Montana Health and Economic Livelihood Partnership (HELP) Demonstration Summative Evaluation and Final Close Out Report

Reporting Period: January 1, 2016 – December 31, 2022

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Contents

I. Executive Summary

The Montana Health and Economic Livelihood Partnership (HELP) 1115 Demonstration (Number: No.11-W-00300/8) was approved by the Centers for Medicare and Medicaid (CMS) in November of 2015, and went into effect January 1, 2016. This Demonstration, also known as the Medicaid Expansion Demonstration, expanded Medicaid coverage to nondisabled adults with incomes up to 138 percent of the federal poverty level (FPL); authorized 12-month continuous eligibility for adults; applied enrollee premiums equal to two percent of aggregate household income; and instituted maximum co-payments allowable under federal law. The approved Waiver also authorized the administration of Medicaid through a Third-Pary Administrator (TPA) for enrollees subject to premiums.

The Demonstration was proposed in Montana Senate Bill 405 in 2015 and passed with bipartisan support. Governor Steve Bullock signed it into law on April 29, 2015. Senate Bill 405 directed the Department of Public Health and Human Services (DPHHS) to seek an 1115 Waiver to achieve its goal of simultaneously expanding eligibility for Medicaid while also requiring premiums and expanding cost-sharing, allowing for a TPA, and increasing efficiency by adding 12-month continuous eligibility. Prior to the HELP Demonstration, Medicaid only covered the elderly, those with a disability, children with family incomes up to 143 percent of the FPL, pregnant women with income up to 157 percent of the FPL, and adults with dependent children up to 24 percent of the FPL. Under HELP, eligibility expanded to cover non-disabled adults with incomes up to 138 percent of the FPL. The HELP Demonstration furthered the objectives of Title XIX by expanding access to Medicaid coverage. It also enabled low-income Montanans to have access to quality, affordable healthcare that included preventative services.

As noted in the Demonstration's final extension approval letter, dated December 21, 2021, the State is required to conduct monitoring and evaluation activities of Demonstration components. Included in the reporting requirements by CMS are a Summative Evaluation and Final Report. These two types of reports would contain similar if not the same information and because of this, CMS has allowed Montana to complete one report covering the requirements of both. Due to the time limited scope of the Demonstration and extensions, the Special Terms and Conditions (STCs) outlined abbreviated monitoring and evaluation requirements relevant to the Demonstration. As directed by CMS, Montana has prepared the following Final Report on how the HELP Demonstration's features met its objectives of increasing enrollment and improving access to services. The following report is an overview and analysis of the Demonstration's approval period from January 1, 2016 through December 31, 2022.

II. General Background Information

The Montana Health and Economic Livelihood Partnership Waiver received approval from CMS for the initial five years in November 2015 with an effective date of January 1, 2016. Although the initial authorization was for five years, there were two additional extensions, one year each, meaning the HELP Demonstration was active for a total of seven years. This report will examine

this entire time frame from the beginning approval date in 2016 until Demonstration authorization ceased in December 2022.

This Waiver was initially proposed in Montana Senate Bill 405 in 2015 and signed into law on April 29, 2015. This directed DPHHS to apply for 1115 Waiver authority from CMS to expand Medicaid with provisions. The key issues the Demonstration sought to address included exploring Medicaid Expansion and increasing Medicaid eligibility to cover more Montanans. During this period, there were also other states implementing similar 1115 Demonstrations to explore Medicaid Expansion. By implementing Medicaid Expansion through an 1115 Waiver, it allowed for more rigorous testing and data analysis to assess whether the State wants to continue these provisions or end the Waiver authorities as the 1115 Waiver also allows for a temporary implementation.

It is important to note, at CMS' invitation, Montana participated in CMS' multi-state 1115 Demonstration Federal Evaluation and Meta-Analysis, which completed multiple reports and met its federal evaluation requirement. The federal evaluation was conducted by the Social and Scientific Systems (SSS) in conjunction with the Urban Institute. The SSS and Urban Institute complete the CMS required reporting for the Evaluation Design, Interim Evaluation, and Summative Evaluation for this Demonstration. These reports conducted extensive research on the HELP Waiver including research not conducted independently by the State. For this reason, the State will refer to some data specific to these reports. In addition to reports and research conducted by the SSS and the Urban Institute, the Montana Healthcare Foundation (MHCF) conducted analysis of the HELP Waiver which will also be referred to later.

HELP expanded Medicaid to more Montanans but with additional features not in place for Montana's Standard Medicaid population. The Waiver authorities utilized in this Demonstration included: §1902(a)(17) to waive Medicaid comparability requirements allowing different treatment of newly eligible adults, such as the application of copayments and premiums on newly eligible adults enrolled in Medicaid through the TPA; §1902(a)(14) to impose monthly premiums equal to two percent of annual income on newly eligible adults enrolled through TPA; §1902(a)(23) to waive Medicaid freedom of choice requirements relative to the TPA; §1902(a)(8) to waive the reasonable promptness requirement and permit disenrollment of participant's with incomes above 100 percent of the FPL who fail to pay required premiums; and §1902(e)(12) to apply 12-month continuous eligibility to all Modified Adjusted Gross Income (MAGI) determined adults.

Through this Waiver request and expenditure authorities, the State sought to: apply copayments and premiums to new adults enrolled in Medicaid and test the impact of copayments and premiums on access to care; impose premiums on Demonstration populations that exceed statutory limitations and test the impact of premiums on access to coverage; require certain HELP program eligible participants receive coverage through the TPA; and, disenroll certain participants who failed to pay required premiums for HELP program participation. To further align with the State's objectives of reducing disruptions in coverage ("churning") and ensuring consistent access to care, Montana also sought 1115 Waiver approval to implement 12-month continuous eligibility for all adults determined eligible based on MAGI criteria.

In December 2017, CMS approved an amendment to Montana's Section 1115 Demonstration Waiver that maintained Medicaid Expansion, 12-month continuous eligibility and premiums, but removed the authorization of the TPA and the premium credit applied to some HELP enrollees' cost-sharing obligations. The amended Demonstration was to have the same initial approval date of January 1, 2016 through December 31, 2020.

On May 9, 2019, Governor Steve Bullock signed House Bill 658, the Medicaid Reform and Integrity Act, that directed DPHHS to request federal 1115 Waiver approval for new Medicaid Expansion program features, including those that condition Medicaid eligibility on participation in work/community engagement. Montana submitted an 1115 Waiver amendment request in August 2019 seeking to condition Medicaid eligibility on work/community engagement requirements, increase monthly premiums based on coverage duration, and remove co-payments. Based on CMS' withdrawal of other state's 1115 Waivers with work/community engagement requirements, CMS communicated with DPHHS that a five-year extension of the Medicaid Expansion Waiver would not include work/community engagement requirements.

