions | 13 | 1,163 | 39 | 1,215 |
| **Dental Preventive Services** | 67,642 | 42,081 | 2,640 | 112,363 |
| **Vaccinations** | 22,950 | 15,265 | 415 | 38,630 |

*Includes both expansion and non-expansion adults.
**Includes seniors who are dually enrolled in Medicare and Medicaid and have services partially funded by Medicaid.
**Billed screenings only; may undercount regularly conducted screenings such as for alcohol abuse.

# Fewer Medicaid members received preventive services in 2024 as Medicaid enrollment decreased following eligibility redeterminations.

## Preventive Service Utilization (CY 2022-2024; Percent Change 2023-2024)

80,000
70,000
60,000
50,000
40,000
30,000
20,000
10,000
-

2022 2023 2024

-14%

Preventive/Wellness Exams

40,000
30,000
20,000
10,000
-

| Service | Percent Change 2023-2024 |
|---|---|
| Breast Cancer Screening | -17% |
| Cervical Cancer Screening | -22% |
| Cholesterol Screening | -16% |
| Colorectal Cancer Screening | -18% |
| Diabetes Screening | -11% |
| Hepatitis B Screening | -15% |
| Hepatitis C Screening | -17% |
| STD Screening | -16% |

Utilization of preventive services decreased in 2024 compared to 2023 as total Medicaid enrollment decreased. The number of Medicaid members who received screenings for cancer including breast cancer, cervical cancer, and colorectal cancer declined by between 17% and 22% in 2024 compared to 2023, and utilization of wellness exams decreased by 14%.

# A larger percentage of Medicaid members received wellness exams in 2024 compared to previous years.

## Unique Members Receiving Wellness Exams as a Percentage of Medicaid Enrollment (CY 2015-2024)

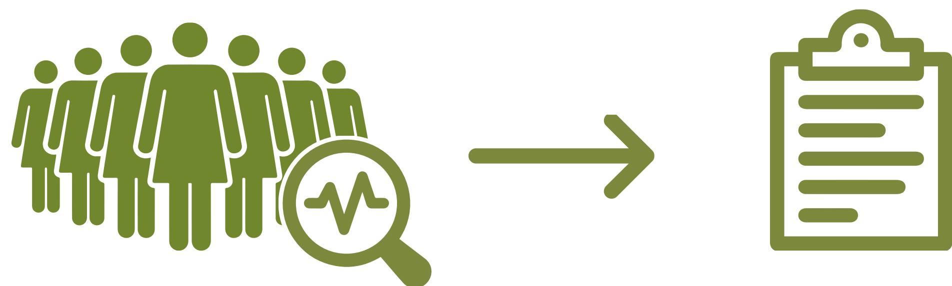
| | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 |
|---|---|---|---|---|---|---|---|---|---|---|
| % Children Receiving Wellness Exams | 36% | 36% | 36% | 36% | 38% | 35% | 37% | 36% | 37% | 39% |
| % Adults Receving Wellness Exams | 11% | 12% | 12% | 14% | 15% | 14% | 15% | 14% | 15% | 17% |

Annual wellness exams are essential to managing ongoing concerns, catching health conditions early, and connecting individuals with treatment. In 2024, nearly two of every five children enrolled in Medicaid received an annual wellness exam, and 17% of adults. While the total number of Medicaid members who received preventive services decreased in 2024 as overall enrollment declined, the percentage of adults and children who receive a wellness exam each year was higher in 2024 than any other year in the past decade. In particular, the proportion of adults who received a wellness exam has steadily increased over the past decade, from 11% in 2015 to 17% in 2024, indicating improved access to preventive care.

# Access to screenings for cancer and other chronic conditions leads to earlier diagnoses and improved health outcomes.

In 2024, more than 6,700 adult Medicaid members were screened for breast cancer, and more than 3,500 were screened for colon cancer. These screenings resulted in the diagnosis of 82 cases of breast cancer and 1,264 potentially averted cases of colon cancer. Like other preventive services, screening and diagnoses of both breast and colon cancer decreased in 2024 compared to 2023 as overall Medicaid enrollment declined. However, the share of Medicaid-enrolled adults receiving these services remained relatively stable in 2024 compared to 2023.

## Breast Cancer



**6,750**

Adult members **screened for breast cancer** in 2024

**82**

**Breast cancer diagnoses** in 2024

## Colon Cancer

**3,531**

Adult members **screened for colon cancer** in 2024*

**1,264**

Potentially **averted cases of colon cancer** in 2024

*Data is a subset of all colorectal screenings included on slide 17.

Data & Sources

# Medicaid coverage supports members with mental health conditions and substance use disorders.

Montana consistently has among the highest rates of behavioral health conditions in the country. In 2024, 36% of Medicaid members (83,055) had a mental health or substance use diagnosis, an increase of about seven percentage points since 2015. Medicaid coverage allows members with behavioral health conditions access to a continuum of screening, outpatient, and specialty mental health and substance use services to support their recovery. However, as overall Medicaid enrollment decreased the number of Montanans with behavioral health needs who are covered by Medicaid also decreased. The number of Montanans covered by Medicaid who had a behavioral health diagnosis decreased from more than 98,000 to 83,000 between 2023 and 2024, a decrease of 15%.

## Medicaid Members with a Behavioral Health Diagnosis* (2015-2024)

Members with a Behavioral Health Diagnosis | Percentage of Members with a Behavioral Health Diagnosis

| Year | Members with a Behavioral Health Diagnosis |
|---|---|
| 2015 | 47,527 |
| 2016 | 67, 635 |
| 2017 | 78.429 |
| 2018 | 89,356 |
| 2019 | 91,567 |
| 2020 | 87,390 |
| 2021 | 94,929 |
| 2022 | 98,628 |
| 2023 | 98,487 |
| 2024 | 83,055 |

Left axis: 0; 20,000; 40,000; 60,000; 80,000; 100,000; 120,000. Right axis: 0%; 20%; 40%; 60%; 80%; 100%.

*De-duplicated count of members with a behavioral health diagnosis recorded on a claim. Results are likely an undercount of true prevalence.

# Earlier diagnoses of chronic physical and behavioral health conditions leads to earlier treatment.

## Hypertension

**2,312** → **7,531**

Treated in 2015 — Treated in 2024 (+226%)

## Substance Use Disorder

**1,115** → **6,972**

Treated in 2015 — Treated in 2024 (+525%)

## Diabetes

**1,610** → **4,554**

Treated in 2015 — Treated in 2024 (+183%)

## Mental Health Conditions

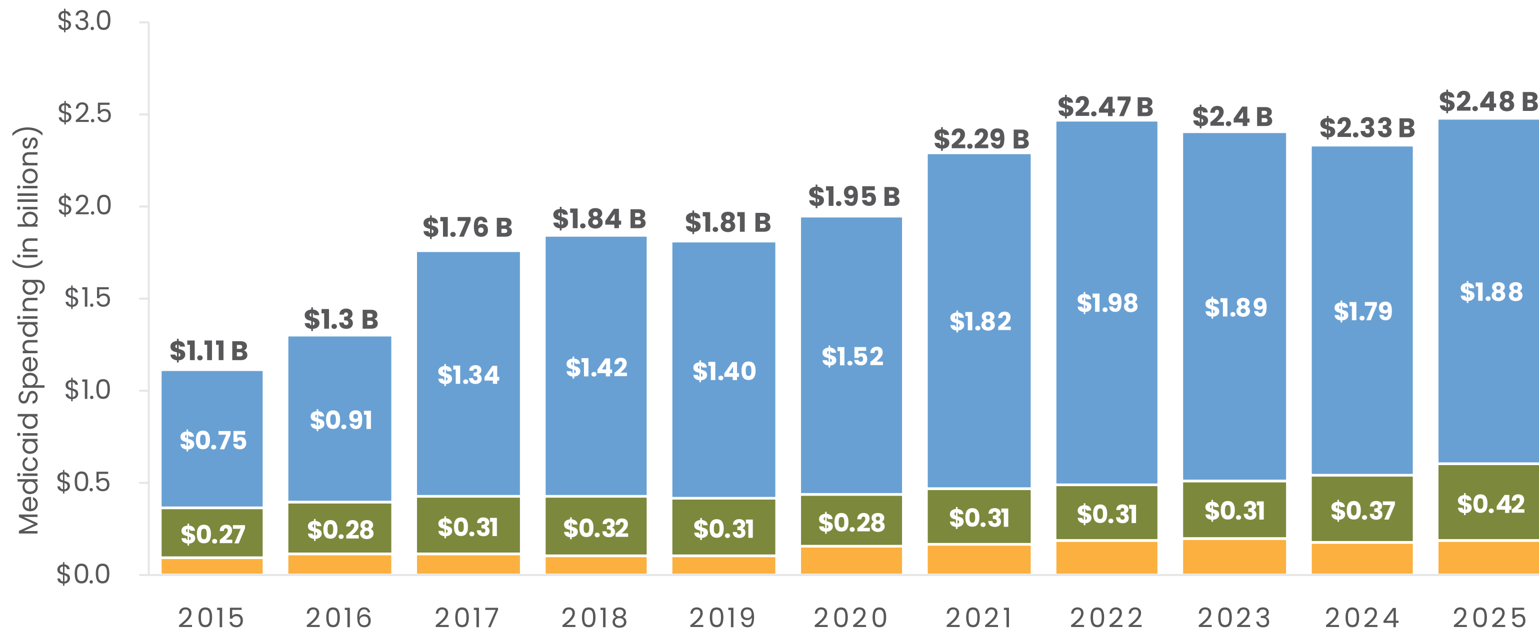
**18,028** → **43,718**

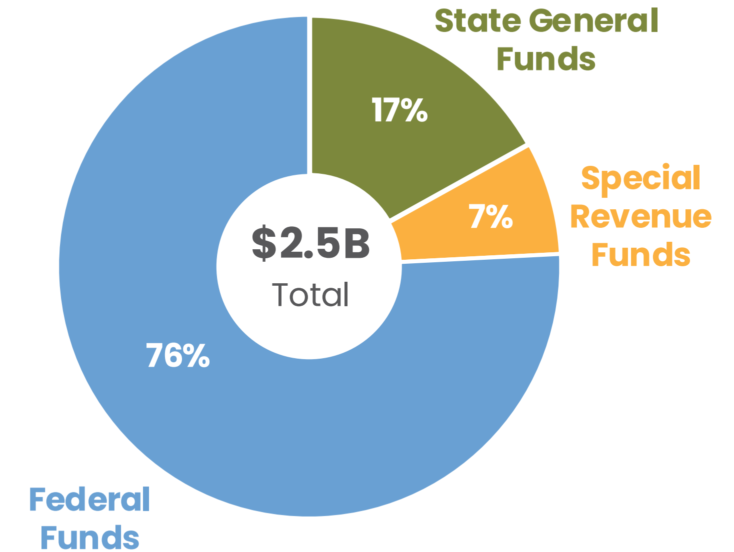
Treated in 2015 — Treated in 2024 (+143%)

Continuous, uninterrupted care for chronic conditions supports better health outcomes and a healthier workforce. Evidence shows gaps in health care coverage increases emergency department use and hospitalizations. As additional Montana adults have been able to access Medicaid coverage, they have also been able to receive early treatment for chronic physical and behavioral health conditions. In 2024, more than 7,500 adult Medicaid members were treated for hypertension (an increase of 226% since 2015), and more than 4,500 were treated for diabetes (an increase of183% since 2015).

