

Federal Evaluation: Montana Health and Economic Livelihood Partnership Plan

A Look at the Program a Year and a Half into Implementation



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Executive Summary

In November 2015, Montana received approval from the Centers for Medicare & Medicaid Services (CMS) to implement a Medicaid Section 1115 waiver demonstration. The demonstration in Montana is called the Montana Health and Economic Livelihood Partnership (HELP), and has been approved through December 31, 2020. Enrollment in HELP began immediately after CMS approval, and was effective starting January 1, 2016. Eighteen months later, more than 80,000 individuals were enrolled in Montana’s HELP program, far surpassing the state’s enrollment projections.

Similar to the Affordable Care Act (ACA) Medicaid expansion demonstrations in other states (e.g., Arkansas, Indiana, and Michigan), HELP encourages enrollees to be prudent health care purchasers and to take personal responsibility for their health care through the use of premiums, copayments, and strategies to promote healthy behaviors. HELP also includes a public-private third party administrator (TPA) plan from which some HELP enrollees receive care, and provisions that allow Montana to disenroll some newly eligible individuals with incomes above 100 percent of the federal poverty level (FPL) who do not pay their premiums on a timely basis. To help improve continuity of care and reduce the “churn” of individuals losing and then regaining insurance, Montana’s demonstration provides for 12-month continuous eligibility for all newly eligible individuals.

In September 2017, the Urban Institute conducted a site visit to Montana to examine three basic questions:

1. How were different components of HELP designed and implemented?
2. What progress has been made in implementing HELP, and what were the successes and challenges of implementing and administering HELP so far?
3. What were enrollees’ understanding of and experiences with HELP?

During the site visit, semi-structured interviews were conducted with a range of HELP stakeholders, including state officials, health care providers and provider associations, consumer and patient advocates, and tribal and Indian Health Services representatives. Focus groups with HELP enrollees were also held.

More than 18 months into the HELP demonstration, the interviewees we spoke with universally viewed HELP as a successful program that launched with just a few minor glitches. Our stakeholder interviews, HELP enrollees focus groups, and document review revealed the following key insights:

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- Stakeholders acknowledged that it took time and compromise to get the Medicaid expansion passed in the Montana legislature. Certain program features in the HELP legislation were seen as critical for passage, including the requirement that enrollees “have some skin in the game,” the public-private partnership of the TPA to administer benefits, and a workforce training program.
 - Most interviewees said that Montana’s biggest accomplishment was the enrollment of more than 80,000 low-income residents in HELP as of June 2017, far exceeding the state’s original projections for enrollment.
 - In June 2017, more than three-quarters of HELP enrollees were exempt from the demonstration and enrolled in standard Montana Medicaid, where they are subject to copayments but not premiums. Only 23.9 percent of HELP enrollees were enrolled in the TPA plan and subject to premiums and copayments.
 - Respondents attributed higher-than-expected enrollment to a robust and coordinated outreach effort mounted by the state, community organizations, and providers. Stakeholders said that enrollment assisters and navigators were critical in getting people enrolled in HELP, a sentiment echoed by participants in the focus groups. Some stakeholders said the enrollment process was challenging because the state sometimes took a long time to make an eligibility determination, but focus group participants felt it went smoothly. Both stakeholders and focus group participants viewed renewal as easy and straightforward.
 - Enrollees receive limited education on how HELP coverage works. Stakeholders had mixed views on how well this has played out. State officials maintained that their education approach has been sufficient, but some non-state interviewees felt that more enrollee education is needed. HELP enrollees in our focus groups echoed this sentiment; when asked how HELP could be improved, they most often said that they wish they had more information about what the program covered.
 - Stakeholders viewed premiums as affordable for enrollees, and focus group participants who were enrolled in HELP said they were reasonable and fair. Even so, some enrollees said they sometimes struggled to pay the premiums. HELP administrative data reinforce these statements. In June 2017, only about 50 percent of HELP enrollees who owed premiums paid them for the month. However, the disenrollment rate for failing to pay the premium (which kicks in if a person is more than 90 days in arrears in premiums payments) in that month was 1 percent, suggesting that most enrollees pay

their premiums within the 90-day grace period, or were protected by disenrollment exemptions as required by state legislation.

- Health care providers say they are not actively billing HELP enrollees for copayments because of the high administrative costs of doing so and because of low expectations of receiving payment.
- Stakeholders described HELP enrollees' access to care as generally consistent with that of privately insured Montanans. Focus group participants agreed, saying that HELP provided good access to high-quality care. But problems were acknowledged in access to mental health and dental care; this was thought to reflect the general shortage of these providers in Montana rather than a deficiency of HELP. Both stakeholders and focus group participants said that new coverage under HELP was facilitating high rates of service use.
- Important changes to HELP are forthcoming. In December 2017, Montana obtained CMS approval of a waiver amendment that will allow the state to drop its TPA plan contract, bring all claims administration in-house to reduce costs, and drop the premium credit (which was deemed administratively burdensome and confusing to enrollees). At the time of our site visit in September 2017, these amendments were under consideration at CMS. More fundamentally, despite widespread support for HELP among the stakeholders we spoke with, interviewees acknowledged considerable uncertainty about the fate of HELP when it comes up for reauthorization by the Montana legislature in 2019.
- HELP enrollees in our focus groups universally praised the program and said it was making a huge difference in their lives. Participants reported that they were highly satisfied with and "grateful" for HELP coverage; they said it gave them "peace of mind," "a safety net," and "security," and that it "saved them a lot of money."

Introduction

On January 1, 2016, Montana’s Medicaid program began covering newly eligible adults ages 19–64 through its Health and Economic Livelihood Partnership (HELP) program,¹ a Medicaid expansion waiver authorized under Section 1115(a) of the Social Security Act. HELP includes the following elements:

- Newly eligible individuals receive care through a third-party administrator (TPA) plan.
- Premiums are charged and capped at 2 percent of income for newly eligible individuals with incomes between 51 and 133 percent of the FPL.
- Individuals are exempt from premiums and enrollment in the TPA plan if their income is at or below 50 percent of FPL, they live in a region (that may include all or part of an Indian reservation) where the TPA is unable to contract with sufficient providers, they are medically frail, or they meet other conditions.
- After notice and a 90-day grace period, individuals with incomes between 101 and 133 percent of FPL who fail to pay premiums, and do not meet exemptions listed in state legislation, are disenrolled; those with incomes between 51 and 100 percent of FPL are not subject to disenrollment.
- Enrollees subject to premiums receive a credit toward copayments up to 2 percent of their income.
- Exempt and nonexempt newly eligible individuals are subject to copayments.
- Exempt and nonexempt newly eligible individuals have 12-month continuous eligibility.

During the week of September 11, 2017, Urban Institute researchers conducted a site visit to Montana to examine three basic questions:

1. How were different components of HELP designed and implemented?
2. What progress has been made in implementing HELP, and what were the successes and challenges of implementing and administering HELP so far?
3. What were enrollees’ understanding of and experiences with HELP?

During the site visit, semi-structured interviews were conducted in Butte, Helena, Havre, and Browning with a range of HELP stakeholders, including state officials, health care providers and provider associations, consumer and patient advocates, and tribal and Indian Health Services representatives.

Four focus groups with HELP enrollees were held in Helena, Havre, and Browning.² In addition to the site visit, we also reviewed various documents about HELP, including publicly available materials produced by the State of Montana, materials given to us by the state or the Centers for Medicare & Medicaid Services (CMS), and the gray literature.

In this report, we begin by providing background on the HELP demonstration, describing its development, goals, and design. We then discuss implementation and early experiences of HELP across major program areas from the perspectives of stakeholders and consumers. Other information (e.g., HELP administrative data) is also used. We conclude with a discussion of potential changes coming to the HELP demonstration.

Development of HELP

Stakeholders we spoke with acknowledged that it took time and compromise to get the Medicaid expansion passed in the Montana legislature. Certain program features in the HELP legislation were seen as critical for passage, including the requirement that enrollees “have some skin in the game,” the public-private partnership of the TPA plan to deliver services, and a workforce training program. In addition, stakeholders noted that it was important that legislation provide sufficient flexibility to conduct waiver negotiations with CMS.

