HELP Act Oversight Committee

Report to the Governor

and Legislative Finance Committee

Submitted on July 15, 2016

Pursuant to Montana Code Annotated § 53-6-1317

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INTRODUCTION

On April 29, 2015, Governor Steve Bullock signed the bipartisan Health and Economic Livelihood Partnership (HELP) Act into law, creating a uniquely Montana plan to expand access to quality affordable healthcare and workforce opportunities to more than 70,000 Montanans. The HELP Act also created an oversight committee to "provide reports and make recommendations to the legislature." The oversight committee is charged with submitting a summary of its "findings and recommendations in a final report to the governor and to the legislative finance committee no later than August 15 of each even-numbered year. Copies of the report must be provided to the children, families, health, and human services interim committee." This report fulfills that obligation.

Early data indicates that the HELP Act has been remarkably successful at decreasing the uninsured rate in Montana and increasing access to high quality health care, including preventive care, while saving state taxpayer dollars in programs previously serving the uninsured population.

HELP ACT OVERSIGHT COMMITTEE MEMBERSHIP

The HELP Act specified the membership of the Oversight Committee, with representatives appointed by the governor and legislative leadership from both parties. The following members currently serve on the committee:

VOTING MEMBERS

- John Goodnow, Great Falls. Qualification: Representative of a hospital. Goodnow is CEO of Benefis Health System.
- Jesse Laslovich, Helena. Qualification: Representative of the State Auditor's Office. Laslovich is the Chief Legal Counsel for the State Auditor's Office.
- Dr. David Mark, Hardin. Qualification: Primary Care Physician. Mark is the Co-Founder, CEO, and a Staff Physician for Bighorn Valley Health Center.
- Cherie Taylor, Cut Bank. Qualification: Representative of a critical access hospital. Taylor is CEO of Northern Rockies Medical Center.
- Tara Veazey, Helena. Qualification: Member of the general public or staff member of the Governor's Office. Veazey is the Governor's Health and Families Policy Advisor.
- Rep. Art Wittich, Bozeman. Qualification: A legislator appointed by the Speaker of the House. Wittich is a Bozeman attorney.
- Sen. Bob Keenan, Bigfork. Qualification: A legislator appointed by the President of the Senate. Keenan is a businessman from Big Fork.
- Rep. Pat Noonan, Ramsay. Qualification: A legislator appointed by the House Minority Leader. Noonan is employed by AWARE, Inc. in Butte.
- Sen. Mary Caferro, Helena. Qualification: A legislator appointed by the Senate Minority Leader. Caferro is The Arc Montana coordinator.

EX-OFFICIO, NON-VOTING MEMBERS

- Mary Dalton, Helena. Qualification: Dalton is the DPHHS Medicaid Director.
- Pam Bucy, Helena. Qualification: Bucy is the Commissioner of Montana Department of Labor and Industry.
- Peg Hasner, Helena. Qualification: Third-party administrator. Hasner is a Divisional Vice President for Montana Medicaid for Blue Cross Blue Shield of Montana.

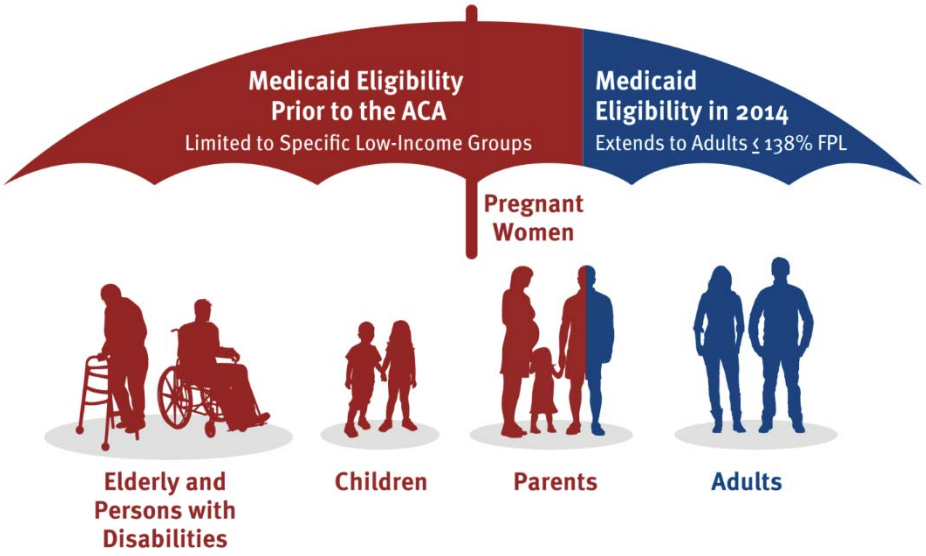
Recognizing the importance of ongoing input from the HELP Act's sponsor and the particular impact of the HELP Act on low-income populations, American Indians, and community health centers, the governor also invited the following individuals to participate in discussions of the committee as ex officio, non-voting members:

- Senator Edward Buttrey, Great Falls. Buttrey is the bill sponsor and a state Senator from Great Falls.
- Kevin Howlett, Arlee. Howlett is the Tribal Health and Human Services Director for the Confederated Salish and Kootenai Tribes.
- Heather O'Loughlin, Helena. O'Loughlin is the Co-Director of the Montana Budget and Policy Center.
- Barbara Schneeman, Billings. Schneeman is the Vice President, Communication & Public Affairs for RiverStone Health.

HELP ACT OVERVIEW

The HELP Act expanded access to health coverage in Montana to more than 70,000 new adults with incomes up to 138 percent of the Federal Poverty Level (FPL). Coverage began January 1, 2016. Prior to the HELP Act, Medicaid health coverage was limited to children, pregnant women, very poor parents of children (under 54% of the federal poverty level), the elderly, and people with disabilities. Now, coverage is available to parents and adults without children living at home who are between the ages of 19-64 with incomes at or below 138% of FPL, or roughly $1,350 a month for one person, and $2,300 a month for a family of three. The HELP Act also included significant provisions related to personal responsibility and workforce development, each discussed in more detail below.

Figure 1: Medicaid Eligibility Prior to the HELP Act



IMPLEMENTATION OF HELP ACT

The HELP Act embodied a truly unique approach to bringing our federal tax dollars home in order to expand healthcare coverage to low-income working Montanans and provide a lifeline to rural hospitals struggling under the weight of uncompensated care provided to uninsured Montanans. Montana was the first state in the country to expand Medicaid using a private Third Party Administrator (TPA) and only the 7th to incorporate personal responsibility provisions such as copays and premiums. In order to implement these unique features, the Montana Department of Public Health and Human Services (DPHHS) had to seek "waivers" from the federal government allowing for deviation from standard Medicaid rules.