Due to a delay in finalizing the STCs for Montana's 1115 Waiver amendment request before the sunset date of December 31, 2020, CMS approved a one-year extension of the 1115 HELP Waiver. The temporary extension was granted to allow the State and CMS to continue working together on approval of the previously submitted application for amendment and extension of this Demonstration. The temporary extension included approval of the amendment to remove the expenditure authority for 12-month continuous eligibility from the 1115 Montana HELP Waiver as directed by the 2021 Montana Legislature. However, the continuous coverage requirements of the Families First Coronavirus Response Act (FFCRA) meant the removal of 12-month continuous eligibility did not actually take effect until April 1, 2023. In this temporary extension, CMS communicated it would not authorize continued premium collection under an 1115 Waiver, providing the State one additional year to phase out the collection of monthly premiums. The second additional and final extension period of performance was January 1, 2022 through December 31, 2022, at which point Waiver authorities expired. At completion of the Demonstration, Medicaid Expansion enrollees maintained coverage through the Alternative Benefit Plan (ABP) and State Plan Authority (SPA).

III. Summary of the Implementation of the Demonstration

CMS approved the HELP Waiver application in November 2015, and Montana launched the program less than two months later, enrolling the newly eligible adults and providing coverage beginning January 1, 2016. By the end of that year, enrollment exceeded expectations, and 88,716 Montanans were receiving health care, many for the first time in years. Enrollment continued to climb for the first four years and then started to slightly decline, until the pandemic and FFCRA's continuous coverage requirement took effect.

In addition to the removal of the TPA in 2018, other changes implemented over the course of the seven years of the Demonstration included removal of the premium credit for cost sharing, then the removal of cost sharing, and removal of 12-month continuous eligibility. The Public Health

Emergency (PHE) played a significant role in providing challenges during the HELP Demonstration period. Enrollment slightly decreased during this time and there was reduced utilization of preventative services. Montana's priorities in addressing the PHE included: access to behavioral health services; COVID-19 testing, treatment, and vaccinations; providing healthcare coverage to those individuals diagnosed with COVID-19 and not insured (this program ceased on July 1, 2021); and expanding telehealth options for exposure protection of members and others. Since this time, access to telehealth has improved and increased. Not only are telehealth options important for those experiencing illness or health issues, but it also helps with increasing access to healthcare for Montana's rural populations.

An unexpected challenge presented itself internally during this Demonstration period. With the removal of the TPA, effectively ending the contract with Blue Cross Blue Shield of Montana (BCBSMT), all Waiver activities moved internal and were taken over by Montana State employees. Another internal difficulty became reporting requirements. Because there were outside parties responsible for some of the reporting requirements but not all, it created some confusion and inconsistencies. One of the primary parties for the reporting requirements was the SSS and Urban Institute. They completed the Evaluation Design, Interim Evaluation, and initial Summative Evaluation. The SSS and Urban Institute only completed reporting requirements for the initial 5-year approval period. Since the Waiver had two additional extension years and therefore additional reporting requirements, this created some barriers. The Summative Evaluation and Final Report were needing to be completed by the State. Those reports are based off the Evaluation Design including measures, goals, and hypotheses. Because the Evaluation Design was not completed by the State, the State was unable to complete some of the measures initially identified. For instance, the SSS and Urban Institute conducted member, provider, and stakeholder outreach, including surveys. The State had not continued this in the final two extension years due to an inability to establish and conduct this type of research with the limited resources of the State at that time. Because of the importance of these reports and the influence they have on the final reporting requirements, this report will refer to some of the findings in the reports completed by the SSS and Urban Institute. This report will also contain information from the MHCF due to the same reasons. Because the SSS and Urban Institute and MHCF played such a large role in the reporting requirements, it seems unjust to complete this report without referring to their findings and measures.

Opportunities for improvement are continued to be explored and exercised in Montana's continuation of Medicaid Expansion under ABP and State Plan authorities. Some of these improvements have been recognized and implemented include the phasing out of premiums and cost sharing. A series of amendments to this Demonstration ultimately resulted in the removal of all elements of the Waiver except the charging of premiums, which CMS would no longer authorize. Premiums and cost-sharing was phased out with the sunset of the 1115 Waiver authorities in 2022. As discussed in the Summative Evaluation completed by the SSS and Urban Institute, cost was considered a barrier to receiving services to some enrollees, especially when it came to vision and dental services. Montanans now face fewer financial barriers to receiving health care benefits than they did under the Waiver's authority.

Another opportunity for improvement would include properly preparing for enrollment of a large population such as Expansion. The Office of Public Assistance (OPA) processes Medicaid and

Medicaid Expansion populations as well as other programs. With the amount of newly eligible Montanans for coverage, OPA was not adequately prepared for the workload. As found in the 2018 SSS and Urban Institute report, some participants had to travel long distances to find an open OPA, while others waited for hours on hold to speak with an OPA staff member through the Montana Public Assistance Help Line. It has been heard by members that these long distances and wait times have caused some barriers to receiving coverage. In addition to improving staffing for eligibility and enrollment, another beneficial improvement could have been enrollee education on their coverage. As reported by the SSS and Urban Institute, many enrollees reported needing more information about how their coverage works. Improving member education in the future could possibly lead to more service utilization, including preventative services and an overall satisfaction with their coverage.

IV. Update on Transition Plan

On October 13, 2022, CMS requested Montana present a description outlining its approach for closing the HELP Program Section 1115 Waiver. On August 30, 2019, DPHHS submitted a Waiver extension and amendment to CMS. On September 29, 2020, CMS informed DPHHS that due to their attention and resources being consumed with litigation challenging the legality of work requirements and the ongoing COVID-19 pandemic, the agency was unable to complete negotiations for Montana's five-year Waiver extension and amendment. Instead, CMS approved a one-year temporary extension of Montana's HELP Waiver, to allow for additional time to negotiate the approval of an amended Waiver. On December 21, 2021, CMS provided Montana with a one-year temporary extension. In this temporary extension approval, CMS also informed the State it would not renew the authority to charge premiums to the adult group after this extension period, terminating premiums effective December 31, 2022.

During the Public Health Emergency (PHE), the State continued to collect monthly premiums, but coverage was not terminated for individuals who failed to pay their premiums due to the federal Medicaid continuous coverage requirements. Individuals who were charged premiums received monthly invoices. DPHHS included language in the invoices informing individuals of the phasing out of premiums effective December 31, 2022. The notification language was: "Effective December 31, 2022, the Department of Public Health and Human Services will no longer be invoicing the HELP premium payments; the December invoice will be the last premium payments you owe". This information was also posted on the online portal where members could pay their premiums and the State's Medicaid website. The State's eligibility and enrollment IT system was also made ready to implement these changes by December 31, 2022. The Call Center and eligibility and enrollment workers were informed of the change and were trained and prepared to answer any questions for enrollees.