It took time and considerable compromise among Montana stakeholders to reach consensus on a Medicaid expansion. Interviewees readily acknowledged that the expansion “took some political maneuvering” and had to be analyzed not as a “pure policy problem but as a political problem” in order to pass the Montana legislature. Stakeholders said they worked to pass expansion in two consecutive legislative sessions, 2013 and 2015.³ Democratic Governor Steve Bullock was described as advocating for a “pure” or “straight” Medicaid expansion during the 2013 legislative session, but the measure failed by one vote.

Between the 2013 and 2015 sessions, the governor worked with stakeholders including Republican state senator Ed Buttrey to develop a compromise bill to put forward in the 2015 session that would expand Medicaid through an ACA coverage waiver. Interviewees said that other states’ ACA waiver programs were reviewed, but HELP was “made in Montana and homegrown.” Sponsored by senator Buttrey, S.B. 405 was introduced in March 2015 and passed in April 2015. Waiver documents were submitted to CMS soon thereafter and, after some revisions to HELP negotiated between the state and CMS, Montana received approval to implement its Medicaid expansion on November 2, 2015.

Enrollee “skin in the game,” the use of a public-private approach to deliver services, and the inclusion of a workforce training program were viewed as essential to getting HELP legislation passed.

Interviewees consistently stated that covering low-income, uninsured Montanans was the main goal of HELP, but stakeholders said several program features were critical to the compromise legislation. One was ensuring that HELP enrollees had “some skin in the game,” which was accomplished by imposing financial and personal responsibility through copayments, premiums, and the risk of program disenrollment for failing to pay premiums. Eliminating copayments for preventive care⁴ was also seen as a way to promote personal responsibility—that is, encouraging HELP enrollees to be proactive in their health care and use primary care services.

Interviewees also said that having a TPA plan deliver health care services under HELP was critical to getting S.B. 405 enacted because it provided a public-private approach. As several interviewees explained, a TPA plan was something that “legislators and policymakers were comfortable with” because a comparable arrangement had long been used in Montana’s Children’s Health Insurance Program (CHIP), which is generally well regarded. In addition, relying on a TPA plan was a “quasi-private market” solution that was “politically palatable.” One stakeholder described the TPA plan as a “creative” compromise because it appealed to stakeholders who wanted to “contain the growth of government,” as well as to those who wanted to keep HELP from becoming only a private-market endeavor.

Another feature many stakeholders said was critical to getting HELP legislation enacted was the inclusion of a workforce development program, called HELP-Link. HELP-Link is a new, voluntary workforce program designed to provide able-bodied HELP enrollees with job training and skills. A primary goal of HELP-Link is to raise HELP enrollees’ income to reduce long-term dependence on Medicaid. Importantly, no Medicaid funds are used to fund HELP-Link; instead, it is financed solely with state revenues. Stakeholders acknowledged that the reach of the HELP-Link program has been limited so far. During 2016, the first year of HELP-Link, about 8,000 of the 92,268 individuals enrolled in HELP during the year completed a HELP-Link assessment survey, and only 1,400 enrollees participated in other aspects of the program.⁵ Stakeholders offered several reasons for the fairly low participation rate among HELP enrollees. A major one was that two-thirds of HELP enrollees already work.⁶ One interviewee thought getting a notice about HELP-Link services was “not very helpful” if you already have a job, and another felt it is difficult for people working one or two low-wage jobs to find the time to go to job training. Other interviewees suggested that HELP-Link participation might increase once HELP enrollees’ unmet health care needs are addressed, at which point “they can take better advantage of job

training.” But stakeholders universally agreed that getting people to move to a higher-paying job is a challenging but important task for HELP.

HELP legislation had to be flexible enough to allow for negotiations with CMS. Interviewees said that it was a “really fine line” to craft legislation that would pass in Montana but “not be so far off the intent [of the ACA] that it would still be granted a waiver.” Stakeholders also said that it was critical that the legislation “give the governor negotiating room [with CMS] on the waiver.” For example, the HELP legislation called for all enrollees to pay premiums, but during waiver negotiations, CMS required Montana to eliminate premiums for those with incomes at or below 50 percent of FPL and other groups, according to state officials. Also during waiver negotiations, CMS required Montana to give HELP enrollees a premium credit up to 2 percent of their income that could be applied toward copayments. Montana officials said the credit was to help provide some financial protection for enrollees subject to premiums.

Major Design Features of Montana HELP

Like ACA Medicaid expansion demonstrations in other states (e.g., Arkansas, Indiana, and Michigan), HELP is designed to encourage enrollees to be prudent health care purchasers and to take personal responsibility for their health care through the use of premiums, copayments, and strategies to promote healthy behaviors. HELP includes provisions that allow Montana to disenroll some newly eligible people with incomes above 100 percent of FPL who do not pay their premiums on a timely basis.⁷

Before HELP, Montana’s Medicaid program covered a range of traditional low-income populations at levels generally comparable to the national average, including children in families with income up to 143 percent of FPL; pregnant women with income up to 157 percent of FPL; and caretakers in families with dependent children with income up to 24 percent of FPL.⁸ In 2015, average monthly enrollment in pre-HELP Medicaid was about 125,000, with children accounting for more than 60 percent of enrollment.⁹ Reflecting the broader Montana health care market, Medicaid services were (and continue to be) delivered and paid for primarily on a fee-for-service basis. Finally, although eligibility standards were comparatively low, Montana’s pre-HELP Medicaid benefit package was comparatively generous, covering several optional services including dental, denture, and vision services.¹⁰

Two delivery systems used in HELP. Although HELP covers the ACA Medicaid expansion population of adults with incomes up to 133 percent of FPL, some newly eligible individuals are exempt from the TPA plan, including those who have incomes at or below 50 percent of FPL or are medically frail, among

others (table 1). Exempt individuals are enrolled in standard Montana Medicaid. Specifically, a person is exempt from the demonstration if any of the following is true:¹¹

- they self-attest to being medically frail
- the state determines that the person has exceptional health care needs, including but not limited to a medical, mental health, or developmental condition
- the person lives in an area where the TPA plan is not able to establish a sufficient provider network
- the person requires continuity of care that is not available or cannot be effectively delivered through the TPA plan
- the person is otherwise exempt from premiums or copayments by federal law (e.g., because the person has income up to and including 50 percent of FPL or is Native American).

Table 1. Selected Program Features of HELP for Adults of Different Incomes

Income	Enrolled in TPA plan or standard Medicaid	Charged premiums	Accumulate premium credit	Charged copayment	Subject to disenrollment for failure to pay premiums	Out-of-pocket costs capped at 5% of income
0–50% of FPL	Standard Medicaid	No	No	Yes, maximum amount allowed by federal Medicaid law	No	Yes
51–100% of FPL*	TPA	Yes	Yes	Yes, maximum amount allowed by federal Medicaid	No	Yes
101–133% of FPL*	TPA	Yes	Yes	Yes, maximum amount allowed by federal Medicaid law	Yes	Yes

*A person with income above 50% of FPL can be determined to be an exempt enrollee and enrolled in standard Medicaid. See bullets directly above Table 1.

In contrast, newly eligible people who do not fit one of the demonstration exclusions receive health care services through an alternative benefit plan that relies on a provider network managed by a TPA. By using a private insurance company to administer the plan, HELP builds on Montana’s CHIP, which also uses a private insurance company to administer benefits.¹² The TPA selected to administer HELP, Blue Cross Blue Shield of Montana (BCBS), also provided the state with a large preexisting provider network, which interviewees said helped with the program’s rapid implementation. The HELP TPA is responsible for, among other things, contracting with a network of providers, reimbursing providers, invoicing enrollees for premiums, and tracking the premium credit for people enrolled in the TPA plan.

HELP cost-sharing. Cost-sharing under HELP includes premiums, premium credits, and copayments, but the extent to which enrollees are subject to them varies by their income and exemption status. Exempt populations are not subject to premiums but are required to pay copayments—which have long been charged in Montana Medicaid—at the maximum level provided by federal Medicaid law; this provision was included in the HELP legislation (table 1). Nonexempt individuals are charged monthly premiums equal to 2 percent of their income. Enrollees in the TPA plan are also subject to copayments, although the size of copayments varies by income. Following federal law governing Medicaid cost-sharing, the maximum allowable cost-sharing differs for enrollees with incomes above and below 100 percent of FPL.¹³ Copayment differences for the two groups can be significant. For example, HELP enrollees at or below 100 percent of FPL are subject to a \$4 copay for a doctor’s visit and a \$75 copay for an inpatient hospital stay, but enrollees above 100 percent of FPL are subject to copays equal to 10 percent of the allowable fee for the same services. HELP enrollees in the TPA plan (and those in standard Medicaid) are not subject to copayments for preventive services, which were broadly defined in HELP.