The leadership and staff of DPHHS should be recognized for the diligence, efficiency and effectiveness with which they worked to move SB 405 from law to implementation. Their work included negotiating and drafting the waivers, negotiating and drafting the TPA request for proposals and contract, drafting and enacting administrative rules and state plan amendments, and overseeing IT and systems integrations necessary for accepting applications, sharing information between state agencies and the TPA, and arranging for provider payments. Because of their hard work, previously uninsured Montanans were able to apply for coverage beginning with the federal "open enrollment period" in the fall of 2015 and begin receiving benefits as of January 1, 2016. Although there are too many people to name individually, the HELP Act Oversight Committee thanks all of the Department staff for their hard work. The following offers just a brief summary of their work to date:

THIRD PARTY ADMINISTRATOR

- ✓ RFP Posted: 7/1/2015
- ✓ RFP Bidders Conference: 7/14/2015
- ✓ Bidders Submitted Formal Questions: 7/20/2015
- ✓ Department Posted Formal Responses: 7/31/2015
- ✓ RFP Proposals Received: 8/18/2015
- ✓ Selected Vendor: 10/1/2015
- ✓ Contract Finalized: 12/16/2015
- ✓ Blue Cross Blue Shield MT (BCBSMT) Began Service Delivery: 1/1/2016

SECTION 1115 AND SECTION 1915(B) WAIVERS

- ✓ Posted Draft Waivers for 60-day public comment period to Centers for Medicare and Medicaid Services (CMS): 7/7/2015
- ✓ Waiver Public Meetings
  - Billings: 8/18/2015
  - Helena: 8/20/2015
- ✓ Waiver Tribal Consultation: 8/19/2015
- ✓ Waiver Presentation to Montana Health Care Coalition: 8/20/2015
- ✓ Waiver Presentation to Child, Family Health and Human Services Interim Committee: 9/14/2015
- ✓ Waiver Submittal to CMS: 9/15/2015
- ✓ CMS Approval of 1115 and 1915(b) Waivers: 11/2/2015
- ✓ Submitted Preventative Services Protocol to CMS: 12/11/2015
- ✓ Submitted Operational Protocol to CMS: 3/1/2016

DPHHS SUBMITTED 11 STATE PLAN AMENDMENTS TO CMS: 12/2015

- ✓ Benefits (TPA and Aligned)
- ✓ Eligibility
- ✓ Cost Sharing
- ✓ Updated Medicaid State Plan Service Limits
- ✓ Dental Program limit

Implemented Medicaid Expansion 1/1/2016

HELP-LINK

The Montana HELP Act also authorized the Montana Department of Labor & Industry (DLI) to administer a workforce program in conjunction with expanded health coverage. This program, HELP-Link, was launched on January 1, 2016 to correspond with the start date of Montana HELP Plan benefits coverage.

Participants are recruited through the following outreach strategies:

- DPHHS mails an approval letter to all enrollees that includes the following language:

  Additional Services Available to You

  HELP-Link, a Montana Department of Labor and Industry workforce program

  For more information about this program, please visit www.jobs.mt.gov or stop by your local Job Service Office. This high quality, free program will provide you with a customized employment plan, connect you with local employers, and open access to training resources to help you find employment or grow your own earning capacity.
- The HELP-Link brochure is provided in Offices of Public Assistance.
- DLI is conducting HELP-Link presentations to local partners and Community Management Teams (CMTs) to increase direct referrals to the HELP-Link program. CMTs are led by Job Service Offices and include private and public social service agencies. These teams exist to improve coordination and local service delivery for low income Montanans. DLI has completed presentations in Glasgow, Miles City, Butte, Helena. Kalispell, Billings, Missoula, Havre, Cut Bank, Livingston, Polson, Glendive, Anaconda, Hamilton, Bozeman, and Great Falls. HELP-Link brochures have been distributed to partner agencies and organizations who participate in CMTs to hand out in their own offices.
- DLI sends follow-up emails to HELP Plan enrollees who complete the initial HELP-Link survey at jobs.mt.gov but have not yet come in for their first appointment.
- DLI mails letter and brochure to all participants of the Montana HELP Plan to invite them to participate in HELP-Link. This letter goes out in waves starting May 16, 2016.
- DPHHS is notifying participants who are facing disenrollment about HELP-Link via letter.
- Individuals who have taken the online survey and have not scheduled an appointment with a Local Job Service are being contacted by phone to help set an appointment. Some of these individuals have mentioned potential barriers they may have on the online survey, and Local Job Service Offices are addressing those barriers in their calls.
- DLI is collecting success stories to highlight through earned and social media that can be used to showcase the program and recruit new participants into HELP-Link.

Participants who decide to enroll in HELP-Link can expect to follow the process below. Montana HELP Plan participants who are unable to come to a Job Service Office due to distance and/or transportation issues may complete the appointment process over the phone.

1. Participant signs in to jobs.mt.gov and takes the HELP-Link assessment survey. If participants do not have internet access or computer skills to take this survey online, they may come into the office or take it over the phone with an employment specialist (ES).
2. Participant makes appointment with Job Service (ES) to review assessment, receive an orientation to services, receive labor market information to better understand the local job market, and develop an Individualized Employment Plan (IEP).
3. The IEP includes a list of services mutually agreed upon by the participant and ES. Example services include: resume classes, one-on-one interview coaching, career planning, and skills assessments.
4. The IEP may also include:
   A) Referrals to in-house training resources, such as Workforce Innovation and Opportunity Act (WIOA) Adult, WIOA Dislocated Worker, services for veterans, and disability services.
   B) Referrals to community training partners, such as Vocational Rehabilitation, private WIOA Adult providers and other workforce partners in the community.
   C) Referrals to community, two-year, tribal, or four-year colleges.
   D) Referrals to additional community resources, such as domestic violence, housing, or legal services.
5. Participants are instructed to receive a minimum of one in-house training service every 90 days to maintain active participation in the program. Staff has been trained to guide participants to take advantage of all applicable services to improve participant employment skills and earning capacity.

If participants go inactive due to failing to meet minimum program standards, they must repeat the initial assessment and IEP process to become an active participant once again.

SUMMARY OF PRELIMINARY REPORTING

LIMITATIONS IN THE INITIAL DATA

The HELP Act Oversight Committee takes seriously its responsibility to review and report on the activities undertaken and data generated during the implementation of the law. The committee also recognizes that the development of the HELP Program is, in many ways, still in its infancy, with benefits and corresponding responsibilities beginning less than eight months ago, on January 1, 2016. For example, Medicaid providers have a full calendar year from the time of service by which to submit claims for payment, thus making a full analysis of payments and utilization patterns premature.

The data and recommendations that follow necessarily will be somewhat limited for this inaugural report. While many indicators reflect tremendous early successes in the program, additional time will be necessary to both (1) measure its full impact on patients, providers, workers, and the economy, and (2) fully evaluate opportunities for further refining and improving the program.

However, initial data indicates early signs of remarkable impacts on patients, providers, and the state budget. These early signs are consistent with comprehensive studies conducted in states that expanded Medicaid prior to Montana.

IMPACT ON MONTANA'S UNINSURED RATE

Insurance and Securities Commissioner Monica Lindeen annually studies Montana's uninsured population in an effort to quantify how many previously uncovered Montanans have gained coverage. Approximately 195,000 Montanans lacked health insurance in 2013, about 20% of the population. In 2015, before Medicaid expansion took effect, an estimated 151,000 Montanans lacked health insurance (15% of the population). Under the HELP Act, the percentage of Montanans who are uninsured plummeted to 7.4%.

IMPACT ON NEW ENROLLEES

DEMOGRAPHIC DATA

As of July 1, 2016, there are 47,399 newly eligible individuals. 32,252 members are provided coverage under the Standard Medicaid Plan (70% due to income, 20% American Indian exemptions, and 10% medical frailty). 15,147 members are provided health coverage under the BCBS Help Plan.

