HELP Act Oversight Committee

2018 Report to the Governor and Legislative Finance Committee

Submitted August 2018

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HELP Act Oversight Committee Summary Findings and Recommendations

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 96,000 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 creating jobs, growing Montana's economy, decreasing the uninsured rate in Montana and increasing access to high quality health care, including preventive care, while saving state taxpayer dollars.

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.
- Kris Hansen, Helena. Qualification: Representative of the State Auditor's Office. Hansen 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.
- Jessica Rhoades, Helena. Qualification: Member of the general public or staff member of the Governor's Office. Rhoades is the Governor's Health and Families Policy Advisor.
- Rep. Kirk Wagoner, Montana City. Qualification: A legislator appointed by the Speaker of the House. Wagoner is a business owner from Jefferson County.
- Sen. Bob Keenan, Bigfork. Qualification: A legislator appointed by the President of the Senate. Keenan is a businessman from Big Fork.
- Rep. Kim Abbott, Helena. Qualification: A legislator appointed by the House Minority Leader. Abbott is a community advocate in Helena.

- Sen. Mary Caferro, Helena. Qualification: A legislator appointed by the Senate Minority Leader. Caferro is The Arc Montana coordinator.

EX-OFFICIO, NON-VOTING MEMBERS

- Marie Matthews, Helena. Matthews is the DPHHS Medicaid Director.
- Galen Hollenbaugh, Helena. Hollenbaugh is the Commissioner of Montana Department of Labor and Industry.
- Senator Edward Buttrey, Great Falls. Buttrey is the bill sponsor and a state Senator from Great Falls.
- 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.

OVERVIEW

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 adults with incomes up to 138% of the federal poverty level (FPL). Recent studies by Manatt Health[1] and the Bureau of Business and Economic Research[2], commissioned by the Montana Healthcare Foundation, found that:

- More than **96,000** Montanans have enrolled in the bi-partisan plan to date, dropping the uninsured rate by half in less than three years. 65,000+ of these enrolled Montanans have accessed preventive care.
- Nearly **9 in 10** of Montana's HELP Act enrollees have incomes below the federal poverty level ($12,140 per year for a single individual in 2018, with $4,320 added for each additional person in the household).
- Nearly a quarter of enrollees are ages 50 to 64, slightly more than a quarter are 35 to 49, and almost half are 19 to 34.
- Approximately 1 in 6 new Medicaid enrollees is Native American.

[1] Medicaid Expansion: How It Affects Montana's State Budget, Economy, and Residents. June 2018. Prepared by Manatt Health for the Montana Healthcare Foundation. Accessed at: https://mthcf.org/wp-content/uploads/2018/06/Manatt-MedEx_FINAL_6.1.18.pdf.

[2] The Economic Impact of Medicaid Expansion in Montana. April 2018. University of Montana Bureau of Business and Economic Research, commissioned by the Montana Healthcare Foundation and the Headwaters Community Foundation. Accessed at https://mthcf.org/wp-content/uploads/2018/04/BBER-MT-Medicaid-Expansion-Report_4.11.18.pdf.

- Federal funding pays most of the costs, with **100%** funding in 2016 that phases down and levels off at **90%** in 2020 and thereafter. The HELP Act has resulted in **more than $58 million in state budget savings** to date, and will continue to save Montana money every year.
- **More than $47 million to date in new tax revenue** has been generated by the increased economic activity.
- Medicaid helps keep rural hospitals and health care providers open to preserve access for rural Montanans of all incomes and type of health plan coverage.
- Following the HELP Act, Montana hospitals have seen a 49% decrease in uncompensated care and Montana's community health centers have seen an increase of $11.7 million in Medicaid revenue.
- Montana's new Medicaid plan has created **5,000 new jobs each year since 2016**. These are healthcare jobs – which are among the highest paying in our state – as well as jobs in retail, trade, construction, services industry, real estate, and technology.
- The economic opportunity this funding brought to Montana has resulted in more than **$270 million in new income for Montanans** each year.
- Among adults with Medicaid coverage[3] in Montana:
  - More than **8 in 10** live in working families.
  - Nearly **7 in 10** are themselves working, ranking Montana in the top 10 for all states.
  - Of those not working, more than **1 in 3** are ill or disabled; the remainder reported that they were taking care of family or home, in school, or had another reason (e.g., were looking for work but could not find it).
- Following the HELP Act and the Montana Department of Labor's HELP-Link workforce development program, more low-income adults are joining the workforce in Montana. From 2015 to 2016, Montana has seen:
  - 9% increase in non-disabled adults working
  - 6% increase in people with disabilities working

While prior to the HELP Act, people with a disability so severe that they were unable to work for a year or more could access Medicaid after a two-year year waiting period as part of the Social Security Administration SSDI program, people with other disabilities as classified by the Americans with Disabilities Act were often not eligible for Medicaid. By offering low-income workers a path to Medicaid solely based on income, rather than having to prove disability, people with

[3] Understanding the Intersection of Medicaid and Work.

Rachel Garfield, Robin Rudowitz and Anthony Damico
Updated: Jan 05, 2018 | Published: Dec 07, 2017 Accessed at https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/

disabilities can now get health coverage without having to leave the workforce for a year to qualify.

MONTANA'S LABOR FORCE ENHANCEMENT COMPONENT: HELP-LINK

Montana's HELP Act created a bipartisan workforce promotion program for Medicaid enrollees that targets state resources toward reducing enrollees' barriers to work or increased their earnings. It matches people with opportunities and resources to help remove their specific barriers.

How HELP-Link Works:

- Enrollees complete an assessment to identify barriers and challenges to employment or greater earnings they are facing, be it limited skills and lack of access to transportation, child care, or other barriers.
- Job service staff analyze the assessment and reach out to people with an offer to match them with personalized services that can help remove the barriers they've identified. This might include job training, an assessment of high-demand fields, financial/credit counseling, child care referral, help with resumes and job searches, career counseling, on-the-job training programs, subsidized employment, or other services.

Montana's program is the only one in the U.S. that can show results. The Montana Bureau of Business and Economic Research (BBER)[4] found that since implementation of the HELP Act, more low-income adults are joining the workforce.

- 9% increase in non-disabled adults working
- 6% increase in people with disabilities working

As the New York Times Editorial Board wrote[5] of Montana's program:

> "And both state and federal health officials may have heard that at least one state has found a way to help Medicaid recipients secure decent jobs without threatening their health insurance. In 2015, Montana implemented a bipartisan, state-funded employment initiative that offers Medicaid recipients a range of services, including career counseling, on-the-job training and tuition assistance. The program is voluntary — people can sign up when they enroll in Medicaid — and it's paired with targeted outreach so that those who stand to benefit most from the program are aware of their options. So far, more than 22,000 Montanans have participated, and employment among nondisabled Medicaid recipients is up 9 percent in the state."

[4] The Economic Impact of Medicaid Expansion in Montana. April 2018. University of Montana Bureau of Business and Economic Research, commissioned by the Montana Healthcare Foundation and the Headwaters Community Foundation. Accessed at https://mthcf.org/wp-content/uploads/2018/04/BBER-MT-Medicaid-Expansion-Report_4.11.18.pdf

[5] New York Times: Do Poor People Have a Right to Health Care? By The Editorial Board. July 7, 2018. Accessed at https://www.nytimes.com/2018/07/07/opinion/sunday/do-poor-people-have-a-right-to-health-care.html

In addition to the increase in workforce participation, the BBER report found that Montana's Medicaid plan:

> "has a substantial effect on Montana's economy. Assuming that enrollment plateaus near current levels, Medicaid expansion will introduce approximately $350 million to $400 million of new spending to Montana's economy each year. This spending ripples through Montana's economy, generating approximately 5,000 jobs and $270 million in personal income in each year between 2018 and 2020. In addition to generating economic activity, Medicaid expansion appears to improve outcomes for Montanans—reducing crime, improving health, and lowering debt. While the state pays a nominal amount for these benefits, the costs to the state budget are more than offset by the savings created by Medicaid expansion and by the revenues associated with increased economic activity."