HELP also has a premium credit, which has had important implications for how copayments have been implemented. Under the credit, every quarter, HELP enrollees in the TPA plan receive a credit equal to what they have paid in premiums, which goes toward paying any copayments they may owe during the quarter. Thus, an enrollee is *only* charged copayments if they exceed the dollar value of premiums they paid in any given quarter. Every three months, enrollees’ premium-copayment comparison is reset. Under the newly established premium credit, Montana has had to shift from authorizing providers to charge enrollees copayments at the point of service (as it had long done) to notifying providers if they can mail a bill to an enrollee for a copayment after a claim has been adjudicated and the premium credit calculated.¹⁴ The one exception to this change is that copayments for prescription drugs continue to be billed at the point of service.

Disenrollment policies for failing to pay premiums on a timely basis. HELP’s disenrollment provisions for failing to pay premiums are also applied differently depending upon an enrollee’s circumstances. Although exempt individuals are not subject to disenrollment provisions, some but not all TPA enrollees are affected by these provisions. Specifically, TPA enrollees with incomes at or below 100 percent of FPL cannot be disenrolled from HELP for failure to pay premiums, but, after notice and a 90-day grace period, TPA enrollees with incomes above 100 percent of FPL can be. However, people who are disenrolled may reenroll if they pay their past-due premiums or when the State of Montana Department of Revenue sends a debt notice, which must be sent no later than the end of each calendar quarter,

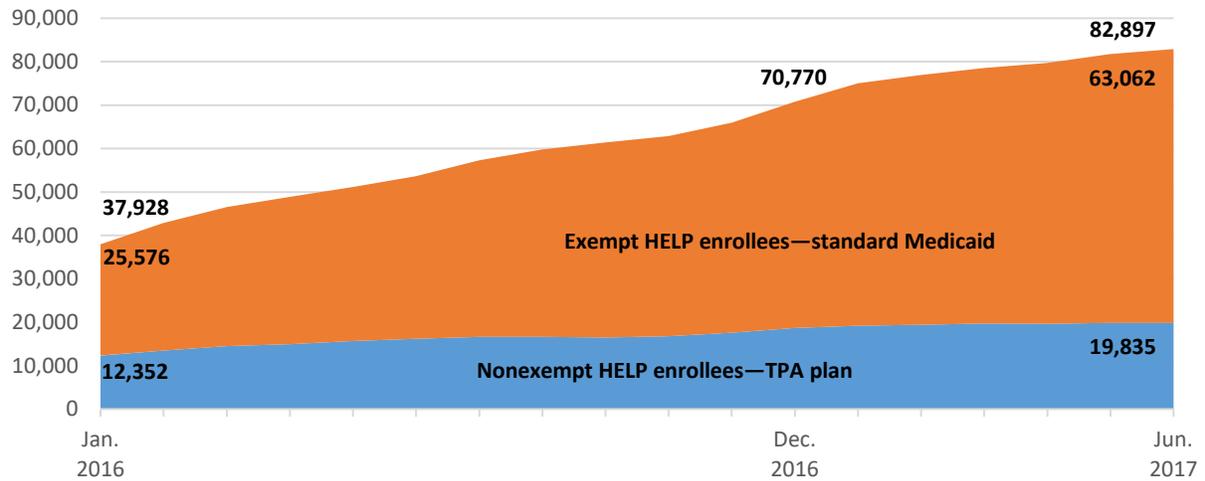
informing them that a portion of their next state tax refund will be withheld to pay for past-due HELP premiums.¹⁵ Also, a new application is not required for disenrolled individuals who seek reenrollment if they are still within their current 12-month continuous eligibility period. Within this period, people can simply pay the past due premiums or receive a debt notice and restore their coverage online.¹⁶ Thus, HELP disenrollment provisions can be considered a soft lockout. State legislation also exempts individuals from being disenrolled if they were discharged from the U.S. military in the previous 12 months, are enrolled in college or a university, or are participating in a workforce program or enrolled in a state-approved healthy behavior plan (e.g., a patient-centered medical home, a tobacco cessation program, a substance abuse treatment program, etc.).¹⁷

Out-of-pocket cap. Consistent with federal limits, enrollees who are subject to premiums *or* copayments (that is, TPA enrollees and exempt populations) pay no more than 5 percent of their household income toward these costs in a quarter.

Implementation and Early Experiences of HELP

The biggest achievement noted by interviewees was the speed and level of enrollment in HELP. By December 2016, 1 year after HELP launched, 70,770 people had signed up for HELP—a number the state had originally thought would take 4 years to achieve. Since then, enrollment has continued to climb, reaching more than 80,000 as of June 2017 (figure 1). State officials cited two main factors that contributed to enrollment exceeding expectations. The first was that Montana’s initial projections assumed that premiums would discourage many people from signing up; this turned out not to be the case, according to state officials and enrollees participating in our focus groups. The second factor was that the state’s projections assumed that all HELP enrollees would be subject to premiums but, as discussed earlier, during waiver negotiations with CMS, this was changed so that those who had incomes at or below 50 percent of FPL or were otherwise exempt are not charged premiums and are enrolled in standard Montana Medicaid. As of June 2017, more than three-quarters of HELP enrollees were exempt and did not pay premiums. More than 90 percent of exempt HELP enrollees had incomes at or below 50 percent of FPL in June 2017 (data not shown).¹⁸

Figure 1. Enrollment in Montana's Medicaid HELP Expansion Waiver Program, by Exemption Status, January 2016 to June 2017



Sources: Montana DPHHS, *Montana HELP Program Demonstration: Section 1115 Waiver Annual Report*, March 2017; Montana DPHHS, *Section 1115 Waiver May 2017 Quarterly Report*; and Montana DPHHS, *Section 1115 Waiver August 2017 Quarterly Report*.

Montana officials said that HELP enrollment has slowed, as expected, in recent months. Several interviewees report that some of the remaining include Montanans who do not want to be perceived as accepting a “handout” or joining a “welfare program” and will never apply for Medicaid “no matter what.” Other interviewees felt that this population was harder to reach (e.g., homeless) and that, with effort, more people could enroll in HELP. Some eligible but not enrolled individuals also could be ones for whom premiums are a challenge though this sentiment was not expressed by interviewees.

Below we discuss the implementation and early experiences of HELP in four major program areas—outreach; enrollment, education and disenrollment; cost-sharing; and access to care. More than 18 months into the HELP demonstration, HELP enrollees, consumer advocates, providers, Montana health care observers, and state officials we spoke with universally view HELP as a successful program that launched with just a few minor glitches, such as long wait times on the state’s HELP application phone line and delays in getting insurance cards.

OUTREACH FOR HELP

Beating enrollment projections was consistently hailed as a great success by interviewees, and was partly attributed to a robust and coordinated outreach effort mounted by the state, community organizations, and providers. A range of strategies were used to publicize HELP, including advertising

campaigns and direct one-on-one outreach to consumers via letters, phone calls, and conversations at health care facilities. Special outreach efforts were used to encourage Montana’s Native American population to enroll in HELP.

Many organizations engaged in public outreach to potential enrollees and providers about the availability of HELP coverage. Stakeholders in Montana attributed the higher-than-expected enrollment to the efforts of numerous organizations. Many of these were private organizations. For example, BCBS ran television, radio, and social media advertisements announcing the HELP program that several interviewees mentioned, and hospital executives said hospitals, too, paid for ads. Meanwhile, Montana Medicaid sent direct mailings and computer-dialed follow-up calls to individuals it had assessed likely to be eligible for Medicaid, based on income data from Supplemental Nutrition Assistance Program and Temporary Assistance for Needy Families (TANF) programs. Montana Medicaid also sent letters to federally qualified health centers (FQHCs) that used national survey data to identify the number of potentially eligible individuals in their county. This was done to help the clinics plan and identify enrollment targets.

Montana Medicaid used a foundation grant to hire a communications firm to design customizable outreach materials for providers (e.g., posters, mailers, business cards) that were posted on Montana Medicaid’s website, and mailed to most existing Medicaid providers. Montana Medicaid also facilitated informational meetings with external stakeholders such as hospitals to educate them about the availability of HELP coverage. HELP enrollees participating in our focus groups mostly reported hearing

BOX 1

FOCUS GROUP FINDINGS:

HOW DO CONSUMERS HEAR ABOUT HELP?