An additional 8,458 individuals transferred into the HELP Plan from other Medicaid programs. The following charts provide demographic information about newly covered individuals by poverty level, gender, age, American Indian status, and county.

FIGURE 2: HELP NEWLY ENROLLED BY FEDERAL POVERTY LEVEL

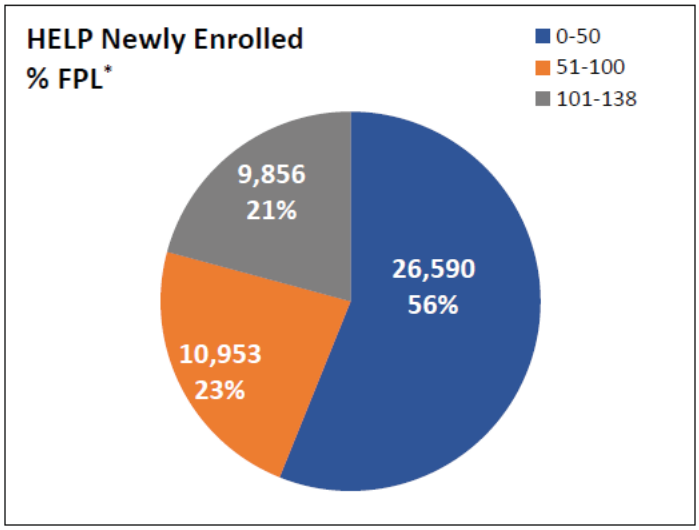


Figure 3: HELP Newly Enrolled by Gender

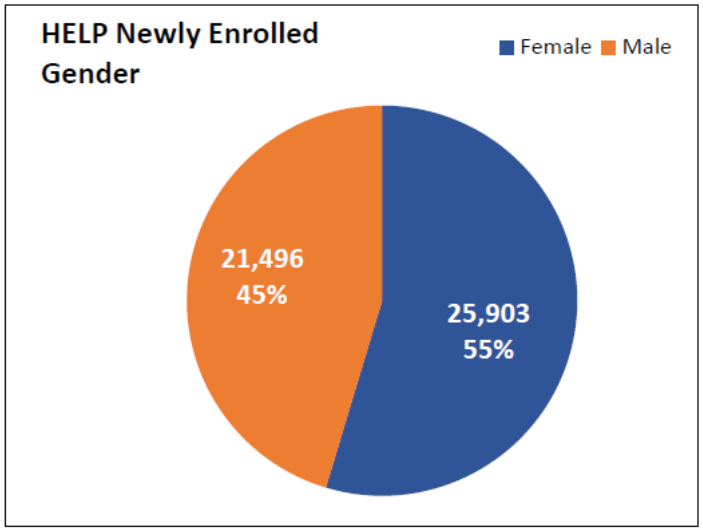


FIGURE 4: HELP NEWLY ENROLLED BY AGE

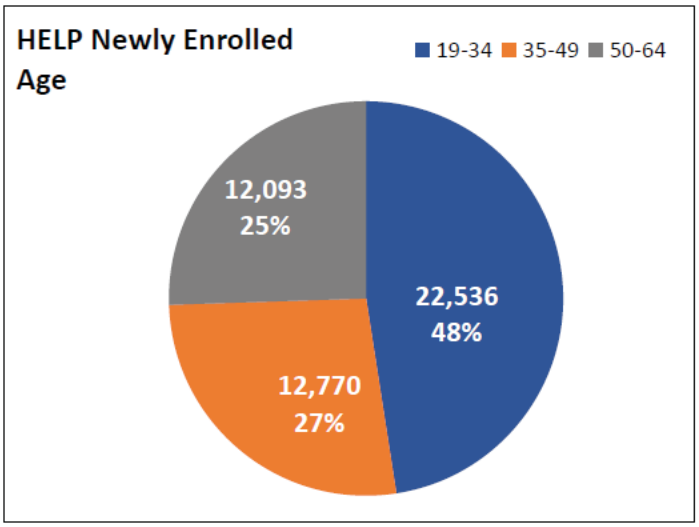


FIGURE 5: ENROLLMENT BY COUNTY

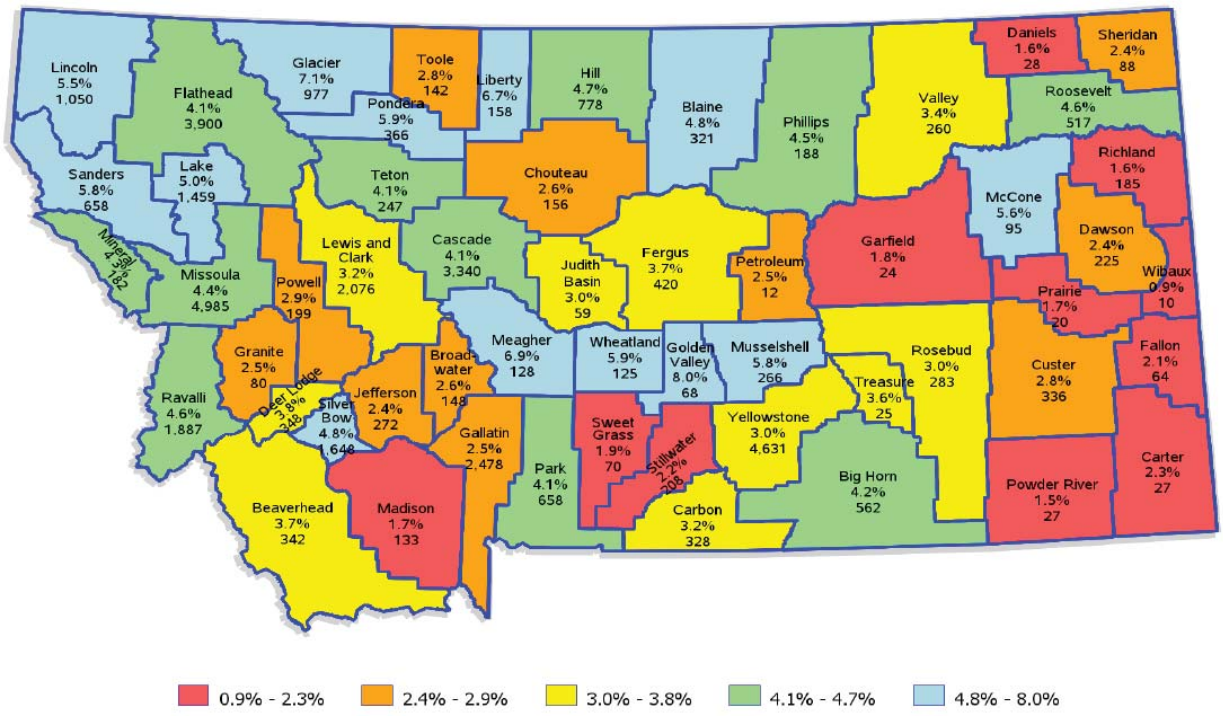
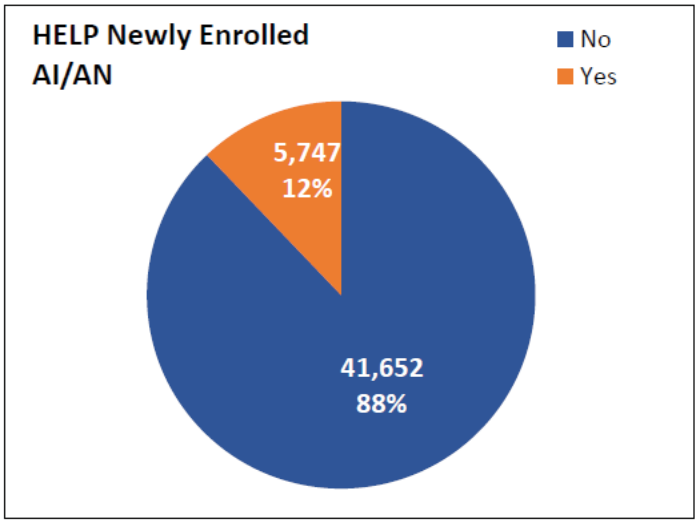


Figure 6: American Indian Medicaid Enrollment



*See Appendix A for Native American Medicaid Enrollment by County.