To reach as many individuals as possible for notification of these changes, DPHHS attempted communications in the following ways. On November 7, 2022, a member newsletter, Montana Health Care Programs "Messenger", was published on the Montana Medicaid and Health Montana Kids *Plus* member education webpage. The "Messenger" newsletter is a quarterly report with updates for members posted on the DPHHS website. A monthly provider newsletter ("The Claim Jumper") is published at the end of each month and emailed to all providers who registered to receive it and is posted on the Montana provider webpage. Provider notices were

issued each month of the quarter, as needed, to notify providers of changes to coverage requirements, claims codes, fee schedules, support service holiday closures, and other significant changes. The annual public forum to solicit comments on the progress of the 1115 HELP Demonstration was held on November 29, 2022. To inform members of the upcoming cessation of premium charges, Montana included the notice stated above on premium invoices. This notice was included on the invoices for October, November, and December of 2022. Contacts were provided to members for any follow-up questions or concerns. Additionally, the following was added to the premium payment portal: "The December invoice will be the last premium payment you owe. For any coverage after December 31, 2022, the Department of Public Health and Human Services will not be charging a premium. The ending of the premium payments does not affect your coverage; therefore, you do not need to reapply as your coverage is not ending". Contacts were again provided for any follow-up questions or concerns.

On January 1, 2023, the cessation of the premium requirements included in the 1115 HELP Waiver was executed. Montana also began the undertaking of reinstatement of the scheduled eligibility redetermination project as well as the termination of 12-month continuous eligibility with the announcement of the Consolidated Appropriations Act, 2023. The redetermination process began in early April 2023 with the aim to have it completed within 10 months of the start date.

With the ending of the HELP Waiver, the State was able to seamlessly transition authorities to the ABP and State Plan for Medicaid Expansion and continue uninterrupted coverage for members. Eligibility, coverage, and services were expected to remain the same under the State's Alternative Benefit Plan apart from the cessation of the premium requirements and the cessation of 12-month continuous eligibility. The Alternative Benefit Plan has aligned itself with the Standard Medicaid Plan through the State for coverage consistency and equality.

V. Budget Neutrality

Montana continued to meet the requirements of budget neutrality throughout the HELP Demonstration and no CAP was needed. The January 1, 2023, HELP population' expenditures reporting moved from an 1115 Demonstration Waiver to the Alternative Benefit Plan which eliminated the need for future budget neutrality considerations. Please see the most current budget neutrality spreadsheet.

VI. Evaluation Methodology

The Demonstration sought to further the objectives of Title XIX by meeting the health needs of low-income Montanans by providing quality, affordable access to Medicaid coverage. It is important to note that the Evaluation Design was completed by SSS and Urban Institute as part of the previous mentioned agreement with CMS. Upon completion of the Evaluation Design, Interim Evaluation, and Summative Evaluations by the SSS and Urban Institute, data was solely collected and evaluated by MHCF and the State of Montana. The data after the completion of the above-mentioned reporting requirements was solely quantitative in measurement with collections and analyses of enrollment and claims data.

It was originally thought that premiums and co-payment liability would encourage enrollees to understand the value of their insurance coverage, be discerning health care purchasers, take personal responsibility for their health care decisions and develop health-conscious behaviors as customers of health services, and engage in healthy behaviors. These along with 12-month continuous eligibility would promote continuity of care.

The HELP Waiver was designed to meet the following policy objectives:

- Increase the availability of high-quality health care to Montanans;
- Provide greater value for the tax dollars spent on the Montana Medicaid program;
- Reduce health care costs;
- Provide incentives that encourage Montanans to take greater responsibility for their personal health;
- Boost Montana's economy; and
- Reduce the costs of uncompensated care and the resulting cost-shifting to patients with health insurance.

The four principle objectives identified for the evaluation of the Demonstration were:

- Understand the design, implementation, and administrative costs of the HELP Demonstration Program;
- Document enrollee understanding of and experiences with HELP, including experiences with premiums, copayments, enrollment, and disenrollment;
- Estimate the overall effects of HELP on health insurance coverage, access and affordability of health care, health behaviors, and health status; and
- Provide timely information on the HELP Demonstration Program to inform CMS, Montana, and other states as they consider ways to improve the Medicaid program with qualitative data being based off member enrollment and claims.

To accomplish these objectives, the assessment consisted of three main elements that relied on qualitative and quantitative analyses:

- Qualitative analyses entailing document review and two rounds of site visits, including conducting informational interviews with HELP stakeholders (such as state officials, health care providers and provider association representatives, and consumer advocates) and focus groups with HELP enrollees; and descriptive analyses using HELP administrative data
- Descriptive analyses also included conducting two surveys of HELP enrollee and disenrollees; and
- Quantitative analyses using national survey data (through 2018) to estimate the impact of the Demonstration on selected outcome measures.

In September 2017 and 2018, the SSS and Urban Institute evaluators conducted document review and site visits that included numerous informational interviews with HELP key stakeholders and focus group discussions with HELP enrolled members. Beneficiary surveys

were also completed in 2017 and 2018 to further obtain qualitative data. Limitations to the qualitative component were interviews and focus groups only represent those participating and not all HELP enrollees. Although these provide some insight into potential and important perspectives, they do not necessarily cover all potential reports. The reporting is also limited to self-reporting which is therefore limited by each individual's memory and interpretation of an experience.

In the impact analysis, both national survey data and Medicaid administrative data were utilized. Qualitative data allowed for a comprehensive evaluation of the consumer perceptions and experiences. The goals of the qualitative analyses were to provide careful documentation of HELP implementation and operations, as well as report on the successes and challenges Montana faced in managing the Demonstration. As the collection of data continued throughout the Demonstration, updated numbers were provided in the annual evaluation reports to CMS.

The impact analysis aimed to gather information on how the HELP Demonstration influenced changes in health care coverage, accessibility, affordability, quality, behaviors, and overall health status. The impact analysis was organized around three research questions:

1. What are the impacts of Montana's Medicaid Expansion Demonstration compared with not expanding Medicaid?
2. What are the impacts of Montana's Medicaid Expansion Demonstration compared with expanding Medicaid without a Demonstration?
3. What are the impacts of Montana's Medicaid Expansion Demonstration compared with expanding Medicaid with a different Demonstration?