Focus group participants were asked how they first heard about HELP and whether, for example, they had seen an advertisement on TV or radio, heard about it from a friend, or learned of the program while visiting a doctor’s office, clinic, or social services agency. Most participants reported that they first learned about HELP from a hospital or clinic-based application assister, or from staff at a consumer advocacy organization or county social services office. Only a small minority of participants said that they had learned of the program via outreach from the state or BCBS.

“I think we were at [the local FQHC] for my granddaughter’s care, and they told us about [HELP].”

“We just recently moved from Washington State. When we came, we went to [the county office], and they enrolled us in it.”

“I had tonsillitis, and getting them removed would have been \$6,000 out of pocket. [My employer] told me to speak with someone at the Medicaid office over in Bozeman. Sure enough, I qualified for [coverage through HELP].”

“I went to ... the Indian Alliance ... because I’m part Native American. They said that my tribe isn’t recognized in Montana because it’s [in] Oklahoma. But they said I qualified for Medicaid.”

“My stepmom works for BCBS, so I heard about it maybe 18 months ago.”

about the availability of HELP coverage from application assisters in provider sites or at community organizations (see box 1).

FQHCs and hospitals frequently encouraged patients to apply for HELP and did “warm handoffs” to on-site enrollment assisters or navigators. According to stakeholders, assisters and navigators were often funded through the Health Resources & Services Administration or the ACA, but in some cases providers paid for them. Assisters and navigators also publicized HELP by attending community events or visiting popular public gathering places (e.g., grocery stores, libraries, coffee shops, county fairs, and TANF offices on the day checks were distributed). In addition, they visited jails and prisons to enroll people who were soon to be released.

The Montana Primary Care Association (MPCA) was a major player in publicizing HELP. MPCA created a website for consumers (www.coverMT.org); advertised on billboards, social media, and radio; and created and mailed brochures to providers to give to patients. MPCA also arranged for state staff to educate assisters and navigators during a two-day, in-person conference in the fall of 2015. In addition, MPCA held 15 webinars on HELP, which several interviewees said were helpful. Finally, MPCA was described as a trusted liaison between enrollment assisters and Montana Medicaid staff, alerting the state about implementation hiccups they encountered (e.g., confusion surrounding notices mailed to enrollees and telephone prompts, and long wait times on the state’s HELP application phone line). At the same time, MPCA shared enrollment tips from the state with enrollment assisters (e.g., times of day when callers were likely to experience the shortest wait times on Montana Medicaid’s phone line).

The program directed targeted outreach to Native Americans who were reported reluctant to enroll. Several interviewees mentioned targeted efforts to enroll Native Americans, such as sending hospital staff to reservations to spread the word about HELP and having enrollment assisters in tribal health care facilities encourage Native Americans to enroll. Montana Medicaid also engaged in outreach through direct contact with tribal councils. Interviewees said that many Native Americans were initially resistant to enrolling in HELP. A commonly reported barrier was Native Americans’ historic distrust of the federal government. Another was that Native Americans already had access to health care services with no cost-sharing through the Indian Health Service (IHS) and tribally operated clinics, and did not see the need to enroll in HELP. One selling point used to try to convince Native Americans to enroll in HELP was that enrolling in HELP coverage would ease the strain on IHS and tribally operated clinics’ budgets (discussed in more detail below).

ENROLLMENT AND COVERAGE

RENEWAL

Stakeholders and focus group participants said that enrollment assisters and navigators were critical to getting people enrolled in HELP. Some stakeholders described the enrollment process as challenging because it sometimes took a long time for the state to make an eligibility determination. Renewal, by contrast, was described as easy and straightforward.

Enrollment assisters and navigators were critical to getting people enrolled in HELP. Interviewees reported that it took assisters 10 to 45 minutes to fill out an enrollment application, depending on the complexity of the consumer’s situation. Some interviewees reported that consumers were overwhelmed by the thought of applying for coverage on their own and would not apply without someone assisting them. One FQHC executive described the process as “cumbersome” for the uninitiated.

HELP enrollees in our focus groups described enrollment as “simple” and often received assistance to complete their applications. Most participants said they learned immediately that they qualified for coverage, but their Medicaid cards took weeks or months to arrive (see box 2).

BOX 2

FOCUS GROUP FINDINGS:

HOW DO PARTICIPANTS ENROLL IN HELP?

Focus group participants were asked how they enrolled in HELP and whether they applied by themselves online or received help from an application assister at a health care clinic or at a county social services office. Participants were also asked what they thought of the process and, specifically, whether it was easy or difficult. Most reported that they worked with an application assister to complete and submit their applications and that they learned they were eligible right away. A minority of participants said they applied without assistance. Participants generally characterized the process as simple and straightforward.

“I sat down with someone [in the Department of Public Health and Human Services]. It took probably 30 minutes, and she was on the phone, she got me in. She really went above and beyond, helping me out. I was taken care of very quickly. It was a relatively easy process.”

“I was thrilled to have an on-site person [at the FQHC] help me apply. The process took probably 30 or 45 minutes. Everything was finished after that first visit. My coverage was confirmed right then and there.”

“It was really easy. When I went to the county clinic, [the assister] sat down and probably did all of it. I have a hard time with applications and stuff. But it was pretty easy when this lady helped me. Pretty much all I did was sign and date the application.”

“I just applied, myself, on the internet. I thought it was pretty straightforward. I think I found out right away that I was eligible, too.”

Although many participants said they were deemed eligible immediately after applying, many also said they experienced delays of up to 6 months before receiving their Medicaid cards. Once enrolled, all consumers reported that they were able to access care even without a card.

“[My Medicaid card] took a couple of weeks to get here.”

Montana Medicaid was nimble and responsive when enrollment glitches occurred, but getting an eligibility determination sometimes took a long time. Some non-state interviewees praised Montana Medicaid for quickly modifying eligibility and enrollment systems once HELP was approved and for quickly responding when stakeholders flagged implementation “hiccups” or “glitches.” One interviewee said, “If anything wasn’t working, it was quickly fixed.” Some early implementation issues included delays in receiving insurance identification cards in the mail and difficulty accessing the state’s online enrollment system because of a surge in users in the early days of the state’s Medicaid expansion. One interviewee reported that it could take a few weeks to get a determination of eligibility from Montana Medicaid, and another month to receive an insurance identification card in the mail.

HELP enrollment renewals were simple and fast. Stakeholders and focus group participants said that renewing coverage was easy (see box 3). One FQHC staffer said that enrollees could renew by simply signing and mailing a document, if their income and family situation had not changed in the past year.

ENROLLEE EDUCATION

Enrollees receive limited education on how HELP coverage works. Stakeholders had mixed views on how well this played out. State officials maintained that their education approach was sufficient, but some external stakeholders said more enrollee education was needed. HELP enrollees in our focus groups agreed that education was lacking; when asked how HELP could be improved, they most often mentioned that they wished they had been given more information about what the program covered.

People may not be getting enough education about HELP coverage once they are enrolled. State officials, health care providers, consumer advocates, and consumers said that enrollees received limited education about how HELP

coverage works. In the standard Medicaid program, enrollee education is essentially nonexistent: the

BOX 3
FOCUS GROUP FINDINGS:
HOW DO CONSUMERS RENEW COVERAGE?

When asked about renewing HELP coverage, consumers generally agreed that the process was simple. Participants who were also enrolled in other public assistance programs (e.g., SNAP) found it especially easy.

“When it was time for my renewal, it came in the mail. It was nothing like I thought it was going to be. It took me two minutes [to indicate that nothing about me had changed], stuck it back in the mail, and sent it back. It was very easy.”

“A lady called me, I told her I definitely wanted to renew, and 2 weeks later I got a letter saying I was renewed. They were able to pull all my information. I don’t know where they got it from.”

“It was my yearly renewal time. [The Department of Health and Human Services] sent me a letter saying, ‘Nothing has changed; you’re still on Medicaid.’”

state simply mails new enrollees an insurance identification card and a link to a website where a benefit book is posted. One state official reported that nitty-gritty details such as how copays are determined were “kept away from members” because it “isn’t a member’s job to know” such things. State officials did not view limited enrollee education as a problem. They maintained that insured people (not just Medicaid enrollees) do not read health insurance materials, so there is not much value in sending them. State officials said they did not consider the lack of a mailed benefit book problematic because they had not received a lot of questions or comments from HELP enrollees.