PREVENTATIVE CARE

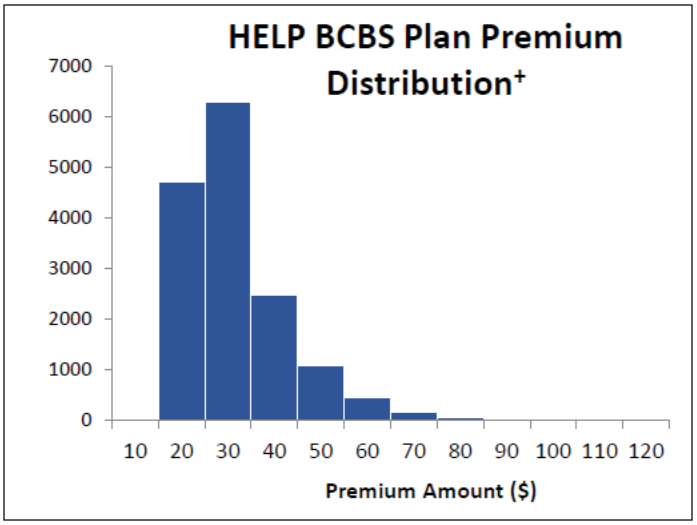
Far from just expanding coverage, the HELP Program reformed the state's Medicaid plan to focus on health improvements and incentivize preventative care. The Montana Department of Health and Human Services reports that as of May 12th, 2016 the HELP Program has provided the following preventative care services to newly covered adults:

- 1,449 Breast Cancer Screenings
- 3,659 Cholesterol Screenings
- 3,047 Colorectal Cancer Screenings
- 62 Healthy Diet & Physical Activity Counseling Sessions
- 209 Osteoporosis Screening
- 165 Tobacco Secession Counseling Sessions
- 2,645 Preventive/Wellness Exams
- 1,350 Vaccinations
- 11,727 Preventive Dental Exams

PREMIUMS, DISENROLLMENT AND ASSESSMENT

Individuals participating in the HELP BCBS TPA Plan must pay the equivalent of 2% of their income in premiums. BCBSMT mails a monthly invoice to participants and is responsible for administering and collecting the payments. Currently, participants pay their premiums by check or money order, but BCBSMT is developing an option for online payment of premiums. The average premium is $26 per month.

FIGURE 7: HELP PLAN PREMIUM DISTRIBUTION



As of July 1, 2016, members enrolled in the HELP TPA plan have paid $1,174,225 in premiums.

Unpaid premiums are considered a collectible debt that may be collected or assessed by the state. Assessment occurs when the Department of Revenue sends a notice of debt to the participant and must occur no later than the end of each calendar quarter.

Individuals with incomes above 100% of FPL are disenrolled if they are more than 90 days past due on premium payments. Participants are exempt from disenrollment if they meet two of the exemption criteria listed in Senate Bill 405:

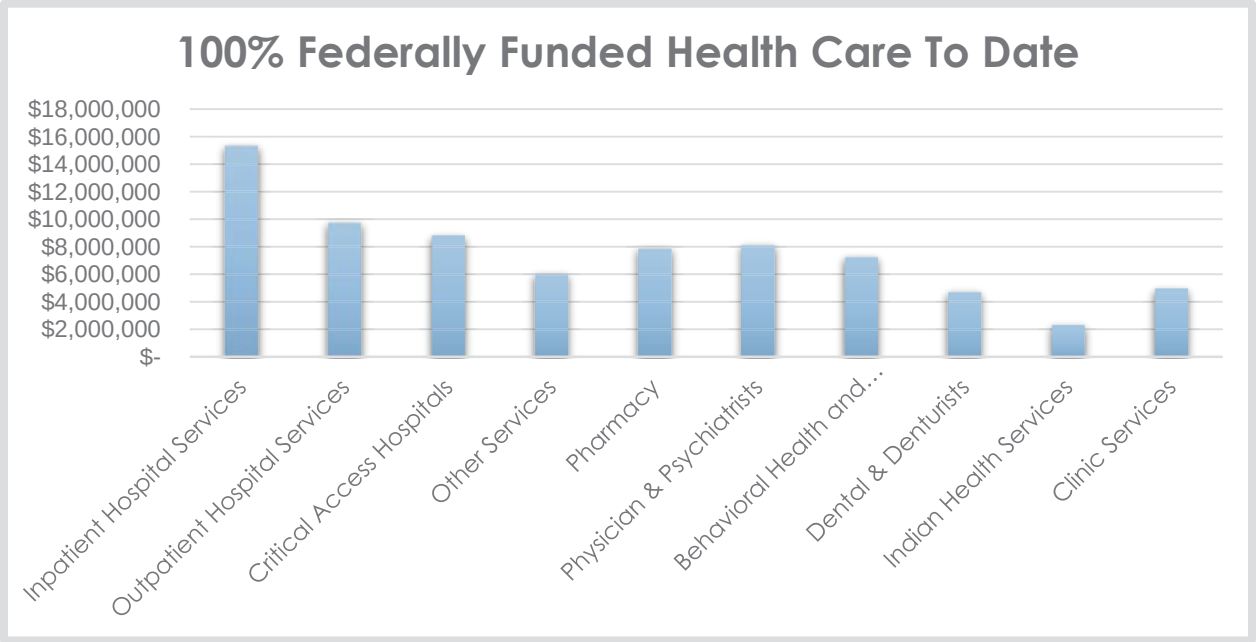
- Discharged from military within the past 12 months
- Enrolled in any college accredited and in Montana
- Participation in workforce development program
- Participation in a healthy behavior plan approved by DPHHS
- Enrolled in a Patient Centered Medical Home (PCMH)
- Participating in a Substance Abuse Treatment Program

In June, 1,435 individuals with unpaid premiums of $184,252 exceed the 90-day threshold and have been transferred from BCBS to DPHHS for inclusion in the Department of Revenue (DOR) tax offset program. In June, 379 individuals over 100% FPL were disenrolled from the program.

IMPACT ON BUDGET

As of July 13, 2016, the state has realized $5.3 million in general fund savings as a direct result of the implementation of the HELP act.

