Montana Health and Economic Livelihood Partnership (HELP) Program Demonstration

Number: No. 11-W-00300/8

SECTION 1115 WAIVER ANNUAL REPORT

State of Montana

REPORTING PERIOD

Demonstration Year: 1 (01/01/16 – 12/31/16)

Date submitted to CMS: March 30, 2017

Introduction

The 2015 Montana Legislature enacted Senate Bill 405, the Montana Health and Economic Livelihood Partnership (HELP) Act, that among other features, provides for the expansion of health care services through the Medicaid HELP Program to new adults ages 19-64 years old and below 138 percent of the federal poverty level (FPL). HELP Program coverage was effective January 1, 2016 and the State implemented its expansion through a Section 1115 demonstration waiver from the Centers for Medicare and Medicaid Services (CMS). The demonstration was designed to tailor the features of expansion to the policy objectives of the HELP Act including:

- Increasing the availability of high-quality health care to Montanans;
- Providing greater value for the tax dollars spent on the Montana Medicaid program;
- Reducing health care costs;
- Providing incentives that encourage Montanans to take greater responsibility for their personal health;
- Boosting Montana's economy; and
- Reducing the costs of uncompensated care and the resulting cost-shifting to patients with health insurance.[1]

In September, 2015, Montana submitted two waivers to CMS. Both waivers were approved by CMS in November, 2015.

The Section 1115 waiver authorizes:

- 12 months of continuous eligibility for all new adults;
- Premiums for new adults participating in the TPA equal to 2% of their household income; and
- Maximum copayments allowable under federal law, with total cost sharing not to exceed 5% of a beneficiary's household income.

The Section 1915(b)(4) waiver authorizes:

- The State to contract with a TPA to administer its Medicaid expansion.

Montana is the first state in the U.S. to use a third party administrator (TPA) model to administer its Medicaid expansion program. In July, 2015, the Department of Public Health and Human Services (DPHHS) issued a request for proposals (RFP), and selected Blue Cross and Blue Shield of Montana (BCBSMT) as the TPA for the HELP Program in September, 2015. Using the TPA model and through its contract with BCBSMT, Montana is utilizing the largest existing provider network in the State. This has allowed rapid implementation of a statewide provider network for the HELP Program. BCBSMT manages provider enrollment, as well as compliance with federal requirements under 42 CFR 455 Subpart E. BCBSMT brings additional value because it exceeds the Montana commercial benchmark benefit plan, offering new adults individualized wellness programs and utilization review services, and providing established systems to monitor and address fraud, waste, and abuse.

HELP Program enrollees receive the Alternative Benefit Plan (ABP), the health care benefit plan provided to Medicaid participants as required by federal law. HELP Program participants are subject to premiums and maximum copayments allowable under federal law.

Demonstration Population

This demonstration affects eligible individuals ages 19 through 64 in the new adult group under the state plan as authorized by Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act, and 42 CFR 435.119; new adults receive all benefits described in an ABP State Plan Amendment.

[1] Montana Department of Public Health and Human Services, *Montana HELP Program Section 1115 Research and Demonstration Waiver Application,* July 7, 2015, http://dphhs.mt.gov/Portals/85/Documents/MedicaidExpansion/MontanaSection1115and1915b4Waivers.pdf.

The following populations are excluded from all portions of the demonstration other than the continuous eligibility provisions in Section VIII. Individuals:

- Who are medically frail;
- Whom the State determines (as described in the TPA ABP State Plan) have exceptional health care needs, including but not limited to a medical, mental health, or developmental condition;
- Who live in a region where the TPA is unable to contract with a sufficient number of providers (as described in the TPA ABP State Plan);
- Whom the state determines, in accordance with objective standards approved by CMS (as described in the TPA ABP), require continuity of coverage that is not available or could not be effectively delivered through the TPA; and
- Individuals with incomes below 50 percent of the FPL.