The goal of the impact analysis was to assess the extent to which HELP has caused the changes in enrollee outcomes that were intended under the Demonstration. The hypotheses included the expectation that the HELP Demonstration would result in increased health care coverage and improved health outcomes when compared to not expanding Medicaid through HELP. Montana also hypothesized an increase in utilization of preventive services over time when contrasted with other non-expansion states. There were no pre-established expectations for the third research question regarding expanding Medicaid in a different type of Demonstration. Any improvements in coverage were expected to subsequently enhance access to and affordability of health care. In assessing HELP, the impact analysis relied on a quasi-experimental difference-in-difference evaluation design and data over time from the American Community Survey (ACS) and the Behavioral Risk Factor Surveillance System (BRFSS) comparing changes over time for adults in Montana to changes for similar adults in similar comparison states. One of the limitations to the impact analysis is no other state matches Montana across all dimensions for comparison (i.e. demographic, social, economic, and political context). Another limitation is the impact analysis is limited to the ACS and BRFSS reports, which means it focuses on the overall impacts of HELP for the outcomes available in those surveys. At the time, the SSS and Urban Institute did not have the data needed to disentangle the impacts of different components of HELP nor the data to look at outcomes beyond those available in the ACS and BRFSS, including more detailed measures of health care access.

There were no enrollment caps in the Demonstration. Eligibility criteria for participation in this Demonstration was:

- A childless adult between 19 and 64 years of age, with an income at or below 138 percent of the FPL or a parent between 19 and 65 years of age with an income between 50-138 percent of the FPL;
- Not enrolled in Medicare;
- A United States citizen or a documented, qualified alien; and
- A resident of Montana. However, individuals who have exceptional health care needs, including but not limited to a medical or mental health or developmental condition, live in a region, including and Indian reservation, where the TPA is unable to contract with sufficient providers, or require continuity of coverage is not available or could not be effectively delivered through the TPA, or are otherwise exempt under federal law (including American Indians), are not eligible for this Demonstration, and will instead be served through the State's current Medicaid program.

The individuals who qualified for the HELP Demonstration received their benefits through an Alternative Benefit Plan that, for the first two years of the Demonstration, was managed by a TPA. The TPA chosen for the HELP Demonstration was BCBSMT. The TPA was responsible for providing a network, reimbursement to providers, and collections of enrollee premiums. The State maintained the same standards and methodologies for HELP Waiver eligibility as those articulated in the State Plan. There were two amendments to the Alternative Benefit Plan (ABP) which included a TPA that administered the ABP without long-term care services and an ABP (not administered by a TPA for those considered exempt from the TPA) that included long-term care services. HELP program participants whose coverage was administered through the TPA were required to pay copayments. A State Plan Amendment (SPA) with copayment schedules was adopted to reflect the maximum allowable copayment amounts under federal law for all individuals with incomes below 138 percent of the FPL. Providers collected applicable copayments at the point of care. The State also imposed monthly premiums equal to two percent of household income for all newly eligible adults with incomes below 138 percent of the FPL who coverage was administered through the TPA. Total contributions and copayments were capped at five percent of quarterly income.

The Demonstration covered the ACA Medicaid Expansion populations, but the following individuals were exempt:

- Individuals who were medically frail;
- Individuals who the State determined (as described in the TPA ABP SPA) have exceptional health care needs, including but not limited to a medical, mental health, or developmental condition;
- Individuals who lived in a region (that may include all or part of an Indian reservation), where the TPA was unable to contract with sufficient providers (as described in the TPA ABP SPA);
- Individuals who the State determined, in accordance with objective standards approved by CMS (as described in the TPA ABP SPA), required continuity of coverage that was not available or could not be effectively delivered through the TPA; or

- Individuals exempted by federal law from premium or cost sharing obligations, who exemption was not waived by CMS, including individuals with incomes up to 50 percent of the FPL.

These exempt individuals instead received coverage through the State's Standard Medicaid program.

VII. Evaluation Findings

The evaluations and findings of the HELP Demonstration have shown dramatic success in expansion of access to health coverage. Enrollment surpassed expectations, thus validating the need for Medicaid Expansion as well as the success of the Demonstration. This expansion of health coverage led to a significant number of Montanans receiving preventive services and screenings they would otherwise have been unlikely to receive, improving their long-term outcomes.

Again, due to the SSS and Urban Institute as well as the MHCF playing such a large role in the reporting requirements of this Waiver, it seems unjust to complete this report without referring to some of their findings and measures as well. Some of the important and interesting measures the SSS and Urban Institute reported on that will not be covered by the State data include member and stakeholder surveys and input, comparisons with other states, and rural area evaluations. Some of these will be discussed in addition to the State's data and analyses as follows. The Montana Healthcare Foundation's reporting will also be discussed as MHCF assisted with continuing the evaluation of HELP when the SSS and Urban Institute reporting was complete. Evaluation of the HELP Demonstration continued after the release of the SSS and Urban Institute reports through a partnership with the MHCF. To help evaluate the ongoing impact of the features of the HELP Demonstration, DPHHS provided data to, and worked closely with, the MHCF to produce reports. These reports analyzed the impact the HELP Demonstration had on increasing enrollment in Medicaid, increasing access to preventive health care, improving health outcomes, decreasing healthcare costs, and advancing health equity. The following data will be broken down by three sections: 1) Evaluation Findings from the SSS and Urban Institute, 2) Evaluation Findings from MHCF, and 3) Evaluation Findings from Montana. By providing information from all three of these parties, it better outlines the full scope and magnitude of the HELP Demonstration from beginning to end.

Social & Scientific Systems and Urban Institute 2020 Federal Evaluation

The Social & Scientific Systems and Urban Institute completed the Evaluation Design, Interim Evaluation, and Summative Evaluation for the State. The Summative or Federal Evaluation released in 2020 covers information from all three of these reports. The following summarizes the SSS and Urban Institutes report's findings.

The SSS and Urban Institute reported high levels of satisfaction among program enrollees, appreciation from stakeholders for the positive economic impacts of the Demonstration,

including decreasing hospital uncompensated care costs and stimulating economic growth in the State. It is important to note that since the release of the SSS report:

1. Co-payments were removed to align with the Montana Medicaid Plan with effective date of January 1, 2020;
2. DPHHS maintained individuals in Medicaid coverage per the federal continuous coverage requirements during the PHE; and
3. Individuals with income above 100% of the federal poverty level were not disenrolled from coverage for failure to pay premiums.