FIGURE 8: 100% FEDERALLY FUNDED HEALTH CARE TO DATE



Strong enrollment is one of the major financial advantages of a funding model that starts off with 100% federal funding and later tapers to no less than 90% federal funding. Montanans who were previously ineligible and had delayed treatment for unmet health care needs are getting these pent up health care needs taken care while federal funds cover 100% of the benefit costs. According to a report by UCLA's Center for Health Policy Research (HPR), initial higher costs of newly enrolled beneficiaries do not tend to persist beyond the first year of enrollment for the vast majority of new enrollees.

FIGURE 9: ENHANCED FMAP SCHEDULE FOR MEDICAID EXPANSION

YEAR	ENHANCED FEDERAL MATCHING RATE NEWLY ELIGIBLE ADULTS UP TO 138% FPL	
	State Share	*Federal Share*
2014	0%	100%
2015	0%	100%
2016	0%	100%
2017	5%	95%
2018	6%	94%
2019	7%	93%
2020+	10%	90%

IMPACT FOR PROVIDERS

As discussed above, complete information about the full impact of the HELP Act for Medicaid providers will not be available until early 2017. However, initial claims data indicates that the program has resulted in increased payments to hospitals. See Figure 9, below, comparing Medicaid payments to hospitals through July 6 for 2015 compared to 2016.

FIGURE 10: MEDICAID REIMBURSEMENT FOR INPATIENT, OUTPATIENT, AND CRITICAL ACCESS HOSPITALS

Reimbursed for Dates of Service from January through June paid by July 6th of each year			
Provider Type	# Providers 2016	2015	2016
Total	176	$79,354,961	$121,346,308
Inpatient Hospitals	55	$35,026,305	$54,139,480
Outpatient Hospitals	121	$23,447,655	$34,037,880
Critical Access Hospitals	46	$20,881,001	$33,168,949

In addition, at the July 2016 HELP Act Oversight Committee, Benefis Health Systems reported preliminary financial results for the first six months of the BHS' fiscal year, ending June 30, 2016, and corresponding to the first six months of HELP Act implementation. Those results are attached at Appendix B. The Oversight Committee will be requesting similar data from all PPS Hospitals in the State, for discussion by the Committee at the next meeting.

CONTINUED EFFORTS TO ELIMINATE FRAUD, WASTE AND ABUSE

DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

DPHHS uses a number of different systems, processes, staff, and cross-checks to verify applications, validate data, and determine eligibility; monitor and review utilization; control, audit, and recover costs; and ensure program integrity. Before they can receive help, Montanans are asked about all types of income that they are currently receiving, recently stopped receiving or expect to receive in the future. DPHHS then uses several different forms of verification to confirm eligibility. These include, but are not limited to, 27 different interfaces for state and federal data systems, hard copy documentation as well as contacting other valid sources such as employers, other agencies, or landlords.

In the past year DPHHS has implemented a number of system and process changes designed to help prevent or detect errors and/or intentional misrepresentations:

- The automated national prisoner verification process has been increased from an annual to a monthly process.
- Pre-authorization reviews are conducted on a rotating basis using a sample of applications with 3 or more family members or earned income. The non-statistical sampling process is designed to ensure supervisory review of employees reviewing higher risk applications.

- Post-authorization reviews are conducted on a sample of targeted application types.
- HCSD has implemented a new Case Review functionality using predictive model analytics to identify cases with common characteristics that may lead to errors. The results of the review are completed to identify, track and correct any errors. The process is done monthly.
- Health Care Coordinators perform quality control reviews of HELP act enrollment, premium, and disenrollment topics.

DEPARTMENT OF LABOR AND INDUSTRY

In addition, in June of 2016, the Montana Department of Labor & Industry contracted with Lexis Nexis to provide the Department with identity authentication tools to reduce the risk of fraudulent unemployment claims. The suite of tools provided by this contract with Lexis Nexis will help to confirm the UI claimant's identity before processing their unemployment insurance claim, identify high risk claims, and allow for more accurate and efficient debt collection.

This contract was the result of a successful six-month pilot project conducted from September 2015 through March of 2016. Lexis Nexis was selected through a contractor engagement process from the State of Montana's IT service contractors list.

Kickoff for implantation of this solution is scheduled for mid-July 2016. Implementation of the identity authentication software solution is slated to include three phases: identity management (Fall 2016), beneficiary integrity batch scan (Spring 2017) and identity contact resolution batch processing (Summer 2017).

REFORM

GOVERNOR'S COUNCIL ON HEALTHCARE INNOVATION

In October of 2015, after signing the HELP Act and securing access to high quality, affordable health care coverage for more than 70,000 Montanans, Governor Bullock appointed a council of private and public payers and providers to guide health care reform in Montana.

The governor charged the Department of Public Health and Human Services with leading this group of healthcare sector leaders in a public-private partnership to (1) identify opportunities to improve care delivery and control costs in Montana's healthcare system, and (2) explore opportunities to coordinate between public and private sectors to improve health system performance and population health.

The Governor asked DPHHS to lead the effort on behalf of the state so that Medicaid could serve as a catalyst for reform and create an inclusive process, recognizing that the implementation of any one strategy by any one sector in isolation will not achieve transformative change and that ongoing collaboration is integral to transformation.

Intensive engagement of a broad range of stakeholders is a centerpiece of the Governor's Council on Healthcare Innovation. DPHHS has sought meaningful input from a wide array of stakeholders through interviews, one-on-one meetings, webinars, conferences, public forums

and industry association meetings. DPHHS oversaw the process of collecting ideas, aligning efforts, and identifying areas of potential common ground across stakeholders.

PATIENT CENTERED MEDICAL HOMES

Montana's payment and delivery system reform efforts have focused in recent years on patient-centered medical homes (PCMHs). State legislation defines a PCMH as a model of health care that is directed by a primary care provider offering family-centered, culturally effective care that is coordinated, comprehensive, continuous, and, whenever possible, located in the patient's community and integrated across systems.

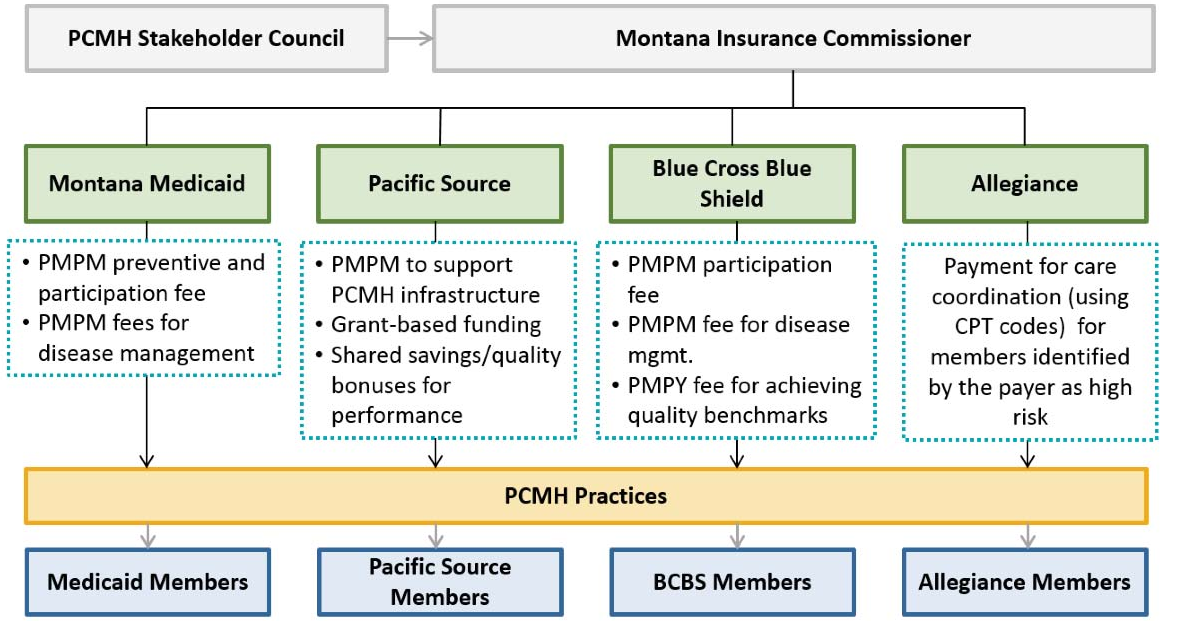
Montana PCMH clinics use a team approach to care that includes a care coordinator and other mid-level practitioners including registered nurses. A significant number of PCMH clinics also have a behavioral health provider and have integrated behavioral health with primary care. The patient is part of the care team and the focus is on chronic disease management and prevention services for the whole patient population. In addition, the clinics usually offer expanded clinic hours, electronic communication, same day appointments, a clinical advice system outside of office hours, a patient portal, and active follow up for patients that have a recent ER or hospital visit.