BBER also noted that:

> "The economic impacts of Medicaid expansion are not limited to the jobs and income it directly or indirectly supports. Medicaid expansion also represents a significant investment in Montanans' health and well-being, and these investments pay off. A substantial body of research from around the U.S. has evaluated the effects of Medicaid expansion and found that it:
>
> • **Improves health.** One study found that Medicaid expansion was associated with a 5.1 percentage point increase in the share of low-income adults in excellent health. This is consistent with a larger body of literature that finds that insurance expansions improve mental health and reduce mortality.
>
> • **Improves financial health.** For instance, one recent study found that Medicaid expansion reduced medical debt by $900 per treated person, prevented 50,000 bankruptcies, and led to better credit terms for borrowers.
>
> • **Reduces crime.** Medicaid expansion reduced crime by more than 3 %, generating social benefits of more than $10 billion-$13 billion annually.

INITIAL DATA NOW AVAILABLE FROM INDEPENDENT REPORTS

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 the development of the HELP Program is, in many ways, still in its infancy, with benefits and corresponding responsibilities beginning less than three years ago.

Assessing the impact of coverage on health is a complex and long-term undertaking: health effects may take a long time to appear, and are often realized decades later when people reach the stage in their lives when they are eligible for Medicare. Nonetheless, several new comprehensive independent studies have been completed since 2016 which have found significant benefits of the program, including new data on the positive impact on patients, providers, workers, and the economy, consistent with comprehensive studies conducted in states that expanded Medicaid prior to Montana.

Montana-specific findings:

- The Economic Impact of Medicaid Expansion in Montana. April 2018. University of Montana Bureau of Business and Economic Research, commissioned by the Montana Healthcare Foundation and the Headwaters Community Foundation. Accessed at https://mthcf.org/wp-content/uploads/2018/04/BBER-MT-Medicaid-Expansion-Report_4.11.18.pdf

- Promising Montana Program Offers Services to Help Medicaid Enrollees Succeed in the Workforce. Center on Budget and Policy Priorities. April 2018. Accessed at https://www.cbpp.org/research/health/promising-montana-program-offers-services-to-help-medicaid-enrollees-succeed-in-the

- Medicaid Expansion: How It Affects Montana's State Budget, Economy, and Residents. June 2018. Prepared by Manatt Health for the Montana Healthcare Foundation. Accessed at: https://mthcf.org/wp-content/uploads/2018/06/Manatt-MedEx_FINAL_6.1.18.pdf

- 2018 Report on Health Coverage and Montana's Uninsured. The Montana Healthcare Foundation commissioned this study of Montana's uninsured rate for 2018. Accessed at https://mthcf.org/wp-content/uploads/2018/06/Uninsured-Report_FINAL-Design_5.17.18.pdf

National Findings:

A substantial body of research has investigated effects of Medicaid expansion on coverage; access to care, utilization, affordability, and health outcomes; and various economic measures. This Kaiser Family Foundation has compiled 202 national, state, and multi-state studies and summarized findings from each.

See:

- The Effects of Medicaid Expansion: Updated Findings from a Literature Review. Kaiser Family Foundation Published March 28, 2018 https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-march-2018/

- Implications of the ACA Medicaid Expansion: A Look at the Data and Evidence Updated May 23, 2018 https://www.kff.org/medicaid/issue-brief/implications-of-the-aca-medicaid-expansion-a-look-at-the-data-and-evidence/

IMPACT ON NEW ENROLLEES

DEMOGRAPHIC DATA

As of June 30, 2018, 96,209 Montanans are enrolled in Medicaid through the HELP Act. Sixty percent of enrollees live outside the seven most populous counties in Montana.

Figure 1: HELP-Medicaid Enrolled by Federal Poverty Level

FPL	Income for single individual
0-50% FPL	$0-$6,070
51-100% FPL	$6,071-$12,140
101-138% FPL	$12,141 - $16,753