In 2018, the SSS and Urban Institute conducted focus groups with participants who had some concerns or questions about enrolling, maintaining, or reactivating their coverage with HELP. Some participants had to travel long distances to find an open OPA, while others waited for hours on hold to speak with an OPA staff member through the Montana Public Assistance Help Line. Despite these issues, the majority of HELP enrollees expressed satisfaction with individual features of the program, such as monthly premiums, the ability to see and choose their doctors , and coverage of needed health care services. Disenrolled respondents who voluntarily left the program reported higher satisfaction levels than those who were disenrolled due to non-payment of premiums. Nonetheless, almost half of the disenrolled respondents expressed interest in re-enrolling in HELP.

Both focus group participants and healthcare providers included in the SSS and Urban Institute study reported the State's eligibility determination for HELP and the time it took for enrollees to receive their insurance identification card in the mail was a consistent issue in both 2017 and 2018. The time it took for participants to receive their insurance identification card after submitting their application ranged from days to weeks, or even a month or two, according to the 2018 focus group. Several participants said their healthcare providers would check if they had HELP coverage online and provide treatment even if they did not yet have a card. State officials acknowledged processing Medicaid applications was taking longer than they preferred, despite staying within the federal required 45-day limit, due to a hiring freeze preventing the Montana DPHHS from replacing departed staff.

Enrollees interviewed in the SSS and Urban Institute study reported they received insufficient education about how HELP coverage worked since the program was implemented. Many HELP enrollees in the focus groups in both 2017 and 2018 said the information provided to them about the program was lacking. The majority of focus group participants believed HELP could be improved by providing more information about the program. External stakeholders, including health care providers and consumer advocates, also felt more enrollee education was needed. In particular, enrollees and disenrollees had incomplete understanding of some of the more complex features of HELP, such as premium credits going towards copays owed and unpaid premiums being collected against future state income tax refunds. Additionally, there were issues with beneficiary outreach and assistance, which could correlate with confusion about eligibility, coverage, and copayments.

HELP required copayments for all enrollees and premiums for those whose income exceeded 50 percent FPL and were not exempted. HELP premiums were widely considered affordable by

stakeholders, and enrollees in focus groups agreed they were reasonable. However, HELP administrative data suggests many enrollees struggled to pay their premiums, indicating they may be difficult for some. Implementing the variable copayment was challenging for Montana officials, as providers generally do not bill enrollees for copayment and struggle to collect them.

While most interviewees and participants in focus groups found HELP coverage to be adequate, some provider associations and health care providers faced challenges accessing primary care and specialty services in rural communities. Provider association representatives attributed these challenges to a shortage of primary and specialty care providers in the State, rather than a specific issue with the HELP Demonstration.

Allowing Montana to use a section 1115 Demonstration resulted in a program that achieved a key goal of both the ACA and the State—a significant expansion in health insurance coverage relative to the comparison states that did not expand Medicaid (Georgia, North Carolina, and Wyoming). As of December 2018, nearly 100,000 Montanans were enrolled in HELP, accounting for about 10 percent of the state's total population. Moreover, based on results from the impact analysis, the expansion in health insurance coverage exceeded the gains that would have been expected relative to the comparison states that expanded Medicaid without a Demonstration (Kentucky and North Dakota) or with a different Demonstration (Michigan and New Hampshire).

Montana Healthcare Foundation Evaluation

The Montana Healthcare Foundation report was released in January 2023. The following summarizes the Foundations reports findings, with contributed state-provided data, on the impact the HELP Demonstration has had on increasing enrollment in Medicaid including increasing access to preventative health care, improving health outcomes, decreasing health care costs, and advancing health equity.

As a result of the HELP Demonstration's Medicaid Expansion to nondisabled adults with incomes up to 138 percent of the federal poverty level (FPL), between 2014 and 2019, the uninsured rate declined by more than 37 percent (16.4 to 10.3 percent). As of 2022, a majority of Montana's adult Medicaid enrollees between the ages of 19 and 64, which amounted to 76 percent of total Medicaid enrollment, reported being employed full-time, part-time, or attending school. Approximately 21 percent of adult Medicaid enrollees reported a disability or difficulty finding work and four percent reported being unemployed without any impediments to work. The vast majority of Montana's adult Medicaid enrollees are employed or attending school. Many Medicaid enrollees work in low-paying jobs, seasonal work, or in the gig economy where commercial insurance is not offered. For example, more than 34 percent of maids and housekeepers, as well as 30 percent of cooks and food preparation workers, are enrolled in Medicaid. Montana's Medicaid program provides a stable source of health coverage for these workers and their employers, ensuring these beneficiaries have access to medical care for both physical and mental health conditions.

Nationally, people living in rural areas experience higher rates of chronic and behavioral health issues as well as higher mortality rates compared to those living in urban areas. Therefore, access to health care coverage is vital for their overall health and well-being. Since Montana expanded Medicaid under the HELP Demonstration, almost 66 percent of Medicaid enrollees reside in rural areas every year.

Montana Medicaid provides coverage for crucial preventive services, allowing people to detect and manage health concerns in their early stages, which is essential for their long-term health and wellness. In 2021 alone, Medicaid facilitated over 62,000 wellness check-ups, 118,000 preventive dental services, and more than 45,000 vaccinations (excluding COVID-19 vaccinations). Expanding Medicaid under the HELP Demonstration helped individuals access screenings, which lead to earlier diagnosis and improved outcomes. In 2021, over 5,500 Medicaid Expansion enrollees were screened for breast cancer and more than 2,700 for colon cancer, resulting in 81 cases of breast cancer being diagnosed and 973 cases of colon cancer potentially being prevented. Both cancer screening and diagnoses increased in 2021, after a decline in 2020 due to the pandemic.

Access to ongoing treatment for chronic physical and behavioral health conditions is crucial for the long-term health and well-being of Montana's population and workforce. Early diagnosis can lead to early treatment. Due to the pandemic, there was a decline of utilization of diabetes and hypertension treatment, but in 2021, more than 6,600 enrollees received hypertension treatment (an increase of 1,200 from 2020) and 3,500 enrollees received diabetes treatment (an increase of 648 from 2020). New telehealth options and increased demand for behavioral health support may have contributed to the increased utilization of mental health and substance use treatment. More than 34,000 Expansion enrollees received mental health services and more than 5,700 received support for substance use disorders (SUD) in 2021.

Better health outcomes are associated with early treatment among Medicaid Expansion enrollees. In Montana, nearly 70,000 individuals were enrolled in Medicaid Expansion for at least two years from the program's inception in 2016 until April 1, 2020, prior to the COVID-19 pandemic. In the first year of enrollment, around 26 percent (17,914) of these enrollees had at least one emergency department (ED) visit. However, during the second year of enrollment, only 15,788 Medicaid Expansion enrollees visited the ED, representing a decline of more than 11 percent. There are also similar declines in ED utilization for individuals with at least three or four years of continuous coverage, although the drops are more gradual, which may reflect the different health needs of the respective populations.