Events Related to Health Care Delivery, Enrollment, or Other Operations

Public Meetings: Prior to HELP Program implementation, leadership from the Montana Department of Public Health and Human Services (DPHHS) delivered several public presentations as part of public notice for the two waivers. Two public meetings, tribal consultation, and a presentation to the Montana Children, Families, Health, and Human Services Interim Committee were held in August and September, 2015. A public notice presentation for the ABP was held in November, 2015. Since implementation of the HELP Program in January 2016, Montana has delivered multiple public presentations and webinars for such stakeholder groups as the Montana Primary Care Association, Montana Hospital Association, Montana Dental Association, Montana Mental Health Advisory Council, Montana Statewide Drug Court Conference, and the Governor's Conference on Aging. During the last year, Montana met with and reported on implementation to both tribal government and tribal health leaders. Additionally, DPHHS and the TPA present and meet quarterly with the HELP Act Oversight Committee to generally review the implementation of the programs established in the HELP Act. The committee consists of nine voting members, including legislative members, industry experts, a representative of the state auditor's office, and a member of the general public or staff member of the Governor's Office.

Participant and Provider Education: DPHHS worked with the TPA to create education materials for HELP Program participants and providers. Upon enrollment, participants receive a Welcome Kit via mail, which includes a welcome letter, Participant Guide, and flyer for the TPA's online portal. Significant materials include:

- HELP Program Participant Guide
  - Describes benefits and responsibilities of the participants, encourages staying healthy by accessing preventive benefits and completing the health assessment, and informs participants about choosing a primary care provider to manage health care needs and utilization of benefits.
- HELP Program Evidence of Coverage
  - Describes detailed benefits information, including covered and non-covered services and prior authorization requirements.
- HELP Program Provider Manual
  - Describes provider's responsibilities, including enrollment, claim submission, preauthorization requirements, and reimbursement.

Participant outreach and communication includes mail and telephonic communication and web-based education. Additionally, local navigators and certified application counselors support participant outreach and communication.

The TPA ensures providers have the information necessary on preventive care, disease-specific, and wellness programs to support participant education, promote compliance with treatment directives, and encourage self-directed care.

Wellness Programs: The TPA implemented a comprehensive health and wellness program, called the HELP Healthy Behavior Plan, for participants in the HELP Program, with a focus on engaging participants and providers. The program is designed to:

- Improve participants' knowledge of lifestyles that are healthy and promote wellness;
- Improve participants' understanding of chronic health conditions;

- Design programs to augment a participants' understanding of lifestyle behaviors that negatively impact their health;
- Ensure continuity of health care;
- Provide easy access to validated, accurate health information;
- Inform participants of health and self-care and how to access plan benefits, provider services, DPHHS programs and other community resources to assist them in engaging in healthy lifestyle behaviors;
- Improve the participant-provider relationship;
- Improve health plan-provider communication; and,
- Engage existing provider and community health education programs in providing participant wellness information and offering participant support for chronic conditions.

TPA and DPHHS wellness programs currently focus on asthma, arthritis, diabetes, hypertension, smoking cessation, weight loss, healthy lifestyles, and other individualized programs that address participants' health needs.

The HELP Program Health Assessment (HA) was developed in late 2015 by a work group of physicians, an epidemiologist, community stake holders, public health educators, and DPHHS program managers. The HA is a tool used to identify program participants who have health conditions that may benefit from case management, wellness programs, individualized wellness programs, or participants who meet the Department's medically frail criteria. If a participant is identified as medically frail, TPA case management works with DPHHS to transition them to the appropriate health coverage option.

Evaluation Activities

State Evaluation

On March 1, 2016, Montana submitted a draft evaluation design as required by STC Section XII (1). Montana received comments on the evaluation design from Mathematica Policy Research and CMS on May 2, 2016.