Meanwhile, BCBS mails TPA enrollees a welcome kit, which includes a welcome letter, a participant guide,

and instructions on accessing an online patient portal. A state official said that explaining the premium credit to TPA enrollees was “one of our biggest challenges,” and that they had spent a lot of time developing language describing the credit that was easy for enrollees to understand. BCBS monthly premium invoices include additional information. BCBS also sends enrollees a quarterly newsletter advertising wellness programs, which reportedly inspired the newsletter Montana Medicaid now sends to its standard Medicaid members.

Many external stakeholders felt that Montana Medicaid and BCBS could do more to educate HELP enrollees, although some did not view this as a priority. As one hospital executive put it, “Nobody really cares how their insurance works.” On the contrary, HELP enrollees in our focus groups said they *did* want more information about how their coverage works. Better information about what HELP does and does not cover and better customer service were the most common recommendations from participants (see box 4).

BOX 4

FOCUS GROUP FINDINGS:

DO ENROLLEES NEED MORE EDUCATION ABOUT THEIR HELP COVERAGE?

We asked participants if Medicaid officials could do anything to make HELP coverage better. Participants had only a few recommendations, and they most often said that they didn’t always know what the HELP program covers (and what it doesn’t). Participants were also frustrated by what they saw as poor customer service, and described how difficult it was to reach representatives at the state and BCBS when they needed help with a coverage-related question.

“That’s the only thing I’ve had trouble with: knowing what Medicaid covers and what it doesn’t. The providers don’t know what’s covered until they submit [a claim]. That’s been difficult, thinking that I may get some big balance or some big copay.”

“Tell us more about what’s covered. Access to someone who can answer questions would be a good thing.”

COST-SHARING UNDER HELP

Stakeholders viewed premiums as affordable and claimed that they have not deterred people from enrolling in HELP. Enrollees in focus groups agreed that premiums were affordable, but some said they sometimes struggled to pay them. HELP administrative data suggest that many enrollees do not pay premiums, suggesting that the cost of premiums can be a challenge for some. In June 2017, for example, only about half of enrollees who owed premiums paid them for the month. Providers said that they were not actively billing enrollees for copayments because of the high administrative costs of doing so and because they did not expect to receive payment.

Premiums are affordable and fair but some enrollees struggle with paying them each month.

Across the board, interviewees felt that HELP premiums, which averaged about \$25 per month in 2016,¹⁹ were affordable for those who had decided to enroll. One state official declared that they had found the “sweet spot of getting premiums right.” A state legislator observed that “people found value in the product.... They are making a decision to prioritize that payment over other things.” State officials said they had “over-worried” that premiums would “dampen” HELP enrollment. Instead, officials reported that 18 months into the demonstration, more than \$4 million in HELP premiums had been collected, 80 percent of premiums owed had been paid, and the disenrollment rate for failing to pay premiums was low. Officials felt that exempting people who are medically frail or have very low incomes was prudent, and acknowledged that this exemption

has contributed to higher premium collection and retention rates than would have been achieved otherwise. Most participants in our focus groups said that premiums were fair and affordable, but a few said that in some months, it was hard to come up with the money (see box 5).

BOX 5 FOCUS GROUP FINDINGS: ARE PREMIUMS AFFORDABLE FOR ENROLLEES?

Many participants enrolled in the TPA plan reported paying monthly premiums of \$12 to \$55 per month, but most enrollees considered those payments to be fair and affordable. Some enrollees reported difficulty making their monthly payments because of cost or confusion over whether they were supposed to pay premiums. However, they appreciated the 90-day grace period policy, which allowed them to catch up on payments while remaining enrolled.

“I was absolutely thrilled that I only pay \$14! I make sure to pay it every month because it’s a godsend.”

“I’m happy to contribute a little bit. It’s better than before, when I didn’t have health care for a long time.”

“I almost feel guilty, like I’m not paying enough.”

“The back of my card says you can be up to 90 days past due before they’ll do anything; I used that to my advantage. There have been ... months when I couldn’t pay, and I made up for it the following month. I appreciated that they didn’t kick me off after just one month of not paying.”

Program administrative data suggest that paying monthly premiums is challenging for many HELP enrollees, particularly those with the lowest incomes. Even though interviewees and HELP focus group participants viewed premiums as affordable, HELP program data suggest that making payments can be challenging. For example, June 2017 program data show that among enrollees with incomes between 51 and 100 percent of FPL who pay premiums, less than half (48.7 percent) paid them that month; among those with incomes above 100 percent of FPL, only 54 percent paid them that month.²⁰ This level of premium payment was also seen in April and May 2017 data.²¹

Disenrollment for failing to pay premiums was

low. Interviewees said it was rare for an enrollee to involuntarily lose HELP coverage, and state officials said that only a “small” number of enrollees are terminated because they do not pay premiums on time. In June 2017, for example, about 1 percent of enrollees with incomes above 100 percent of FPL who are required to pay premiums were disenrolled because they had not paid their premiums in over 90 days. This rate fluctuated. In May 2017, for example, the disenrollment rate for failing to pay premiums was nearly 3 percent, but it was about 1 percent in April 2017. Reports of disenrollment for nonpayment were infrequent in our focus groups as well (see box 6).

BOX 6

**FOCUS GROUP FINDINGS:
HOW DO CONSUMERS GET DISENROLLED FROM HELP?**

Only one participant in our focus groups reported being disenrolled for nonpayment: he fell behind with his premium payments and did not know that it could lead to his losing coverage. He said that regaining HELP coverage was challenging and took two months.

“[I didn’t know I’d lose my coverage] because I couldn’t read the paperwork. I made so many phone calls [to try and reestablish my coverage]. They said I owed \$176.... They didn’t send me any bills, they just shut me off and sent me the bill after that. [With help from an FQHC counselor,] we found out that [my] premium was \$22 per month. Ever since then, I’ve been paying \$44 every two months, so I have leeway if I don’t have the money.”

A sizable minority of enrollees owe collectible

debt to the state of Montana because of HELP premiums. As noted earlier, enrollees who fail to pay premiums on time receive notifications from the state that a portion of their next state tax refund will be withheld to pay overdue premiums. Enrollees with the lowest incomes were most likely to have these debts. In June 2017, among HELP enrollees who are subject to premiums and had incomes between 51 and 100 percent of FPL, more than a quarter (29 percent) had collectible debt owed to Montana’s Department of Revenue because of past-due HELP premiums; among those with incomes above 100 percent of FPL, 12 percent had such debt.²²

No charities or organizations are paying cost-sharing on enrollees' behalf. No interviewees reported that charitable organizations were helping to pay HELP enrollees' cost-sharing. We were told that consumer advocates and foundations had discussed this possibility early on. One provider association said it had also considered helping to pay enrollees' cost-sharing but ultimately decided against it because of concerns that this would run afoul of antikickback statutes.

Premium credits are regarded unfavorably. State officials, insurance industry stakeholders, and providers disapproved of the premium credit and felt, on balance, that it does not work. Stakeholders felt that the concept of a premium credit is complex and has been difficult for state officials to explain and for enrollees to understand. One stakeholder from the insurance industry described the premium credit as “overly complex for this population, any type of population.” Providers disliked the premium credit because it meant they could no longer collect enrollee copays at the point of service, which is administratively easier and less costly than generating and mailing bills for copays after a service has been delivered. State officials complained that the premium credit was difficult to administer and required the development of new support technology. One interviewee said that, more fundamentally, comingling premiums for coverage and copayments for using medical benefits is inconsistent with general insurance standards. The stakeholder said that if we want HELP enrollees to “understand the social and economic value of insurance and ... make it affordable, reduce the premium, reduce the amount of out-of-pocket [payments],” but keep premiums and copayments separate.