All PCMH practices report quality metric data on three of four quality measures: A1C control, blood pressure control, child immunizations up to age three, and tobacco cessation counseling. In 2016/17, the program added depression screening as an additional quality measure. The Commissioner's 2015 report shows that the PCMH clinics are generally meeting or exceeding the Montana Healthy People 2020 targets for these measures. Initial PCMH reports have already shown improvements in diabetes control, child immunization, blood pressure control, and tobacco cessation.

Four payers, including Medicaid, Blue Cross Blue Shield of Montana, Allegiance, and PacificSource currently participate in the PCMH Program. Initial results are promising and provide an ideal foundation upon which other delivery and payment reform efforts can be built.

BCBSMT has the largest number of members attributed to a PCMH practice with 29,260 members participating for at least seven contiguous months. BCBSMT pays a monthly care coordination fee, plus additional monthly fees for monitoring patients with one or more chronic illnesses. In addition, BCBSMT pays quality bonuses to the PCMH clinics with which they have contracts. Montana Medicaid has a pilot PCMH program that covers 8,586 members as of April 30, 2016. Medicaid uses a similar payment structure to BCBSMT, however does not include quality bonuses. BCBSMT administers a portion of the Medicaid expansion population for DPHHS, and BCBSMT anticipates offering PCMH services to Medicaid expansion plan participants beginning in July 2016.

FIGURE 11: STRUCTURE OF PATIENT CENTERED MEDICAL HOMES IN MONTANA



COMPREHENSIVE PRIMARY CARE (CPC+)

CPC+ is a new primary care payment initiative from Medicare aimed at reinventing how primary care is paid for. It is designed to transform payment and practices towards community health and the value-based payment systems of the future.[1]

CPC+ gives practices the flexibility to deliver primary health care in more innovative ways, designed to better meets patients' needs and without being tethered to the 20-minute office visit. It allows practices to pool this "non-visit based funding" from multiple public and private payers and apply it to whole-population proactive primary care management strategies.

For example, practices might offer non–face-to-face visits (eg, over the web or telephone), offer visits in alternate locations, using team-based care or simply provide longer office visits for patients with complex needs. In exchange, public and private payers come together to align payment models and quality incentives.

Under the model, participating practices will be expected to demonstrate a care management strategy, to improve patient access, to devote resources to care coordination across settings, to measure and improve quality at the site level, and to have an active process for improving patient experience, with specific, aligned metrics.

States must apply to CMS to be chosen as a CPC+ state, and only 20 areas will be chosen. The process is competitive and scored in large part based on a state's ability to demonstrate that a high percentage of the public and private insurance market is willing to participate and

[1] CPC+ is also a Qualified Advanced Payment Model that exempts providers from MACRA reporting requirements and automatically earns a 5% Part B bonus.

coordinate future efforts. DPHHS led the effort to coordinate a multi-payer application process from Montana, with Blue Cross Blue Shield of Montana, Medicaid, Pacific Source, and Allegiance all submitting applications in June 2016. If Montana is chosen, providers in our state will have the option to apply if they choose, beginning in mid-July.

NEW DELIVERY MODELS

In addition, Medicaid is participating in multi-payer efforts to advance new delivery models in Montana, including Collaborative Care, Community Resource Teams, and Medicaid Health Home pilots which will build on the PCMH foundation to more effectively serve target populations with access barriers and disparities. These models are described below:

ECHO-Enhanced Collaborative Care: Project ECHO is a technology-enhanced model that provides collaboration from specialists at a "hub" to remote primary care physicians and providers seeking to increase specialized knowledge in treating complicated conditions. Collaborative care is an evidence-based integrated physical and behavioral health care model that that has proven to be effective at treating mental health conditions such as depression and anxiety. Increasing collaborative care can be challenging in a large, rural state like Montana with significant behavioral health workforce shortages. In an effort to overcome these challenges, Montana's pilot proposes to use simple Project ECHO technology and protocols to provide psychiatric expertise, training and consult to remote collaborative care teams.

Community Resource Teams: Community Resource Teams bring interdisciplinary providers and staff together to help "super utilizer" patients by addressing patient needs outside of the traditional care setting (e.g., in the community or home). Mountain Pacific Quality Health will be leading an effort in Montana to pilot Community Resource Teams in three communities over the next two years, using a "hotspotting" approach to support super-utilizer patients with the goal of reducing patient utilization, preventing readmissions, and improving patient and provider satisfaction.

Medicaid Health Homes: Patients with multiple or severe chronic conditions can benefit from better coordination and management of the health and long-term services they receive. Health homes are designed to be person-centered systems of care that facilitate access to and coordination of the full array of primary and acute physical health services, behavioral health care, and long-term community-based services and supports. The health home model of service delivery is specific to Medicaid, and expands on the traditional medical home model by building additional linkages and enhancing coordination and integration of medical and behavioral health care to better meet the needs of people with multiple chronic illnesses. The model aims to improve health care quality and clinical outcomes as well as the patient care experience, while also reducing per capita costs through more cost-effective care. Medicaid Health Homes will be piloted by four sites (two mental health centers and two federally qualified health centers) to provide integrated primary, mental health and substance use services for 16 to 25 year olds. The results of these pilots will help the Montana Department of Health and Human Services evaluate how Health Homes may be able to address behavioral health and chronic conditions for other populations.

Data Infrastructure: In order for Montana to engage in payment reform models that pay and reward for outcomes and not just volume, payers and providers need the ability to collect and analyze data in a meaningful way. As new care and payment models evolve, establishing such a platform could open doors to more innovative ways of delivering and coordinating care and paying for services. A collaboratively developed health information exchange (HIE) has the potential to create pathways to improvements within our systems of care and assist in targeting limited resources to those most in need. An alliance of providers in Billings is currently implementing an HIE pilot project with Blue Cross Blue Shield of Montana, and Medicaid has secured a seat at the table. Concurrently, the Montana Medical Association, in collaboration with the Montana Hospital Association, is leading a statewide group of stakeholders to receive updates and learn from the pilot and use those learnings to begin planning a statewide effort.