Medicaid Expansion enrollees with chronic physical and behavioral health conditions had fewer ED visits as their coverage continued. It is especially important for these enrollees to have access to ongoing healthcare services. Medicaid Expansion under the HELP Demonstration provided access to primary care services and chronic care management that would not be available otherwise. Over time, those enrolled in Medicaid Expansion for at least three years with conditions such as diabetes, respiratory disease, mental health disorders and SUD had fewer ED visits. For example, in the first year of enrollment, over 4,200 individuals with a SUD had ED visits. However, by their third year of enrollment, only 3,850 of those individuals had an ED visit, representing a ten percent reduction.

Oral health is a vital component of overall health, well-being and employability. Medicaid Expansion enrollees with at least three years of coverage experienced a significant decrease in ED visits due to preventable dental conditions. In states that did not offer dental coverage, 60 percent of Medicaid-enrolled adults reported their mouth and teeth appearance affected their job interview ability, almost double the number in states where dental coverage was provided (35 percent). For Medicaid Expansion enrollees under the HELP Demonstration, preventive dental services such as exams, cleanings, fillings, and dentures were covered, which provided a more affordable and accessible pathway for dental treatment compared to expensive and acute ED visits. For Montanans covered by Medicaid Expansion under the HELP Demonstration, there was almost a 40 percent decline in ED visits for preventable dental conditions, such as tooth loss and diseases of pulp and periapical tissues, over a three-year period.

Medicaid Expansion enrollees with coverage for at least three years experienced a decrease in healthcare costs for each individual over time. The costs shifted from more expensive emergency and inpatient care to less intensive outpatient services and pharmacy costs. In the first year of coverage, the average cost per enrollee was $9,430, but this amount decreased by three percent to $9,161 in the third year of coverage. Also, the cost for enrollees became more focused on outpatient, pharmacy, and dental services rather than emergency and inpatient services. For instance, per-enrollee pharmacy costs increased from $1,209 in the first year of enrollment to $1,526 in the third year of enrollment, which represented a rise of 26 percent.

The healthcare costs of Medicaid Expansion enrollees decreased every year they remained covered, with a significant decrease in spending on emergency and inpatient care. Montanans who were enrolled in Medicaid Expansion for at least three years, starting from the program launch in 2016, had an average of $3,289 in emergency and inpatient costs in their first year of enrollment. However, by the third year of enrollment, the costs had decreased by over 18 percent to $2,692 per enrollee. The increase in outpatient and pharmacy costs suggests that Expansion enrollees were able to access ongoing primary care and medications needed to manage their health conditions instead of relying on emergency services for intensive care.

Medicaid Expansion has given access to care that was previously unavailable to more than 19,000 American Indians in 2021, reducing health disparities faced by American Indians in Montana and nationally. American Indians face significant health disparities due to structural disconnections from the healthcare system, health care service underfunding, extreme poverty, and discrimination. The Indian Health Service (IHS) is a federal agency that provides health services to American Indian populations in Montana directly through tribally contracted and operated programs and indirectly through purchased/referred care (PRC). Historically, PRC referrals in Montana have been limited to “life or limb” emergencies due to chronic and severe underfunding. However, as more American Indians received coverage through Medicaid Expansion, demand on PRC funds eased, and facilities were able to expand access to preventive, primary, secondary, and tertiary care services. The number of PRC referrals on limited PRC funds increased by 116 percent between 2016 and 2021. The federal government covers 100 percent of Medicaid costs for services delivered to American Indians through IHS facilities. IHS also provides a limited amount of funding for Urban Indian Health Programs, but services

provided by these programs and centers may not universally qualify for 100 percent federal reimbursement.

Montana's American Indian community can now access preventive services and treatments through Medicaid Expansion. In 2021, more than 9,100 American Indians in Montana received preventive services, over 4,600 received mental health treatment, and more than 1,200 received SUD treatment due to Medicaid Expansion. American Indians also showed increased utilization of preventive services in 2021, following a decline during the pandemic. Furthermore, the use of mental health and SUD treatment services by American Indian enrollees increased steadily over time as they gain access to the needed treatments.

Medicaid Expansion has brought new federal funds to support historically underfunded Indian Health Services and tribal health facilities in Montana without any costs to the State. Montana Medicaid reimbursed more than $179 million to IHS and tribal health facilities in 2022, with nearly half of those payments made for health care services provided to Medicaid Expansion enrollees. These payments are crucial annual sources of revenue for under-resourced IHS and tribal health facilities, which support the health of American Indians on and off reservations in Montana. Medicaid Expansion helped address long-term underfunding by providing new federal dollars to Montana, and all Medicaid services for American Indians are coordinated through these facilities and qualify for 100 percent federal reimbursement. Compared to other federally funded health care programs, IHS historically received the lowest allocation of money per capita. According to a 2017 analysis by the Government Accountability Office (GAO), Medicare, Medicaid, the Veterans Health Administration, and federal prisons all receive two to three times more federal spending per person than the IHS.

MHCF's report also found the majority of Expansion enrollees utilized preventive services, and about a quarter received mental health services during 2021, one of the challenging years of the pandemic. MHCF also found decreasing costs and emergency department utilization for enrollees over their time enrolled in Medicaid. For preventable dental conditions, emergency department use declined by more than 40 percent over three years of coverage. Uncompensated care costs have declined since the expansion of Medicaid coverage, and the report noted no rural hospitals have closed since its implementation. Additionally, implementation of the HELP Act, including Medicaid Expansion, generated state budget savings of more than $27 million in State Fiscal Year (SFY) 2022.

The State of Montana Evaluation

The following data was collected by the State of Montana's Operations Research Bureau under DPHHS. This data is solely based on claims and eligibility pulled from the Montana's Medicaid Management Information System (MMIS).

Initial projections estimated 70,000 new adults would be eligible for Medicaid under the HELP Waiver. This projection was almost immediately surpassed with the commencement of this Waiver. At its peak enrollment in 2019, 130,057 Montanans received Medicaid coverage under HELP, demonstrating the enormous need met by this Waiver. Since the HELP Waiver expanded

coverage to the newly eligible population including adults ages 19-64, the following graph compares the Expansion population to the Traditional Medicaid population within the same age group. The unique member counts for HELP and Traditional Medicaid do not display the same patterns for increases and decreases by years. For instance, from 2016 to 2019, Medicaid Expansion increased member counts, whereas Traditional Medicaid decreased except for a slight uptick in 2019. Both Medicaid Expansion and Traditional Medicaid then remained consistent with slight increases per year from 2020 to 2022.