# Medicaid Spending

# Medicaid is jointly funded by the federal and state governments.




In SFY 2025, Montana's Medicaid budget was $2.5 billion, 76% of which ($1.88 billion) was reimbursed by the federal government. Like other states, Montana's total Medicaid spending has increased over time. Montana and other states experienced a significant increase in Medicaid spending in SFY 2025. As federal funding decreased following the end of the public health emergency, Montana's standard federal matching assistance percentage (FMAP) rate also decreased (the FMAP for expansion adults is still 90%).** In addition to state general funds, Montana uses special revenue funds, including assessments and a hospital utilization fee to fund the state share of Medicaid.^

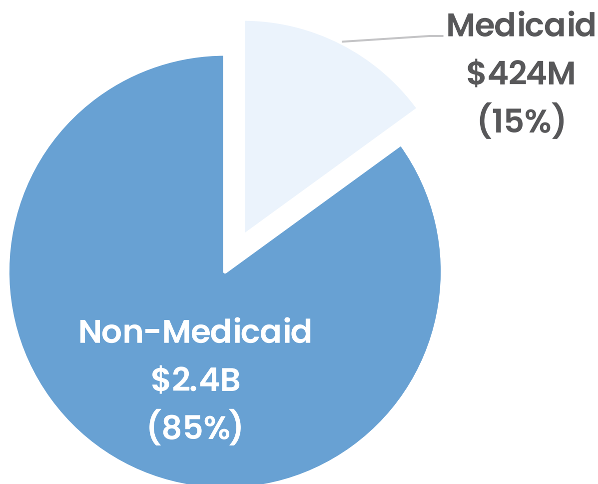
*SFY 2025 data are estimates and may change when actual SFY 2025 fiscal data is available.

**Montana's standard FMAP has decreased over time as per-capita income in Montana increased compared to the US average. Montana's standard FMAP was 67% in SFY 2015 and 62% in SFY 2025. A five percentage point reduction means the state has to fund an additional five cents of every dollar, or $100 million of a $2 billion budget.

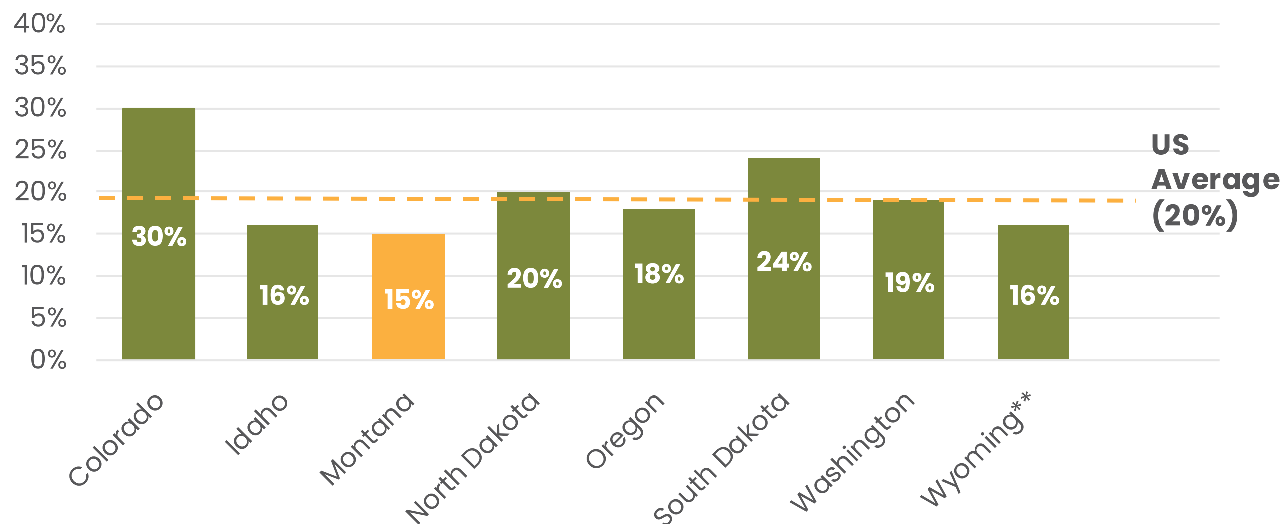
^Effective October 1, 2026, Montana will no longer be able to increase its hospital utilization fee, consistent with new requirements in H.R.1.

# Compared to peer states, Montana leverages less of its state general fund to finance Medicaid.

## Medicaid as Percentage of State General Fund Spending (SFY 2025)*




## Medicaid as a Percentage of State General Fund Spending (SFY 2025)



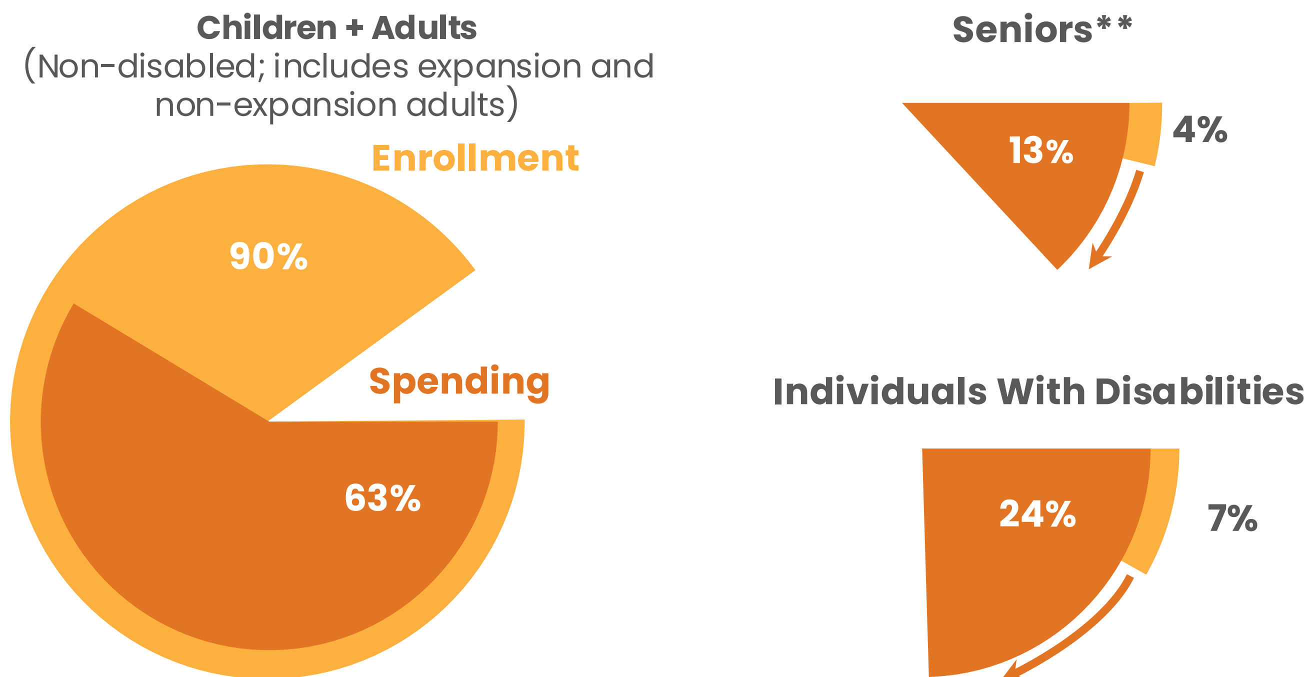

Montana spends a low proportion of its state general fund on Medicaid compared to the national average and peer states. During SFY 2025, Montana had the 11th lowest rate of state general fund spending on Medicaid nationally and a lower rate of spending than all peer states, including those that have not expanded Medicaid to cover adults with low income.^

*SFY 2025 data are estimates and may change when actual SFY 2025 fiscal data is available.
**States that have not expanded Medicaid.
^ Peer states were selected as comparators based on demographic, geographic, and Medicaid expansion characteristics.

Data & Sources

# Seniors and individuals with disabilities comprise only 11% of Medicaid enrollment but account for 37% of expenditures.

## Medicaid Enrollment and Spending by Population Group* (SFY 2024)




Medicaid spending varies by age group and disability status. Nondisabled children and adults comprise most of Medicaid enrollment (90%) but contribute to a lower proportion of Medicaid spending (63%).

Seniors and individuals with disabilities, on the other hand, often require high-intensity and high-cost services to support their daily living. In 2024, seniors and individuals with disabilities comprised only 11% of Medicaid enrollment but accounted for 37% of Medicaid spending. Similar spending patterns are observed nationally.

*Medicaid spending only, excludes Medicare spending. CHIP spending is estimated based on aggregate budget data. Spending excludes Disproportionate Share Hospital (DSH) and supplemental provider payments. Enrollment percentages are based on member months and may not align with other values in this report. Analysis includes individuals enrolled in traditional Medicaid, Medicaid expansion, CHIP, and Healthy Kids Expansion. Past reporting included additional enrollment categories such as Medicare Savings Programs.
**Categories are mutually exclusive. "Individuals with Disabilities" includes individuals from all age categories. "Seniors", "Children" and "Adults" exclude individuals with disabilities.

Data & Sources

# Higher Medicaid spending for seniors and individuals with disabilities reflects the large share of spending on long-term services and supports.

## Average Member Spending per Month by Population Group and Service Category* (SFY 2024)

Nondisabled

Children 32% $366 Monthly Spending Average Per Member

Adults (Non-expansion) 39% $512

Seniors 76% $2,338

Disabled 58% $2,411

Adults (Expansion) 39% $602

Hospitals & Clinics | Physician | Pharmacy | LTSS | Behavioral Health | IHS | Dental | All Other

Many seniors and people with disabilities rely on Medicaid for LTSS, including nursing home care and home and community-based services that are not otherwise covered by Medicare. In 2024, more than three-quarters of Medicaid spending on seniors and 58% of Medicaid spending on people with disabilities was for LTSS. Medicaid spending on children and adults, including expansion adults, remains more concentrated on hospital and clinic services.

*Medicaid spending only (excludes Medicare and CHIP). Spending excludes DSH and supplemental provider payments. Analysis includes individuals enrolled in traditional Medicaid, Medicaid expansion, CHIP, and Healthy Kids Expansion. Past reporting included additional enrollment categories such as Medicare Savings Programs, which led to lower average member spending for seniors in past years.

Data & Sources

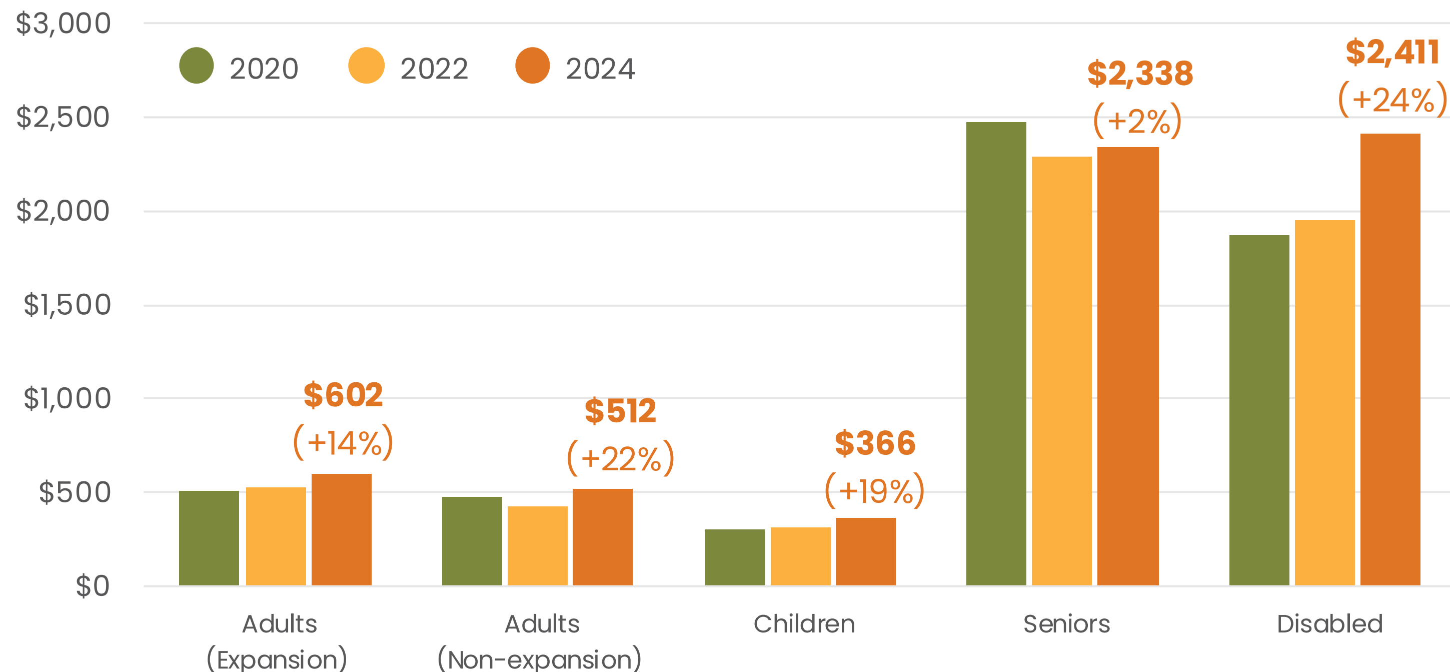
# In 2024, average per-member Medicaid spending increased for all eligibility groups.