Promising Pregnancy Care: Promising Pregnancy Care is an evidence-based health care delivery system that combines the prenatal visit with group education. It is a joint collaboration between Montana Medicaid and the Family Community Health Bureau to allow state approved Medicaid providers to be reimbursed for group prenatal care. The Promising Pregnancy Care training is designed for individuals providing direct prenatal care, i.e. advanced practice nurses, nurses, nurse practitioners, physician assistants, physicians, direct entry midwives, certified nurse midwives, etc. An upcoming Promising Pregnancy Care training in July is specifically designed for providers who deliver services to Native American populations and incorporates culturally appropriate education into the group pregnancy care program. Each participating program must include specific elements and must report defined data metrics to the department.

A 2007 study showed low risk-women who participated in group care are 33% less likely to deliver a preterm infant. The women also reported improvements in pregnancy knowledge, readiness for labor, satisfaction with care, and breastfeeding initiation rates. A 2012 study performed at Greenville Memorial Hospital in South Carolina showed a higher mean gestational age for women who participated in centering group care than those who participated in traditional care. The mean birth weight for the women in the centering group was also higher than that of the traditional care group. This study showed an overall 47% reduction in preterm birth for low-risk women involved in group care in comparison to traditional care.

HELP-LINK WORKFORCE PROGRAM PRELIMINARY DATA

The Montana HELP Act authorized the Montana Department of Labor & Industry (DLI) to administer a workforce program in conjunction with the health coverage provided through expanding Medicaid. This program, HELP-Link, was launched on January 1, 2016.

As of June 30, 2016, 1,004 Montana HELP Plan participants have or are currently receiving workforce services from DLI through the HELP-Link, WIOA, and RESEA programs. WIOA is the DLI workforce training program focused on serving low income Montanans, and RESEA is the Unemployment Insurance partnership program that provides intensive services to Montanans who have recently lost a job and are targeted to receive intensive, early intervention employment services. Each workforce program includes the following components: labor market information, intensive one-on-one employment planning and case management, and access to subsidized training resources. The following charts provide select demographic data and services provided to HELP Link participants.

FIGURE 12: NUMBER OF PARTICIPANTS BY PROGRAM

Program	Number of People
HELP-Link Survey Completers	3,787
DLI Qualifying Program Participants	1,004
Total HELP-Link Participants Served	565
Current HELP-Link Participants	487
RESEA Participants	379
WIOA Participants	400

FIGURE 13: DEMOGRAPHICS OF HELP-LINK, RESEA AND WIOA PARTICIPANTS

		All HELP-Link	Dual Enrolled	All RESEA	All WIOA
	Number of Participants	487	228	379	400
	Average Age	43	41	41	35
Gender	Female	52.8%	54.4%	49.2%	65.5%
	Male	47.2%	45.6%	51.6%	34.5%
Race	American Indian	10.9%	10.1%	14.4%	17.3%
	Unknown	14.0%	15.4%	12.5%	8.5%
	White	74.1%	74.6%	73.1%	74.3%
	No	79.1%	82.9%	81.9%	78.8%

Employed	Yes	20.9%	17.1%	18.9%	21.3%
Work Disability	No	93.6%	95.6%	95.5%	94.5%
	Undefined	5.7%	4.4%	5.1%	5.5%
	Yes	0.6%	0.0%	0.3%	0.0%
ADA Disability	Blank	3.9%	4.8%	3.2%	8.3%
	No	90.6%	92.1%	94.1%	86.5%
	Yes	5.5%	3.1%	3.5%	5.3%
Homeless	Blank	3.1%	2.2%	1.3%	5.0%
	No	91.4%	93.9%	95.7%	88.5%
	Yes	5.5%	3.9%	3.7%	6.5%
In School	In-School, Alternative School	0.8%	0.4%	0.8%	2.0%
	Not Attending School, H.S. Dropout	7.4%	9.2%	8.5%	13.8%
	Not Attending School, H.S. Grad	64.7%	66.7%	64.9%	61.0%
	In-School, Post-H.S.	7.2%	7.0%	4.8%	16.5%
	In-School, H.S. or less	1.0%	0.0%	1.1%	3.5%

Notes: The most common responses of HELP Link participants is in bold. Employed, Worker Disability, ADA Disability, Homeless, and In School indicators came from the client table in MWorks. In the case of dual enrollment and Help-Link only, gender, date of birth, and race were taken from CHIMES. Data as of 06/30/16.

FIGURE 14. NUMBER OF HELP-LINK PARTICIPANTS AND SURVEY COMPLETERS BY COUNTY

County	Active Participants	Survey Completers	County	Active Participants	Survey Completers
BEAVERHEAD	4	42	MEAGHER	1	3
BIG HORN	8	37	MINERAL	1	14
BLAINE	0	11	MISSOULA	36	532
BROADWATER	2	7	MUSSELSHELL	1	10
CARBON	0	15	PARK	11	54
CASCADE	34	453	PHILLIPS	2	8
CHOUTEAU	1	5	PONDERA	0	4
CUSTER	3	49	POWELL	1	26
DAWSON	6	38	PRAIRIE	0	2
DEER LODGE	4	53	RAVALLI	40	228
FALLON	1	8	RICHLAND	6	55
FERGUS	2	34	ROOSEVELT	8	51
FLATHEAD	56	412	ROSEBUD	0	12
GALLATIN	26	194	SANDERS	18	54
GARFIELD	0	1	SHERIDAN	0	4
GLACIER	5	43	SILVER BOW	23	220
GRANITE	0	5	STILLWATER	1	21
HILL	15	117	SWEET GRASS	0	1
JEFFERSON	5	22	TETON	0	10
JUDITH BASIN	0	1	TOOLE	1	9
LAKE	47	183	TREASURE	0	1
LEWIS AND CLARK	29	232	VALLEY	4	34
LIBERTY	0	5	WHEATLAND	0	2
LINCOLN	32	144	WIBAUX	0	1
MCCONE	0	1	YELLOWSTONE	50	496
MADISON	0	12			

Notes: Data compiled on 06/30/16. Counties not listed do not have any active participants or survey completers.

FIGURE 15: SERVICES PROVIDED TO HELP-LINK ACTIVE PARTICIPANTS

SERVICE CATEGORY	COUNT
CAREER GUIDANCE	**110**
Career Assessment Inventory	1
Career Interest Inventory	3
Interest Profiler - Onet	3
Montana Career Information System Assessment and Profile	23
PEP- Personalized Employment Plan and Career Testing	3
JOB SEARCH SERVICES	**386**
Application Instructions & guidance including ATS	42
Assistance with job matching	60
Cover Letter Assistance	31
Interview Tips & Guidance	36
Job Development	10
Job Seeker Workshops	16
Resume Assistance	165
WORKFORCE INFORMATION SERVICES	**565**
Job Identification of high growth / high demand	15
Labor force supply and demand	112
Short and long term projections	10
INTENSIVE SERVICES	**565**
TOTAL ACTIVE PARTICIPANTS WITH A SERVICE[2]	**565**

[2] There are 317 (65%) active participants who have received both LMI and an intensive service in Montana Works.