Unique Members Counts – Medicaid Expansion and Traditional Medicaid

	2016	2017	2018	2019	2020	2021	2022
Total Unique HELP Members	88,716	114,565	125,721	130,057	116,679	120,314	129,336
Total Unique Traditional Medicaid Members (Ages 19-64)	46,234	39,147	35,336	37,199	35,712	39,632	46,695

Although Medicaid Expansion covered about 118,000 members per year on average, the costs for members were significantly less than those covered by Traditional Medicaid. The charts below depict the per member per month (PMPM) for Medicaid Expansion and Traditional Medicaid. The PMPM for Traditional Medicaid was pulled only for those in the 19-64 age range for appropriate comparisons. The first chart breaks down how the PMPM is calculated for the HELP Waiver and the second chart only shows the actual PMPM. On average, the PMPM for Medicaid Expansion was $431, whereas the PMPM for Traditional Medicaid in the same age group was $1,085.

PMPM – Medicaid Expansion Actual Expenditures

	2016	2017	2018	2019	2020	2021	2022
Spending Total ($)	276,519,152	388,913,823	266,873,664	415,585,049	637,420,935	670,763,860	773,077,657
Member Months Total	666,385	1,016,759	1,197,188	1,165,791	1,119,406	1,289,353	1,406,729
PMPM ($)	415	383	223	356	569	520	550

PMPM – Traditional Medicaid Actual Expenditures (Adult Ages 19-64)

	2016	2017	2018	2019	2020	2021	2022
PMPM ($)	1,073.77	1,114.01	1,064.07	1,082.78	1,185.33	1,090.53	981.91

The graphs below outline dental utilization, broken down by service type and year, for Traditional and Expansion Medicaid. Preventative dental services are an important utilization measure as it can often relate to ED visits as discussed in the MHCF report. As expected, in 2020, preventative service utilization for both Expansion and Traditional Medicaid decreased from the year prior and this is expected to be COVID-19 related. Although preventative services for 2020 decreased, extractions and other dental services increased from the year prior. This is thought to be because the extractions and other dental services would include more necessary procedures due to pain or other urgencies that could not be postponed; whereas preventative dental services could be. In addition, if members are utilizing fewer preventive services, it is expected more acute services would be required such as extractions and other dental services.

Medicaid Expansion Dental Services

	2016	2017	2018	2019	2020	2021	2022
Preventative	11.85%	14.41%	12.38%	12.57%	11.41%	13.36%	12.66%
Extractions	5.74%	5.89%	4.23%	3.35%	3.69%	3.96%	3.59%
Other Dental Services	29.88%	33.17%	25.51%	24.31%	24.42%	26.24%	25.08%

Traditional Medicaid Dental Services

	2016	2017	2018	2019	2020	2021	2022
Preventative	9.84%	11.54%	12.57%	12.70%	12.18%	15.24%	14.87%
Extractions	3.76%	3.74%	3.35%	3.15%	3.20%	3.23%	2.90%
Other Dental Services	23.40%	24.95%	24.31%	23.82%	24.34%	27.84%	26.77%

The following graphs are separated for Expansion and Traditional Medicaid and broken down by percentage of population and average number of visits for the percentage of that population.

Medicaid Expansion utilization of ED services is consistently lower than Traditional Medicaid except for 2019. This is an unexpected increase but does correlate with an overall decrease in the utilization of preventative services with the exception of slight increases in 3 of the 10 preventative services measured (Alcohol – increase of 0.09%, Diabetes – increase of 0.05%, and Tobacco – increase of 0.07%) for 2019. Preventative services are important as they can decrease the utilization of ED services. It is thought that with a decrease in 70% utilization of the preventative services measured for the Medicaid Expansion population in 2019, this could have an impact in the increase of ED utilization for that year. With that being said, Traditional Medicaid members also decreased their utilization of preventative services in six out of the ten measures and their ED utilization decreased by 2.15% in 2019. There are some challenges in analyzing this data as ED services are not broken down by continuous coverage as is seen in the

MHCF report where they found correlations between continuous coverage and decreased ED visits.

Of note, from March 2020 through the end of this reporting period in 2022, the COVID-19 Public Health Emergency was active. It is thought this would lead to a significant increase in hospital utilization and visits, but this is not shown in the data. It is apparent this age group being measured (19-64) was not impacted as severely as the younger and older populations.

Medicaid Expansion Emergency Department Services

	2016	2017	2018	2019	2020	2021	2022
Percentage of Population	26.70%	28.38%	26.94%	31.00%	25.34%	27.30%	25.60%
Average Number of Visits*	2.33	2.40	2.25	2.40	2.19	2.21	2.15

*Total unique ED visits divided by # of members who had any ED visit.

Traditional Medicaid Emergency Department Services

	2016	2017	2018	2019	2020	2021	2022
Percentage of Population	31.16%	31.83%	31.00%	28.85%	28.39%	31.63%	28.94%
Average Number of Visits*	2.40	2.39	2.40	2.31	2.24	2.23	2.23

*Total unique ED visits divided by # of members who had any ED visit.

Medicaid Expansion Preventative Services

	2016	2017	2018	2019	2020	2021	2022
Alcohol	0.19%	1.47%	2.06%	2.15%	2.04%	2.87%	2.89%
Breast	2.07%	3.20%	4.63%	4.48%	4.30%	5.06%	5.06%
Cervical	7.04%	7.37%	8.02%	7.66%	7.24%	7.84%	7.17%
Cholesterol	11.43%	12.21%	13.11%	13.01%	14.03%	16.41%	16.58%
Diabetes	9.28%	10.98%	11.23%	11.28%	12.21%	14.07%	14.47%
Hep B	3.57%	4.49%	4.31%	4.30%	4.36%	4.36%	4.08%
Hep C	3.85%	5.14%	5.10%	4.71%	4.87%	5.77%	6.45%
Prev Wellness	3.59%	4.05%	4.78%	4.64%	4.66%	5.27%	5.20%
STDs	11.44%	14.08%	15.59%	14.99%	14.68%	15.49%	15.00%
Tobacco	1.42%	1.77%	2.28%	2.35%	2.13%	2.35%	2.28%
Vaccines	0.79%	0.66%	0.71%	0.61%	0.44%	0.32%	0.24%