Per-capita health care costs increase over time due to rising drug prices, increased service costs, and other external factors. Nationally, per-member Medicaid spending on health care increased by 51.6% between 2008 and 2024, slightly under per-member cost growth for Medicare (59.5%) and significantly under that for the private market (96.5%).

In Montana, per-member Medicaid spending increased for all groups between 2022 and 2024, consistent with national trends. The largest increases were seen among individuals with disabilities (+24% between 2022 and 2024) and non-expansion adults (+22%). These increases may be partially driven by rate increases in Montana for some LTSS and behavioral health services.

*Using inflation-adjusted dollars.
**Analysis includes individuals enrolled in traditional Medicaid, Medicaid expansion, CHIP, and Healthy Kids Expansion. Past reporting included additional enrollment categories such as Medicare Savings Programs.

## Average Monthly Medicaid Spending per Member (SFY 2020-2024, Percent Change SFY 2022-2024)**




| | Medicaid Spending (Average PMPM) | | | Change (2022-2024) | |
|---|---|---|---|---|---|
| | 2020 | 2022 | 2024 | Total | Change (%) |
| Adults (Expansion) | $502 | $528 | $602 | +$74 | +14% |
| Adults (Non-expansion) | $471 | $419 | $512 | +$93 | +22% |
| Children | $298 | $308 | $366 | +$58 | +19% |
| Seniors | $2,471 | $2,290 | $2,338 | +$48 | +2% |
| Disabled | $1,875 | $1,952 | $2,411 | +$459 | +24% |

Data & Sources

## Approximately $2 billion was paid to Medicaid health care providers in 2024, with more than 25% of payments going to hospitals and clinics.

In 2024, $2.02 billion was paid to health care providers to support care for Medicaid members. Although enrollment decreased, overall spending grew in 2024 compared to 2022, consistent with national trends and Medicaid rate increases in Montana. Similar to previous years, most provider payments were for hospitals and clinics (26%) and LTSS (25%).

*Includes Indian Health Service (IHS) and pharmacy spending, and other tribal spending; does not include urban Indian center reimbursement.
**Analysis includes individuals enrolled in traditional Medicaid, Medicaid expansion, CHIP, and Healthy Kids Expansion. Past reporting included additional enrollment categories such as Medicare Savings Programs.
^Includes Comprehensive School and Community Treatment previously reported in the "schools" category.

Medicare Buy-in



Data & Sources

# Medicaid spending increased for many provider types between SFY 2022 and 2024.

## Medicaid Payments by Provider Type (SFY 2020-2024, Percent Change SFY 2022-2024)*

Medicaid Payments ($ in millions)

Legend: 2020, 2022, 2024

Y-axis: $0, $100, $200, $300, $400, $500, $600

| Provider Type | 2024 | Percent Change |
|---|---|---|
| Behavioral Health^ | $144 | (+4%) |
| Dental | $72 | (-6%) |
| Hospitals & Clinics | $526 | (+3%) |
| IHS** | $172 | (+0%) |
| LTSS | $509 | (+19%) |
| Medicare Buy-in | $51 | (+41%) |
| Pharmacy | $150 | (-1%) |
| Physician & Mid-Level Practitioners | $230 | (-1%) |
| Other | $144 | (-10%) |

In 2024, Medicaid spending for many provider types increased between SFY 2022 and 2024. The biggest increases were for LTSS (+19%) and behavioral health (+4%), consistent with rate increases for those services. Payments for Medicare buy-in also increased from approximately $36 million in 2022 to $51 million in 2024. Spending decreased for other provider types, including dental (-6%) and pharmacy (-1%).

*Analysis includes individuals enrolled in traditional Medicaid, Medicaid expansion, CHIP, and Healthy Kids Expansion. Past reporting included additional enrollment categories such as Medicare Savings Programs.

**IHS includes Indian Health Services and pharmacy spending, and other tribal spending; does not include urban Indian center reimbursement .

^Includes Comprehensive School and Community Treatment previously reported in the "schools" category.

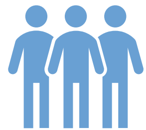
Data & Sources

# The Impact of Medicaid Expansion

# Since 2016, Montana Medicaid has provided health care coverage for nondisabled, nonelderly adults with low incomes.

Effective January 1, 2016, Montana expanded Medicaid eligibility to include nondisabled, nonelderly adults with incomes up to 133% of the FPL. In 2025, Governor Gianforte signed House Bill 245, which made the Medicaid expansion population (referred to as "adults with low income" and "expansion adults" in this report) a permanent Medicaid eligibility group in Montana.

By providing health care coverage to adults with low income, Montana has:



**Expanded Health Care Coverage:** Improved access to health insurance through Medicaid has reduced Montana's uninsured rate.

**Improved Access to Health Services and Health Outcomes:** Expanded coverage has improved access to screenings, preventive services, and ongoing care for chronic physical and behavioral health conditions. In turn, individuals use less emergency and inpatient care over time.

**Created State Budget Savings and Reduced Costs of Care:** Medicaid expansion has offset previously state-funded services, resulting in budget savings. At the same time, reductions in high-cost emergency and inpatient care help control rising health care costs.

Having reliable health insurance and better access to health care services contributes to reduced use of emergency department and inpatient services, helping control health care costs over time.

# Recent federal Medicaid legislation will impact how the program is financed and who it covers.

The 2025 budget reconciliation legislation H.R. 1 imposes new requirements on state Medicaid programs that will impact how states are able to finance their Medicaid programs and who will be eligible for coverage.

## Work Requirements**

Beginning January 1, 2027, states must condition eligibility for Medicaid coverage on compliance with work reporting requirements. Adults with low income must demonstrate 80 hours per month of work or other qualifying activities, with some exemptions for specific populations.

## Redeterminations

Beginning December 31, 2026, states must redetermine eligibility for adults with low income once every six months, with the exception of adults who are AI/AN. Currently, Montana and other states redetermine eligibility once every 12 months.

## Provider Tax Changes

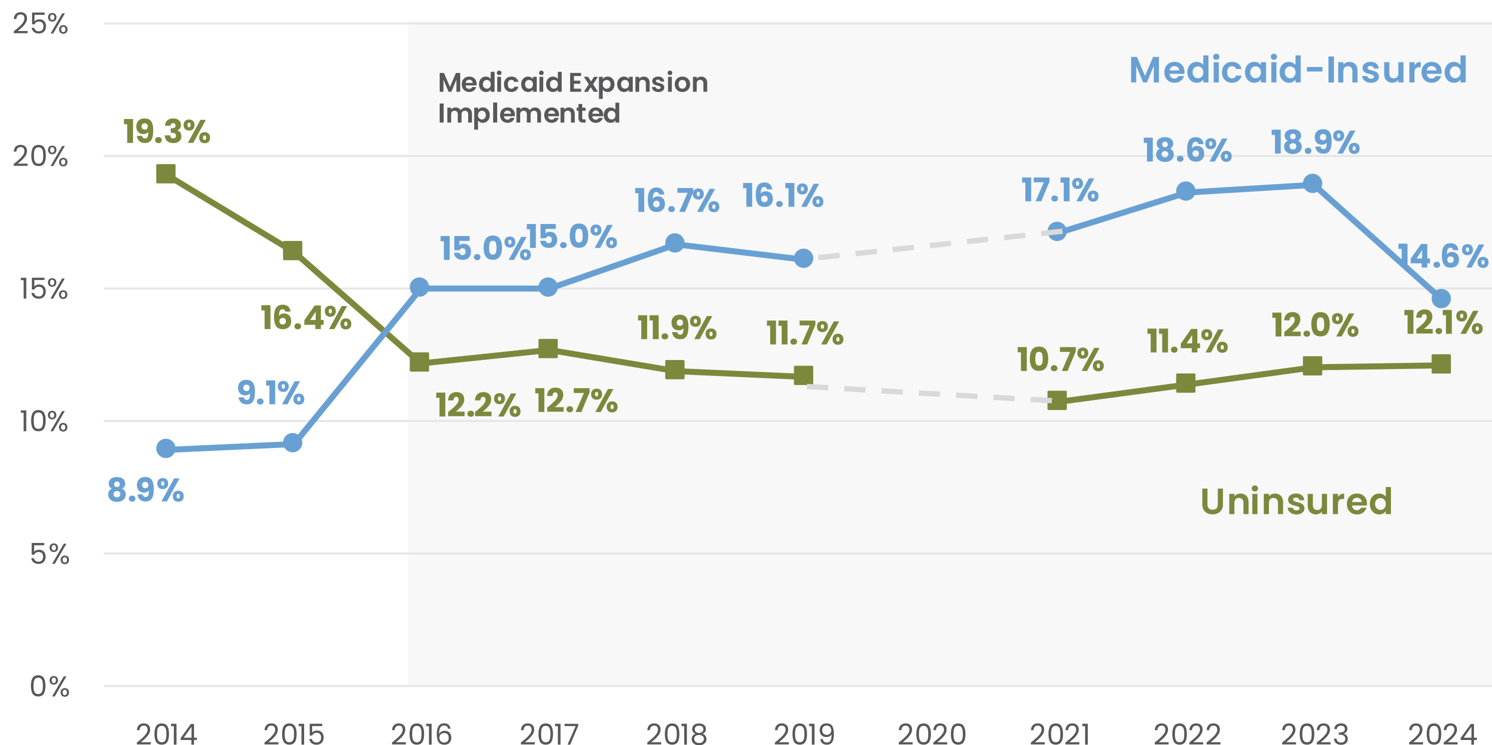
Beginning October 1, 2026, the law prohibits implementation of new Medicaid provider taxes or increases to existing provider taxes, a common method for state financing of Medicaid programs. For example, Montana's hospital utilization fee is used to finance approximately one-fourth of the non-federal share of Medicaid expenditures in the state.

## Rural Health Funding

Beginning in 2026, the law makes available $50 billion over a five-year period for states with an approved rural health transformation plan. In December 2025, Montana was awarded $233 million for workforce development, telehealth expansion, technology innovations, innovative care models, and community health investments for 2026.

*For more information on the expected impact of the budget reconciliation legislation on Montana Medicaid's enrollment and financing, see the MTHF brief "The One Big Beautiful Bill Act: Impacts on Montana Medicaid."
**For more information on how states are seeking to comply with federal work requirements while maintaining coverage for eligible members, see the MTHF brief "Implementing Medicaid Work Requirements: Best Practices".

# Montana's uninsured rate has slowly increased in recent years.




*The American Community Survey did not release the one-year estimates for 2020 due to significant disruptions to the data collection because of COVID-19.

Expanding Medicaid has reduced uninsured rates nationally. People who are uninsured are more likely to delay or forgo care, and there is evidence they are also less likely to receive screenings, preventive services, and care for chronic conditions. High uninsured rates can lead to a less healthy population and higher long-term health care costs.

After Montana expanded Medicaid in 2016, Montana's uninsured rate for adults nearly halved, falling from 19.3% in 2014 to 10.7% in 2021. However, since 2021, Montana's uninsured rates for adults have increased back to pre-pandemic levels, as Medicaid enrollment declined. In 2024, Montana's uninsured rate for adults was at its highest level since 2018. At the same time, in 2024 the proportion of Montanans who received health insurance through Medicaid also decreased to its lowest level since before Montana expanded Medicaid (14.6%).