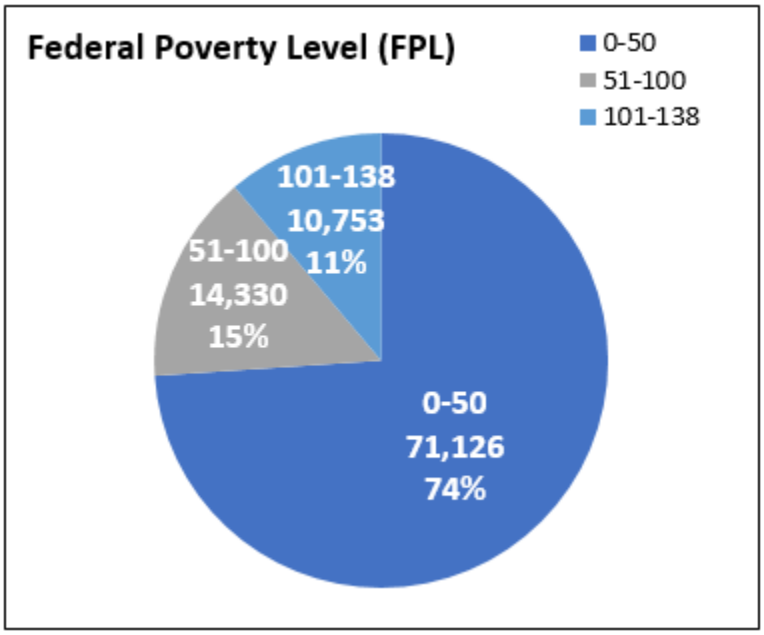


Figure 2: HELP-Medicaid Enrolled by Gender

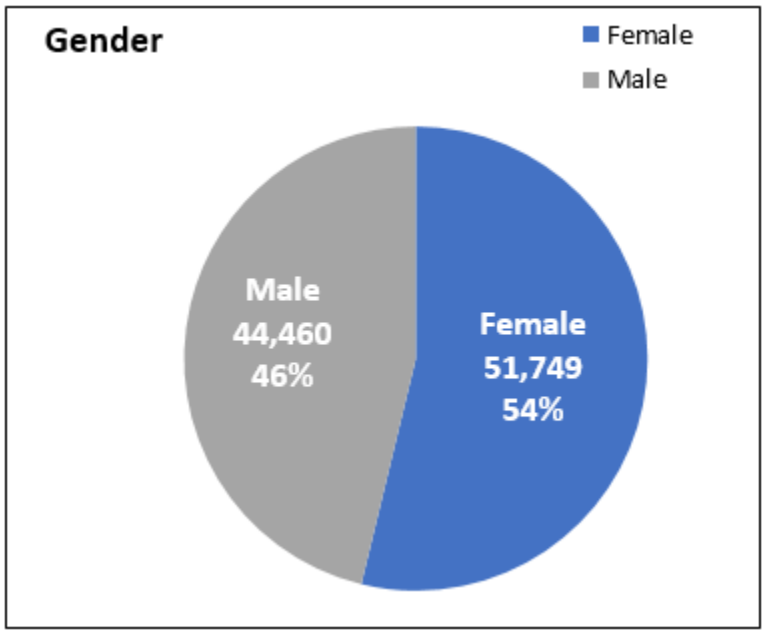


Figure 3: HELP Medicaid Enrolled by Age

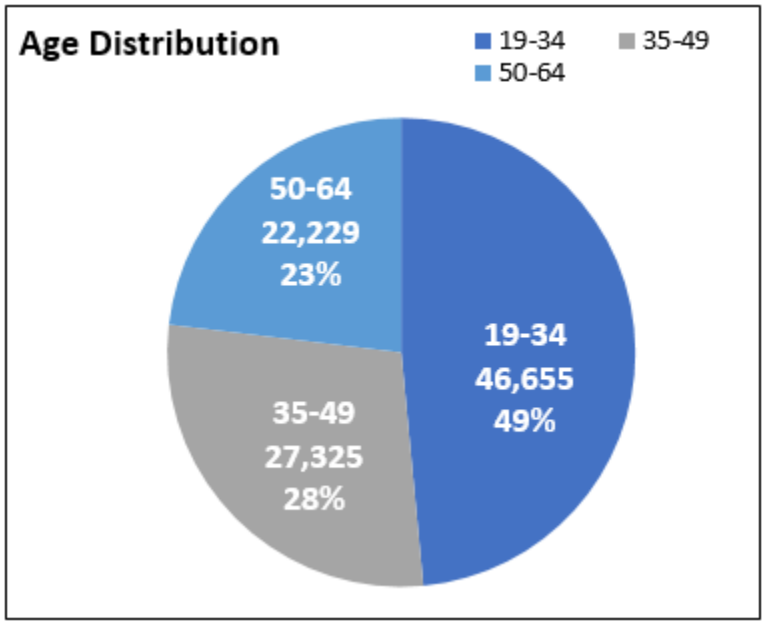


Figure 4: Enrollment by County

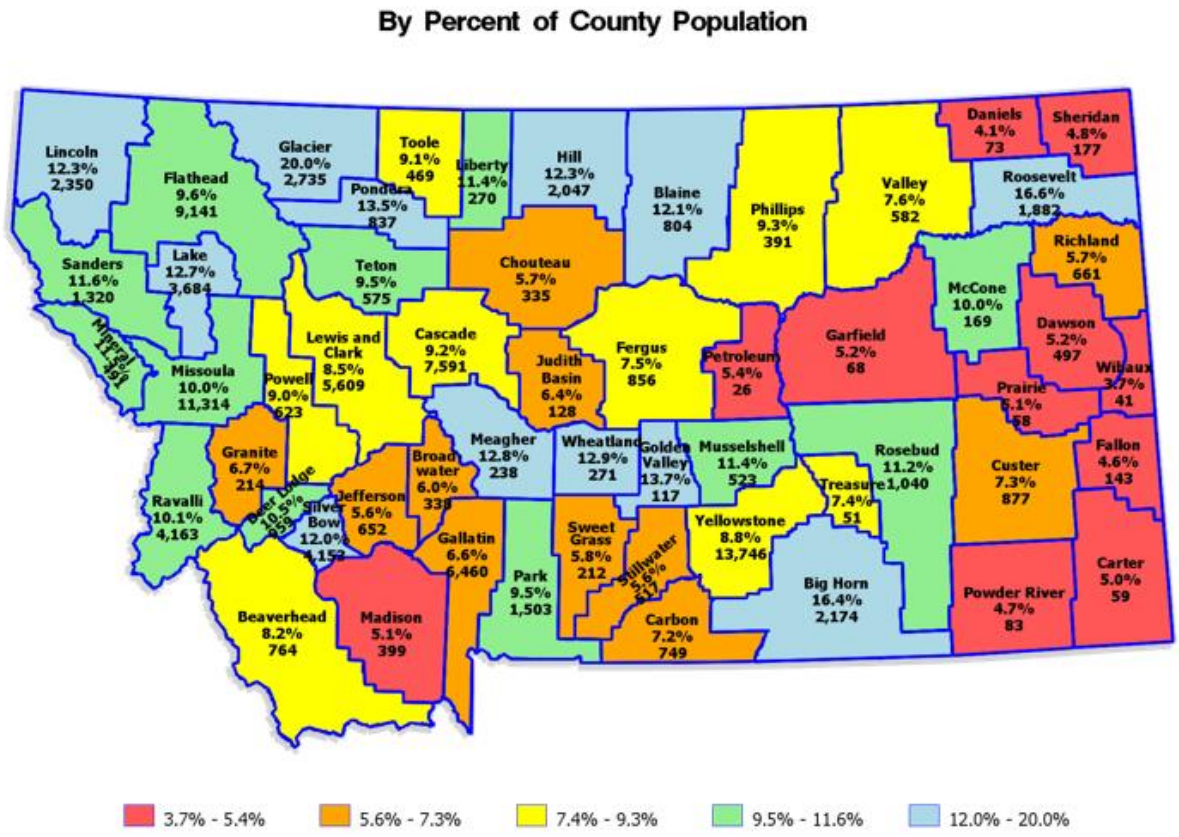
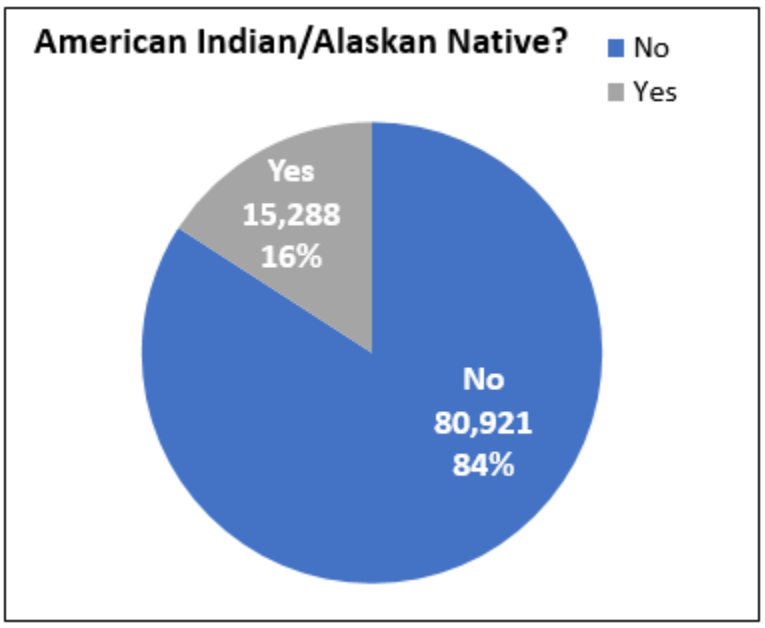


Figure 5: American Indian Medicaid Enrollment*



*See Appendix A for Native American Medicaid Enrollment by Major Reservation and Major Urban County.

NATIVE AMERICAN OUTREACH AND ENROLLMENT

Over the past two years, American Indian enrollment in Medicaid Expansion has increased by 9,541 enrollees. As of July 1, 2018, 15,288 American Indians were enrolled in Medicaid through the HELP Act. This represented 16% of the total number of Montanans enrolled, and a significant increase over 2016 Native enrollment. In Montana, the American Indian population makes up about 8% of Montana's 1 million residents. The 2016 HELP Oversight Committee report reported 5,747 American Indians enrolled, or 12% of total enrollment.

While initial enrollment numbers for tribal communities were small, over the past two years, the numbers for American Indians enrolling in Medicaid through the HELP Act have steadily increased each reporting period. This evidences the continued need for health coverage for the American Indian population in Montana. It is important to note that the Indian Health Service is not health insurance, nor does it include an established benefit package.

The largest enrollment increase of 400% has been in Rosebud County which encompasses the Northern Cheyenne Reservation (161 individuals on 3/2/16 to 804 individuals on 7/1/18). Enrollment figures in all other major reservation counties have doubled and tripled since the initial reporting period of Medicaid Expansion enrollment numbers. Major Urban Counties that include a large population of Native Americans show continued increase also.