DPHHS developed and released an RFP in August 2016, for the independent evaluation of the Section 1115 HELP Demonstration Waiver. The RFP process closed on September 6, 2016, and no proposals were received. Montana's Department of Administration approved direct negotiation with Health Management Associates (HMA) to perform the evaluation and Montana is currently negotiating the contract with HMA. DPHHS and the TPA have worked on the logistics and content of surveying both participants and providers and expects HMA will use participant and provider surveys to measure qualitative aspects of the HELP Program.

Federal Evaluation

Montana was presented with the Urban Institute and Social & Scientific Systems, Inc.'s federal evaluation design and timeline in December 2016, and has since given extensive feedback to ensure the evaluation provides a comprehensive view of the HELP Program. Montana signed a data use agreement with SSS in preparation to submit eligibility and claims data to SSS for the evaluation in May 2017. Beneficiary surveys and focus groups are scheduled to begin in June 2017. Montana will continue to assist with the federal evaluation as needed. As this evaluation has not begun, no findings are available at this time.

Challenges

The most significant challenge that Montana faced was an extremely short implementation timeline between waiver approval and Program launch. While negotiating the waivers with CMS, the State began a parallel effort to implement the HELP Program. These efforts focused on coordinating a multi-department, multi-vendor team, who collaborated to prepare the DPHHS eligibility system, Medicaid Management Information System (MMIS) and the TPA to expand eligibility and operate the HELP Program. As mentioned previously, BCBSMT was selected as the TPA for the HELP Program in September 2015, shortly before implementation in January 2016. Montana's dedicated team successfully launched the HELP Program on January 1, 2016, consistent with the project plan. Concurrently, Montana made several revisions to its standard Medicaid program, including an update to its Cost Share State Plan as well as a new ABP SPA.

During the planning stage for the HELP Program, the State estimated approximately 25,800 would enroll within the first year of operations. Enrollment greatly exceeded first year projections with 70,770 individuals enrolled as of December 2016. The tremendous enrollment response to Medicaid expansion greatly contributed to the large reduction in Montana's uninsured rate, which has plummeted from 15% in 2015 to 7% in 2016. This success can be attributed to an enrollment campaign spearheaded by State stakeholders including DPHHS and the Governor's Office, enrollment organizations, BCBSMT, and provider groups, such as the Montana Primary Care Association and Montana Hospital Association. Outreach materials focused on how to apply for Montana's new high quality health care plan under the HELP Program, including application through the federally facilitated marketplace (FFM). Because initial uptake was significantly higher than anticipated, Montana was required to shift staffing resources to accommodate the enrollment demand.

Key Milestones and Accomplishments

Preventive Care

The expansion of Medicaid in Montana has been an opportunity to dramatically improve the health of the state by incentivizing primary and preventive care. To promote use of high value health services, the state did not apply copayments for preventive health care services. As of December 31, 2016, more than 700,000 preventive care exams, screenings, pharmacy, or other preventive services, as described in Montana's Preventive Services Protocol, have been conducted. Excluding pharmaceuticals, the ten most commonly used preventive services are below:

Preventive Service	Unduplicated Number of Clients
Dental Preventive	15,778
Cholesterol Screening	8,218
Preventive/Wellness Exams	6,573
Diabetes Screening	5,222
Colorectal Cancer Screening	4,807
Vaccines	4,711
Cervical Cancer Screening	4,359
Chlamydia Screening	4,154
Gonorrhea Screening	3,964
Abdominal Aortic Aneurism Screening	2,452

Provider Network

Montana is a primarily rural state, with a small population dispersed over a large geographic area. It is one of three states, along with Alaska and Wyoming, which have been designated as a Frontier State[2]. Additionally, the State's existing network of fee-for-service Medicaid providers is sparse, particularly in remote rural regions. Montana's goal in using the TPA model is to leverage an existing commercial insurer with established statewide provider networks, turnkey administrative infrastructure, and expertise to administer efficient and cost-effective coverage for new Medicaid adults. This approach has been successful and allowed for rapid implementation and adequate provider network capacity for the HELP Program. The table below demonstrates the increase in provider enrollment between the CMS readiness review in December 2015, and December 2016:

Provider Enrollment	December 2015 – CMS Readiness Review/Program Implementation	December 2016 – 12 Full Months Post Implementation
Hospitals	92%	100%
Behavioral Health Providers	89%	91%
OB/GYNs Providers	87%	92.4%

[2] The Affordable Care Act, *Sec. 10324, Protections for Frontier States*, May 1, 2010, http://housedocs.house.gov/energycommerce/ppacacon.pdf.