# The number of Montanans covered by Medicaid expansion has reached its lowest count since 2017.

## Medicaid Expansion Enrollment by Month (CY 2016-2025)

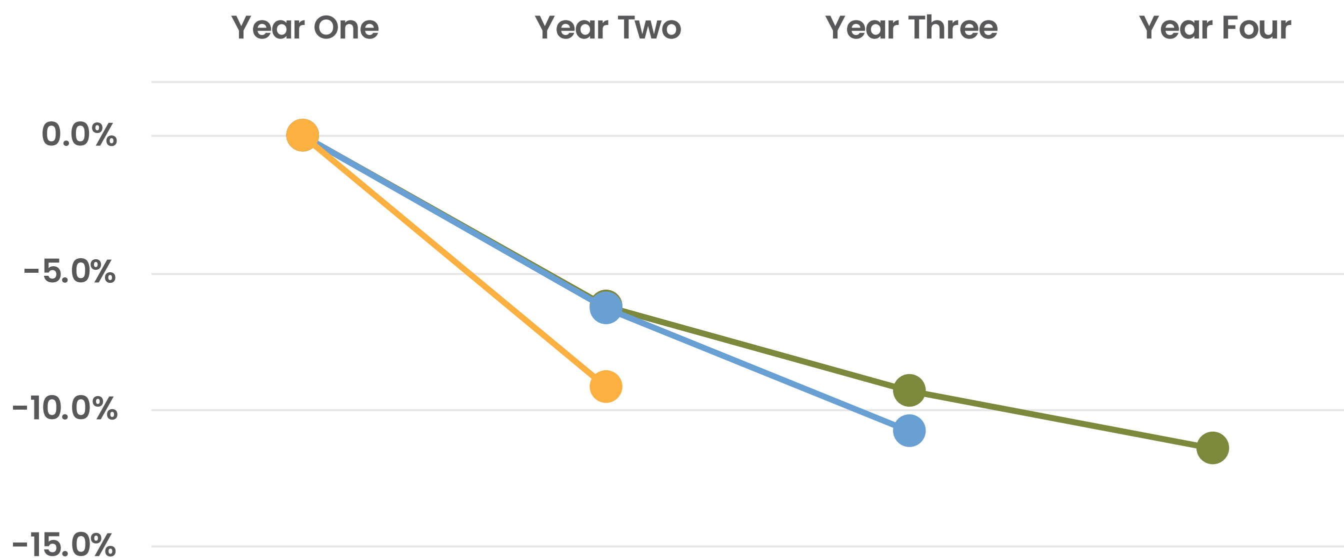


The number of adults with low income enrolled in Medicaid has shifted over time. Enrollment rose to nearly 100,000 by 2018 before falling to about 80,000 in early 2020. Continuous coverage during the COVID-19 public health emergency then drove enrollment growth until redeterminations resumed in March 2023, leading to significant declines. Enrollment of adults with low income peaked at 125,000 in April 2023 and declined to 75,000 in October 2025.

# Access to Medicaid contributes to better health outcomes and fewer emergency department visits for adults with low income.

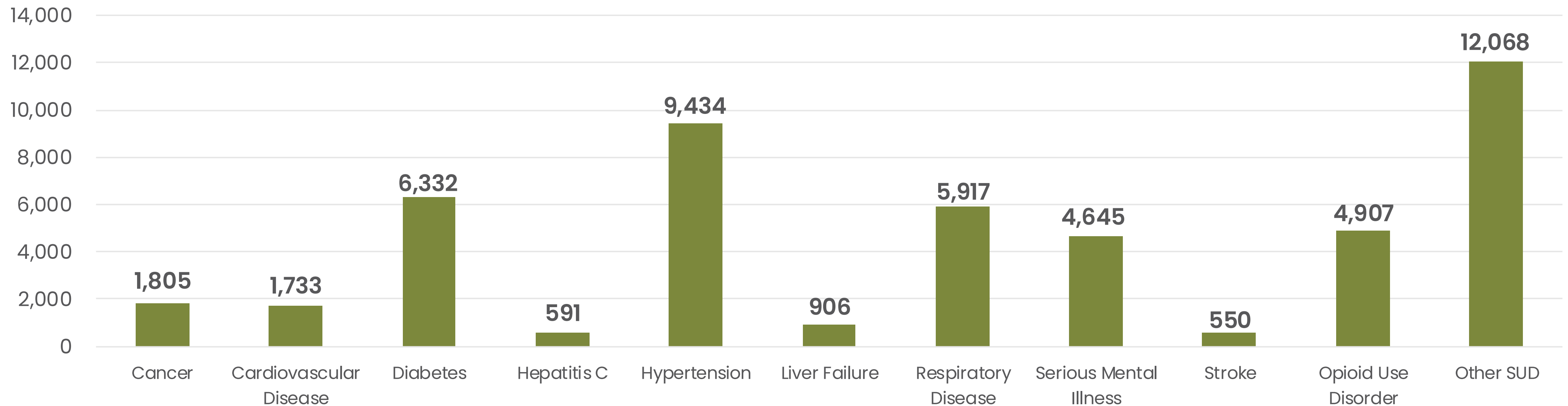
More than 47,000 adults with low income were enrolled in Medicaid for at least three full years between January 2016 and August 2025. During their first year of enrollment, 18,872 (around two in five) had at least one ED visit. By their third year, only 16,833 people visited the ED, a decline of 10.8%. Declines in ED use over time are similarly observed for expansion adults with at least two or four years of continuous Medicaid coverage.

Fewer costly ED visits may indicate a healthier population and/or one that is utilizing lower-cost settings to address their health care needs.




| Continuous Coverage Period | Total Pop. | People Visiting the ED | | | | Percent Change (From Year 1) | | |
|---|---|---|---|---|---|---|---|---|
| | | Year One | Year Two | Year Three | Year Four | Year Two | Year Three | Year Four |
| **Pop. with Two Years Continuous Enrollment** | **74,432** | 28,959 | 26,276 | | | -9.2% | | |
| **Pop. with Three Years Continuous Enrollment** | **47,669** | 18,872 | 17,682 | 16,833 | | -6.3% | -10.8% | |
| **Pop. with Four Years Continuous Enrollment** | **30,859** | 12,402 | 11,632 | 11,247 | 10,984 | -6.2% | -9.3% | -11.4% |

# Montana Medicaid covers low-income adults with chronic physical and behavioral health conditions.




Consistent, affordable health care coverage is essential when managing a chronic condition as it allows individuals to receive ongoing monitoring from their clinicians and timely access to medication and treatment. Research shows Medicaid-enrolled adults with a chronic condition access health care at a higher rate than their uninsured peers, driving improved health outcomes and fewer ED visits. In Montana, Medicaid expansion plays a critical role in covering this population. Of the approximately 82,000 adults with low-income enrolled through Medicaid expansion in 2024, more than 32,500 had one of the listed chronic conditions (40%),* and approximately 16,500 (20%) had serious mental illness and/or a SUD.**

*De-duplicated count of expansion adults with any of the conditions shown. Results are counts of unique members with at least one claim in the chronic condition category and likely an undercount of true prevalence.
**De-duplicated count of expansion adults with serious mental illness, opioid use disorder, and/or other SUDs.

# Medicaid coverage decreases the use of emergency department care among members with chronic conditions.

Expanding Medicaid coverage allowed adults with low income to access appropriate ongoing care for chronic physical and behavioral health conditions, which helps reduce reliance on more intensive, costly care when chronic conditions worsen.

Among adults with low income covered through Medicaid expansion for at least three years, people with diabetes, respiratory disease, serious mental illness and SUD* all visited the ED less frequently over time. For example, in the first year they had coverage, more than 9,500 expansion adults with a SUD visited the ED. By their third year of coverage, only 8,624 of those members visited the ED, a decline of 10.1%.

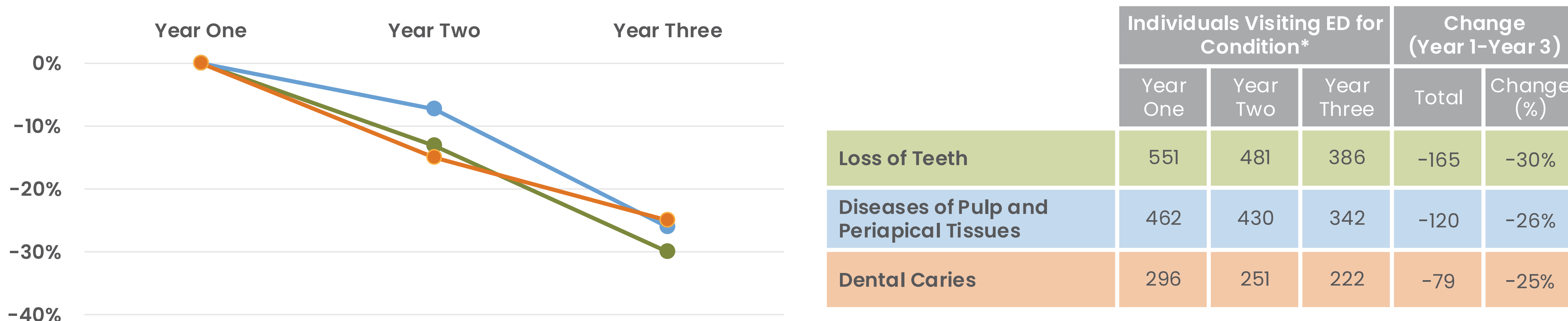
## Expansion Adults with an ED Visit by Diagnosed Condition and Year of Enrollment



*Members with a recorded diagnosis on a claim with at least three years of continuous Medicaid enrollment between Jan 2016 and Aug 2025.
**De-duplicated count of individuals with opioid use disorder and other SUDs.

# Medicaid provides access to treatment for common dental conditions, contributing to fewer emergency department visits.

## Expansion Adults with an ED Visit for Preventable Dental Conditions




| | Individuals Visiting ED for Condition* | | | Change (Year 1-Year 3) | |
|---|---|---|---|---|---|
| | Year One | Year Two | Year Three | Total | Change (%) |
| **Loss of Teeth** | 551 | 481 | 386 | -165 | -30% |
| **Diseases of Pulp and Periapical Tissues** | 462 | 430 | 342 | -120 | -26% |
| **Dental Caries** | 296 | 251 | 222 | -79 | -25% |

Montana is one of 39 states that covers dental care for Medicaid members, including exams, cleanings, fillings, and dentures. This coverage can help reduce the need for emergency room care for problems such as dental infections. For adults with low income,* ED use for preventable dental conditions, including loss of teeth and diseases of pulp and periapical tissues, declined by approximately 27% among individuals enrolled for at least three years.

Oral health is critical to overall health, well-being, and employability. As one national study noted, 60% of Medicaid-enrolled adults in states that did not provide dental coverage reported that the appearance of their mouth and teeth affected their ability to interview for a job, nearly double those reporting similarly in states that provided dental coverage (35%).