American Indian Medicaid Expansion Enrollment	AI/AN #	AI/AN %
7/1/18 - Reporting Period	15,288	16%
7/15/16 - HELP Act Oversight Committee Report	5,747	12%
INCREASE OVER 2 YEAR PERIOD OF AI/AN ENROLLMENT	**9541**	

Tribes, Indian Health Service and Enrollment Organizations continue to work diligently in their communities and have found that differing approaches like meeting people where they are at are proving successful. That could mean an individual meeting at one's home or meeting at a restaurant. One-on-one engagement often is most effective for individuals who may not have ability to travel or feel comfortable attending a community outreach event.

The Department has executed agreements with four tribal communities Tribes that allow them to determine Medicaid eligibility for those they serve in their respective areas. The increased access from these partnerships has reached a new population of eligible American Indians. Those four tribes are Chippewa Cree, Confederated Salish and Kootenai Tribes,

Blackfeet and Fort Belknap Indian Community. As these four Tribes operate their own Tribal TANF programs, federal law allows these tribes to enter into these agreements with the Department, which supports these partnerships.

The Indian Health Service informed the Department during a visit in the spring of 2018 that the additional Medicaid expansion revenue has allowed it to increase their services to American Indians. Indian Health Service has a priority level system for their Purchased and Referred Care program and has now been able to move from a level 1 to a level 4 in all of the five service units they operate in Montana. Importantly, this change in priority levels means that American Indians now have greater access to preventative treatment (such as a colonoscopy) which can reduce the need to seek treatment later on for an advanced disease when the chance of survival is minimal. This is important if we are to change the fact that American Indians die 20 years younger than Whites in Montana.

HOW MONTANA ENROLLMENT COMPARES TO OTHER STATES

Montana is among 33 states including the District of Columbia that have elected to expand Medicaid. About 24.9% of Montanans are covered by all Medicaid and CHIP programs combined, which is consistent with the national average of 23.9%.[6] About half of these covered in Montana are children.

For comparison, the percentages of people in other states covered by Medicaid/CHIP include:

- Oregon: 24.7%
- Nevada: 21%
- Louisiana: 24%
- New Mexico: 26.7%

PREVENTIVE CARE

Far from just offering coverage, the HELP Program reformed the state's Medicaid plan, strengthening care delivery across the state and helping beneficiaries prevent health problems before they occur and prevent chronic conditions and other health problems from worsening.

As Manatt Health reports, over **65,000** covered adults accessed preventive services in CYs 2016-2017.[7]

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[6] MACPAC, 2017, analysis of the following: CMS, Office of the Actuary, 2017, e-mail to MACPAC, July 24; analysis of CMS, Office of the Actuary, 2017, e-mail to MACPAC, August 15; NHIS data; and U.S. Bureau of the Census, 2017, Monthly population estimates for the United States: April 1, 2010 to December 1, 2017, National totals: vintage 2016, https://www.census.gov/data/tables/2016/demo/popest/nation-total.html. Accessed at

https://www.macpac.gov/wp-content/uploads/2015/01/EXHIBIT-1.-Medicaid-and-CHIP-Enrollment-as-a-Percentage-of-the-US-Population-2016-millions.pdf

As of 6/30/18, enrollees have received over 20,310 vaccines, 22,869 wellness visits, and 108,280 preventive dental exams, suggesting that few low-income adults had access to dental care before 2016.

The top 10 Medicaid preventive services include[8]:

Preventive services	Number
Dental preventive	108,280
Cholesterol screening	34,062
Preventive or wellness exam	22,869
Vaccines	20,310
Diabetes screening	27,982
Colorectal cancer screening	34,062
Chlamydia screening	21,017
Cervical cancer screening	20,074
Gonorrhea screening	20,074
Abdominal aortic aneurysm screening	14,950

PREMIUMS, DISENROLLMENT AND TAX OFFSET

Montana's Medicaid plan requires "shared responsibility": all but the lowest income enrollees pay premiums for their coverage, and most have copayments for the services they use.

COST SHARE STRUCTURE

The HELP Act required Montana to adopt a copayment schedule that reflects the maximum copayment amount under law. Federal guidance in 42 CFR 447.52(b) allows states to impose cost sharing at levels at or below amounts listed in the table below, except as provided in 42 CFR 447.56(a) which includes, but is not limited to: emergency services, family planning services, and preventive services, provider-preventable diseases, pregnancy-related services, or a Native American eligible to receive, or who has received, services in the past at an Indian health care provider. Additionally, SB 405 required the state to waive copayment for generic drugs.

[8] Medicaid Expansion: How It Affects Montana's State Budget, Economy, and Residents. June 2018. Prepared by Manatt Health for the Montana Healthcare Foundation. Accessed at: https://mthcf.org/wp-content/uploads/2018/06/Manatt-MedEx_FINAL_6.1.18.pdf

Services	Individuals with family income ≤100% of the FPL	Individuals with family income 101-138% of the FPL
Outpatient Services (physician visit, physical therapy, etc.)	$4	10% of cost the agency pays
Inpatient Stay	$75	10% of total cost the agency pays for the entire stay

COST SHARE MAXIMUM LIMITS

Federal regulation requires that total cost share (including premiums) incurred by all individuals in a Medicaid household may not exceed an aggregate limit of 5% of the family's income applied on either a quarterly or monthly basis. Montana calculates the maximum out of pocket on a quarterly basis, see example below.

Category	Number of People in Household: 1		
	Annual Individual Income	Monthly Premium	Annual Out of Pocket Maximum (including premiums)
Individuals with income ≤100% of the FPL	Less than or equal to $12,140	Up to $20 per month	Up to $607
Individuals with income 101-138% of the FPL	Between $12,140 - $16,753	Between $21 - $28 per month	Between $607 - $838

The number of member characteristics, service types, and financial components, including the quarterly out of pocket maximum, create complexity around calculation of an individual's copayment, so that it cannot be estimated before claims adjudication. As such, providers are not permitted to collect copayment until after claim adjudication, as adopted in ARM 37.85.204(7).

PREMIUMS

- Enrollees with incomes at or above 50% FPL ($6,191 per year for an individual) are required to pay premiums equal to 2% of their income. Individuals with income above 100% FPL are dis-enrolled if they fail to pay the premium, and unpaid premiums for all enrollees are subtracted from future state tax refunds.
- On average, the Department currently bills approximately $400,000 in premiums monthly. To date, the Department has collected over $9 million in premiums, including those collected by tax offset. Because the federal government pays for most of the cost of this coverage, the state must remit the same share to the federal government that Montana receives.
- Montana was the first state to require premiums for people under the federal poverty level. Even under the new federal administration, Montana still charges the highest premiums in the nation to people who earn less than the federal poverty level – charging two to four times what the only two other states who assess premiums to such low-income people require. Iowa and Kentucky now have premiums for people at 50-100 % FPL – but at a fraction of the amount Montana must charge.[9]

The HELP Act encourages healthy behavior by exempting from disenrollment those who meet two of the 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