Providers are not billing for copayments. As mentioned earlier, under HELP, providers can no longer charge Medicaid enrollees copayments at the point of service; instead, if they want to collect the copayment, they must mail enrollees a copayment bill after a claim is adjudicated and, if applicable, after it has been determined that the payment is above the enrollee's premium credit. In interviews, leaders of hospitals and FQHCs said they responded to this policy by not billing HELP enrollees for copayments owed or only sending bills if the cost-sharing was above some threshold amount, or were sending only one bill and then not following up if payment was not received. One representative of a provider group said, “One and done—it's not worth the time and money.” Providers said they often assumed HELP enrollees were not likely to pay bills for copayments. One provider said that billing after the service is “so unsuccessful. You are not going to spend a lot of money trying to get a dollar out of someone who is eligible because they have no money.” Another provider noted that “the perception of going after someone who has a tough time to pay” would be bad. Hospitals said they were writing off lost revenue from unpaid copayments. Providers may be reluctant to pursue copayments because

Montana Medicaid is a fairly generous payer though no interviewee expressed this sentiment. For example, in 2016, Montana ranked second among states for physician payment across all services.²³ State officials were aware of that providers were generally not billing for copayments but maintained that collecting copayments is providers’ responsibility. Officials highlighted that eliminating copayments and having Montana Medicaid pay the full amount to providers would be a “huge cost to the state.”

Copayments and concerns about copayments did not deter enrollees from seeking health care. Consumer advocates, providers, and provider associations all said that HELP enrollees did not seem to avoid seeking health services because of concerns about paying copays. This may be because providers are not billing for copayments or because the premium credit protects many enrollees from having to pay copayments. Moreover, Montana’s expansive definition of preventive services (i.e., what is not subject to copayments) includes secondary and tertiary treatment of chronic conditions, further shielding HELP enrollees from copayments. Most participants in our focus groups said they were not asked to make copayments, but when they were, the payments were affordable (see box 7).

BOX 7
FOCUS GROUP FINDINGS:
DO ENROLLEES FACE COPAYMENTS?

Few participants reported having to make copayments for care under HELP. When copayments were required, they were generally seen as affordable.

“I just pay copayments for my medication. But it’s a lot cheaper than having to pay for the meds yourself!”

“They charge me \$5 for an office visit.”

“I paid a nominal amount [for a doctor’s visit]. I don’t remember if it was a percentage or a flat fee.”

Emergency room (ER) copayments for nonemergent care were not implemented. Although Montana received approval from CMS to implement an \$8 copayment for using nonemergency ER services, the state ultimately decided not to implement this policy. State officials thought that the copayment would be administratively burdensome for hospitals and emergency room physicians because they would have to determine if an encounter was nonemergent.

ACCESS TO CARE UNDER HELP

Stakeholders described HELP enrollees’ access to care as generally consistent with that of privately insured Montanans. Focus group participants said that access was good under HELP. Interviewees acknowledged problems in access to mental health and dental care, but this was thought to reflect the general shortage of these providers in Montana rather than a problem with HELP. Stakeholders and focus group participants said that new coverage under HELP facilitated high rates of service use.

HELP enrollees have good access to care. Consumers, state officials, and providers had generally positive views of access to care under the HELP program and thought that access to care was generally consistent with that of privately insured populations in the state. Access to certain types of health care, including mental health and dental care, was more limited, but stakeholders said this reflected the general shortage of providers in Montana rather than a problem with HELP. Interviewees reported that HELP did not exacerbate access problems in the state by overwhelming providers or creating longer waitlists. In fact, additional state funds from the HELP program were being used to build capacity and to increase the number of providers in underserved specialties, particularly in mental health and addiction treatment.

HELP enrollees are accessing health care services appropriately. Interviewees cited HELP enrollees' high use of preventive services as evidence of appropriate health care use. In the first year of HELP, 60 percent of enrollees used a preventive service, with dental care being the most commonly used service, followed by cholesterol screenings, wellness exams, diabetes screenings, and colorectal cancer screenings.²⁴ Interviewees felt that some of this use could be attributed to pent-up unmet health care need among the previously uninsured. At the same time, Montana encouraged early use of these services by expanding its definition of preventive services—which have no cost-sharing requirements—to include secondary and tertiary treatment of chronic conditions. Providers reported that HELP enrollees' use of preventive services allowed them to take a more proactive role in their own health. One physician said, “Whether it’s women being able to access contraception, or people with unmanaged chronic diseases who are now getting those managed, people enrolled in Medicaid expansion are getting health care that they would not otherwise have been able to get or would have put off.”

Hospital emergency department use did not decrease. Although enrollees were using preventive services and primary care, hospital interviewees said they had not observed a decrease in aggregate emergency department (ED) use. One hospital interviewee said that enrollees had “pent-up need, so utilization goes up, but as they address health concerns you will start to see it flatline a bit and then get down to a new normal.” The state’s decision not to institute a copay for nonemergency ED use could also have contributed to the lack of decline in ED use. But providers generally were hopeful that addressing previously unmet needs through preventive care services and providing some education to consumers about how to appropriately use health care would eventually lead to fewer costly ED visits.

Access to mental health and dental care was more limited. Interviewees attributed mental health and dental care access problems to statewide shortages of providers of and low Medicaid reimbursement rates for these services. Although some dental practices and mental health treatment facilities had longer waitlists and fewer slots for Medicaid beneficiaries than for the privately insured, access was a problem for all Montana patients, particularly in rural parts of the state. Despite these difficulties, providers and advocates reported that HELP enrollees used dental and mental health services, and these services were considered among the most important benefits in the HELP plan. One FQHC representative described access to dental care as a “game changer” and cited patients who found full-time employment after getting dentures for the first time. HELP was seen as highly beneficial for low-income Montanans with mental health and addiction issues, particularly those with anxiety and depression that affected their day-to-day functioning but were not so debilitating that they were eligible for disability. Many providers reported hiring additional mental health staff to accommodate increased demand from HELP and marketplace enrollees.

Native American groups felt that HELP significantly benefited Montana’s Native American population. Interviewees said HELP has given Native Americans far greater access to elective screenings and more consistent access to providers than the Indian Health Service had. They also said that before HELP, uninsured Native Americans living on reservations in Montana generally got their health care through IHS facilities or through health care facilities run by tribes.²⁵ Any services not provided by IHS facilities or tribal clinics, which tend to be limited to primary care, had to be paid for with funds in the “purchased and referred care” budget set by IHS to pay non-IHS providers for treating IHS patients. But, according to interviewees, the purchased and referred care budget has been underfunded for decades; funds often ran out midway through the year. These shortfalls led many IHS facilities and tribal clinics to adopt a “life-or-limb-only priority” standard for purchasing outside care. One interviewee observed that if you’re a Native American who relies on IHS or tribal clinics for services and “want a mammogram and your facility doesn’t offer it, you are out of luck.... If your doctor recommends a colonoscopy for colon cancer screening and you have three siblings who died from it ... you are not going to get it.”²⁶ Under HELP, access to health care services for enrolled Native Americans has reportedly transformed. With HELP coverage, every IHS facility has moved off the life-or-limb referral policy and can now make referrals for elective screening and procedures, according to interviewees. One observer summed up how HELP has affected Montana’s Native American population: “The fact that Indian patients can now access

preventive services whereas before it was only life threatening emergencies—that has been a dramatic success.”

Focus group participants mostly agreed with stakeholders’ positive assessments of access under HELP. Participants said access to care was very good and improved for Native Americans who had previously relied only on IHS facilities. New coverage under HELP facilitated high rates of service use among people who previously could not afford to go to the doctor or dentist (see box 8).

Going Forward

Important changes are coming to HELP. In December 2017, Montana received CMS approval for a waiver amendment that allows the state to drop its contract with the TPA plan and bring all claims administration in-house to reduce costs, and to drop the premium credit because it was too difficult to administer.²⁷ At the time of our site visit in September 2017, these amendments were under consideration at CMS. More fundamentally, despite widespread support for HELP among the stakeholders we spoke with, interviewees acknowledged considerable uncertainty surrounding the fate of the program when it comes up for reauthorization by the Montana legislature in

BOX 8

FOCUS GROUP FINDINGS: DO ENROLLEES HAVE ADEQUATE ACCESS TO CARE UNDER HELP?

Focus group participants were asked whether they have been able to access the care they need through HELP and whether having coverage has affected their ability to get care. Participants generally reported little trouble finding doctors who accepted Medicaid, but finding a dentist was sometimes more difficult. Participants also said that they have been able to obtain health care much more frequently now than when they were uninsured or could only get care at IHS facilities. Finally, participants were very satisfied with the quality of care they received, and only a few reported receiving substandard care while enrolled in Medicaid.

“I didn’t have trouble finding a provider to do my knee surgery. I’ve had success finding medical providers. It’s been harder on the dental side.”

“All the help I’ve gotten at [FQHC] has been amazing.”