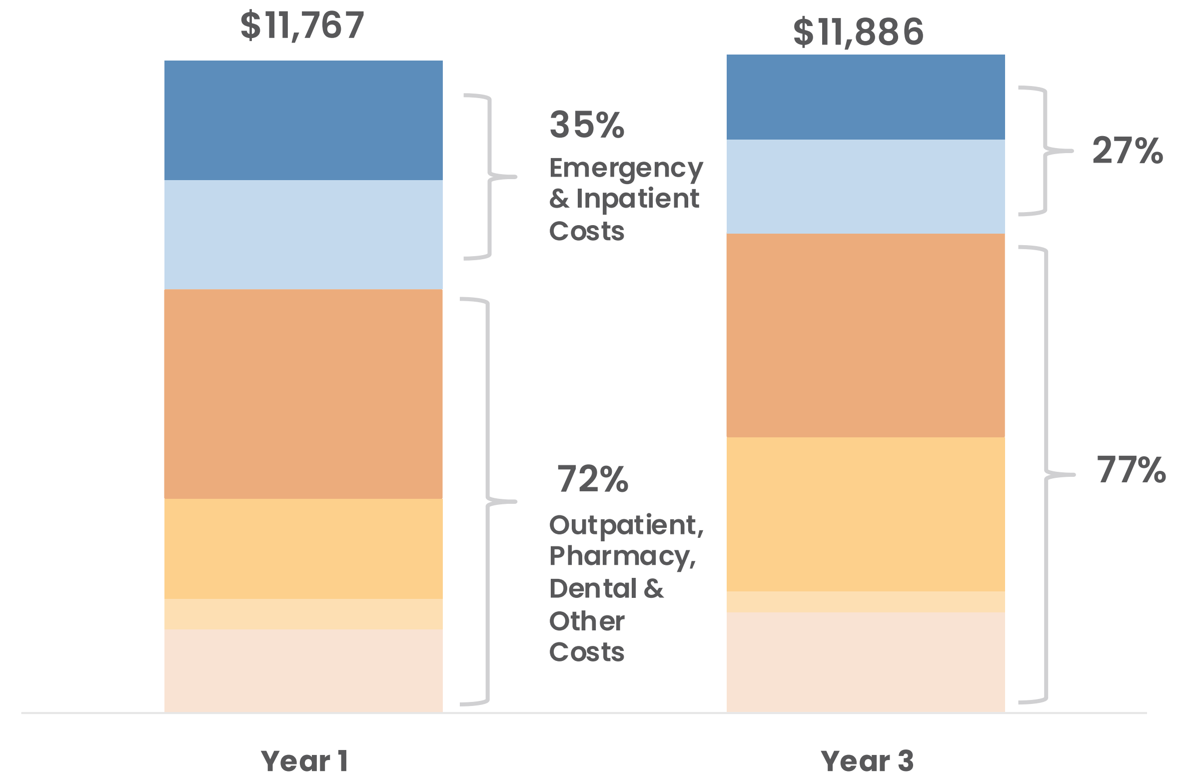
*Members with at least three years of continuous Medicaid enrollment between Jan 2016 and Aug 2025.

# Health care costs for adults with low income shift from high-cost emergency department visits to lower-cost outpatient and pharmacy services over time.

On average, adults with low income with Medicaid coverage for at least three years (47,669 members) had $11,767 health care costs in their first year of coverage. By their third year, average per-member costs held approximately constant despite annual average inflation of over 3%.^ The composition of health care costs also shifted over time, with reductions in higher-cost emergency and inpatient care and increases in outpatient, pharmacy, and dental services.

| Service Type | Average Cost per Member *Year One* | Average Cost per Member *Year Three* | % Total *Year One* | % Total *Year Three* |
|---|---|---|---|---|
| **Total Costs** | **$11,767** | **$11,886** | **100%** | **100%** |
| **Emergency Costs*** | $2,142 | $1,544 | 18% | 13% |
| **Inpatient Costs** | $2,002 | $1,682 | 17% | 14% |
| **Outpatient, Clinics and Specialty Services Costs**** | $3,767 | $3,681 | 32% | 31% |
| **Pharmacy Costs** | $1,793 | $2,808 | 15% | 24% |
| **Dental Costs** | $567 | $375 | 5% | 3% |
| **Other Costs (e.g., labs)** | $1,497 | $1,796 | 13% | 15% |

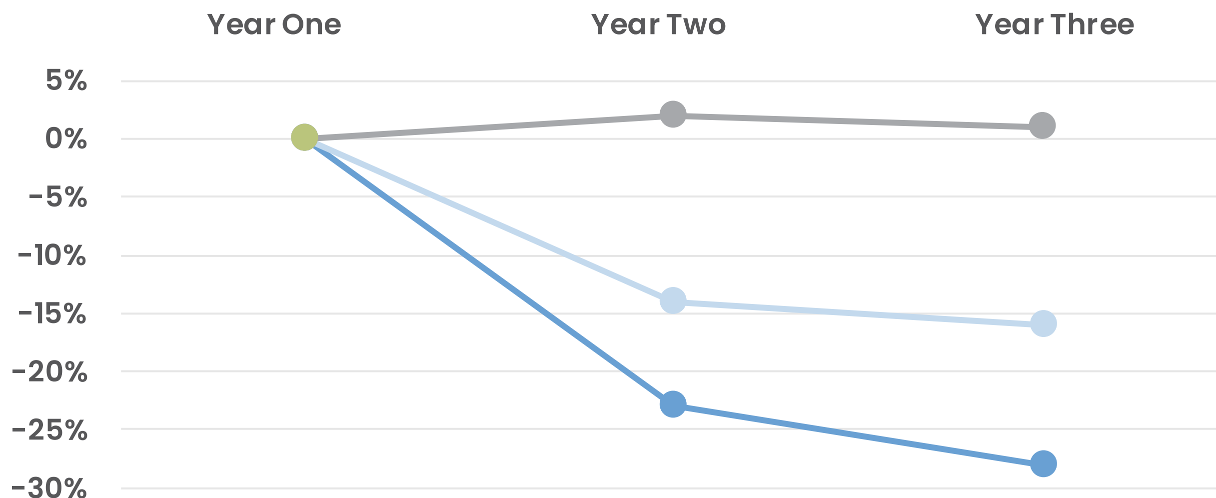
## Average Expansion Adult Health Care Costs by Service Type and Year of Enrollment




*Includes ED and emergency inpatient costs.
**Includes hospital outpatient, primary care, physician, clinic, and IHS costs.
^Inflation over the period of analysis was 3.1% on average, and medical inflation was 2.5%. When adjusted for inflation, per-member costs in year three were on average $12,254 an increase of approximately 1% compared to year one costs.

# Spending on emergency and inpatient services decreases the longer people are enrolled in Medicaid.

## Average Expansion Adult Emergency and Inpatient Costs by Year of Enrollment




| | Average Costs Per Member | | | Percent Change (From Year 1) | |
|---|---|---|---|---|---|
| | Year One | Year Two | Year Three | Year Two | Year Three |
| **Total Costs** | **$11,767** | **$11,997** | **$11,886** | **+2%** | **+1%** |
| **Emergency Costs*** | $2,142 | $1,657 | $1,544 | -23% | -28% |
| **Inpatient Costs** | $2,002 | $1,729 | $1,682 | -14% | -16% |
| **Outpatient, Clinic, and Specialty Services Costs**** | $3,767 | $3,892 | $3,681 | +3% | -2% |
| **Pharmacy Costs** | $1,793 | $2,535 | $2,808 | +41% | +57% |
| **Dental Costs** | $567 | $469 | $375 | -17.3% | -34% |
| **Other Costs (e.g., labs)** | $1,497 | $1,715 | $1,796 | +15% | +20% |

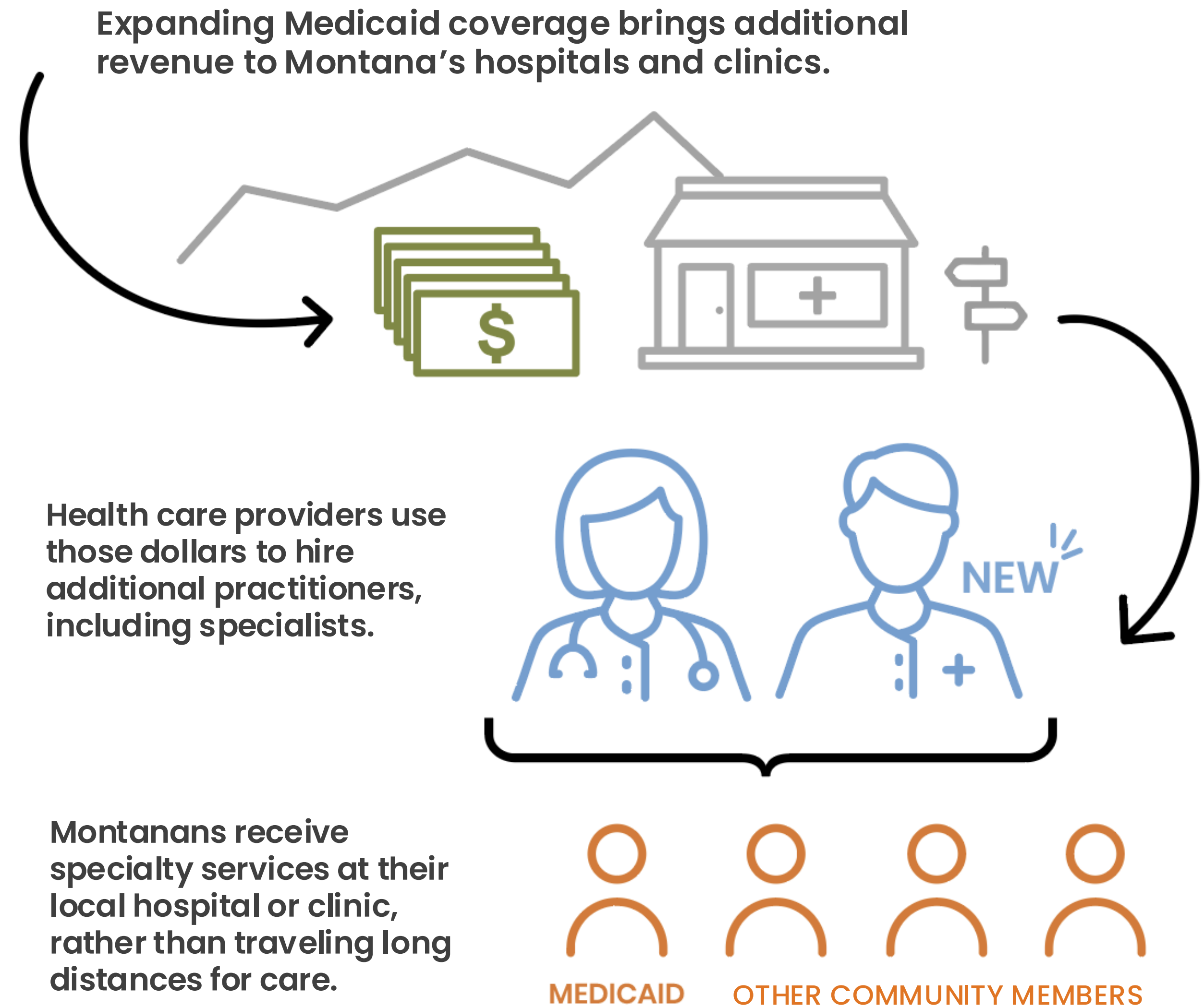
Adults with low income who are enrolled in Medicaid for at least three years saw decreases in emergency and inpatient costs. Adults with low income with Medicaid coverage for at least three full years, on average, had $2,142 in emergency costs during their first year of enrollment. By their third year, those costs dropped to $1,544, a decline of approximately 28%.^

*Includes ED and emergency inpatient costs.
**Includes hospital outpatient, primary care, physician, clinic, and IHS cost.
^Inflation over the period of analysis was 3.1% on average, and medical inflation was 2.5%.

# Expanding Medicaid allowed rural providers to expand specialty services, increasing access for all community members.

Rural communities often lack access to specialty care, and residents must travel long distances to larger cities for services that aren't available close to home. Expanding Medicaid to cover adults with low income provided a new source of reimbursement for rural health care providers. As a result, many rural health centers, federally qualified health centers (FQHC), and critical access hospitals have been able to expand their service offerings and offer additional specialty services.

**Expanded capacity of rural health care providers to provide specialty care benefits everyone in Montana's rural communities, not just those enrolled in Medicaid.**



# Expanded access to Medicaid coverage helped rural hospitals increase their capacity to treat all community members who need specialty care.