BENEFITS TO STATE BUDGET

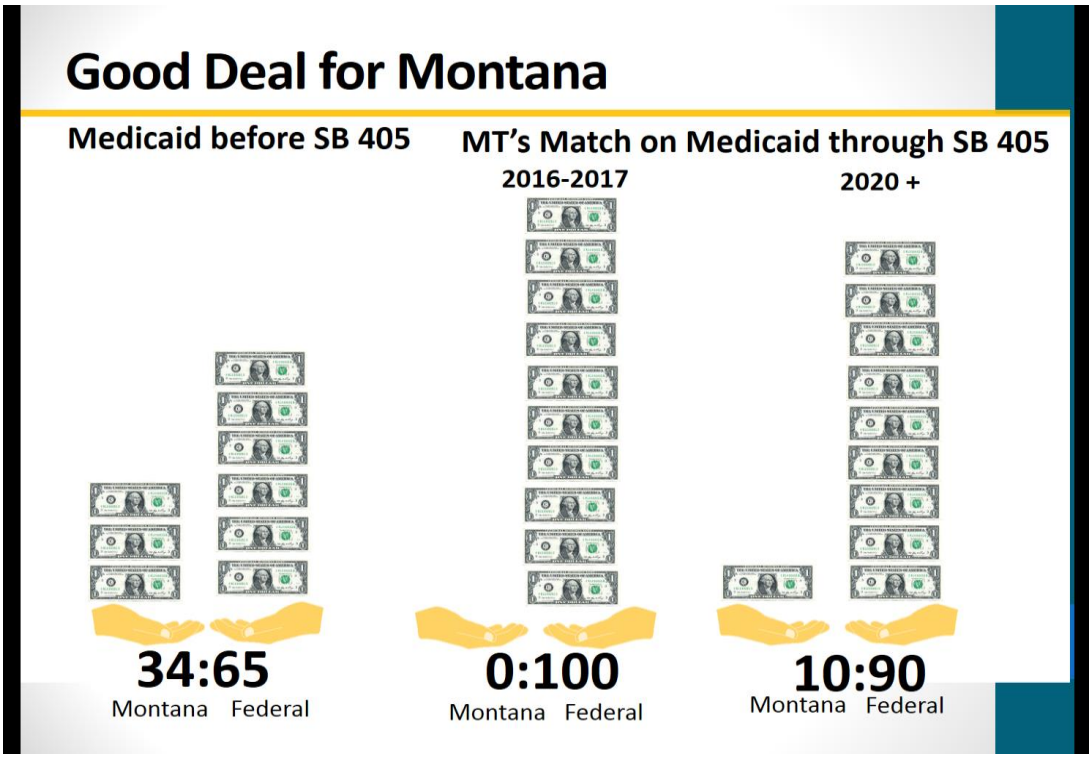
- Federal funding pays most of the costs, with **100%** funding in 2016 that phases down and levels off at **90%** in 2020 and thereafter.
- The HELP Act has resulted in more than $58 million in state budget savings, per Department analysis.
- More than $47 million to date in new tax revenue has been generated by the increased economic activity, found an analysis by BBER.

[9] Families USA: Waiver Elements, What's been approved? July 2018. Accessed at https://familiesusa.org/sites/default/files/documents/waiver_elements_approved.pdf

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 or while the percentage covered by federal funds is as high as possible.

In contrast, federal funding for medical services provided through other Medicaid programs is 65% - significantly less than the lowest Federal Medical Assistance Percentages (FMAP) for HELP Act enrollees.

Figure 8: Enhanced FMAP Schedule for Medicaid



IMPACT FOR PROVIDERS

The HELP Act has brought significant benefits to health care providers, including important rural community providers like community health centers and critical access hospitals, according to Manatt Health. Their report found that:

- The HELP Act has led to a decrease in uncompensated care costs for hospitals in Montana. For calendar year 2016 (the first year in operation), these costs fell by **$103 million** (44.9%) relative to calendar year 2015.
- For the 12-month period ending Sep. 2017, these costs fell by **$35 million** (-29.0%) relative to the 12-month period ending Sep. 2016.
- Net patient revenues from all sources increased by **$216 million** (11.6%) between 2016 and 2017, and hospital profitability increased.

The report notes that individual hospital experience varies based on a variety of factors. In some cases, some gains are offset by patients moving from other coverage to Medicaid, which typically pays less than commercial rates. Overall, however, it finds that Medicaid has helped keep hospitals open.

This finding is consistent with observations from other states. A recent study published in Health Affairs found that hospitals in Medicaid expansion states were about six times less likely to close than hospitals in non-expansion states. The authors also noted that Medicaid expansion was associated with improved hospital financial performance and substantially lower likelihoods of closure, especially in rural markets and counties with large numbers of uninsured adults before Medicaid expansion.[10]

For Montana's 17 community health centers, which are all recognized as Patient-Centered Medical Homes by the National Committee for Quality Assurance and play a key role in ensuring access to primary care throughout the state, the HELP Act has been critical. According to the same Manatt Health report, between 2015 and 2016, Medicaid revenues for these providers nearly doubled, from $12.2 million to $23.9 million (23 percent of all revenues). The number of Medicaid patients served also increased substantially, from 19,000 to more than 35,000 (33 percent of all patients). The number of uninsured patients decreased by a nearly equivalent amount.

Medicaid has provided financial stability at a time when health centers have been facing substantial uncertainty regarding federal funding. Continuing the stability of this Medicaid funding would enable health centers to provide Montana's local communities with additional mental health, substance use disorder, dental, and other high-demand services.

HELP Act and Provider Innovation: With the improved fiscal certainty derived from a more secure revenue source, FQHC's in Montana have been able to develop new models of care delivery. The examples of innovation are most noticeable in the move to integrate multiple service lines into a single experience for the patient, including primary care, behavioral health, oral health and substance abuse treatment. In the face of our nation's burgeoning opioid epidemic, the ability to provide integrated substance use disorder treatment—including medication-assisted treatment for opioid use disorder—represents an important evolution of our healthcare delivery model.

CONTINUED EFFORTS TO ELIMINATE FRAUD, WASTE, ABUSE; IMPROVE EFFICIENCY, AND REDUCE COSTS

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 coverage, 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 when needed. These include, but are not limited to, 27 different

[10] Understanding The Relationship Between Medicaid Expansions And Hospital Closures. Lindrooth, Perraillon, Hardy & Tung. January 2018. Health Affairs, Vol 37, N 1. https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2017.0976

interfaces for state and federal data systems, and hard copy documentation, as well as contacting other valid sources such as employers, other agencies, or landlords.

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 determined based on predictive modeling 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.
- Post-eligibility verification is conducted on applications that the state receives, between three and six months after submission. The state's business process is to conduct the post-eligibility verification at three months.
- In addition, Montana DPHHS contracts with Experian to provide remote, multi-factor identity proofing for the entire Medicaid, SNAP, and TANF population to confirm the identity of applicants before eligibly can be processed. In upcoming years, the Department will be increasing its capacity to electronically verify and normalize addresses, improving the ability to monitor members and providers.
- In June of 2016, the Montana Department of Labor & Industry contracted with LexisNexis to confirm unemployment insurance claimants' identities before processing their unemployment insurance claim, identify high risk claims, and allow for more accurate and efficient debt collection.

DPHHS has continued to invest in technology and process solutions to prevent and detect fraud and improper payments in the Medicaid program. Improper payments are defined by the Centers for Medicare and Medicaid (CMS) as "any payment that should not have been made or was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements or where documentation is missing or not available."

Ensuring that all active providers are properly credentialed and have no prohibitions on participating in the Medicaid program is a top priority of CMS. Over the past year, DPHHS completed provider re-validation for over 8,600 providers, but using a functional but inefficient solution. This summer, DPHHS has solicited and procured a modern provider management system, which will allow the re-validation process to be done more efficiently in the future. The implementation of this system in 2019 will enhance the screening and monitoring of all providers, thanks to its additional sources of data and real-time verification.

Effectively monitoring Medicaid activity at both provider and member level are a critical component of DPHHS program integrity efforts. Evaluations of claims data based on noticed anomalies, referrals and risk areas are continually completed by program officers and surveillance and utilization review staff. DPHHS is investing in tools that will improve the effectiveness and efficiency of this work. In 2017 DPHHS solicited and procured a data analytics reporting solution. The implementation of the enhanced data analytics reporting capabilities in

2019 will provide comprehensive reporting and analytics tool to improve the identification of potential fraud, waste, and abuse.