“Medicaid is more affordable [than private or employer-sponsored insurance]. The quality of care I get is the same. The biggest issue that comes with it is the stigma from the [clinic] staff. But if you take that away, you get the same care.”

“Yeah, if it wasn’t for this insurance I wouldn’t be making too many doctor’s appointments. I’m very happy with the quality. The system here is incredible.”

“[Before Medicaid,] we came to the IHS community hospital. It was not good. You had to be at the clinic at 6 a.m. if you wanted a dental appointment. You waited until 7:30 a.m., and they passed out numbers in the order you arrived. So, you’re there for three hours just waiting to see if you can get an appointment.”

“I’ve probably been [to the doctor] 15 times in the past year. [During the previous year without insurance] I never went.”

“I used to have Kaiser ... in California. That was outstanding. But I have to tell you, [HELP] ranks right up there. This is outstanding care.”

2019. Meanwhile, HELP enrollees in focus groups universally praised the program and said it was making a huge difference in their lives.

Because of Montana’s budget situation, the 2017 legislature passed legislation (S.B. 261) calling for the termination of Medicaid’s contract for TPA services provided under HELP. This is set to take place on January 1, 2018, pending CMS’s approval. State stakeholders said that eliminating the TPA plan and moving the administration of all HELP enrollees’ claims into the state’s Medicaid agency would yield considerable cost savings. One state official said that while it was difficult to make a directly equivalent comparison, BCBS’s administrative costs are about three times those of standard Montana Medicaid. A BCBS representative said that although Montana Medicaid and BCBS have comparable provider networks, BCBS’s systems and processes are more sophisticated than those generally available in state government, citing premium billing processes as an example. BCBS also has health care management programs and provides case management services, which could contribute to higher costs. Several state officials said that BCBS has been a good partner in HELP and “definitely brings some things to the table,” but having BCBS run the TPA “is not worth the money. We [the state] can do some things for less money.”

In addition to furnishing direct cost savings, state officials contended that HELP administration will be administratively simpler and more efficient with the elimination of the TPA plan. Further, one official said “providers will be happy....because there will be just one” claims adjudicator. State Medicaid officials also maintained that the elimination of the TPA plan will not meaningfully change the provider network available to HELP enrollees. One official said, “If anything, our network is a little better than Blue Cross’s.” In addition, officials said that eliminating the TPA plan would reduce “philosophical differences” on service coverage between Medicaid and private insurance. One official said that in private insurance, “there are a lot of services that are denied, maybe as a business practice. With Medicaid, our philosophy is to get people as much care as possible.” Even though state officials were optimistic about efficiently and seamlessly absorbing TPA plan enrollees, they admitted that Medicaid has work to do to make the transition work well, including building premium billing and health risk assessment structures and processes.

External stakeholders had more mixed reactions to dropping the TPA plan. Some felt that the change would not affect patients or providers or that the state was better equipped to manage the Medicaid population. Others, however, were concerned that Montana Medicaid could not handle the influx of

20,000 TPA HELP enrollees with no additional resources. Several interviewees also felt that BCBS had reduced the stigma of HELP for higher-income enrollees by resembling “real” commercial insurance. These stakeholders worried that enrollees may be less likely to sign up for a Medicaid-branded plan.

The premium credit may be eliminated. Montana has submitted a waiver amendment proposing to eliminate the premium credit. If approved, HELP enrollees who pay premiums would, on a quarterly basis, owe 2 percent of their income in premiums and up to another 3 percent of their income in copayments, with no premium credit toward their copayments. State officials said they were asking to get rid of the premium credit not for budgetary reasons, but because the credit was “amazingly administratively inefficient for not a lot of gain—difficult for clients to understand and for us to administrate.”

HELP reauthorization in 2019 remains uncertain. Legislative authority for HELP automatically sunsets in mid-2019, at which point the program must be reauthorized in order to continue. Stakeholders acknowledged that HELP remains a controversial program and is not universally supported by the legislature. Stakeholders highlighted two concerns for the 2019 session. One is Montana’s current fiscal crisis: many interviewees worried that the state’s revenue shortfall could be a major hurdle for reauthorization of HELP, especially given the

BOX 9

FOCUS GROUP FINDINGS:

HOW DOES HELP AFFECT CONSUMERS’ LIVES?

At the end of each focus group, we asked participants about the difference that HELP coverage has made in their lives. Without exception, participants said that obtaining health coverage through HELP has been extremely beneficial, given them peace of mind, opened the door to health care services that were previously unobtainable, and saved them a great deal of money.

“I’d describe it as huge. [Having health coverage] is a rung on the ladder that I’m climbing to be a productive member of society, to not be in poverty, to be a mom. I can use this as a tool to climb. It’s been a stepping stone. It’s been huge for my family.”

“I’ve been incredibly grateful for the care I’ve gotten. I’m a much stronger person now, because of Medicaid.”

“I can see the doctors I need to see. For years, I didn’t have coverage ... I didn’t know where to go or who to see. It was tough to have to come up with the money [to obtain care]. For me, it’s been great to get the care I need.”

“It brings our tax dollars back to making Montanans healthier. I think it’s great.”

“It’s like having a safety net, just in case something does go wrong. It’s a secure feeling to know that you have something, as opposed to nothing.”

“This is a real boon to me. About 10 years ago, I went bankrupt because of medical costs. I was trying to pay for [my care] with credit cards. Now, I don’t have to worry about that, and I can still pay rent and buy food and gas. I’m really grateful for this. I think someone had a great idea.”

“We [Native Americans] are not afraid of getting sick and having to wait for a full day at a clinic.”

“I’ve been very thankful to be on HELP. It’s saved me and my family so much money. I got a free pair of glasses ... my tonsils out ... I went to the dentist, had a couple of fillings. I couldn’t have done that without this coverage.”

increase in the state’s share of the cost of Medicaid coverage for HELP enrollees. The second concern is enrollment in HELP-Link, the workforce development program included in the 2015 HELP legislation. To date, HELP-Link has had limited reach, and several interviewees said that if enrollment does not expand by 2019, the program could be a major liability for HELP’s reauthorization. As one stakeholder put it, low enrollment in HELP-Link “is the elephant in the room. Everyone knows that it’s a problem, everyone keeps hoping the numbers will turn around before the 2019 session.”

Consumers, however, are unequivocal about the benefits of HELP. Enrollees in our focus groups universally praised the program and said it was making a huge difference in their lives (see box 9).

Appendix: Methodological Approach

Focus Groups with HELP Program Enrollees

As part of our qualitative data collection under the Montana Medicaid expansion evaluation, we conducted focus groups with current beneficiaries enrolled in coverage through the Health and Economic Livelihood Partnership program (HELP). These focus groups captured HELP enrollees' reflections on their experiences in the program and obtained their perspectives and opinions on the program's strengths and weaknesses. Focus groups provide valuable and nuanced insights into individuals' experiences with a particular product, process, or program (in this case, HELP). But by their nature, focus groups obtain information from relatively few people and thus cannot be presumed to represent the entire population of interest. Over three consecutive days in September 2017, Urban Institute researchers conducted four focus groups in the Montana towns of Helena, Havre, and Browning, composed of different types of participants:

- One focus group composed solely of HELP enrollees in the exempt category (in Helena)
- One focus group composed solely of HELP enrollees in the third-party-administered (TPA) plan through BCBS (in Helena)
- Two focus groups composed of a mix of HELP enrollees in the exempt category and in the TPA plan (in Havre and Browning, with the latter taking place on the Blackfeet Indian Reservation)

HELP enrollees were recruited for focus group participation with the assistance of the Medicaid agency of the state of Montana, which gave evaluators recruitment lists containing the names, contact information, and demographic information (e.g., income, ethnicity, Native American status) for samples of both exempt and TPA plan HELP enrollees living in Helena, Havre, and Browning. In each locality, proportional subsamples were drawn from the larger full samples to approximately represent the distributions of enrollees by income (less than 51 percent of FPL, 51 to 100 percent of FPL, more than 100 percent of FPL), eligibility status (HELP enrollees in either the exempt category or TPA category), and self-reported Native American status. A focus group ideally has between 8 and 10 people; to allow for no-shows, we recruited between 13 and 15 people for each group. Thus, for each of the four focus groups, recruitment efforts proceeded until recruiters secured affirmative commitments to attend from between 13 and 15 participants.