## Medicaid Members Receiving Specialty Services in Critical Access Hospitals (CY 2015, 2019, 2024)



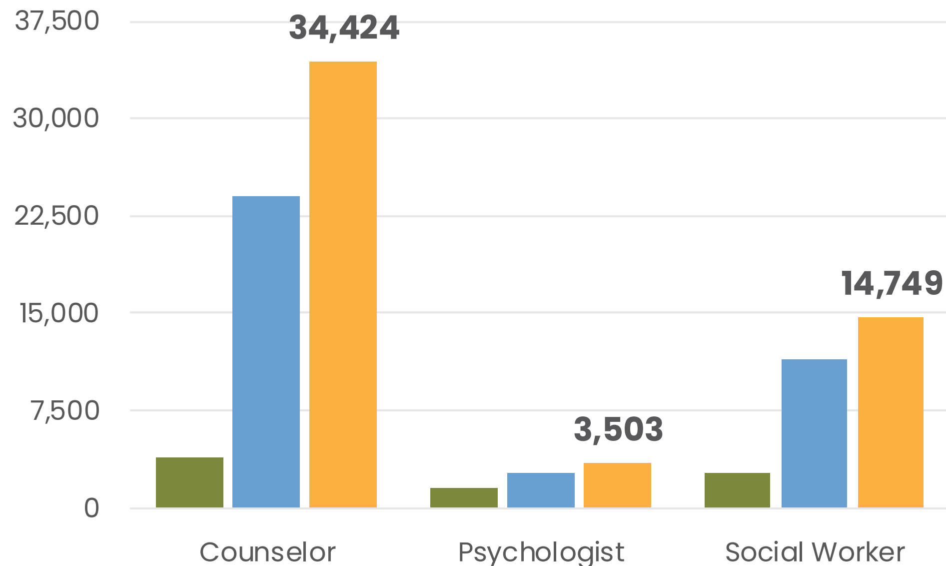
Between 2015 and 2024, the availability of specialty services at critical access hospitals significantly increased.

In 2024, more than 1,700 Medicaid members had a claim related to orthopedic surgery at one of Montana's 50 critical access hospitals, compared to only 700 in 2015 (an increase of 153%). Access to surgical and specialty care can help Montanans address debilitating injuries, return to work or school, and improve long-term health and well-being.

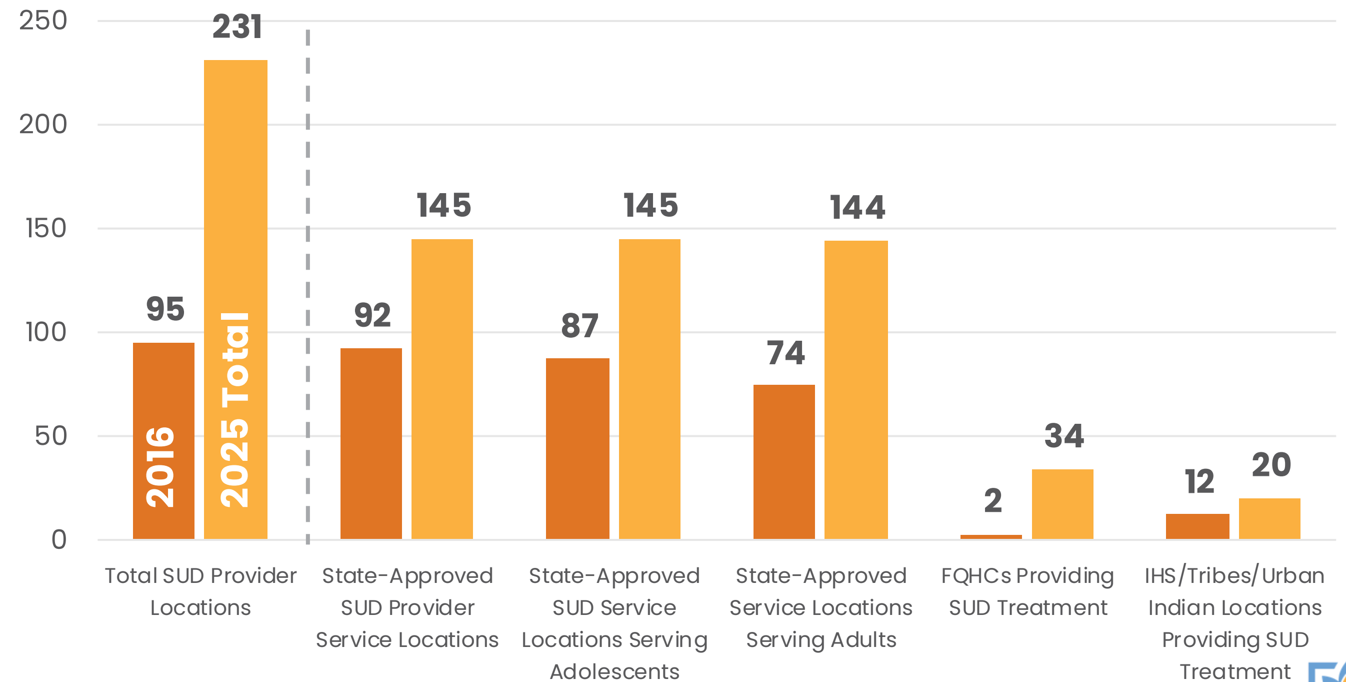
# Expanding Medicaid provided additional funding for mental health and substance use treatment.

In 2024, more than one-third of Medicaid members (85,000) had a behavioral health diagnosis.* Expanding Medicaid to cover adults with low income has allowed hospitals and clinics to expand provider networks and access to treatment for behavioral health conditions. Between 2015 and 2024, the number of claims for services provided by a behavioral health counselor in a FQHC or rural health clinic increased more than eight times, from about 3,900 to 34,400. Between 2016 and 2023, the number of authorized SUD providers more than doubled.

## Claims for Specialty Behavioral Health Services in FQHCs and Rural Health Clinics (CY 2015, 2019, 2024)

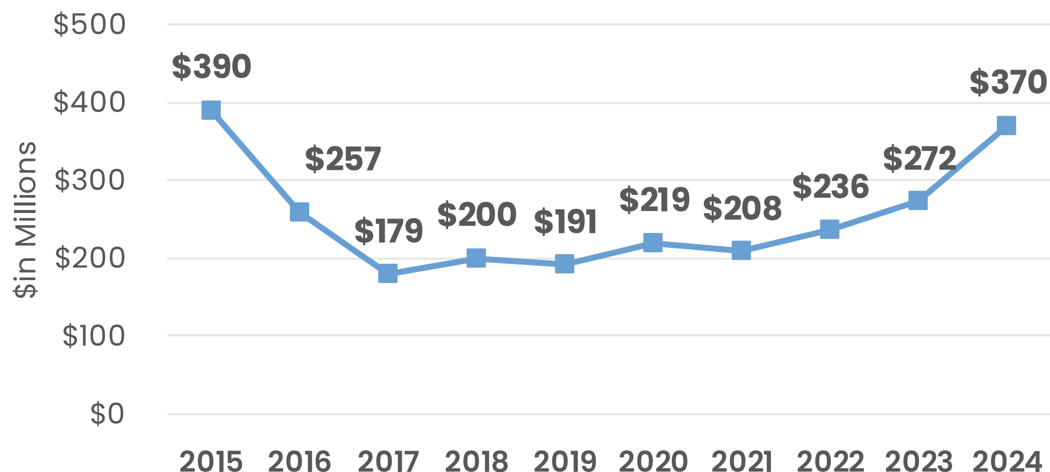


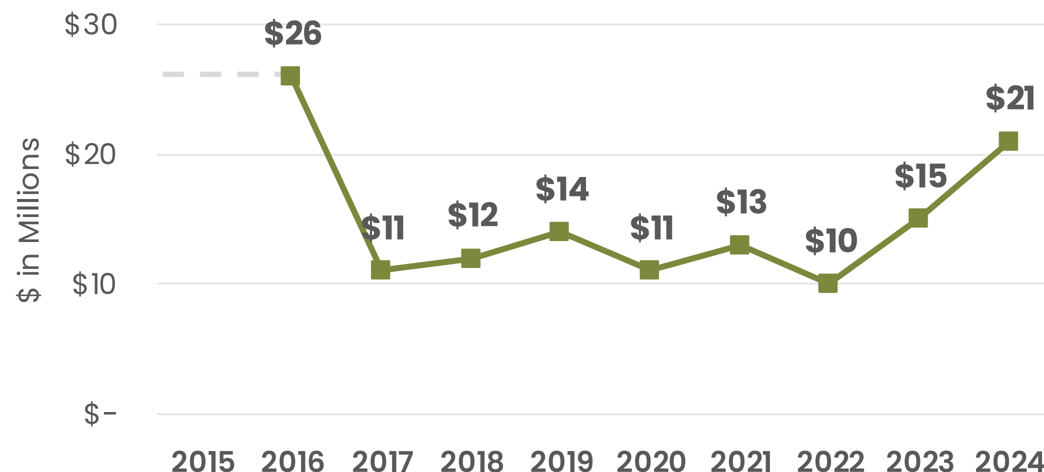

## Montana SUD Treatment Providers (CY 2016, 2025)




*Recorded on a claim.

# Lower uninsured rates reduced the financial burden of uncompensated care for Montana hospitals, supporting financial sustainability.




Before Medicaid expansion, many uninsured people could not pay their medical bills, resulting in uncompensated hospital care costs. Nationally, rural hospitals in non-expansion states have lower median operating margins than those with expanded Medicaid. Between 2016 and 2020, 72 rural hospitals closed nationwide; no rural hospitals in Montana closed in that period.

Beginning in 2016, Montana hospitals saw Medicaid reimbursement for additional Montanans, resulting in decreased uncompensated care costs. However, as enrollment declined in 2023 and 2024, uncompensated care costs also increased. Critical access hospitals were especially affected: between 2023 and 2024, uncompensated care in Montana's critical access hospitals increased from approximately $15 million to $21 million (+40%).

*Data provided by the Montana Hospital Association and sourced from the American Hospital Association Annual Survey of Hospitals. Inclusive of charity care and bad debt.

**2015 data not available for Critical Access Hospitals. Includes charity care only.

# The HELP Act generated state budget savings of approximately $24 million in SFY 2025.

The HELP Act brought additional federal dollars to Montana, allowing savings of state funds that would have otherwise been spent on Medicaid.

Without Medicaid expansion, some individuals (including medically needy individuals, some pregnant women, and individuals with previous coverage under a waiver or the breast and cervical cancer program) would be covered in other Medicaid eligibility groups at a lower federal match rate (62% in SFY 2025). With the expansion, those individuals are covered at a higher federal match rate (90%), with Montana saving the difference. Those stays are now paid for through federal Medicaid, resulting in additional savings.^





*Additional savings may not be captured, including approximately $16 million for individuals with previous coverage under the Health Insurance Flexibility and Accountability (HIFA) waiver.
**Assumes Section 9 of the HELP Act was not adopted, and the state would pay 80% of charges for inmate services.
^Previous reporting also included individuals in the mental health services program and individuals previously receiving state-funded SUD treatment. Many individuals would be captured in the HIFA waiver population or other savings categories.