Traditional Medicaid Preventative Services

	2016	2017	2018	2019	2020	2021	2022
Alcohol	0.19%	1.34%	1.85%	1.54%	1.49%	2.10%	2.25%
Breast	2.35%	2.99%	4.17%	4.06%	3.74%	4.57%	4.35%
Cervical	10.43%	9.75%	9.28%	8.63%	8.71%	9.54%	8.20%
Cholesterol	10.04%	11.39%	11.70%	11.81%	12.72%	14.68%	12.61%
Diabetes	15.22%	15.56%	15.84%	15.95%	16.62%	17.58%	15.30%
Hep B	5.58%	5.86%	5.23%	5.27%	5.33%	5.10%	4.54%
Hep C	6.46%	6.18%	5.94%	5.97%	6.25%	6.66%	6.89%
Prev Wellness	3.74%	4.20%	4.19%	4.23%	4.75%	6.02%	5.95%
STDs	17.28%	17.23%	16.70%	16.41%	16.63%	18.20%	16.83%
Tobacco	1.33%	1.56%	2.08%	2.03%	2.00%	1.98%	1.91%
Vaccines	0.83%	0.70%	0.66%	0.53%	0.48%	0.36%	0.24%

The HELP Demonstration provided coverage for crucial preventive services allowing Montanans to identify and manage health concerns in the early stages, leading to better long-term outcomes. It should be pointed out, the vaccine category for the preventative services measures does not include the COVID-19 vaccine in the graph above.

The telehealth utilization measures displayed below are first broken out by Medicaid Expansion and Traditional Medicaid for percentage of population and average number of visits within that percentage of member utilizing services. The charts following those are broken out the same way but are specific to mental health utilization. Telehealth utilization is an important measure for this time period as it has dramatic utilization increases correlating with the Public Health Emergency (PHE). At the height of the PHE in 2020, telehealth utilization increased by 18.99% for the Medicaid Expansion population and by 20.96% for the Traditional Medicaid population. Not only did overall telehealth services increase exponentially but telehealth specific to mental health increased beyond that. From 2019 to 2020, the number of telehealth visits where the primary diagnosis was mental health related increased more than 650% for Medicaid Expansion, providing continuity of care for those members.

Medicaid Expansion Telehealth Utilization

	2016	2017	2018	2019	2020	2021	2022
Percent of Population	1.39%	2.25%	2.24%	2.95%	21.94%	18.99%	16.14%
Average # of Visits*	5.26	8.27	6.59	6.37	5.85	6.36	6.22

*Total unique telehealth visits divided by # of members who had any telehealth visit.

Traditional Medicaid Telehealth Utilization

	2016	2017	2018	2019	2020	2021	2022
Percent of Population	1.74%	2.83%	2.95%	2.72%	23.68%	20.41%	17.12%
Average # of Visits*	5.57	8.24	6.37	6.34	5.57	6.35	6.26

*Total unique telehealth visits divided by # of members who had any telehealth visit.

Medicaid Expansion Mental Health Telehealth Utilization

	2016	2017	2018	2019	2020	2021	2022
MH # of Members	867	1,981	2,593	2,639	16,945	16,527	15,542
MH # of Visits	4,715	16,487	18,118	19,557	127,781	129,171	116,998
Other # of Members	73	133	253	342	12,847	9,469	7,644
Other # of Visits	116	183	409	590	22,643	16,545	12,951

Traditional Medicaid Mental Health Telehealth Utilization

	2016	2017	2018	2019	2020	2021	2022
MH # of Members	764	1,065	968	900	5,786	5,840	6,006
MH # of Visits	4,416	9,012	6,516	6,216	39,515	44,952	44,839
Other # of Members	72	64	90	90	4,106	3,316	2,898
Other # of Visits	103	110	126	126	7,782	6,533	5,314

The following charts will explore utilization specific to tribal facilities and IHS facilities. The data comes from claims paid to tribal and IHS facilities only. The first chart will show total member counts and total number of services to get an average number of services per member by year for Medicaid Expansion. Traditional Medicaid will be explored in the same way for comparisons. The total number of services is based on ICN count or total count of submitted claims specific to tribal and IHS facility payments. This data remains specific to the age grouping of 19-64.

Total member counts for Medicaid Expansion far surpassed that of Traditional Medicaid by almost three times on average from 2018 to 2021. This shows how Medicaid Expansion through the HELP Waiver was a needed source of coverage for this population. The data also shows that Medicaid Expansion members utilized more services on average than Traditional Medicaid including preventative services.

Medicaid Expansion Tribal Total Member Count and Number of Services

	2016	2017	2018	2019	2020	2021	2022
Total Member Count	6,397	10,074	12,575	13,149	12,078	12,178	12,429
Total Number of Services	93,814	177,225	224,886	287,898	262,803	293,882	311,626
Average Number of Services per Member	14.7	17.6	17.9	21.9	21.8	24.1	25.1

Traditional Medicaid Tribal Total Member Count and Number of Services

	2016	2017	2018	2019	2020	2021	2022
Total Member Count	5,256	4,573	4,289	4,251	4,148	4,820	5,318
Total Number of Services	67,711	60,018	60,719	76,081	75,560	96,749	110,843
Average	12.9	13.1	14.2	17.9	18.2	20.1	20.8

VIII. Conclusions

The benefits of the HELP Demonstration have reached far and wide across the State of Montana, benefitting not only the individuals newly able to access health care coverage, but also the broader healthcare systems and economy at large. The HELP Demonstration accomplished its goals of increasing the availability of high-quality health care to Montanans, reducing the health care costs, providing value to the tax dollars spent on Montana Medicaid, boosting Montana's economy, and reducing the burden of uncompensated care.

The HELP Demonstration allowed Montana adults working low-wage jobs to have access to quality, affordable health coverage – for many, for the time in their lives. It has provided a safety net, keeping Montanans from the potential catastrophic financial disaster of being uninsured when they find themselves between jobs. It has provided essential coverage for American Indians, who have historically faced life-threatening disparities in health care access. The HELP Demonstration made it possible for Montanans to receive preventive health services when they otherwise would not have had access, thereby improving their long-term success. It has benefitted businesses who have not had to shoulder the burden of providing health insurance because their employees were able to find coverage through Medicaid and Expansion. It has kept open the doors of critical access hospitals around the State, stopping in its tracks the wave of closures making its way across the State. Without the HELP Demonstration, none of these gains would have been possible.

Providing coverage to approximately a tenth of Montanans, Medicaid Expansion has proven itself essential to Montanans, the healthcare system, and the economy of the state at large. The State moved forward at the end of this Demonstration by continuing to provide essential Medicaid benefits to this population of individuals who would have previously been excluded from coverage. The positives seen from this Demonstration will continue through the Alternative Benefit Plan and State Plan authorities.

Montana appreciates CMS' partnership in the delivery of the HELP Demonstration and looks forward to partnering again in the future to continue to improve health outcomes for the people of Montana.