RECOMMENDATIONS

The HELP Act Oversight Committee recognizes that it is early to make substantial recommendations regarding the program. Early data indicates that the program has been remarkably successful at decreasing the uninsured rate in Montana and increasing access to high quality health care, including preventive care, while saving the state taxpayers in programs previously serving the uninsured population. The Committee also acknowledges additional data will be necessary for a full evaluation of utilization trends and impacts to health care providers. With that in mind, the Committee offers the following recommendations to the governor, the Department of Public Health and Human Services, and legislative leaders. First and foremost, the Committee recommends the continuation of the HELP Act, while also offering insights on promising practices that may offer additional enhancements. The Committee does not believe additional legislation is necessary to pursue these recommendations. The Committee also recognizes the broad fiscal responsibilities of the state and DPHHS, and offers these recommendations under the assumption and hope that increased state spending will not be necessary to fulfill them.

- In the first seven months of the Montana HELP plan, more than 47,000 low-income Montanans have received affordable health coverage. While it is too early to determine the health impacts of the HELP plan in the population served, we recommend that both the health plan and the HELP-Link programs created by the HELP Act remain intact and continue. Over time, healthcare claims data and data from the HELP-Link workforce program will provide opportunities for data-based decision making leading to refinements which could result in improved health outcomes and greater workforce opportunities for HELP Plan participants.

- HELP Plan demographic data indicates that many newly eligible American Indians have yet to enroll in the HELP Plan. We recommend the Governor's Office of Indian Affairs, the Office of American Indian Health at the Montana Department of Public Health and Human Services and other relevant state government departments collaborate with private and nonprofit advocates and providers to develop and implement coordinated and expanded efforts to identify, educate and enroll eligible American Indians in the Montana HELP Plan.

- Understanding healthcare and health insurance is a challenge for many people regardless of age or income-level. So that newly enrolled individuals in the HELP Plan can become wise consumers of healthcare, we recommend that ample training, resources and support be available upon enrollment and re-enrollment. These efforts should be coordinated among the state, providers, healthcare advocates and experts, and potential private funders. Furthermore, as an additional data collection point, we recommend that HELP Plan participants be asked about their experience in the health insurance market so that education and training resources can be more effectively targeted.

- Montana HELP Plan participants, regardless of whether their benefits are administered through the third-party administrator or through the Department of Public Health and Human Services, should receive consistent materials, information and support, including but not limited to welcome packets and information on benefits, co-payments and premiums (if applicable) in clear, easy to understand terms for the participants. Furthermore, since traditional Medicaid benefits and benefits through the HELP Plan are largely the same, we recommend materials, information and support across both programs also be the same wherever possible.

- By October 2017, we recommend beginning analysis and evaluation of emergency department use to inform possible intervening practices and strategies, including but not limited to modifying the existing Medicaid Health Improvement Program to intervene in order to decrease inappropriate emergency department utilization.

- By October 2017, begin evaluating the effectiveness of premiums and copays in promoting personal responsibility in healthcare decision making and utilization.

- By October 2017, begin evaluating utilization trends, costs, and potential reforms or interventions related to areas of care such as mental health, chemical dependency, maternal health, and/or health disparities.

APPENDIX A: NATIVE AMERICAN MEDICAID ENROLLMENT BY COUNTY

Native American Medicaid Enrollment by County March 2016		
COUNTY	**Medicaid**	**HELP**
Beaverhead	45	8
Big Horn	3,396	537
Blaine	1,182	203
Broadwater	19	3
Carbon	22	7
Carter	1	0
Cascade	1,833	533
Chouteau	32	6
Custer	74	18
Daniels	22	4
Dawson	37	8
Deer Lodge	43	17
Fallon	6	1
Fergus	50	15
Flathead	358	123
Gallatin	246	61
Garfield	0	0
Glacier	3,482	802
Golden Valley	1	3
Granite	2	1
Hill	2,007	410
Jefferson	44	11
Judith Basin	1	2
Lake	3,006	665
Lewis And Clark	448	128
Liberty	6	0
Lincoln	54	28
Madison	14	0
Mccone	6	1

Meagher	3	1
Mineral	16	3
Missoula	1,145	327
Musselshell	51	8
Park	46	15
Petroleum	0	0
Phillips	214	38
Pondera	361	71
Powder River	2	0
Powell	11	11
Prairie	11	0
Ravalli	115	42
Richland	32	10
Roosevelt	2,817	519
Rosebud	1,564	265
Sanders	181	50
Sheridan	26	4
Silver Bow	292	118
Stillwater	23	4
Sweet Grass	9	1
Teton	19	2
Toole	28	11
Treasure	6	0
Valley	333	46
Wheatland	2	3
Wibaux	1	0
Yellowstone	2,880	603
Other	11	3
Grand Total	**26,636**	**5,750**

APPENDIX B: INITIAL FINANCIAL IMPACT AT BENEFIS HEALTH SYSTEMS

July 13, 2016

For our report to the Legislature, I have several other specific things I think the HELP Act Oversight Committee should know and I'm sure the Legislature would like to know too and that we should include in our first report. What the Committee will need from the State's large (PPS) Hospitals - and this should be easy information for each of those large hospitals (including BHS, of course) to provide is the following:

1. What is your year-to-date, 2016 percentage of "self-pay" (uninsured) patients compared to 2015 full year?
2. What is your year-to-date, 2016 charity care, in dollars and percentage, compared to 2015 full year?
3. What is your year-to-date, 2016 bad debt, in dollars and percentage, compared to 2015 full year?
4. One of the goals of Medicaid Expansion in Montana was to assure more Montanans are insured **and** less cost shifting occurs to the Commercially Insured. What is your year-to-date average mark-up to your commercially insured patients as a percentage of Medicare (250% of Medicare or whatever it is) compared to full year 2015, prior to Medicaid expansion?
5. What is your year-to-date 2016 operating margin compared to full year 2015?

Benefis Health System is on a calendar year fiscal year and we have just compiled our financial results for the 6 months ending June 30th. Our preliminary information, in regard to the questions above is as follows:

1. Uninsured at BHS reduced from 7.30% in 2015 to 3.66%, basically a 50% reduction in the uninsured. This percentage differs from the uninsured percentage in our service area due to this being based on dollars (vs individuals) and because it only includes the folks who came to BHS for service of course.
2. Charity care expense based on the first six months of 2016 would be $11,870,000 annualized, compared to $11,300,000 for 2015, so essentially unchanged. However, there would be some carry over from 2015 to early 2016 + more folks with commercial insurance now have high deductible plans and can't afford the deductible (and quality for charity care at BHS), so those factors also impact this number.
3. Bad debt was $36,000,000 in 2015 and annualized from the first 6 months of 2016 would be $20,360,000 – so a very major difference in bad debt experience. While bad debt reduction isn't fully attributable to Medicaid expansion, a large portion certainly would be.
4. We are completing negotiations with a major commercial insurer so we will answer this question once that is complete.
5. The BHS operating margin was 6.15% in 2015, but 2015 was an anomaly driven by unexpectedly high volumes. 2016, thru the first 6 months, is 4.6%, which is still better than our traditional average of 3 to 4% per year. While many factors impact upon our operating results, including our cost reduction efforts, Medicaid expansion and the reduction in our bad debt expense definitely play a factor.