Third Party Liability (TPL)
The Human and Community Services and Quality Assurance Divisions lead the Department's efforts to identify third parties liable for payment of a Medicaid member's medical costs. Third parties include Medicare, private health insurance, auto accident policies and workers' compensation. Medicaid also recovers payments made for certain long term services from the estates of members who have passed away. This identification of third party liability resulted in avoidance of over $179 million in SFY 2015 and $165.4 million in SFY 2016.

Program and Payment Integrity Activities
Improper payments in Medicaid drain vital program dollars, impacting members and taxpayers. Such payments include those made for treatments or services not covered by program rules; that were not medically necessary; that were billed but never actually provided; or that have missing or insufficient documentation to show the claim was appropriate. Improper payments are most often the result of inadvertent errors due to clerical errors or a misunderstanding of program rules.

Medicaid also has programs to detect fraud and abuse. Fraud involves an intentional act to deceive for gain, while abuse typically involves actions that are inconsistent with acceptable business and medical practices. Medicaid's claim processing system, known as the Medicaid Management Information System (MMIS), has hundreds of edits that stop payment on many billing errors. However, no computer system can be programmed to prevent all potential Medicaid billing errors. Medicaid protects taxpayer dollars and the availability of Medicaid services to individuals and families in need by coordinating or cooperating with efforts to identify, recover and prevent inappropriate provider billings and payments.

Two state agencies share responsibility for protecting the integrity of the state Medicaid program. The DPHHS Quality Assurance Division is responsible for insuring proper payment and recovering misspent funds and the Attorney General's Medicaid Fraud Control Unit (MFCU) is responsible for investigating and ensuring prosecution of Medicaid fraud. At the federal level, both the CMS and the Office of Inspector General (OIG) of the Department of Health and Human Services oversee state program and payment integrity activities. Both CMS and OIG audit the state's Medicaid program on a regular basis.

The Medicaid program is also audited by two federal audit contractors. The Payment Error Rate Measurement (PERM) audit is conducted every three years. This is a comprehensive audit of claims payment and eligibility determination. The total overpayment identified for Montana in 2014 was $75,044. Montana's eligibility audit error rate was 0.4% compared to a national error rate of 3.3%. The fee-for-service payment error rate was 5.8%. This compares to a 10.6% error rate nationally. The second federal audit is the Recovery Audit Contractors (RAC), which is targeted to look at high risk and/or high cost services. In SFY 15, RAC recoveries totaled $485,113 and in SFY 16 the total was $871,480. The contractor receives 10% of recovered funds.

Actions resulting from the program and payment integrity efforts may include:

- Clarification and streamlining of Medicaid policies, rules and billing procedures

- Increased payment integrity, recovery of inappropriately billed payments and avoidance of future losses
- Education of providers regarding proper billing practices
- Termination of providers from participation in the Medicaid program
- Referrals to the Attorney General's Medicaid Fraud Control Unit (MFCU)

Montana Fraud Control Unit Investigations Outcomes Data for 2016 (the most recent available) Office of the Inspector General 2017 report:

- Investigations - 55
- Indicted/Charged - 7
- Convictions - 6
- Civil Settlements/Judgments - 13
- Recoveries - $1,593,763

Resources

- MFCU Expenditures - $679,021
- Staff on Board – 6

PENALTY FOR NON-PAYMENT OF PREMIUMS

The HELP Act requires disenrollment for non-payment of premiums. This disenrollment takes place every month. Individuals can be eligible for re-enrollment in the program if they have paid their debt in full or been assessed by the Department of Revenue.

HELP Dis-enrollments due to non-payment of premiums	
Calendar Year	**Count of Beneficiaries**
2016	3,024
2017	3,117
2018 (through 6/30)	936

APPLICATIONS DENIED

- Overall, on average the Department denies about 34% of the requests for health coverage. This amounts to denied coverage for around 90,000 applications from 2016 to present.

TAXPAYER INTEGRITY FEE

Federal law requires all states to base Medicaid eligibility on income, rather than the complex system based on health status, asset tests, and income disregards that was used in the past. Today, the tax income formula called "Modified Adjusted Gross Income" (MAGI) is consistent across states. This has simplified and improved the efficiency determining eligibility for Medicaid, so that more applicants can apply online and have their eligibility determined electronically and verified independently without submitting paper documents. However, SB 405 created a "taxpayer integrity fee" (TIF) to be assessed by the Department of Revenue if a taxpayer meeting certain criteria is participating in Medicaid.

TIF CRITERIA

The fee is $100 a month, plus an additional $4 a month for each $1,000 in assets above the following amounts:

- Primary residence and attached property of $250,000
- More than one light vehicle, and
- Cash and cash equivalent of $50,000

DEPARTMENT OF REVNUE TIF IDENTIFICATION AND SCREENING PROCESS

To identify individuals that may be subject to the taxpayer integrity fee, the Montana Department of Revenue uses state tax data to:

- match taxpayer households at or below the Medicaid eligibility threshold, 138% FPL, with Montana property tax records, using total appraisal value of each property based on its unique property number,
- examine the amount of interest income to determine who if anyone meets the $50,000 cash/cash equivalent threshold

Since vehicle ownership information cannot be provided by the Montana Department of Justice, the Department of Revenue assumes that everyone meets the threshold of owning more than one light vehicle.

Everyone who meets the criteria above receives notice of assessment of the taxpayer integrity fee or must verify whether or not they are enrolled in Medicaid and meet the three criteria outlined in SB 405.

HOW MANY INDIVIDUALS HAVE BEEN SUBJECT TO TIF?

To date, the Department of Revenue has identified and assessed four individuals found to have met these criteria, three through its data screening process and one individual who self-reported. Of these:

- Three individuals provided proof that they were not enrolled in Medicaid, so were not subject to the TIF.

- One individual who self-reported has been assessed and is currently in a payment plan. The total assessment was $2,298.

REFORM

TOBACCO PREVENTION

Smoking alone kills more people each year than alcohol, car crashes, illegal drugs, homicide and suicide combined. Tobacco hurts Montana financially too. Tobacco and related diseases kill 1,600 Montanans each year.

Tobacco costs Montanans more than $440 million in health care costs each year. Every Montana household now pays nearly $800 extra in taxes every year to help cover the costs of smoking. And smoking costs Montana businesses $370 million annually in lost productivity.

Medicaid has made several recent advancements in its tobacco cessation coverage.[11] These include removing barriers to smoking cessation coverage:

- No copayments for smoking cessation,
- Not requiring counseling along with smoking cessation medications, and
- No limit on lifetime quit attempts, recognizing that it typically takes many attempts to succeed at quitting.

Montana Medicaid covers five of the seven FDA-approved cessation medications (all except nicotine inhalers and nasal sprays). Medicaid also covers individual counseling, but like most states, does not cover group counseling.

The most common barriers to smoking cessation coverage include prior authorization requirements (with 39 states including Montana reporting this cost control for certain populations or plans).

DEPARTMENT MEMBER COMMUNICATIONS

Recognizing that health care coverage and eligibility is complicated and challenging for most individuals of all ages and income, the Department significantly overhauled and revised its communications to help make this complex topic more clear for its members. The Department streamlined and simplified its notices around eligibility, enrollment, premiums, disenrollment, and health promotion/prevention programs available to members. It worked with national experts in health communications writing to ensure the revised notices meet current best practices.

The Department also improved its connection with the enrollment assister community, which often connects face-to-face with Medicaid members and fills a critical role in consumer assistance across the state. The Department kept the assister community apprised of upcoming

[11] Center for Disease Control: State Medicaid Coverage for Tobacco Cessation Treatments and Barriers to Coverage — United States Accessed at https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6442a3.htm

notices and communications to ensure they could be best prepared to assist Medicaid members who presented with questions.