# Coverage for Tribal Communities

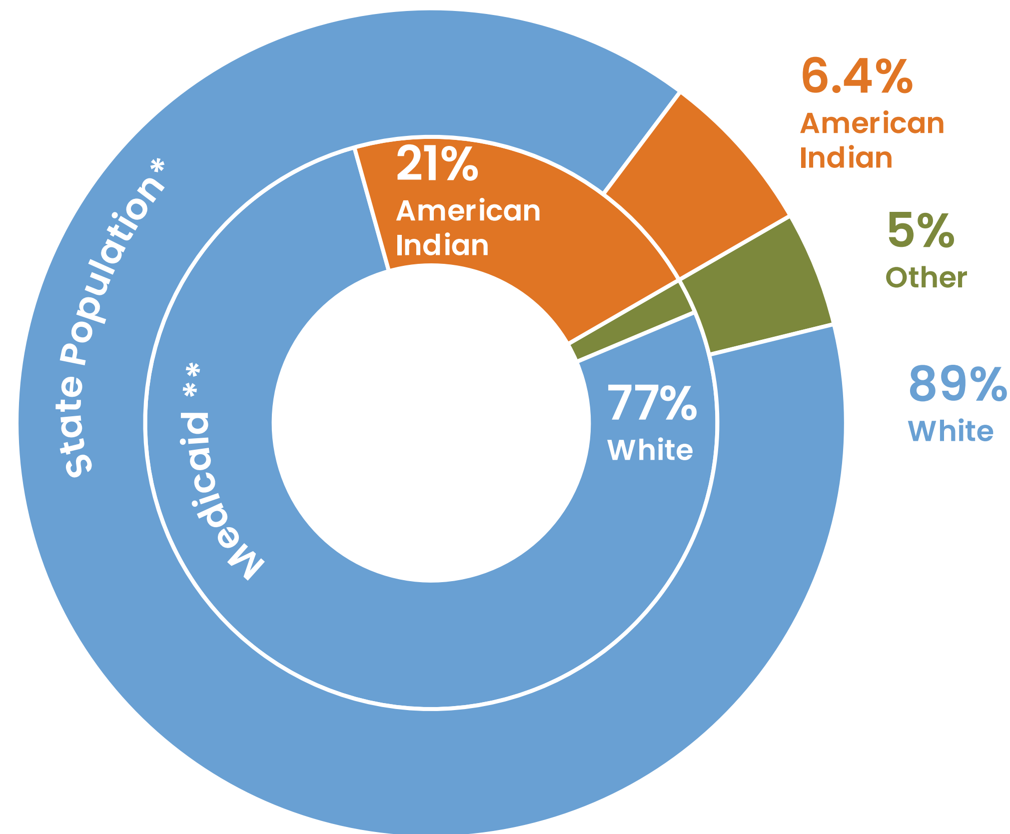
# Medicaid is an important source of coverage for American Indian people in Montana.

Medicaid is a particularly important source of coverage for American Indian people, who comprise 6.4% of the state population but 21% of Medicaid enrollment (about 40,000 members).

Montana is home to 12 federally recognized tribes on seven reservations and a large urban Indian population. Despite the ongoing and innovative efforts of tribes and health leaders to improve health and well-being in tribal communities, American Indian people in Montana face significant health disparities due to underfunding of the tribal health care system and longstanding challenges such as trauma, unemployment, overcrowded housing, and discrimination.

However, increased access to Medicaid coverage and increased funding for the tribal health care system may be changing this narrative. In 2024, the all-cause mortality rate for American Indian people in Montana fell to its lowest level since 2018.

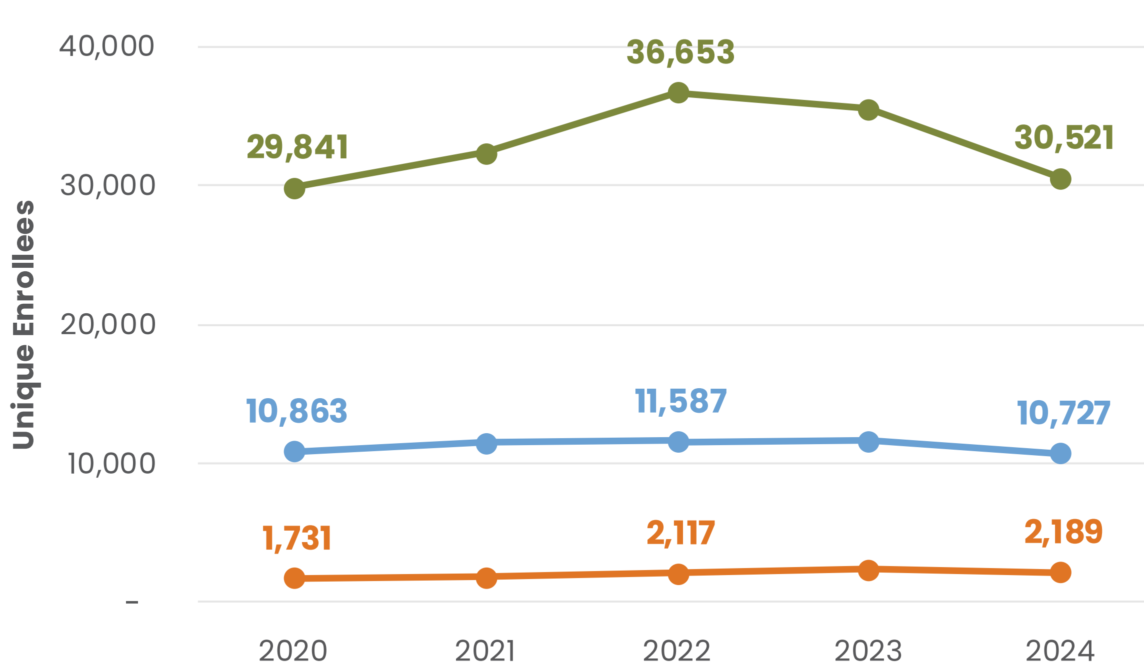
## Medicaid Demographics in Comparison with State Demographics (CY 2025)




*State demographic data is only available for 2024. Numbers may not total to 100% due to rounding.
**The race demographics category excludes approximately 25,000 members did not report their race. Reporting assumes individuals in the "Unknown" race category are distributed normally across race categories.

# Medicaid increases access to preventive services and treatment for American Indians.

## American Indian Members Accessing Preventive Services and Treatment on Medicaid (CY 2020, 2022, 2024)




| | 2020 | 2022 | 2024 |
|---|---|---|---|
| **Preventive Services Delivered** | 29,481 | 36,653 | 30,521 |
| **Mental Health Treatment** | 10,863 | 11,587 | 10,727 |
| **Substance Use Treatment** | 1,731 | 2,117 | 2,189 |

| | | 2020 | 2022 | 2024 |
|---|---|---|---|---|
| **Breast Cancer** | Screenings | 557 | 780 | 738 |
| | Diagnoses | 17 | 17 | 18 |
| **Colon Cancer** | Screenings | 345 | 485 | 442 |
| | Potentially Averted | 112 | 150 | 136 |
| **Diabetes** | Newly Diagnosed | 442 | 596 | 559 |
| | Treatments | 743 | 923 | 735 |
| **Hypertension** | Newly Diagnosed | 549 | 750 | 659 |
| | Treatments | 871 | 1,094 | 843 |

More than 30,000 American Indian Medicaid members received preventive services in 2024, nearly 11,000 received treatment for mental health issues, and more than 2,000 received SUD treatment. Like for other Medicaid populations, screenings, diagnoses and treatment for chronic physical and behavioral health conditions for American Indian members peaked in 2022 when continuous coverage requirements were in place and declined between 2022 and 2024 as enrollment decreased following the redetermination period. However, while access to most preventive services decreased as enrollment decreased, utilization of SUD treatment has steadily increased among American Indian members between 2020 and 2024.

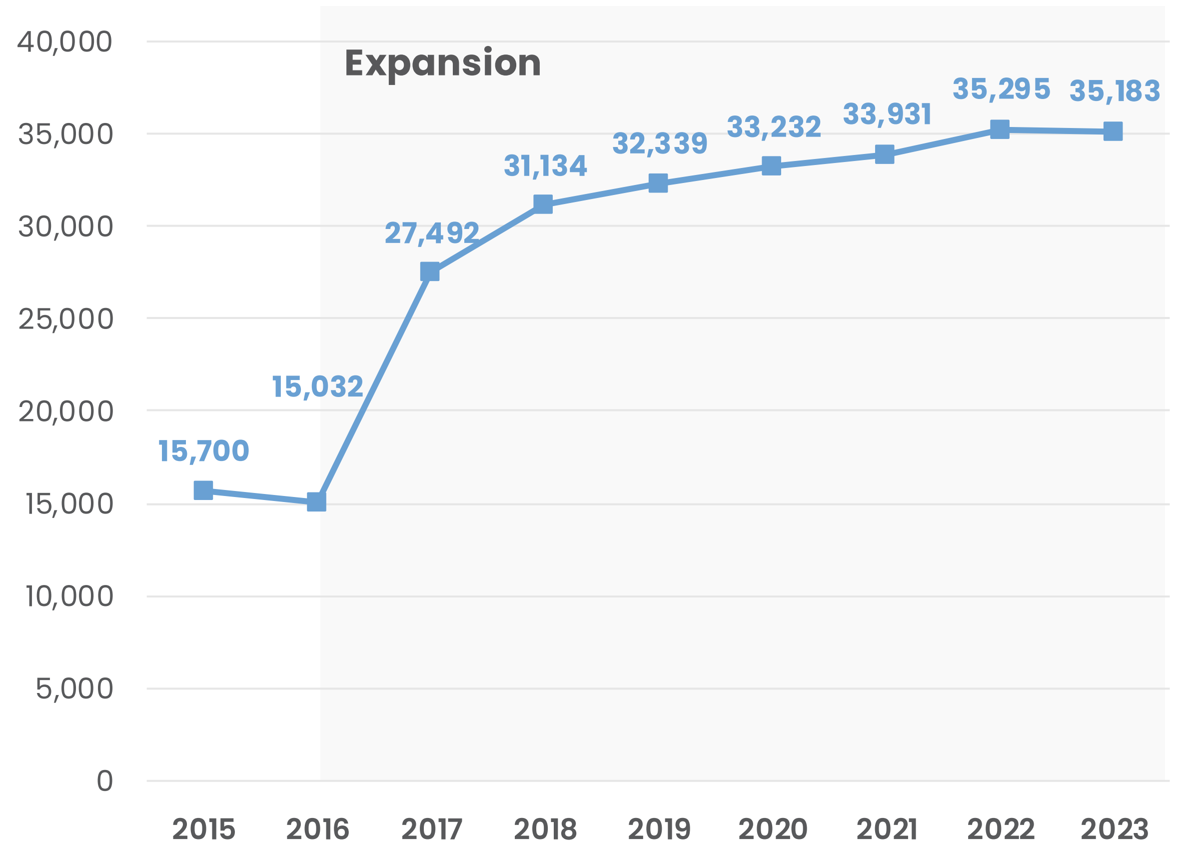
# Medicaid helps the Indian Health Service stretch its limited budget, improving access to non-emergency health services at no cost to Montana.

IHS is a federal agency that provides health services for American Indian people. It does this in three ways: directly through IHS facilities, tribally-operated programs, and Purchased/Referred Care (PRC). PRC is a limited, capped budget used to reimburse for services unavailable in IHS or tribal facilities.

Because of IHS' chronic underfunding, historically PRC funds have only been available for "life or limb" emergencies. All other care – like specialty consultation, surgery, hospitalization, and even cancer screening and treatment – was not generally covered by PRC and unavailable to many American Indian people.

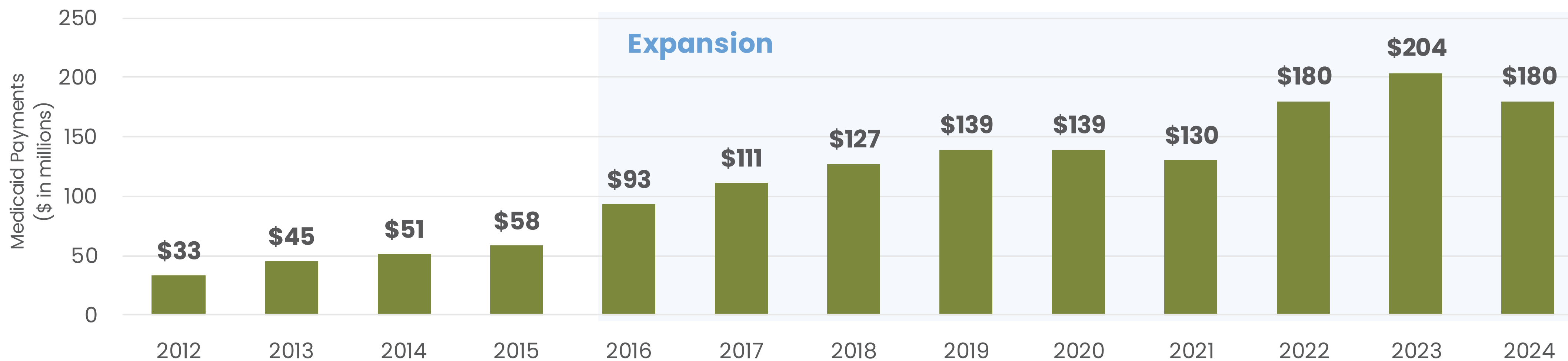
Medicaid provides a new source of reimbursement, reducing the demand for PRC funds. As a result, PRC referrals increased significantly after Montana expanded Medicaid to cover additional adults (including American Indian adults). This care is delivered at no cost to Montana: the federal government covers 100% of PRC and Medicaid costs for services delivered to American Indian people through IHS and tribal facilities.