Reimbursement

The TPA developed, designed, and implemented reimbursement system that can adjudicate HELP Program claims and produce the same pricing outcomes as the DPHHS MMIS. Targeted user acceptance testing (UAT) and random parallel testing were performed in late 2015 and early 2016 to assess the accuracy of the TPA's reimbursement system relative to the DPHHS MMIS. DPHHS worked with the TPA to execute and validate outcomes for each testing case, including professional, inpatient, outpatient, and APR-DRG claims. During the Readiness Review with the TPA on December 29, 2015, the TPA provided a claims processing system demonstration and review of UAT results. Below is a summary of the testing results:

Parallel Testing Completion Date	Type of Claim	Percent of Accuracy
4/25/16	Professional	99%
5/10/16	Inpatient	100%
7/4/16	Outpatient	99%

Additional Events Related to Health Care Delivery

Participant Enrollment

Medicaid expansion enrollment has grown to 70,770 as of December 2016. Montana is very proud of the Program's enrollment since early estimates suggested it would take four years to reach 70,000 enrollees. It is anticipated that enrollment will level out in 2017.

Comprehensive Primary Care Plus (CPC+) Model

Montana Medicaid is collaborating with BCBSMT, PacificSource, and Medicare in the CPC+ Model to support Montana primary care practices in a delivery model that rewards value and quality through innovative payments that support comprehensive care. Montana is 1 of only 14 regions in the country participating in the CPC+ Model developed by the CMS Innovation Center to test the effects of transitioning primary care from fee-for-service to value-based payments in efforts that are deliberately aligned across payers and in support of a common care delivery model.

In Montana, 54 primary care practices are participating in CPC+ and Medicaid is contracting with all 54. CPC+ providers are required to fulfill five key functions: access and continuity; care management; comprehensiveness and coordination; patient and caregiver engagement; and planned care and population health. Medicaid will pay CPC+ providers monthly care management payments based on a member's health risk. Medicaid will also retrospectively pay CPC+ providers annual performance-based incentive payments, based on a combination of utilization (i.e., ER visits and hospitalizations) measures and quality measures (i.e., A1C and blood pressure control).

Participants enrolled in the HELP Program through the TPA will be included in BCBSMT's CPC+ program, and will follow BCBSMT's attribution and payment methodologies.

Patient-Centered Medical Home (PCMH)

The Montana Medicaid PCMH model of care, implemented in December 2014, is designed to provide Medicaid members with a comprehensive, coordinated approach to primary care. PCMH providers receive additional reimbursement for each member enrolled for providing enhanced access to comprehensive, team-based care that is coordinated throughout the health care system with an emphasis on prevention, chronic disease management, and patient engagement. DPHHS has contracts with 5 providers to test the PCMH model. Currently, over 8,800 Medicaid members are being served by PCMH providers.

Providers participating in the Medicaid PCMH pilot receive one of three per member per month (PMPM) fees, for each attributed member, depending on the member's current health condition. PCMH providers are required to conduct outreach to members attributed to their practice, address gaps in care for preventive care and chronic conditions, engage the member in health care decisions and treatment plans, and report quality measures to DPHHS. PCMH providers receive a monthly member registry identifying which PMPM payment they will receive for each member.

In addition, providers receive a quarterly quality measures report that identifies the gaps in care the PCMH provider must attempt to correct with their members.

Participants enrolled in the HELP Program through the TPA will be included in BCBSMT's PCMH program.