This is an ongoing process, and the Department continues to make changes to improve communications clarity and help members build their health literacy.

MEDICAID PAYMENT AND DELIVERY REFORM

Based on growing evidence that interventions that are targeted to specific patient populations, clinical areas, provider types, and community needs typically have a greater impact on quality improvement and cost containment than broader approaches, recent Montana Medicaid advances include working with providers to more finely calibrate payment and delivery reforms as follows:

COMPREHENSIVE PRIMARY CARE

Comprehensive Primary Care Plus (CPC+) is a national, advanced primary care medical home model demonstration that aims to strengthen primary care through a regionally based multi-payer payment reform and care delivery transformation. Montana Medicaid, Pacific Source, Blue Cross Blue Shield, and Allegiance were chosen to participate in the program in coordination with Medicare. States applying to participate had to demonstrate that a significant percentage of their adult population would be included in the demonstration. Without Medicaid, and the additional lives covered through the HELP Act, Montana would likely not have been selected because it would have failed to meet the threshold.

CPC+ includes two primary care practice tracts with incrementally advanced care delivery requirements and payment options to meet the diverse needs of primary care practices. The care delivery designs ensure practices in each track have the infrastructure to deliver better care that results in a healthier patient population. The multi-payer payment redesign gives practices greater financial resources and flexibility to make appropriate investments to improve the quality and efficiency of care, and reduce unnecessary health care utilization. CPC+ began on January 1, 2017, and provides practices with a robust learning system, as well as actionable patient-level cost and utilization data feedback, to guide their decision making. CPC+ providers must report patient level data back to the Department on specific quality measures to ensure patients are receiving appropriate preventive medical services based on national health recommendations.

As of June 30, 2018, 61,065 Medicaid members were seeing primary care providers participating in CPC+.

PATIENT CENTERED MEDICAL HOMES

The Patient Centered Medical Home (PCMH) model of care was implemented in December 2014 with five providers and is currently being expanded to add additional providers. PCMH is designed to provide Montana Medicaid members with a comprehensive coordinated approach to primary care where the member is put at the forefront of care. For each member enrolled in the PCMH, primary care providers receive reimbursement for providing enhanced services, reporting quality measures, and supporting comprehensive infrastructure. To be eligible

to participate in this program, providers must be a National Committee for Quality Assurance (NCQA) recognized PCMH provider, and cannot be participating in CPC+. As of June 30, 2018, there were 38,610 Medicaid members seeing primary care providers that belonged to one of these PCMHs.

COMPLEX CARE MANAGEMENT

Complex Care Management (CCM) is a new tier of PCMH model of care that will launch in August 2018. Recognizing that 5% of patients attribute to more than 50% of the healthcare costs—largely through high emergency room and inpatient hospital utilization—the CCM program is aimed at those five percent. The purpose of this program is to reduce high or preventable use of the emergency room and inpatient services for a specific population. This new tier is based on a model currently deployed by Partnership Health in Missoula. Members must meet certain enrollment criteria and the care team must work directly with members in their home. The care team includes a nurse, behavioral health professional and social worker with a maximum number of 30 members per care team. This approach allows more time for individual care with the member and the member's family to determine the member's need and assist in finding resources to meet these needs. Partnership currently has 18 Medicaid members enrolled and has seen a reduction of unnecessary emergency room visits and inpatient stays for this population. Medicaid expects the program to serve up to 210 members in its first year.

RECOMMENDATIONS FROM THE HELP OVERSIGHT COMMITTEE

The HELP Oversight Committee makes the following recommendations:

1. The committee recognizes the absolute importance of continuing Montana's bi-partisan Medicaid plan/the HELP Act in Montana, and recommends it be continued beyond its scheduled sunset date and recommends making sure that, one way or another, the state's budget has the money to fund the state's small share of the cost.

2. To date, more than 25,244 HELP participants have received or are currently receiving workforce services from the Department of Labor through HELP-Link, WIOA, and RESEA programs. We recommend continuing and strengthening HELP-Link funding in order to continue to provide participants with access to workforce training and assessment and assist them with removing barriers to employment and greater earnings.

3. Montana should continue and build upon its efforts to eliminate fraud, waste, and abuse. The departments administering the act should evaluate ways to make the programs more efficient and effective, including economies of scale or shared contracts where possible.

4. Montana should explore the use of health care claims, clinical data, and data from the Medicaid and HELP-Link workforce program to increase data-based decisions, leading to refinements which could result in improved health outcomes; reductions in unnecessary, fraudulent, duplicative and wasteful expenditures; and increased workforce opportunities for HELP Plan participants. Policymakers should pay particular attention to the impact of

policy changes on access to coverage, avoiding unnecessary barriers to enrollment that will negatively impact health outcomes and reduce access to coverage.

American Indians Enrolled in HELP Act (Medicaid Expansion)

for Major Reservation County Only

as of July 1, 2018

Contact: Lesa Evers, Tribal Relations Manager, Montana DPHHS, 406.444.1813, levers@mt.gov

Note: Each box below represents a reporting period.

Reservation	Major County	Other Reservation Counties not included	March 2, 2016 Enrolled HELP - All	March 2, 2016 Enrolled HELP - AI/AN		March 15, 2016 Enrolled HELP - All	March 15, 2016 Enrolled HELP - AI/AN		April 1, 2016 Enrolled HELP - All	April 1, 2016 Enrolled HELP - AI/AN		April 15, 2016 Enrolled HELP - All	April 15, 2016 Enrolled HELP - AI/AN	
Blackfeet	Glacier	Pondera	811	612	75.50%	977	678	69.40%	1032	719	69.67%	1089	761	69.88%
Crow	Big Horn	Yellowstone	494	354	71.70%	562	403	71.71%	610	437	71.64%	660	479	72.58%
Flathead	Lake	Sanders, Missoula, Flathead	1266	444	35.10%	1459	529	36.26%	1602	594	37.08%	1680	622	37.02%
Fort Belknap	Blaine	Phillips	248	146	58.90%	321	173	53.89%	337	176	52.23%	355	190	53.52%
Fort Peck	Roosevelt	Valley, Daniels, Sheridan	454	340	74.90%	517	390	75.44%	613	457	74.55%	655	486	74.20%
Northern Cheyenne	Rosebud	Big Horn (*included in Crow #s)	245	161	65.70%	283	186	65.72%	307	201	65.47%	326	214	65.64%
Rocky Boy's	Hill	Chouteau	687	312	45.40%	778	342	43.96%	909	398	44.08%	928	402	43.32%
			All Enrolled in HELP		32,832	All Enrolled in HELP		38,298	All Enrolled in HELP		42,166	All Enrolled in HELP		44,144
			AI/AN in HELP = 4003 or 12.2%			AI/AN in HELP = 4597 or 12%			AI/AN in HELP = 5100 or 12%			AI/AN in HELP = 5384 or 12%		