## Purchased/Referred Care Referrals (CY 2015-2023)*




*IHS data only available through 2023.

# Medicaid helps mitigate the longstanding federal underfunding of the Indian Health Service.




The federal government has historically allocated less per capita to IHS than any other federally funded health care program. In 2017, an analysis from the Government Accountability Office (GAO) found that Medicare, Medicaid, and the Veterans Health Administration received two to three times more federal spending per person than IHS.* In 2024, Medicaid made approximately $180 million in federally reimbursable payments to IHS and tribal health facilities, down from $204 million in 2023, potentially attributable to Medicaid enrollment declines among tribal populations.

*GAO findings should be considered in the context of program differences. IHS, VA Administration, and Medicaid have different program structures, service populations, and services/benefits.

# Conclusion

# Conclusion

Medicaid is an essential safety net program that provides Montanans with low income access to health care coverage to support their health and well-being. Members can access a continuum of physical, dental, and behavioral health services to address their individualized health care needs. Receipt of preventive services – including screenings for chronic conditions, mental health conditions, and SUD – allows members to address health care concerns early and stay in the workplace and out of the ED.

Medicaid expansion continues to be a critical resource for adults with low income living across the state, providing access to health care services that support Montanans health and well-being. Through Medicaid expansion, Montana has experienced reduced uninsured rates, reduced ED utilization for preventable conditions, and generated state budget savings exceeding $24 million in SFY 2025.

# Looking Ahead

In 2025, Governor Gianforte signed House Bill 245, which made Medicaid expansion permanent in Montana: a watershed moment and testament to its broadly accepted value. However, in 2026, Montana's Medicaid program – like many states across the nation – will confront new challenges and opportunities as it seeks to serve Montanans. Enrollment has declined after the state conducted eligibility redeterminations following the end of the COVID-19 public health emergency.

Mandatory work requirements for adults with low income and other provisions in H.R. 1 will require the state to implement new systems to confirm member eligibility - or risk jeopardizing coverage for vulnerable populations. All while an influx of federal Rural Health Transformation Program dollars offers Montana a once-in-a-generation opportunity to build new health care system capabilities in its frontier communities.

# Acknowledgements

**Montana Healthcare Foundation** is a 501(c)3 private foundation that makes strategic investments to improve health in Montana. It provides funding, leadership, and expertise to help communities tackle Montana's most important health problems. It conducts policy analysis so that Montanans can be well-informed and engaged in decisions that impact their health. It prioritizes supporting the health and well-being of people and communities at increased risk for poor health outcomes because of income, geographic barriers, the availability and accessibility of health and social services, and health disparities. To learn more, visit mthf.org.

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**This report would not have been possible without the support and partnership of DPHHS.**

**Visit the Montana Healthcare Foundation's website for more information about the report, for links to other Medicaid in Montana reports, and to download the accompanying data book. For any questions about the report, contact the Montana Healthcare Foundation at info@mthf.org.**

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*Data Source*

"Health Insurance Coverage of The Total Population," Kaiser Family Foundation. Available here.

DHPPS direct data request.

*Technical Note*

Average monthly enrollment from January-June 2025. Totals include individuals enrolled in traditional Medicaid, Medicaid Expansion, CHIP, and HK Expansion. Enrollment data excludes the Plan First waiver, Section 9, Mental Health Service Plan, and Medicare Savings Plan members.

**Page 8**

"10 Things to Know About the Unwinding of the Medicaid Continuous Enrollment Provision," Kaiser Family Foundation. June 2023. Available here.

*Data Source*

DHPPS direct data request.

*Technical Note*

Average monthly enrollment from January-June 2025. Totals include individuals enrolled in traditional Medicaid, Medicaid Expansion, CHIP, and HK Expansion. Enrollment data excludes the Plan First waiver, Section 9, Mental Health Service Plan, and Medicare Savings Plan members.

**Page 9**

*Data Source*

DPHHS direct data request.

"Quick Facts: Montana," U.S. Census Bureau. Available here.

*Technical Note*

Rural/urban definitions are from the University of Washington Rural Health Research Center's RUCA Census data crosswalk. Available here . RUCA was last updated in 2006. Rural/urban classifications have likely shifted in Montana since the last update, though distributions remain comparatively accurate.

Race information is voluntarily reported.

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*Data Source*

DHPPS direct data request.

*Technical Note*

Average monthly enrollment from January-June 2025. Totals include individuals enrolled in traditional Medicaid, Medicaid Expansion, CHIP, and HK Expansion. Enrollment data excludes the Plan First waiver, Section 9, Mental Health Service Plan, and Medicare Savings Plan members.

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*Technical Note.*

Race information is voluntarily reported.

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*Data Source*

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*Data Source*

DPHHS direct data request.

*Technical Note*

Average duration for all population groups is likely inflated due to continuous coverage requirements.

Duration represents the average number of months of continuous enrollment. The time period for the study is January 2016 to December 2021. All individuals were enrolled in the month of December 2021. Durations represent continuous enrollment in the same enrollment category the individual was in in December 2021 (e.g., if a child switched into an "adult" enrollment category, their duration on the child plan would end and would begin on the adult plan).

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*Data Source*

DPHHS direct data request.

*Technical Note*

Counts represent unique individuals accessing each preventive service. Counts include billed screenings only, which may undercount regularly conducted screenings such as for alcohol abuse.

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**Page 17**

*Data Source*

DPHHS direct data request.

*Technical Note*

Counts represent unique individuals accessing each preventive service. Counts include billed screenings only, which may undercount regularly conducted screenings such as for alcohol abuse.

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*Technical Note*

Counts represent unique individuals accessing each preventive service. Counts include billed screenings only, which may undercount regularly conducted screenings such as for alcohol abuse.

**Page 19**

*Data Source*

DPHHS direct data request.

*Technical Note*

Counts of unique adult members screened or diagnosed at any point during the calendar year.

**Page 20**

*Data Source*

DPHHS direct data request.

*Technical Note*

Service counts are indicated by number of Medicaid claims; a claim may comprise multiple units of service.

**Page 21**

*Data Source*

DPHHS direct data request.

*Technical Note*

Counts of unique adult members screened or diagnosed at any point during the calendar year.

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*Data Source*

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"2025 State Expenditure Report, Fiscal 2023-2025", NASBO. Available here.

"How Has U.S. Spending on Healthcare Changed Over Time?" Peterson-KFF Health System Tracker. December 2023. Available here.

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"2025 State Expenditure Report: Fiscal 2023-25" National Association of State Budget Offices (NASBO). Available here.

*Technical Note*

Peer states were selected to provide a diverse sample of states with both similar and disparate populations, geographies, political leanings, and Medicaid expansion action for ongoing reporting.

**Page 24**

*Data Source*

DPHHS direct data request.

*Technical Note*

The following payments were eliminated from spending and per member spending totals: hospital utilization fee; HUF (HRD) HELP SSR; Disproportionate Share Hospital payments; DSH (FMAP) payments.

Categories are mutually exclusive. "Individuals with Disabilities" includes individuals from all age categories. "Seniors", "Children" and "Adults" exclude individuals with disabilities.

Analysis includes individuals enrolled in traditional Medicaid, Medicaid expansion, CHIP, and Healthy Kids Expansion. Past reporting included additional enrollment categories such as Medicare Savings Programs.

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*Data Source*

DPHHS direct data request.

*Technical Note*

The following payments were eliminated from spending and per member spending totals: hospital utilization fee; HUF (HRD) HELP SSR; Disproportionate Share Hospital payments; DSH (FMAP) payments.

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*Data Source*

DPHHS direct data request.

*Technical Note*

The following payments were eliminated from spending and per member spending totals: hospital utilization fee; HUF (HRD) HELP SSR; Disproportionate Share Hospital payments; DSH (FMAP) payments.

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*Data Source*

DPHHS direct data request.

*Technical Note*

The following payments were eliminated from spending and per member spending totals: hospital utilization fee; HUF (HRD) HELP SSR; Disproportionate Share Hospital payments; DSH (FMAP) payments.

Categories are mutually exclusive. "Individuals with Disabilities" includes individuals from all age categories. "Seniors", "Children" and "Adults" exclude individuals with disabilities.

The "behavioral health" category includes Comprehensive School and Community Treatment previously reported in the "schools" category.

Analysis includes individuals enrolled in traditional Medicaid, Medicaid expansion, CHIP, and Healthy Kids Expansion. Past reporting included additional enrollment categories such as Medicare Savings Programs.

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*Data Source*

DPHHS direct data request.

*Technical Note*

The following payments were eliminated from spending and per member spending totals: hospital utilization fee; HUF (HRD) HELP SSR; Disproportionate Share Hospital payments; DSH (FMAP) payments.

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Analysis includes individuals enrolled in traditional Medicaid, Medicaid expansion, CHIP, and Healthy Kids Expansion. Past reporting included additional enrollment categories such as Medicare Savings Programs.

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*Data Source*

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*Technical Note*

MHCF's "2020 Report on Health Coverage and Montana's Insured" found a similar decline in uninsured rates after Medicaid expansion. MHCF's 2020 report shows uninsured rates for the entire Montana population, while Kaiser Family Foundation data shows uninsured rates for the nonelderly adult population only.

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*Data Source*

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*Data Source*

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*Technical Note*

Analysis includes enrollees with at least two, three, or four years of continuous enrollment between January 2016 and August 2024.

Previous reporting included members enrolled for at least two years between 2016 and March 2020 to mitigate the impact of the continuous coverage requirement in place during the public health emergency on results. The current analysis includes members enrolled for at least two years between 2016 and 2024. Recognizing some individuals may have been enrolled during the public health emergency but were not actively utilizing Medicaid, this analysis excludes individuals that did not have a Medicaid claim in each year of enrollment.

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*Data Source*

DPHHS direct data request.

*Technical Note*

Analysis includes members with at least three years of continuous enrollment between January 2016 and August 2024.

Previous reporting included members enrolled for at least two years between 2016 and March 2020 to mitigate the impact of the continuous coverage requirement in place during the public health emergency on results. The current analysis includes members enrolled for at least two years between 2016 and 2024 Recognizing some individuals may have been enrolled during the public health emergency but were not actively utilizing Medicaid, this analysis excludes individuals that did not have a Medicaid claim in each year of enrollment.

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Analysis includes members with at least three years of continuous enrollment between January 2016 and August 2024.

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*Data Source*

DPHHS direct data request.

*Technical Note*

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*Data Source*

DPHHS direct data request.

*Technical Note*

Analysis includes members with at least three years of continuous enrollment between January 2016 and August 2024.

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*Data Source*

DPHHS direct data request.

Manatt analysis of Montana Medicaid enrollment and spending data, SFY 13-24.

*Technical Note*

There may be additional savings that are not captured, including approximately $16 million for individuals with previous coverage under the HIFA waiver. For inmate savings, analysis assumes Section 9 of the HELP Act was not adopted, and the state would pay for 80% of charges for inmate services. Previous reporting also included individuals in the mental health services program and individuals previously receiving state-funded SUD treatment. Many of these individuals would be captured in the HIFA waiver population or in other savings categories.

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*Date Source*

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*Technical Note*

Race information is voluntarily reported. Analysis excludes members with "unknown" race category.

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*Data Source*

DPHHS direct data request.

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*Data Source*

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*Note*

Data is not available for the Confederated Salish and Kootenai Tribes of the Flathead Reservation and the Chippewa Cree Indians of the Rocky Boy Reservation, which have assumed management of the PRC program for the IHS.

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*Data Source*

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*Technical Note*

The federal government covers 100% of Medicaid costs for services delivered through IHS.