Oversight and Monitoring

TPA Oversight

A readiness review of the TPA was performed by Montana staff in December 2015. The readiness review addressed: TPA administration, provider network, participant materials and services, claims administration and invoicing, benefits, care coordination and wellness, program integrity, cost sharing, and information technology.

Montana submits numbered letters as needed, as official correspondence to the TPA. Types of numbered letter items that are sent include: contract management and administration, reporting, provider, reimbursement, participant outreach and eligibility, benefit policies, and wellness.

DPHHS staff meet in-person with the TPA HELP team on a monthly basis. Agenda items as well as a TPA task list are reviewed and discussed. Task list items include any form of follow-up or completion items for the TPA such as policies and protocol, quality assurance, and systems. The TPA provides weekly, monthly, quarterly, and annual reports that include call center quality assurance, participant premium delinquency, preauthorization turn-around-time, subrogation activity, fraud, waste, abuse, wellness participation, network adequacy, site visits, and utilization review. Montana can also request ad-hoc reporting at any time. DPHHS staff also attend an annual review meeting at the TPA that includes an assessment of any milestones or changes that have occurred throughout the year, as well as highlights of significant business processes. The annual review for DY 2016 was held on February 23, 2016.

The TPA is required to submit quarterly compliance tables for both the section 1115 HELP demonstration waiver and the 1915(b)(4) waiver, as well as all TPA contract provisions. Montana reviews the compliance grids and requires the TPA to provide a corrective action plan for any item deemed non-compliant.

Additionally, for any inaccurate, delayed, or non-compliant information technology items, Montana requires the TPA to provide an incident report within two business days of occurrence, to include details of the item, resolution, and timeline.

Monitoring Tools

Below is a list of monitoring tools used by DPHHS for the TPA.

Tool	Description	Frequency
Readiness Review	Assess operational readiness of TPA prior to implementation	December 2015
Annual On-Site Visit	Assess ongoing operational functions of TPA	Annually
In-Person Meetings with TPA	Discuss agenda items and TPA task list	Monthly
Waiver Compliance Tables	Includes both section 1115 and 1915(b)(4) waiver requirements – the TPA must demonstrate compliance with all requirements	Quarterly
Numbered Letters	Official correspondence to the TPA	As needed
Incident Reports	Description of inaccurate or non-compliant IT items, the TPA must provide details of the item, resolution, and timeline	Within two business days of occurrence

Deliverables	IT, policy, participant and provider education and correspondence, and materials.	Ongoing
TPA Reporting Requirements	TPA reports provided to the state to monitor premiums, claims, utilization, wellness programs, and other aspects of the programs	Weekly, Monthly, Quarterly, Annually

Post Award Forum

Public notice of the six-month post award forum was published in the Montana *Billings Gazette*, the *Great Falls Tribune*, the *Missoulian* and the DPHHS e-calendar on May 15, 2016. It provided the date, time, location, and WebEx information for the post award forum. In the public notice, DPHHS provided a summary of date, time, and location of the forum; the public comment process and comment deadline of June 27, 2016; and a description of where the slides and handouts from the forum can be found online at http://dphhs.mt.gov/healthcare. The post award forum was held on June 15, 2016, in Helena, Montana. No attendees joined by phone or in-person. During the forum, DPHHS provided a summary of Medicaid waiver descriptions and an overview of the HELP Program including Senate Bill 405, eligibility, application process, benefits, premium and copayments, administrative rules of Montana, statistics, and resources and contact information.

Demonstration Waiver Deliverable Timeline

Please refer to **Appendix A – Montana HELP Program 1115 Demonstration Waiver Deliverable Timeline**

Total Annual Expenditures for the Demonstration Population

Demonstration Year	Benefit Expenditures TPA	Benefit Expenditures Standard Medicaid	Administrative Costs	Total Annual Expenditures
DY 1	$25,980,579	$262,780,688	$14,789,511	$303,550,778