Reservation	Major County	Other Reservation Counties not included	May 1, 2016 Enrolled HELP - All	May 1, 2016 Enrolled HELP - AI/AN		May 15, 2016 Enrolled HELP - All	May 15, 2016 Enrolled HELP - AI/AN		July 1, 2016 Enrolled HELP - All	July 1, 2016 Enrolled HELP - AI/AN		August 1, 2016 Enrolled HELP - All	August 1, 2016 Enrolled HELP - AI/AN	
Blackfeet	Glacier	Pondera	1130	784	69.38%	1148	802	69.86%	1113	758	68.10%	1174	801	68.23%
Crow	Big Horn	Yellowstone	696	506	72.70%	737	537	72.86%	797	594	74.53%	868	655	75.46%
Flathead	Lake	Sanders, Missoula, Flathead	1742	642	36.85%	1805	665	36.84%	1833	684	37.32%	1959	738	37.67%
Fort Belknap	Blaine	Phillips	377	198	52.52%	392	203	51.79%	375	193	51.47%	418	229	54.78%
Fort Peck	Roosevelt	Valley, Daniels, Sheridan	701	516	73.61%	714	519	72.69%	702	514	73.22%	767	567	73.92%
Northern Cheyenne	Rosebud	Big Horn (*included in Crow #s)	366	248	67.76%	383	265	69.19%	400	272	68.00%	431	292	67.75%
Rocky Boy's	Hill	Chouteau	964	405	42.01%	984	410	41.67%	977	384	39.30%	1035	422	40.77%
			All Enrolled in HELP		45,799	All Enrolled in HELP		46,979	All Enrolled in HELP		47,399	All Enrolled in HELP		50,211
			AI/AN in HELP = 5618 or 12%			AI/AN in HELP = 5750 or 12%			AI/AN in HELP = 5747 or 12%			AI/AN in HELP = 6252 or 12%		

Reservation	Major County	Other Reservation Counties not included	August 15, 2016 Enrolled HELP - All	August 15, 2016 Enrolled HELP - AI/AN		September 1, 2016 Enrolled HELP - All	September 1, 2016 Enrolled HELP - AI/AN		November 15, 2016 Enrolled HELP - All	November 15, 2016 Enrolled HELP - AI/AN		January 1, 2017 Enrolled HELP - All	January 1, 2017 Enrolled HELP - AI/AN	
Blackfeet	Glacier	Pondera	1202	823	68.47%	1272	878	69.03%	1541	1093	70.93%	1744	1252	71.79%
Crow	Big Horn	Yellowstone	884	668	75.57%	917	694	75.68%	1076	838	77.88%	1228	961	78.26%
Flathead	Lake	Sanders, Missoula, Flathead	1985	746	37.58%	2081	759	37.37%	2397	925	38.59%	2639	1028	38.95%
Fort Belknap	Blaine	Phillips	430	238	55.35%	444	250	56.31%	510	301	59.02%	565	339	60.00%
Fort Peck	Roosevelt	Valley, Daniels, Sheridan	796	587	73.74%	850	630	74.12%	1040	812	78.08%	1175	923	78.55%
Northern Cheyenne	Rosebud	Big Horn (*included in Crow #s)	432	293	67.82%	454	307	67.62%	564	386	68.44%	640	446	69.69%
Rocky Boy's	Hill	Chouteau	1062	437	41.15%	1100	460	41.82%	1327	573	43.18%	1460	651	44.59%
			All Enrolled in HELP		51,330	All Enrolled in HELP		52,817	All Enrolled in HELP		61,233	All Enrolled in HELP		67,515
			AI/AN in HELP = 6435 or 13%			AI/AN in HELP = 6737 or 13%			AI/AN in HELP = 8299 or 14%			AI/AN in HELP = 9337 or 14%		

American Indians Enrolled in HELP Act (Medicaid Expansion)

for Major Reservation County Only

as of July 1, 2018

Contact: Lesa Evers, Tribal Relations Manager, Montana DPHHS, 406.444.1813, levers@mt.gov

Note: Each box below represents a reporting period.

Reservation	Major County	Other Reservation Counties not included	February 1, 2017 Enrolled HELP - All	Enrolled HELP - AI/AN		May 1, 2017 Enrolled HELP - All	Enrolled HELP - AI/AN		July 15, 2017 Enrolled HELP - All	Enrolled HELP - AI/AN		September 15, 2017 Enrolled HELP - All	Enrolled HELP - AI/AN	
Blackfeet	Glacier	Pondera	1827	1326	72.58%	2024	1477	72.97%	2182	1627	74.56%	2301	1729	75.14%
Crow	Big Horn	Yellowstone	1332	1052	78.98%	1575	1265	80.32%	1735	1410	81.29%	1813	1476	81.41%
Flathead	Lake	Sanders, Missoula, Flathead	2735	1058	38.68%	2878	1151	39.99%	3092	1263	40.85%	3235	1319	40.77%
Fort Belknap	Blaine	Phillips	596	358	60.07%	656	396	60.37%	708	416	58.76%	733	438	59.75%
Fort Peck	Roosevelt	Valley, Daniels, Sheridan	1260	993	78.81%	1445	1150	79.58%	1586	1273	80.26%	1670	1352	80.96%
Northern Cheyenne	Rosebud	Big Horn (*included in Crow #s)	677	473	69.87%	788	570	72.34%	863	639	74.04%	898	672	74.83%
Rocky Boy's	Hill	Chouteau	1530	690	45.10%	1688	780	46.21%	1788	847	47.37%	1829	878	48.00%
			All Enrolled in HELP		71,002	All Enrolled in HELP		77,154	All Enrolled in HELP		80,806	All Enrolled in HELP		83,882
			AI/AN in HELP = 9916 or 14%			AI/AN in HELP = 11,228 or 15%			AI/AN in HELP = 12,276 or 15%			AI/AN in HELP = 12,927 or 15%		

Reservation	Major County	Other Reservation Counties not included	January 15, 2018 Enrolled HELP - All	Enrolled HELP - AI/AN		March 1, 2018 Enrolled HELP - All	Enrolled HELP - AI/AN		May 15, 2018 Enrolled HELP - All	Enrolled HELP - AI/AN		July 1, 2018 Enrolled HELP - All	Enrolled HELP - AI/AN	
Blackfeet	Glacier	Pondera	2571	1927	74.95%	2628	1968	74.89%	2,693	2,029	75.34%	2,735	2,056	75.17%
Crow	Big Horn	Yellowstone	1966	1606	81.69%	2042	1669	81.73%	2,127	1,746	82.09%	2,174	1,795	82.57%
Flathead	Lake	Sanders, Missoula, Flathead	3462	1430	41.31%	3591	1491	41.52%	3,676	1,553	42.25%	3,684	1,590	43.16%
Fort Belknap	Blaine	Phillips	791	493	62.33%	807	499	61.83%	806	507	62.90%	804	514	63.93%
Fort Peck	Roosevelt	Valley, Daniels, Sheridan	1811	1473	81.34%	1852	1513	81.70%	1,874	1,542	82.28%	1,882	1,537	81.67%
Northern Cheyenne	Rosebud	Big Horn (*included in Crow #s)	968	742	76.65%	1020	781	76.57%	1,056	814	77.08%	1,040	804	77.31%
Rocky Boy's	Hill	Chouteau	1995	971	48.67%	2031	984	48.45%	2,052	1000	48.73%	2,047	987	48.22%
			All Enrolled in HELP		91,563	All Enrolled in HELP		93,950	All Enrolled in HELP		96,302	All Enrolled in HELP		96,209
			AI/AN in HELP = 14,259 or 16%			AI/AN in HELP = 14,701 or 16%			AI/AN in HELP = 15,213 or 16%			AI/AN in HELP = 15,288 or 16%		

American Indians Enrolled in HELP Act (Medicaid Expansion)

for Major Urban County Only

as of July 1, 2018

Contact: Lesa Evers, Tribal Relations Manager, Montana DPHHS, 406.444.1813, levers@mt.gov

Note: Each box below represents a reporting period.

City	Major County	July 1, 2018 Enrolled HELP - All	Enrolled HELP - AI/AN	
Billings	Yellowstone	13,746	1,767	12.85%
Butte	Silver Bow	4,153	271	6.53%
Great Falls	Cascade	7,591	1,236	16.28%
Helena	Lewis & Clark	5,609	373	6.65%
Missoula	Missoula	11,314	816	7.21%
		All Enrolled in HELP		96,209
		AI/AN in HELP = 15,288 or 16%		