HELP enrollees were recruited for focus group participation by way of “cold” telephone calls (and, in some cases, text messages). Using the telephone numbers listed in the state-provided recruitment lists, recruiters tried to reach HELP enrollees by phone to describe the purpose of the focus groups and solicit their participation. Enrollees who expressed interest in participating in the focus group were asked to state their preferred method for receiving written confirmation. Most requested that confirmation be delivered by e-mail and provided their e-mail addresses, but some requested confirmation by phone or text message. Recruiters followed up multiple times between initial recruitment and the day of the focus groups to provide confirmation of event logistics (e.g., start time, location). In addition, “reminder” calls were placed to each person who had agreed to participate on the day before each focus group.

As detailed in exhibit 1 below, a total of 17 HELP enrollees participated in the four focus groups (though between 13 and 15 recruits had repeatedly confirmed their intent to attend each focus group). In Browning, attendance was particularly poor (1 participant), which was likely exacerbated by the sudden onset of poor weather on September 14 (40 degrees, rain and sleet). Still, a productive in-depth interview was conducted with this individual using the same moderator’s guide used in the other focus groups. Overall, roughly equal numbers of attendees across all four focus groups fell into the exempt (8) and TPA (9) categories. Nine of the 17 participants were female, and two were Native American.

Exhibit 1. Focus Group Composition and Participation

Participant type	Number of groups	Number of participants
Exempt HELP enrollees	1	4
TPA HELP enrollees	1	7
Mixed exempt/TPA HELP enrollees	2	6
Total	4	17

Each focus group lasted between 90 and 120 minutes. Each participant received a gift card worth \$60 in appreciation of their participation. Boxed lunches were also provided to participants.

During the focus group design phase, the evaluation team developed a moderator’s guide that included a core set of questions, as well as unique questions tailored for use with each type of HELP enrollee (exempt or TPA). Questions explored enrollees’ experiences across the following dimensions:

- marketing and outreach
- HELP enrollment process
- enrollees’ first impressions of the HELP program
- renewal process
- cost-sharing and affordability (only TPA plan enrollees were asked about monthly premiums)
- access to care, benefits, and health care use
- satisfaction with quality of care
- overall impacts of having health coverage on daily life
- enrollees’ suggestions for improving the HELP program

At the start of each focus group, all participants were given two copies of an informed consent form in accordance with Urban Institute Institutional Review Board rules, regulations, and prior approval. The form emphasized that enrollees’ participation was voluntary and that participants’ privacy would be protected. After summarizing the content of the informed consent form, participants were asked to sign one copy for the evaluators and were allowed to keep a copy for their own records. All focus group proceedings were digitally recorded and transcribed; recordings were destroyed upon completion of transcription and cleaning of notes.

To analyze the results of the focus groups, the evaluation team used commonly accepted qualitative research methods. Unabridged transcripts, along with field notes, served as the basis for the analysis. Evaluators carefully reviewed focus group notes and transcripts and categorized participant responses using a structure that mirrored the content of the focus group moderator’s guides. Dominant themes, divergent opinions, and experiences of participants were noted and summarized. Finally, relevant quotations were selected based on frequency and richness to illustrate key points.

- ¹ When Montana received approval for HELP, it also received a Section 1915(b)(4) Fee-for-Service Selective Contracting Waiver, which authorized a defined provider network and is associated with the HELP demonstration. The Section 1915 waiver is not covered in this report.
- ² A description of focus group methods is provided in the appendix. Although focus groups provide rich details about HELP enrollees' perceptions and experiences, they (by definition) do not provide fully representative feedback on the demonstration. Such feedback will be provided through the HELP Beneficiary Surveys, the first wave of which was simultaneously being conducted during the time of the site visit. The study design also did not include focus groups with individuals who were eligible for HELP but not enrolled, which limits our ability to know why such individuals may have chosen not to enroll in the program.
- ³ The Montana legislature meets for 90 days every other year.
- ⁴ Before the HELP demonstration waiver, Montana charged Medicaid enrollees copayments.
- ⁵ Montana Department of Labor and Industry, *HELP-Link Program: 2016 Annual Report* (Helena: Montana Department of Labor and Industry, 2017); and Montana Department of Public Health and Human Services, *Montana Health and Economic Livelihood Partnership (HELP) Program Demonstration: Section 1115 Waiver Annual Report*, report 11-W-00300/8 (Helena: Montana Department of Public Health and Human Services, 2017).
- ⁶ See note 5.
- ⁷ CMS, "Special Terms and Conditions: Montana Health and Economic Livelihood Partnership (HELP) Program Demonstration," approved November 2, 2015, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mt/mt-HELP-program-ca.pdf>.
- ⁸ Based on Medicaid and CHIP eligibility in Montana as of June 1, 2016, for "Parent/Care Taker," as summarized from Montana's state plan at "Medicaid and CHIP in Montana," Centers for Medicare & Medicaid Services, <https://www.medicaid.gov/medicaid/by-state/stateprofile.html?state=montana>, accessed November 7, 2017; "Medicaid and CHIP Income Eligibility Limits for Pregnant Women, 2003-2017," Kaiser Family Foundation, <https://www.kff.org/medicaid/state-indicator/medicaid-and-chip-income-eligibility-limits-for-pregnant-women/?currentTimeframe=0&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D>, accessed November 7, 2017; and "Medicaid Income Eligibility Limits for Parents, 2002-2017," Kaiser Family Foundation, <https://www.kff.org/medicaid/state-indicator/medicaid-income-eligibility-limits-for-parents/?currentTimeframe=0&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D>, accessed November 7, 2017.
- ⁹ Montana Department of Public Health and Human Services, *The Montana Medicaid Program: Montana Department of Public Health and Human Services Report to the 2017 Legislature, State Fiscal Years 2015/2016* (Helena: Montana Department of Public Health and Human Services, 2017).
- ¹⁰ "Medicaid Benefits Data Collection," Kaiser Family Foundation, <https://www.kff.org/data-collection/medicaid-benefits/>, accessed November 7, 2017.
- ¹¹ CMS, "Montana Health and Economic Livelihood Partnership (HELP) Program Demonstration," <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mt/mt-HELP-program-ca.pdf>
- ¹² See note 1. Under a separate 1915(b)(4) selective contracting waiver, also granted in November 2015, Montana received approval to provide services to nonexcluded HELP enrollees through a TPA plan.
- ¹³ "Overview of Medicaid Cost Sharing and Premium Requirements" (PowerPoint presentation, November 25, 2014), <https://www.medicaid.gov/state-resource-center/mac-learning-collaboratives/learning-collaborative-state-toolbox/downloads/cost-sharing-premium-requirements.pdf>.
- ¹⁴ Another feature of HELP copayment policy is that a service is considered to have occurred on the date the claim is paid, not on the date of service, to determine which quarter a service occurred. Interviewees said that this runs counter to standard practice in the insurance industry.
- ¹⁵ See note 7.
- ¹⁶ "HELP Members," Montana Department of Public Health and Human Services, accessed November 8, 2017, <http://dphhs.mt.gov/helpplan>.
- ¹⁷ S. 405, 64th Leg., Reg. Sess. (Mont. 2015).
- ¹⁸ Montana DPHHS, *Section 1115 August 2017 Quarterly Report*.
- ¹⁸ Montana DPHHS, *Section 1115 Waiver Annual Report*.
- ²⁰ See note 17.
- ²¹ See note 17.
- ²² Comparable data for those with incomes above 100 percent of FPL are not available because these people would be disenrolled if they were 3 months in arrears with premiums.
- ²³ "Medicaid-to-Medicare Fee Index," Kaiser Family Foundation, <https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/?currentTimeframe=0&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D>.
- ²⁴ Montana DPHHS, *Section 1115 Waiver Annual Report*.
- ²⁵ Montana has 12 different tribes and seven reservations. On some reservations, IHS provides most services; on other reservations, tribes contract with IHS and deliver health services directly. Some reservations have a mixture of IHS- and tribe-provided services.
- ²⁶ Native Americans who do not live on a reservation face different circumstances. In Montana there are five urban programs for Native Americans; these programs deliver care through a contract with IHS, essentially operating as FQHCs, according to interviewees. However, interviewees said urban programs do not receive any purchase and referred care dollars.
- ²⁷ As mentioned earlier, since the time of our site visit in September, Montana received approval from CMS to amend its waiver to remove the TPA plan and to drop the premium credit in December 2017.