2016 Monthly Enrollment for the Demonstration Population

Month	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
TPA	12,352	13,453	14,482	14,953	15,667	16,228	16,660	16,634	16,514	16,785	17,620	18,704
Standard Medicaid	25,576	29,404	32,053	33,956	35,498	37,380	40,642	43,175	44,878	46,110	48,337	52,066
Total	**37,928**	**42,857**	**46,535**	**48,909**	**51,165**	**53,608**	**57,302**	**59,809**	**61,392**	**62,895**	**65,957**	**70,770**

APPENDIX A

Montana HELP Program
1115 Demonstration Waiver Deliverable Timeline

Quarterly Reports	**Submit to CMS**
April 2017 - DY2, Q1	5/31/2017
Q2	8/31/2017
Q3	11/30/2017
Q4	2/28/2018
April 2018 - DY3, Q1	5/31/2018
Q2	8/31/2018
Q3	11/30/2018
Q4	2/28/2019
April 2019 - DY4, Q1	5/31/2019
Q2	8/31/2019
Q3	11/30/2019
Q4	2/28/2020
April 2020 - DY5, Q1	5/31/2020
Q2	8/31/2020
Q3	11/30/2020
Q4	2/28/2021
Annual Reports	
2016 - DY1	3/31/2017
2017 - DY2	3/31/2018
2018 - DY3	3/31/2019
2019 - DY4	3/31/2020
2020 - DY5	3/31/2021
Draft Interim Report	6/30/2018
Final Interim Evaluation Report	60 days after CMS comment
Draft Final Evaluation Submission	4/30/2016
Final Evaluation Report	60 days after CMS comment
Post Award Forum	
2016 - DY1	7/1/2016
2017 - DY2	7/1/2017
2018 - DY3	7/1/2018
2019 - DY4	7/1/2019
2020 - DY5	7/1/2020
Extension Request	7/1/2020
Demonstration Ends	12/31/2020

APPENDIX B

Montana HELP Program

Annual Reporting Measures for First Demonstration Year

#	Measure	Definition	Result
1	Annual distinct count of total enrollment	Number of unduplicated individuals enrolled at any time during the year	92,268
2	Annual distinct count of beneficiaries who owed a premium during the year	Annual distinct count of beneficiaries who owed a premium during the year	29,583
3	Annual distinct count of total disenrollment for non-payment of premium	Number of beneficiaries disenrolled from the HELP program mid-year in the reporting year	3,024
4	Annual distinct count of beneficiaries who have accessed incentivized preventive services, overall	Total number of beneficiaries enrolled at any point in the year who utilized any incentivized preventive services in the year	54,905
5	Average premium for those owing a premium	Average of all premiums owed per month per member	$25.14

			Per member per month (PMPM)	Per member per year (PMPY)
6	Per-member-per-month (PMPM) use of preventive services, by incentivized service	Total number of preventive services provided during year, divided by the total number of member months	1.09 preventive services PMPM	13.14 preventive services PMPY
7	Physician service utilization (PMPM)	Total number of physician visits during the year, divided by the total number of member months	.48 physician visits PMPM	5.82 physician visits PMPY
			.67 physician and mid-level visits PMPM	8.07 physician and mid-level visits PMPY
8	Prescription drug use (PMPM)	Total number of prescription fills greater than 28 days provided during the year, divided by the total number of member months	.97 prescription fills PMPM	11.64 prescription fills PMPY
9	Emergency department utilization, emergency (PMPM)	Total number of emergency department visits for emergent conditions (i.e. those not subject to a copayment) during the year, divided by the total number of member months	.07 emergent ED visits PMPM	.84 emergent ED visits PMPY

#	Measure	Definition	Result	
10	Emergency department utilization, non-emergency (PMPM)	Total number of emergency department visits for non-emergent conditions (i.e. those subject to a copayment) during the year, divided by the total number of member months	0 non-emergent ED visits PMPM	0 non-emergent ED visits PMPY
11	Inpatient admissions (PMPM)	Total number of inpatient admissions during the year, divided by the total number of member months	.01 inpatient admissions PMPM	.15 inpatient admissions PMPY